

Working with Married Youth: A Curriculum for Peer Educators



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Overview: Working with Married Youth

Demographic research has shown that up to three-fifths of women age 15 to 19 years in South Asia and sub-Saharan Africa are married.¹ Marriage commonly marks the point in a woman's life when childbearing becomes socially acceptable, and in some cultures, women face extreme pressure to demonstrate their fertility soon afterwards.² Early marriage is, therefore, a strong determinant of early childbearing with its associated risks. Each society may have a different definition of early marriage and in some cases it can be under 18 years of age, even if laws are in place to set legal limits.

It is critical to recognize that gender roles and norms significantly influence the marital status of young people. Traditions and cultural expectations for both girls and boys often push them to be married before they are physically or emotionally prepared. Despite the fact that both boys and girls are subjected to early marriages, it is most often girls who are married at young ages.

In many developing country settings, marriage brings radical change to an adolescent woman's life. Her marriage will often prescribe where she lives, with whom she is permitted to associate, and what happens to her sexually, physically, and emotionally. Pregnancy and motherhood commonly cut short a young woman's education, thereby undermining personal development, economic prospects, employment opportunities, and social networks.

The misconception persists that once women are married, they are protected from STIs and HIV. In some societies, this belief is a reason for encouraging girls to marry at very young ages.³ However, early marriage often exposes women to unprotected sexual activity with partners who are often older men, and who by virtue of their age, have a greater chance of being infected with STIs and/or HIV.⁴ Additionally, when women marry men who are much older than they are, they are at even greater risk because there is a sizeable inequality in power. Research in sub-Saharan Africa has found that married adolescent women have higher rates of HIV than their unmarried, sexually-active peers.⁵ A review of research on forced sexual relations among young married women in developing countries also found that between 3% and 23% of women age 15 to 24 had engaged in non-consensual sex with a current or former spouse, and that women who marry in adolescence are more likely to experience sexual violence than women who marry later.⁶

¹ Measure DHS. Survey indicators.

² Mathur, S., et al. 2003. A. Too young to wed: The lives, rights, and health of young married girls. Washington, DC: International Center for Research on Women.

³ Chowdhury, F. D. 2004. The socio-cultural context of child marriage in a Bangladeshi village. *International Journal of Social Welfare* 13: 244-253

⁴ Bruce, J. & Clark, S. 2004. The implications of early marriage for HIV/AIDS policy, Brief based on background paper prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents. New York: Population Council.

⁵ Clark, S. 2004. Early marriage and HIV risks in sub-Saharan Africa. Harris School Working Paper Series No. 04.06. Chicago: University of Chicago.

⁶ Population Council. 2004. Forced sexual relations among married young women in developing countries. New Delhi, India.

Research has also revealed that married adolescent girls have more limited support systems and social networks, less freedom of mobility, and less exposure to information and media than both their unmarried counterparts and older married women. They also have less schooling than unmarried girls, and less decision-making power in their households than older married women.^{7,8,9} Since married women are often restricted to their homes, it is difficult to reach them alone, away from the pressure of family members. As a consequence, married adolescent women are at a distinct disadvantage in accessing critical health information and services, even from their peers.

Young married men are also affected by a lack of health-care information and services. A comprehensive report on men's reproductive health in 23 countries revealed a high unmet need for family-planning services, HIV testing, and STI treatment.¹⁰ Some men infected with STIs reported that they tried to treat themselves, or sought care from traditional healers, because they were more affordable, more respectful, and less judgmental than healthcare workers. Many married men expressed the desire to plan the timing of births or to not have any more children, but a significant proportion were not protected by a modern method of contraception. Educating men to practice safer sexual behaviors, coupled with an expanded scope of available services, can positively impact men, their partners, and their children.

Despite the urgent need for reproductive health information and services for married adolescents, few programs exist for this population.¹¹ Most adolescent health interventions target unmarried youth. They often emphasize abstinence and rarely include discussion of antenatal and obstetric care or parent to child transmission of HIV. Programs are also commonly conducted in schools or youth centers, places not usually frequented by married couples. In the absence of targeted interventions, married adolescents are frequently excluded by default.

This curriculum is for trainers who want to train peer educators to provide information, support, and services to young married men and women by understanding their reproductive health needs and the influences in their lives.

This curriculum was written with the assumption that the program is working with married youth and they are young people under the age of 24.

⁷ Haberland, N. et al. 2004. A world apart: The disadvantage and social isolation of married adolescent girls, Brief based on background paper prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents. New York: Population Council.

⁸ Amin, S. et al. 2002. Baseline survey report on rural adolescents in Bangladesh. Dhaka: Ministry of Women's Affairs, Government of Bangladesh.

⁹ Santhya, K. et al. 2003. The gendered experience of married adolescent girls in India: Baseline findings from the First Time Parents project. Paper presented at the Second Asia and Pacific Conference on Reproductive and Sexual Health, Bangkok, October 6-10, 2003.

¹⁰ Alan Guttmacher Institute. 2002. In their own right: Addressing the sexual and reproductive health needs of men worldwide. New York, NY.

¹¹ Bruce, J. 2001. Married adolescent girls: Human rights, health and developmental needs of a neglected majority. Briefing for the UNICEF Working Group on Girls, Steering Committee, New York, 6 September, 2001.

About the Curriculum

Who is this curriculum for?

This curriculum is for trainers who want to work with peer educators to reach out to young married men and women. It was created to train peer educators on how to provide information, support, and services to young married men and women by understanding their reproductive health needs and the issues that influence their lives. The training will also help peer educators to reach out to community members and help them create a supportive environment that meets the reproductive health needs of young married couples.

How was this curriculum developed?

This curriculum is a compilation of activities adapted from several curricula EngenderHealth has developed over the years in order to meet the needs of youth, including EngenderHealth's Men As Partners (MAP) Curricula, the Youth-Friendly Services Curriculum, and curricula developed for community-based participatory reproductive health projects in Nepal.

How should this curriculum be used?

Before beginning the training, it is important that the facilitator and/or trainer read the entire curriculum to understand how it is organized and what it contains.

Many of the activities complement each other. Past experience has shown that it is most effective to use the complete set of activities (or select a group of activities from each section), rather than facilitating one or two alone. When the majority of the activities are completed with a group, it is more likely to produce richer and more rewarding reflections than if implemented alone. The majority of the activities are participatory and are most effective when carried out in small groups with no more than 20 people.

What is included in this curriculum?

Below, you will find a number of sample agendas with a range of activities for trainers to use as they plan for training. Depending on the amount of time that is set aside for the training, the sessions outlined in the agenda can be conducted over several consecutive days or spread out over a longer period of time. You need to decide what is most appropriate for your program and its participants.

Sections 1-10 cover a variety of topics that will help peer educators understand the reproductive health needs of young married men and women and the issues that might affect young married men and women from meeting these needs.

An additional resource for trainers is a description of the Ecological model which is included in the Appendix. The information about the Ecological model can be read and used to help the trainer consider how to encourage peer educators to think about community wide education, action and impact.

NOTE

It is critical that you adapt the curriculum for local use and to fit the needs of the married youth with whom you are working before implementing the training.

This curriculum may also be adapted for use with low-literacy audiences. Some suggestions to do so are mentioned throughout the curriculum. Other modifications can be made to activities to include more visual and hands-on work, including role-plays, pictures, and other visual media.

What information is included for each activity?

The curriculum presents information for each activity in a standardized format. Each activity may include some, but not necessarily all, of the following:

- Objectives of the activity
- Time required for the activity
- Materials and advance preparation needed for the activity
- Steps for implementing the activity
- Facilitator's Notes on how to implement the activity most effectively
- Handouts that may be given out during the activity
- Trainer's Resource sheets to be referred to during the activity
- Examples of teaching aids such as case studies that may be used during the activity

Each of these elements is discussed in more detail below:

Objectives

This section describes what participants will take away from the activity. It is a good idea to begin each activity by describing its learning objectives, so participants understand why they are doing it and what they can hope to get out of it. In order to review what has been covered, repeat the learning objectives at the end of each day.

Time

This indicates how long the activity should take based on past experience, though length of time can vary depending on the number of participants and other factors. The activities in the curriculum are designed to take between 30 and 90 minutes; in some cases a time range is provided. It is most important to work at the pace of the participants. In general, sessions should not be longer than two hours. It is also important to remember that most agendas for a workshop are full ones. Spending too long on one activity may mean you do not have time for others. Try to stick to the time suggested.

Materials

These are the materials you will need and should prepare before the workshop begins. For the most part, they are comprised of basic materials, such as flipchart paper and markers. If the materials cannot be easily accessed, feel free to improvise. For example, flipchart and markers can be substituted with chalkboard and chalk.

Advance Preparation

These are the preparations that need to be made before the activity is implemented.

Steps

These are the steps you should take to perform the activity well. The numbered instructions should be followed in order. For the most part, the activities can be easily adapted to groups with different reading and writing levels but be attentive to whether the steps are feasible and appropriate. For example, if the procedure calls for participants to read a text, yet many of the participants cannot read, you can read it aloud instead.

The steps will often include questions to help guide the discussion on the activity topic. Feel free to add to them or to rephrase them to fit the local context. It is not necessary for the group to discuss all of the suggested questions or that you adhere strictly to the order in which they are listed. Rather, focus on encouraging as many participants as possible to express their opinions. It is important to be patient, since some participants may be shy in the beginning or may not feel comfortable discussing these subjects with each other. Never force anybody to speak.

Facilitator's Notes

These notes will help you to facilitate the activity better. They point out important aspects of the process and provide background information and tips to help you prepare. Make sure you have read these notes before you begin.

Handouts

Some activities have handouts. These are included after each activity. The handouts include information for participants to take away with them or for you to review with them. If possible, make enough copies of handouts for all participants. Another option is to write the information on flipchart paper for the participants to refer to during the activity.

Trainer's Resource Sheets

This is additional information for the facilitator to review when preparing an activity. Not all activities will have resource sheets.

Teaching Aids

Some activities include examples of a diagram or chart for use during the activity. Other activities may include case studies, which are based on real life experiences of peer educators who have worked on a married youth program. These case studies are included to help participants understand some of the challenges and successes that come with this work.

Sample Agendas

The following are sample training agendas. They should be modified according to the needs of your program and knowledge level of your participants. For example, if your participants are well-versed in family planning, but need more knowledge and skills-building in the area of maternal health, you can remove the family-planning sessions from your agenda and add more activities related to maternal health. You can also shorten or lengthen the sessions to better fit your needs and schedule.

As discussed earlier, these sessions can be conducted over several consecutive days or over a longer period of time, depending on your programmatic context and the time availability of participants and facilitators. If you choose to schedule the sessions over time, it is important to not let too much time elapse between them. At least one session per week is ideal.

Sample Agenda: Two Days or 14 Sessions

8:30 – 9:00	Welcome and Ground Rules
9:00 – 9:30	Participant Introductions
9:30 – 9:45	What is a Peer Educator?
9:45 – 10:00	TEA BREAK
10:00 – 11:00	Working With Married Youth: Case Studies
11:00 – 11:30	Gender and Sex
11:30 – 12:15	Reproductive Health Needs of Married Youth
12:15 – 1:15	LUNCH
1:15 – 2:30	The Importance of Delaying First Birth and Using Family Planning
2:30 – 3:45	Understanding and Ensuring Safe Motherhood
3:45 – 4:00	TEA BREAK
4:00 – 4:30	Reaching Married Youth and Influential Adults
4:30 – 5:15	Developing an Action Plan
5:15 – 5:30	Wrap-up and Reflection

Sample Agenda: Two Days or 18 Sessions

DAY ONE

8:30 – 9:00	Welcome and Ground Rules
9:00 – 9:30	Participant Introductions
9:30 – 9:45	What is a Peer Educator?
9:45 – 10:45	Working with Married Youth: Case Studies
10:45 – 11:00	TEA BREAK
11:00 – 11:45	The Problem Tree
11:45 – 12:15	Gender and Sex
12:15 – 1:00	Defining Reproductive Health
1:00 – 2:00	LUNCH
2:00 – 3:00	Reproductive Health Needs of Married Youth
3:00 – 3:15	TEA BREAK
3:15 – 4:30	The Importance of Delaying First Birth and Using Family Planning
4:30 – 5:00	Men's Role in HIV Prevention
5:00 – 5:15	Wrap-up (Complete a daily wrap-up, using the final activity on page 121. You can modify the question each day.)

DAY TWO

8:30 – 8:45	Warm-up and review of Day One
8:45 – 10:00	Practicing Communication Skills
10:00 – 10:15	TEA BREAK
10:15 – 11:30	Understanding and Ensuring Safe Motherhood
11:30 – 12:15	Finding the Gaps in HIV Knowledge
12:15 – 1:15	LUNCH
1:15 – 2:00	Types of Violence and Abuse
2:00 – 2:30	Reaching Married Youth and Influential Adults
2:30 – 3:00	Types of Peer Education Activities
3:00 – 3:15	TEA BREAK
3:15 – 4:15	Practicing Peer Education
4:15 – 5:00	Developing an Action Plan
5:00 – 5:15	Wrap-up and Reflection

Sample Agenda: Three Days or 26 Sessions

DAY ONE

8:30 – 9:00	Welcome and Ground Rules
9:00 – 9:30	Participant Introductions
9:30 – 9:45	What is a Peer Educator?
9:45 – 10:45	Working with Married Youth: Case Studies
10:45 – 11:00	TEA BREAK
11:00 – 11:45	The Problem Tree
11:45 – 12:15	Gender & Sex
12:15 – 1:15	LUNCH
1:15 – 2:15	Gender Fishbowl
2:15 – 2:30	TEA BREAK
2:30 – 4:00	Reproductive Anatomy & Physiology
4:00 – 4:45	Defining Reproductive Health
4:45 – 5:00	Wrap-up (Complete a daily wrap-up using the final activity on page 121. You can modify the question each day.)

DAY TWO

8:30 – 8:45	Warm-up
8:45 – 9:30	Reproductive Health Needs of Married Youth
9:30 – 10:30	Family Planning Methods
10:30 – 10:45	TEA BREAK
10:45 – 11:15	Partner, Family and Community Support for Family Planning
11:15 – 12:30	Importance of Delaying First Birth and Using Family Planning
12:30 – 1:30	LUNCH
1:30 – 2:00	Steps to Using a Condom Correctly
2:00 – 3:15	Practicing Communication Skills
3:15 – 3:30	TEA BREAK
3:30 – 4:00	Burning Questions About STIs
4:00 – 4:45	Finding the Gaps in HIV Knowledge
4:45 – 5:15	Men's Role in HIV Prevention
5:15 – 5:30	Wrap-up (Complete a daily wrap-up using the final activity on page 121. You can modify the question each day.)

DAY THREE

8:30 – 8:45	Warm-up and Review of Day Two
8:45 – 10:00	Understanding and Ensuring Safe Motherhood
10:00 – 10:30	Partner, Family and Community Support for Safe Motherhood
10:30 – 10:45	TEA BREAK
10:45 – 11:30	Types of Violence and Abuse
11:30 – 12:30	Sexual Consent
12:30 – 1:30	LUNCH
1:30 – 2:00	Reaching Married Youth and Influential Adults
2:00 – 2:30	Types of Peer Education Activities
2:30 – 3:30	Practicing Peer Education
3:30 – 4:15	Developing an Action Plan
4:15 – 4:45	Wrap-up and Reflection

1. Introductory Activities

1.1 Welcome and Ground Rules

Objectives

1. To welcome participants to the workshop
2. To inform participants of what the workshop will cover
3. To establish expectations for behavior during the training session

Time

30 minutes

Materials and Advance Preparation

- Flipchart paper and markers
- Sufficient copies of the agenda for all participants

Steps

1. Introduce yourself and the other facilitators. Welcome the participants and explain that this workshop will train them to be a peer educator in reproductive health in their community and teach them about health issues affecting young married couples. Tell the participants that what they learn in this workshop will help them to communicate more effectively with young married couples and provide information and support that can greatly improve the quality of the young people's lives. Besides learning new skills, having fun is a top priority during this time together!
2. Hand out the workshop agenda to all participants. Direct everyone to the training objectives and goals and read them aloud or have participants read them aloud. Then review the agenda, pointing out the main subjects that will be discussed at each session. Be sure to note when the workshop starts and ends each day.
3. Explain that there is only so much information that can be covered in a (one, two, or three) day training workshop. Let participants know that a great deal of information will be shared at this first training, but that the program will continue beyond this training. Explain to them how you will continue working with them and talking to them about issues that are of importance or interest to them.
4. Discuss how important it is, before beginning, that participants honestly and clearly establish their expectations about how to behave as a group. Write "Ground Rules" on flipchart paper and ask for suggestions on how everyone should conduct themselves during the workshop. Write these ideas down on the flipchart paper as they are suggested. You may want to ask if everyone agrees to the rule before recording it. If someone disagrees, ask that person how he or she would like to change it, and see if the group agrees. If the participants have trouble getting started, suggest the following:

- Participate at your level of comfort; it is okay to pass.
 - Honor confidentiality—what is said here, stays here.
 - Be on time when starting and after breaks.
 - Ask questions.
 - Have fun.
 - Respect others while they are talking—no interrupting.
5. Ask participants to reflect on the list, then ask: “Is everyone comfortable with these rules? If not, how can we change them so that we all agree?”
 6. Once the list is finished, tell participants that if someone violates a rule, he or she will be referred back to the list and asked to follow what everyone agreed to at the start.
 7. Post the ground rules in a spot visible to all participants, where it will stay for the remainder of the training.

1.2 Participant Introductions

Objectives

1. To provide a fun and interactive opportunity for participants to introduce themselves
2. To provide an opportunity for participants to get to know each other

Time

30 minutes

Materials and Advance Preparation

Prepare small pieces of blank paper to be handed out to participants.

Facilitator's Notes

The facilitator(s) should also participate in this exercise. If the participants feel shy about speaking up, the facilitator should initiate the exercise and introduce him or herself with some personal information.

Steps

1. Explain that this exercise will help participants get to know each other better. Hand out one small piece of blank paper to each person. Ask them to write 1, 2, or 3 on the paper.
2. Once they have done this, ask them to think of one, two, or three personal things—depending on the number they wrote on their paper—that they would like to share with the others. If someone wrote 1, they will share one personal thing with the rest of the participants. If they wrote 2, they will share two personal things, etc. They can share any personal information they would like: hobbies, how many children they have, what they like to do in their free time, their favorite movie, etc. Emphasize that there is no right or wrong responses in this exercise.
3. Ask everyone to form a circle so they can see each other. Go around the room and ask each participant to share their name, where they are from, what brought them to this workshop, and the personal information they would like to share.

1.3 What Is a Peer Educator?

Objective

1. To introduce participants to the basics of peer education

Time

15 minutes

Materials and Advance Preparation

- Flipchart Paper
- Markers
- Trainer's Resource Sheet 1: What Is a Peer Educator?
- Sufficient copies of Handout 1: Community Peer Education in Action – Stories from the Field for all participants.

Facilitator's Notes

If you have additional time, you can read the peer educator stories as a group and have a discussion about the information and experiences shared in those resources.

Steps

1. Ask participants if they have ever met or known a peer educator. If they have, ask participants to what they liked and did not like about these peer educators. Write these down on flipchart paper. Now ask participants to identify what some of the roles might be of a peer educator. Write these down on flipchart paper.
2. Using Resource Sheet 1 as a guide, explain to participants what a peer educator does and what their roles and responsibilities might be.
3. When you have completed the lecture, ask and answer any questions that participants may have concerning their future roles as peer educators.

Handout 1:

Community Peer Education in Action – Stories from the Field

Esther's Story: A Health Champion Makes a Lasting Impact

April 2007

Esther Nyokabi has lived in Njoro Division of Nakuru, Kenya, for all of her life. Like many women in her area, Esther had little schooling and is illiterate. She got married in her teenage years and has delivered 10 children, including two sets of twins. Only once did she deliver in a hospital. Following one of her births, she suffered pelvic damage that affected her ability to walk. For seven years, she could only crawl and could rarely leave her home. Fortunately, she eventually received treatment for her condition. When Esther started walking again, she became active in her community. She is a member of Piave Women's Group which was founded in 2004 to help the growing number of children orphaned in Njoro due to HIV/AIDS.

The Piave Women's Group chose Esther to represent them on the Community Postabortion Care Project (COMMPAC), which the ACQUIRE Project initiated in 2005 in Kenya. COMMPAC achieves results by empowering community members and is modeled after a community postabortion care program in Bolivia.

Previously, Esther had never participated in a group setting that included men. She had never held a leadership position, nor had she ever spoken before a group. As she learned about postabortion care and family planning, she became passionate about the issue. She went back to the women's group and shared what she learned, kindling their concern about postabortion care as well. The COMMPAC sessions were based on the three delays often cited in pregnancy-related mortality: delay in deciding to seek medical help for an obstetric emergency; delay in reaching an appropriate obstetric medical facility; and delay in receiving adequate care at the facility. For the first time, the participants learned that communities had the ability to prevent these delays and thereby prevent needless deaths.



Esther led her group to mobilize 300 people to attend a meeting with local government officials, where a vote was being held on the use of the Community Development Funds the government had made available to local districts. With Esther's leadership, the 300 people she brought to the meeting helped to divert the funds from the building of a market to the building of a dispensary, the repair of a road, and the building of a bridge. In Nakuru—where the distances and rough terrain make transport almost impossible, especially during the rainy season—this infrastructure is critical

to saving lives. In addition, Esther and Piave Women's Group got the police to build a post near the dispensary, because the road was not safe and women had been delaying their travel for emergencies until the daylight hours.

It was through COMMPAC that Esther learned the data about deaths related to postabortion care. And Esther's passion was fueled by the fact that her friends, neighbors, and family members had either died or suffered due to hemorrhage and lack of family planning services. She knew of at least three deaths in the past year due to hemorrhage in her community. She was inspired to learn that death and suffering are preventable through community efforts. Since the initiation of COMMPAC, there have been no deaths due to hemorrhage. She knows this because women now report bleeding early and recognize the need for medical care earlier. A fund is in place to pay for women's transportation to facilities with postabortion care services.



At the new dispensary, the doctor there spoke of Esther's commitment. He said that it was because of her passion that he invited the women from Piave Women's Group to the dispensary for some additional training regarding postabortion care. Additionally, the women are now working with the doctor and the local Parliament minister to build a maternity wing and to build the doctor a house so that he can be available 24 hours a day.

The district health hospital and the community have formed a partnership. In the beginning, the providers and the community had a contentious relationship. Through COMMPAC, a meeting was held and both sides aired their issues. Here again, Esther helped to bridge the gap. She also addressed equipment and supply needs. Postabortion care services were limited due to the lack of manual vacuum aspiration kits. Esther and Piave suggested that the fees charged for services be used to purchase these kits. In addition, few providers were trained in postabortion care due to staff turnover, but Esther convinced at least one private provider to donate his services monthly.

This effort has become a model for other groups. The Ministry of Health is so impressed by the community efforts that it has made postabortion care training a priority in the coming year's work plan. As COMMPAC expands, Esther and other champions will be part of the training team, educating others about postabortion care. Esther's inspiration reaches beyond the borders of Njoro, as communities learn they have the power to prevent unplanned pregnancy and to save lives needlessly lost daily to hemorrhage.

Photo credit: Nancy Russell/The ACQUIRE Project



Sita's Story: Lifting the Veil through Courage and Leadership

July 2008

Until two years ago, Sita Devi Shah was dismissed as the “shopkeeper woman,” and like other women in her neighborhood of Dhanusha District, she rarely left her home. When she did go out, she always covered her face with the veil of her sari. Then, in August 2005, the ACQUIRE Project's Reproductive Health for Married Adolescent Couples (RHMAC) began in Nepal.



Krusa Shura Purba and his wife, who were neighbors of Sita's, were chosen as peer educators for Ward 8. However, when Krusa's wife had to drop out due to pregnancy, the health management committee asked for new applicants. Sita's husband did not want Sita to apply, but her mother-in-law was supportive, and Sita was chosen to work with Krusa.

It is unusual for women to leave the walls of their

family's compounds, and going door-to-door or holding open meetings were new concepts in Sita's community. After learning the special health issues related to young marriage and the importance of birth spacing and other reproductive health issues, Sita immediately began reaching out to her neighbors. The training in communication skills that she received gave her confidence to hold monthly meetings in her home and to initiate interaction groups for mothers-in-law, students, and others. She hung the plastic coated poster developed by ACQUIRE on the outside of her home, marking it as the home of a RHMAC peer educator.



As Sita became known in her community as someone who had knowledge and information, neighbors sought her guidance. Five women came to her with complaints that sounded like possible sexually transmitted infections (STIs). She referred these women to the health post for an examination. The man in charge of the health post sent them back, refusing to examine them due to their low caste, and said that Sita should examine them herself. Following this incident, a public forum related to health was being organized by CARE under another project. At this meeting, Sita stood up and asked the man to explain his actions. After much grilling by those present, he agreed to see the clients and has since improved his attitude.

Following this incident, Sita received even more positive recognition: A local nongovernmental organization (NGO) hired her to teach literacy classes two hours every day. Sita says that she is

happy to be making use of her Student Leaving Certificate (SLC) education and enjoys teaching. She also continues to volunteer, and she works closely with three special friends (called “Tin Sahti”), accompanying one of them to the clinic for family planning counseling and staying with her while her friend receive her first Depo Provera injection. Every month, Sita holds meetings for mothers-in-law and reports that more mothers-in-law now accompany their daughters-in-law to antenatal care visits. The health management committee was so pleased with her work that they presented her with a special shawl.



Sita and her daughter in Sita's "special shawl"

In February, Sita was chosen to take part in leadership training offered by ACQUIRE/RHMAC. At this workshop, Sita learned about laws related to health and about the relationship between the national and local governments. The legal age at marriage in Nepal is 18 for girls and 20 for boys; however, this law is ignored in much of the area where Sita lives.

When she returned, she learned that a neighbor planned to marry off his 13-year-old daughter, Sangita. Sita met with the family and convinced them to delay the marriage. She is now working with them to find resources to enable Sangita to go to school. Sita now serves as secretary in the local anti-child marriage committee. This is one of 25 committees that will hold a district-wide conference on child marriage in May. Sita plans to attend and advocate for a free education for girls until grade 10. If girls were able to stay in school at no cost to their parents, it would be easier to delay more marriages like that of Sita's neighbor.

Prior to Sita's role as a peer educator, her husband had a small local shop and barely managed to care for his family. Sita's success and enthusiasm for her work have sparked him to acquire a new shop in Janakpur. He is now very busy and is proud of Sita's fame.



Sita, with her husband and son

Sita says that now the neighbors look to her with respect and call her “Sita Didi,” a sign of respect, rather than “shopkeeper woman.” Modestly, Sita says that she is a “good Hindu, but she is also open,” and people respect her for that. Sita Devi Shah lives in Thera VDC in Dhanusha District. Married at 16, she is now 26, has three children, and recently decided to have a tubal ligation.

Photo credit: Nancy Russell/The ACQUIRE Project



Trainer's Resource Sheet 1:

What Is a Peer Educator?

What is a peer educator?

A peer educator is a volunteer from the community who is trained and supported to inform and encourage others in their social network to adopt healthy lifestyle choices. A peer is a credible and trusted role model who educates those individuals (or couples) who may be hard to reach for many reasons (you can add local examples here).

Who is a peer educator?

Peer educators are dedicated individuals who commit to learning about health or social topics and passing on their knowledge to others in their community. They commit to teaching others for a specific amount of time per month, to checking in with their peer leaders or supervisors, and to attending any on-going training as required.

Why do peer educators do what they do?

Peers often feel empowered by their ability to reach their own community with new information on a variety of topics. They use their own established ways of sharing information, so while peer education is challenging, it is not a burden to carry out their information-sharing tasks. Peers know that they are often more successful than professionals in passing on information because people identify with them and peers speak the language of their social and geographic community.

Where do peer educators work?

Peer educators work where their social networks are located – and they move with them. Peers can work in homes with individuals and families or with groups in community gathering places (for example: markets, community gathering places, houses of worship, school, or work).

When do peer educators reach out to my community and how often?

Program supervisors can give guidance to peers on the amount of time peers can expect to work with individuals or groups per week or per month. Selecting times that are convenient to the peer educators and their peers is key, so that the number of people reached is maximized and to ensure that information is understood. The program can lay out the objectives and goals for each individual peer educator.

Do peer educators get paid or have other incentives or motivations?

The peer education program can give guidance on compensation for peers, however, most programs rely on volunteers. Volunteers often receive small incentives to keep them motivated to work, including additional training opportunities, transportation allowance, T-shirts, hats or other identifying clothing.

Mostly, peer educators work for relatively little while getting large amounts of satisfaction as motivation to continue. In the shorter term, some peer educators go on to become supervisors of peer educators or trainers. In the longer term, we note that peer educators may need to finish school, go to work, or support their families but they will always have the information they learned as a peer educator to continue giving correct information in the community.

2. Married Youth: Needs and Challenges

2.1 Working with Married Youth: Case Studies

Objectives

1. To understand the importance of working with young married couples
2. To understand the needs of young married couples
3. To understand the issues, pressures, and influences in the lives of young married couples

Time

60 minutes

Materials and Advance Preparation

- Flipchart paper and markers
- Sufficient copies of Handout 2: Case Studies for all participants
- Prepare a flipchart with the following questions:
 - ▶ Could the story in this case apply to young married couples in your community? Why or why not?
 - ▶ Is the story in the case study similar to your personal experiences? In what way?
 - ▶ What would be some of the concerns of the young woman in the story? The young man?
 - ▶ What pressures, if any, might the young woman be experiencing in the story? The young man?
 - ▶ What support would be useful to the young woman? The young man?
 - ▶ What might be some of the health needs of the young woman? The young man?
 - ▶ Is this scenario common in your community?

Facilitator's Notes

Please review the case studies carefully. You may need to change them so that the names and situations better fit the reality of young married men and women in the country in which you are working. If some participants in the group are illiterate you can read the questions aloud before breaking into small groups as well as posting them at the front of the room on a flipchart.

Steps

1. Explain that this exercise will help participants understand some of the needs, pressures and influences in the lives of young married people.
2. Divide the participants into four groups and give each group one of the case studies. If there are a large number of participants, create more than four and give the same case study to more than one group.
3. Ask the groups to review their case studies and discuss the questions listed on the flipchart. Give them 25 minutes to do. Each group should then choose one member to read the case study aloud to the room and summarize, in five minutes, the group's discussion.
4. After everyone has reported back, ask all the groups to consider the following questions:
 - ▶ What were some of the common concerns faced by young women in all the case studies?
 - ▶ What were some of the common concerns faced by young men in all the case studies?
 - ▶ What kind of support did the young women and men need?
 - ▶ What were some of the health needs of the young women and men?
 - ▶ How may these situations affect the relationships that the young people have with people in the community?
5. Conclude the activity by explaining that when a young woman or man gets married, his or her life can change both positively and negatively. Depending on the person's support structure, culture, economic situation, and personal relationships, a new marriage can create challenges for which he or she may not be prepared. Some of these challenges will be explored in this workshop because they may seriously impact an individual's ability to make decisions about health, including reproductive health.

Many people assume that once young men and women are married, they are fully equipped to make the best decisions for themselves. This is not always the case. The primary purpose of this program is to ensure that young people, especially young women, get the support, information, and services necessary to address the challenges they may face when married.

Handout 2: Case Studies

Case Study One

Reema is a 16-year-old girl who is married, but she is still living with her parents. She is planning to move to her husband's home when she is 18. Her husband, Ashok, who is 21, is from a district close to hers, but is currently working in the Gulf to earn some extra money for his family. When Reema turns 18, Ashok will move back to his parents' house, and he and Reema will live there with Ashok's older brother and his family. Reema has been receiving good grades in school and would like to continue her studies after she gets married. In fact, she wanted to delay her marriage, but couldn't because of family pressure. She is hoping that her husband will support her in her desire to continue her studies, but she is scared, because in many families, once a young girl gets married, she is expected to stop her studies and start a family immediately.

Case Study Two

Bacia is 18 and a class-12 graduate. She recently got married and is currently living with her husband, Dembe, and his parents, grandparents, and younger brother. Dembe, who is four years older than Bacia, helps oversee his father's plastics factory in the town in which they live. Bacia and Dembe met in school and have a love marriage. Bacia currently works part-time in the town where they live, but she must also take care of her husband's family. In general, Bacia gets along well with her in-laws, but she has recently been facing a lot of pressure from them to leave her job and have a child. Dembe also wants to have a child, but understands Bacia's wish to delay it. But Dembe is also facing a lot of peer pressure because many of his friends already have young children.

Case Study Three

Joseph is 22 and lives with his wife, Tusnelde (who is 18), and his parents. Both Joseph and Tusnelde are very happy because she is expecting their first child. They both want to deliver at a hospital, but are facing some resistance from Joseph's parents because Joseph and all his siblings were delivered at home. Joseph's mother feels that it is not necessary to deliver in the hospital. Tusnelde often argues with her mother-in-law about how to behave during pregnancy and where to deliver. Her mother-in-law, for example, does not think it is important for Tusnelde to seek antenatal care four times before giving birth. She never needed that kind of care and got all the information and assistance she needed from the traditional birth attendants. She wants the same for her first grandchild.

Case Study Four

Marcos, 25, and his wife, Julia, 18, recently had their first child. They were married one year ago, and were hoping to wait to have children, but they did not have enough information about family planning or where to get help. They also faced pressure from both their parents to have a child. Julia delivered her baby at home, with the help of a skilled birth attendant. They were interested in delivering at the hospital, but were told by their families that it was unnecessary. Julia now wants to start family planning because she wishes to wait at least three years before having another child. Marcos is not sure if he wants the same thing because he worries that the family-planning methods could be harmful to her, and feels they should have another child in a year.

2.2 The Problem Tree

Objective

1. To better understand the context of young married couples' lives

Time

45 minutes

Materials and Advance Preparation

Prepare a simple flipchart drawing of a tree showing the roots, trunk, and branches. In large letters, write: "CAUSES: Why is it like this?" next to the roots; "CONSEQUENCES: What happens when it's like this?" next to the branches; and "PROBLEM: Early Marriage" on the trunk.

Facilitator's Notes

Trainers may choose to cover only one subject (either getting married at an early age or having a child immediately after early marriage) depending on time constraints and the focus of the participants in the training. You may also change the subject to better fit the issues affecting young married couples in the country in which you are working.

Steps

1. Explain that this exercise will help participants understand the issues and pressures in young people's lives and the factors affecting a married young person's health.
2. Divide the participants into groups of three to five people. Ask each group to choose one person to report back to all the participants at the end of the session.
3. Explain that the groups will use a tool called "A Problem Tree" in this activity. Each group will focus on a different issue: half will focus on marriage at an early age; the other half will focus on having a child immediately after marriage.
4. Give a flipchart and a few markers to each group and ask one member from each to draw a large tree with their assigned problem on the trunk ("Early Marriage," for example).
5. Explain that this "Problem Tree" represents the causes and consequences of an issue. Each cause of early marriage is represented by a root and each consequence of early marriage is depicted as a branch. The trunk represents the problem: "Early Marriage." Use the problem tree you prepared in advance as an example.
6. Give each group 15 minutes to brainstorm the causes and consequences of their assigned issue.
7. Bring everyone back together. Have one person from each group present their problem tree. After each presentation, ask if anyone has additional comments. Ask if the other groups agree with the causes and consequences identified by the group.
8. Encourage discussion with the following questions:

- ▶ How many of the causes and/or consequences were similar among the groups? Was this surprising? Why or why not?
 - ▶ Were any of the causes and consequences surprising? If so, how?
 - ▶ What impact might these causes and consequences have on a person's health?
9. Ask all the groups to hang their problem trees around the room so that they can refer back to them later on in the workshop.

3. Gender and Power

3.1 Gender and Sex

Objectives

1. To understand the difference between gender and sex
2. To understand the gender issues that can affect young married couples

Time

30 minutes

Materials and Advance Preparation

- Flipchart paper with the definitions of “Sex” and “Gender,” as indicated below
- Blank flipchart paper
- Markers
- Sufficient copies of Handout 3: The Gender Game for all participants
- Trainer’s Resource Sheet 2: The Gender Game
- Pens or Pencils

Facilitator’s Notes

Step three asks you to refer to the problem tree. If you have not done the problem tree exercise earlier in the training, end the activity after the gender game has been completed. If there are participants in the group who are illiterate, you can read the questions aloud and ask members who think the answer is gender to move to one side of the room and those who think the answer is sex to move to the other side of the room. Have one person from each side share why they think that is the correct answer and then share the response with the group. Ask them to come back to the center of the room before you read each statement.

Steps

1. Ask participants if they have heard the terms “sex” and “gender.” Ask them what they think of when they hear the term “sex.” Note their responses on flipchart paper. Then ask them what they think of when they hear the term “gender.” Note their responses on flipchart paper.
2. Display the flipchart you prepared with the following definitions of “sex” and “gender”:

Sex refers to physical features that identify a person as male or female. This includes the type of genital organs, most common type of hormones circulating in the body, ability to produce sperm or ova (eggs), and ability to give birth and breastfeed children.

Gender refers to widely shared ideas and societal rules concerning women and men. These include ideas about typically feminine or female and masculine or male characteristics and commonly shared expectations about how women and men should behave in certain situations. For example, men are supposed to be strong and women are supposed to take care of the children.

Hang these definitions in the room so they can be used for future reference.

3. Illustrate the meaning of these terms by playing the Gender Game. Pass out Handout 3 and ask participants to complete the game. Give everyone 10 minutes to do so.
4. Discuss the answers as a group, clarifying why the statement either refers to gender or sex.
5. Ask participants to refer back to their problem trees and to circle the causes and consequences related to “gender.”
6. Ask the following questions:
 - ▶ Were you surprised by how many causes and consequences were gender-related?
 - ▶ What were some of the common gender-related causes and consequences? How might these affect young people’s health?

Handout 3: The Gender Game

Read the following statements and indicate if they refer to "sex" or "gender."

Sex	Gender	
		1. Women give birth to children; men don't.
		2. Girls are gentle; boys are tough.
		3. Most truck drivers are men.
		4. Many women do not make decisions independently and freely, especially regarding sex and relationships.
		5. Men's voices change with puberty, women's voices do not.
		6. Women's risk for HIV infection is often determined by their partner's sexual behavior.
		7. Women are biologically more at risk for HIV than men.
		8. Women can breastfeed babies, men can bottle feed babies.
		9. In ancient Egypt, women managed household affairs and inherited property; men did not. Men stayed at home and did the weaving.
		10. Women in sub-Saharan Africa contribute an average of 70% of the labor for food production, yet rural women are poorer than men and have lower levels of literacy, education, health, and nutrition.
		11. In 2006, a baseline study conducted in Nepal found that the majority of married adolescent couples believe that women's main work is to stay at home and look after the home and children.
		12. Of the estimated six to seven million people around the world who inject drugs, four-fifths are men.

Adapted from "Gender or Sex: Who Cares?" by Ipas

Trainer's Resource Sheet 2: The Gender Game

Read the following statements and indicate if they refer to "sex" or "gender."

Sex	Gender	
X		1. Women give birth to children; men don't.
	X	2. Girls are gentle; boys are tough.
	X	3. Most truck drivers are men.
	X	4. Many women do not make decisions independently and freely, especially regarding sex and relationships.
X		5. Men's voices change with puberty, women's voices do not.
	X	6. Women's risk for HIV infection is often determined by their partner's sexual behavior.
X		7. Women are biologically more at risk for HIV than men.
X		8. Women can breastfeed babies, men can bottle feed babies.
	X	9. In ancient Egypt, women managed household affairs and inherited property; men did not. Men stayed at home and did the weaving.
	X	10. Women in sub-Saharan Africa contribute an average of 70% of the labor for food production, yet rural women are poorer than men and have lower levels of literacy, education, health, and nutrition.
	X	11. In 2006, a baseline study conducted in Nepal found that the majority of married adolescent couples believe that women's main work is to stay at home and look after the home and children.
	X	12. Of the estimated six to seven million people around the world who inject drugs, four-fifths are men.

Adapted from "Gender or Sex: Who Cares?" by Ipas

3.2 Gender Fishbowl

Objectives

1. To give women and men an opportunity to speak out and be heard about gender issues
2. To develop a better sense of understanding of, and empathy for, the opposite sex

Time

60 minutes

Materials and Advance Preparation

None

Facilitators Notes

If you have a single sex group, simply have a discussion with the questions provided and ask participants to consider how they think someone of the opposite sex would react to their answers.

Steps

1. Explain to participants that since they have just learned about gender and how it can impact the lives of men and women, in this activity, they will have an opportunity to better understand the ideas and needs of the opposite sex.
2. Divide the participants by sex.
3. Ask the women to sit in a circle in the middle of the room and the men to sit in another circle around them, facing in.
4. Inform the men that they are only to observe and listen to what is being said. They should not speak out, react, or make any noise. Begin a discussion with the women by asking the questions for women below.
5. After the women have talked for 25 minutes, close the discussion. Then have the men switch places with the women. Inform the women that they are only to observe and listen to what is being said. They should not speak out, react, or make any noise. Begin a discussion with the men by asking the questions for men on the next page.
6. Discuss the activity with everyone after both groups have finished. Ask the men and women if they were surprised by anything the opposite sex said, how it felt to talk as a single-sex group, and if they held back because they knew they were being watched by the opposite sex.

Fishbowl Questions

Questions for Women

- ▶ What is the most difficult thing about being a young married woman in your community?
- ▶ What do partners need to better understand about young married women?
- ▶ What do you find difficult to understand about young married men?
- ▶ How can men support young married women?
- ▶ What is something that you never want to hear again about young married women?
- ▶ What rights are hardest for young married women to achieve in your community?
- ▶ What do you remember about growing up as a girl in your community? What did you like about being a girl? What did you not like?
- ▶ What are some of the pressures that are put on young married women in your community?
- ▶ How hard is it to live up to those expectations?
- ▶ Who are some of the positive male influences in your life? Why are they positive?
- ▶ Who are some of the positive female influences in your life? Why are they positive?

Questions for Men

- ▶ What is the most difficult thing about being a young married man in your community?
- ▶ What do partners need to better understand about young married men?
- ▶ What do you find difficult to understand about young married women?
- ▶ How can men support and empower young married women?
- ▶ What is something that you never want to hear again about young married men?
- ▶ What do you remember about growing up as a boy in your community? What did you like about being a boy? What did you not like?
- ▶ What are some of the pressures that are put on young married men in your community?
- ▶ How is it hard to live up to these expectations?
- ▶ Who are some of the positive male influences in your life? Why are they positive?
- ▶ Who are some of the positive female influences in your life? Why are they positive?

4. Reproductive Health and Married Youth

4.1 Reproductive Anatomy and Physiology

Objective

1. To provide participants with basic information about reproductive anatomy and physiology

Time

90 minutes

Materials and Advance Preparation

- Large, clearly labeled pictures of the female and male reproductive systems and genitalia (Trainer's Resource Sheet 3: The Male Reproductive System and Genitalia, Trainer's Resource Sheet 4: The Female Reproductive System and Internal Genitalia and Trainer's Resource Sheet 5: The Female Reproductive System and External Genitalia.) to display at the front of the room
- Sufficient copies of Handouts 4: Male Reproductive System and Genitalia, 5: Female Reproductive System and 6: Female External Genitalia for all participants
- Sufficient copies of Handout 7: Definitions of the Male Reproductive System and the Female Reproductive System and Genitalia for all participants

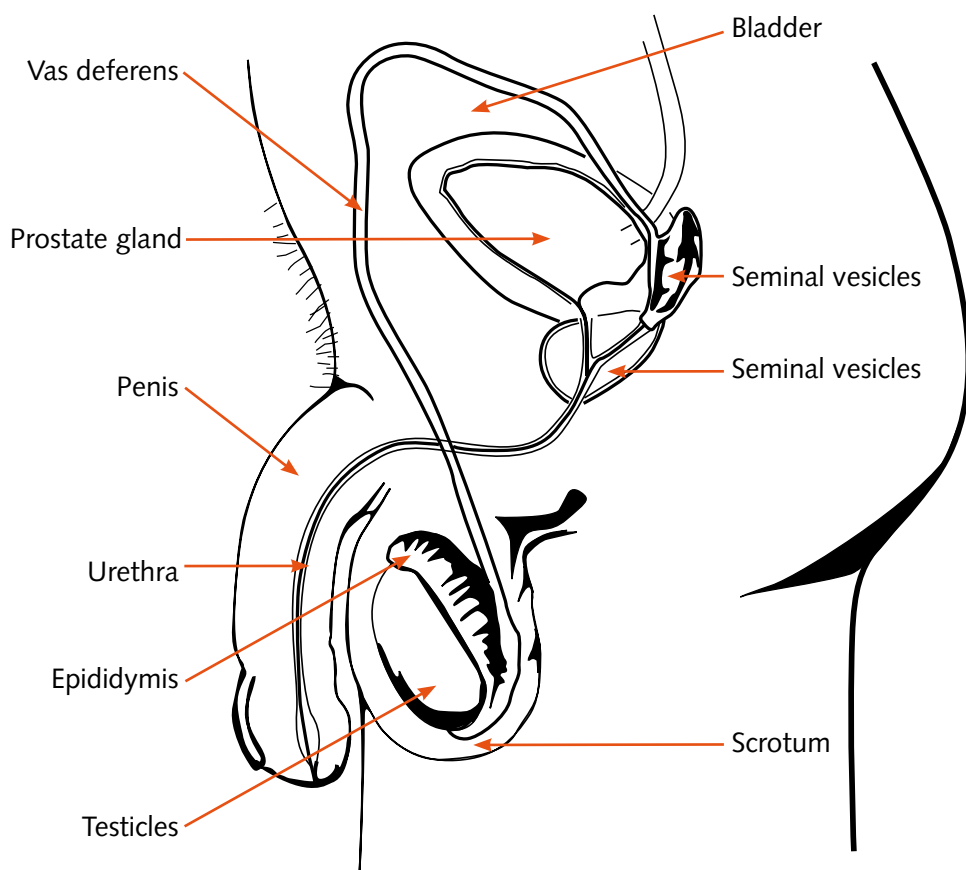
Steps

1. Display labeled pictures of the male and female reproductive systems at the front of the room so that all participants can see them.
2. Hand out the unlabeled pictures of the male and female reproductive systems and tell the participants to label them as you identify the parts together. Use Handout 7 as a guide to describe the function and purpose of each part of the labeled anatomy on the male and female reproductive system charts that are displayed. Encourage as many questions as possible by reassuring participants that everyone has questions about reproductive anatomy and physiology and that they should not be afraid to ask them. If it seems people are shy, tell them to submit their questions in writing.
3. After reviewing all the parts of the anatomy, ask the participants if someone can explain the process of pregnancy. After they have described it, provide a brief overview of the process, making sure to include the points below. As you mention the various parts of the male and female reproductive systems, point to them in the pictures displayed.
 - When a man's sperm enters a woman's vagina, the sperm swim up through the cervix, past the uterus, and into the fallopian tubes, where if they find an ovum they will attempt to fertilize it. When the egg and sperm meet it is called conception.

- Once the egg is fertilized, it goes into the uterus and implants itself in the uterine lining, a wall that the body has built up to support a pregnancy. This lining provides nourishment to the fetus while it is growing.
- During pregnancy, the fetus is housed in the amniotic sac. This sac, which is connected to the mother, delivers food to the fetus and carries waste away. It is important to have at least four pre-natal visits with a doctor, midwife, or professional to make sure that the woman and fetus are both doing well.
- After roughly nine months of growth, the child is born either through the birth canal (the vagina) or, if there are complications, via a C-section. During a C-section, the abdomen is cut and the baby is removed. Complications during birth are rare, but it is always important to make preparations to deliver with a skilled birth attendant and arrange for blood donations and transportation to a hospital, if necessary.

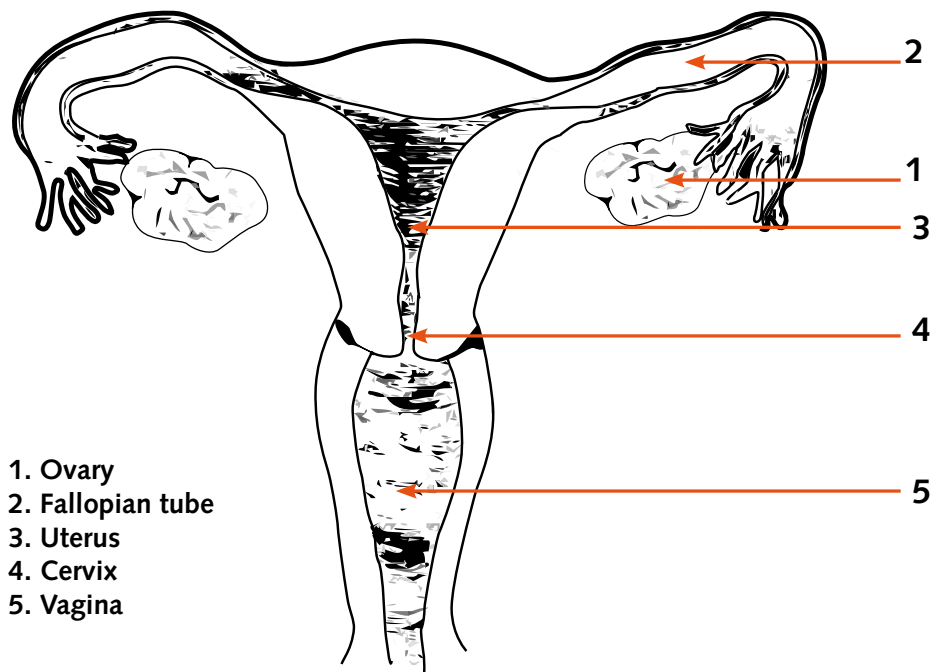
Trainer's Resource Sheet 3: The Male Reproductive System and Genitalia

The Male Reproductive System and Genitalia



Trainer's Resource Sheet 4: The Female Reproductive System and Internal Genitalia¹²

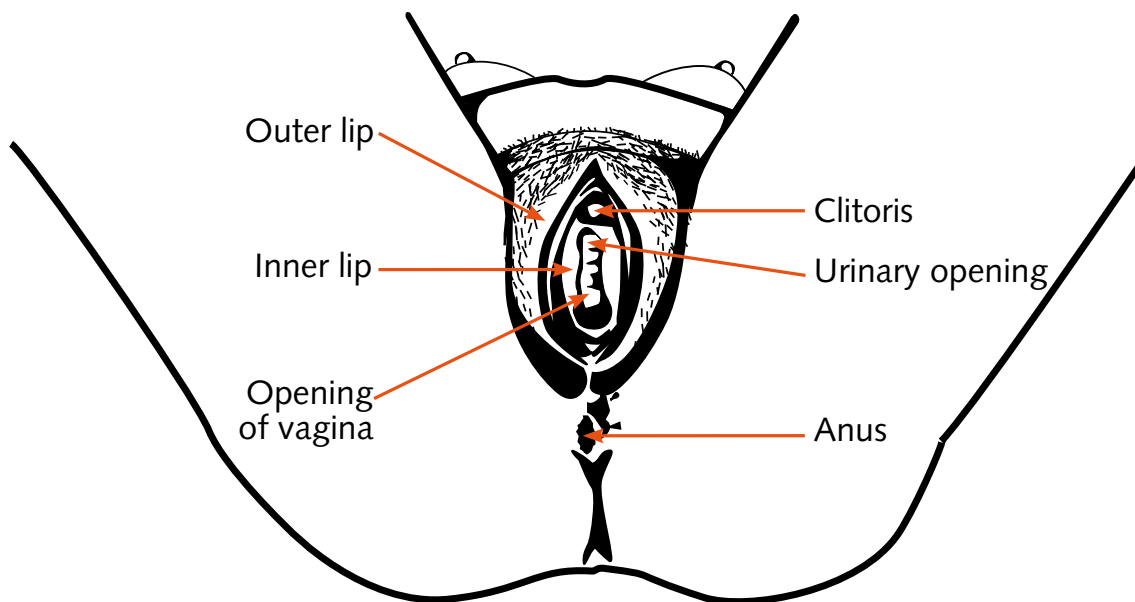
The Female Reproductive System and Internal Genitalia



¹² Knebel, E. 2003. My changing body: Fertility awareness for young people. Washington, DC: Institute for Reproductive Health and Research Triangle Park, North Carolina: Family Health International.

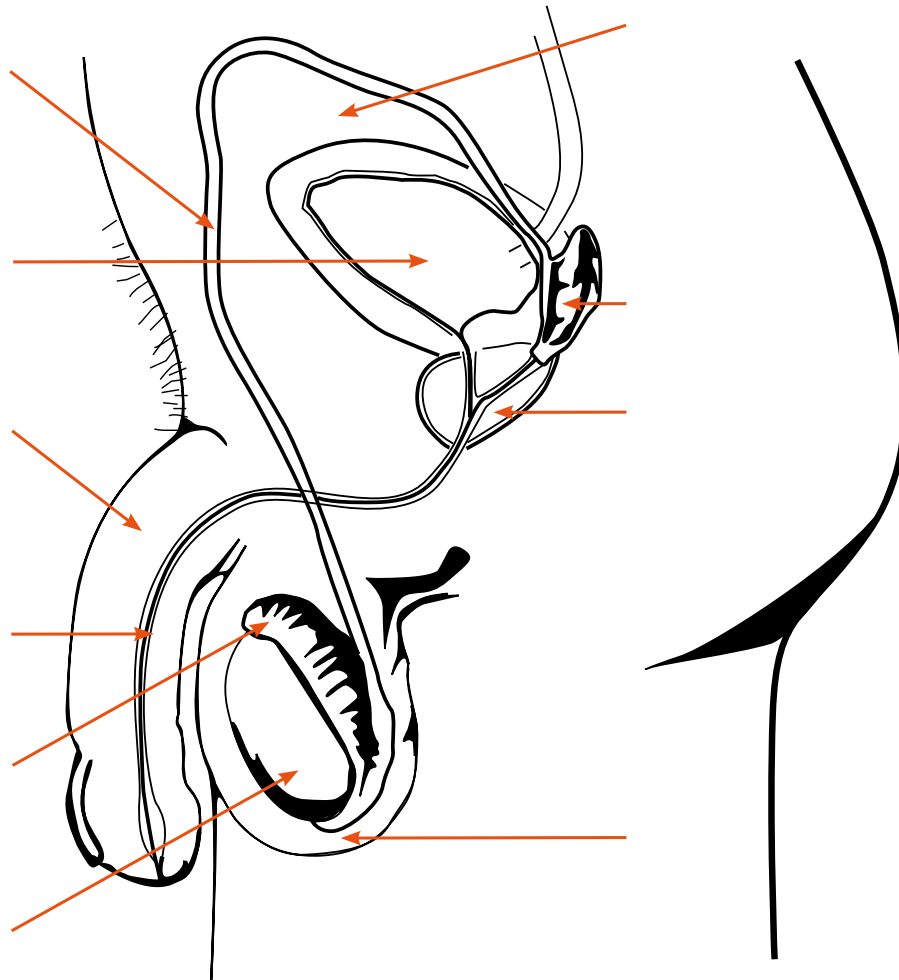
Trainer's Resource Sheet 5: The Female Reproductive System and External Genitalia¹³

The Female Reproductive System and External Genitalia

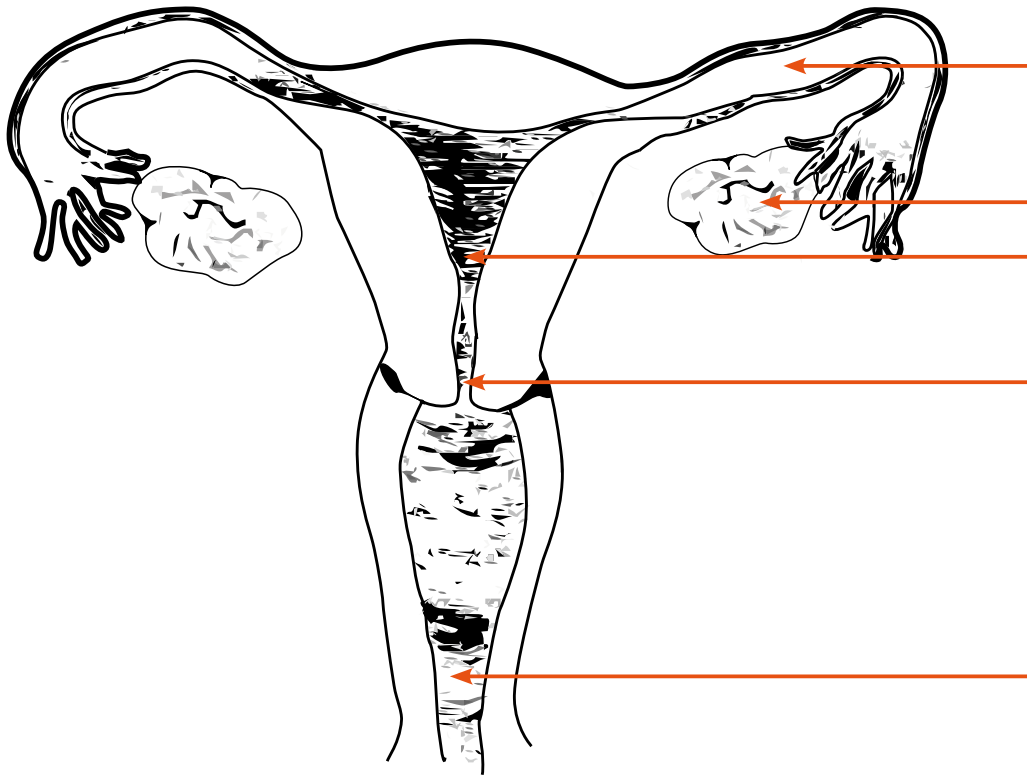


¹³ Knebel, E. 2003. My changing body: Fertility awareness for young people. Washington, D.C: Institute for Reproductive Health and Research Triangle Park, North Carolina: Family Health International.

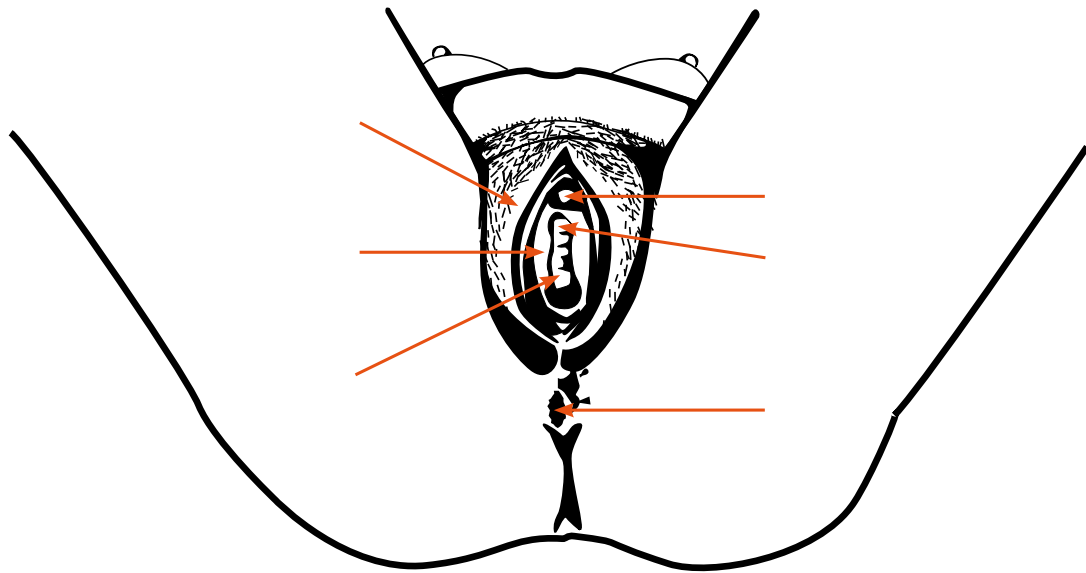
Handout 4: The Male Reproductive System and Genitalia



Handout 5: Female Reproductive System



Handout 6: External Genitalia



Handout 7:

Definitions of the Male Reproductive System and the Female Reproductive Systems and Genitalia

The Male Reproductive System and Genitalia

From puberty on, sperm are continuously produced in the testicles (or testes), which are found inside the scrotum. As the sperm mature, they move into the epididymis, where they remain to mature for about two weeks. The sperm then leave the epididymis and enter the vas deferens. These tubes pass through the seminal vesicles and the prostate gland, which releases fluids that mix with the sperm to make semen. During ejaculation, the semen travels through the penis and out of the body by way of the urethra, the same tube that carries urine. The urethral or urinary opening is the spot from which a man urinates or ejaculates.

Key words:

Ejaculation: Forceful release of seminal fluid from the penis.

Epididymis: Organ where sperm mature after they are produced in the testicles.

Penis: External tubular male organ protruding from the body that is used for urination or for sexual stimulation. The size of the penis varies from man to man. It remains soft and flaccid most of the time. During sexual excitation, the spongy tissue in the penis fills with blood and the penis gets larger and harder, a process called an erection. In the sexual act, when highly stimulated, the penis releases a liquid called sperm or semen, which contains spermatozoa. The ejaculation of the sperm produces an intense feeling of pleasure called an orgasm.

Prepuce or foreskin: The skin that covers the head of the penis. When the penis becomes erect, the prepuce is pulled back, leaving the glans (or the “head” of the penis) uncovered. When this does not occur, the condition is called phimosis, which can cause pain during sexual intercourse and hamper personal hygiene. Phimosis is easily corrected through surgical intervention, using a local anesthetic. In some cultures or countries, or in some families, the foreskin of boys is removed in a procedure called circumcision. When the foreskin is present, it is important to clean underneath it daily.

Prostate gland: Gland that produces a thin, milky fluid that enables the sperm to swim and become part of the semen.

Scrotum: Pouch of skin behind the penis that holds the testicles. Its appearance varies according to the state of contraction or relaxation of the musculature. In cold, for example, it becomes more contracted and wrinkled and in heat it becomes smoother and elongated.

Semen: Fluid that leaves a man’s penis when he ejaculates.

Seminal vesicles: Small glands that produce a thick, sticky fluid that provides energy for sperm.

Sperm: A male sex cell. The Path of Sperm: Sperm travel from the testes to the epididymis, where they remain to mature for about 14 days. From there, sperm travel into the vas deferens, which carries the sperm towards the urethra. At this point, seminal vesicles produce a nourishing fluid that gives the sperm energy. The prostate gland also produces a fluid that helps the sperm swim. The mixture of sperm and the two fluids is called semen. During sexual arousal, the Cowper's gland secretes a clear fluid into the urethra. This fluid, known as pre-ejaculate or "pre-cum," acts as a lubricant for the sperm and coats the urethra. During sexual excitement, an ejaculation of semen may occur. The small amount of semen that is ejaculated (one or two teaspoons) can contain up to 400 million sperm.

Testicles (testes): Male reproductive glands, which are held in the scrotum and produce sperm. One of the hormones produced is testosterone, responsible for male secondary characteristics, such as skin tone, facial hair, tone of voice and muscles. The testes have the form of two eggs and to feel them, one only has to touch the scrotum pouch. They are positioned outside the body because sperm can be produced only at a temperature lower than the body's normal temperature. The scrotum actually relaxes away from the body when warm and shrinks toward the body when cold in order to regulate the perfect temperature for sperm production. The left testicle usually hangs lower than the right. Testicular self-examination once a month is an important health safeguard. Roll the testes between the fingers. Any lumps, swelling, or pain should be examined immediately by a doctor.

Urethra: Canal that carries urine from the bladder (the place where urine is collected in the body) to the urinary opening. In males, the urethra also carries semen.
Urethral (urinary) opening: Spot from which a man urinates.

Vas deferens: Long, thin tubes that transport sperm away from the epididymis.

The Female Reproductive System and Internal Genitalia

Every female is born with thousands of eggs in her ovaries. The eggs are so small that they cannot be seen by the naked eye. Once a girl has reached puberty, a tiny egg matures in one of her ovaries and then travels down a fallopian tube on its way to the uterus. This release of the egg from the ovary is called ovulation. The uterus prepares for the egg's arrival by developing a thick and soft lining like a pillow. If the girl has had sex in the last few days before she ovulates, by the time the egg arrives in the fallopian tube, there might be some sperm waiting to unite with the egg. If the arriving egg is united with the sperm (called fertilization), the egg travels to the uterus, and attaches to the lining of the uterus and remains there for the next nine months, growing into a baby. If the egg is not fertilized, then the uterus does not need the thick lining it has made to protect the egg. It throws away the lining, along with some blood, body fluids, and the unfertilized egg. All of this flows through the cervix and then out of the vagina. This flow of blood is called the "period" or menstruation.

Key Words:

Cervix: Lower portion of the uterus, which extends into the vagina. The cervix is a potential site for cancer. Therefore, it is important for women to be tested for cervical cancer, whenever possible.

Fallopian tubes: Tubes that carry the egg from the ovaries to the uterus. An ovum (an egg cell) passes through the fallopian tubes once a month. If sperm are present in the fallopian tubes, the ovum might become fertilized.

Fertilization: Union of the egg with the sperm.

Menstruation (menses): The monthly discharge of blood and tissue from the lining of the uterus.

Ovaries: Two glands that contain thousands of immature eggs. The ovaries begin to produce hormones and release an ovum once a month when a woman reaches puberty.

Ovulation: The periodic release of a mature egg from an ovary.

Secretion: The process by which glands release certain materials into the bloodstream or outside the body.

Uterus: Small, hollow, muscular female organ where the fetus is held and nourished from the time of implantation until birth. The uterus is also known as the womb and is about the size of a woman's fist. The lining in the uterus thickens each month as it prepares for a potential pregnancy. If an egg is fertilized, it will be implanted in the lining of the uterus. The womb is remarkably elastic and can expand to many times its original size during pregnancy.

Vagina: Canal that forms the passageway from the uterus to the outside of the body. It is a muscular tube about 7 to 10 cm long. The vagina is often referred to as the birth canal because it is the passageway for a baby during a normal delivery. The vagina is also where sexual intercourse takes place. If a woman is not pregnant, the menses will pass out of the vagina once a month. The menses consist of cells, mucus, and blood.

4.2 Defining Reproductive Health

Objective

1. To develop a group definition of reproductive health that they can apply to their work as peer educators

Time

45 minutes

Materials and Advance Preparation

- Blank flipchart paper
- Index cards
- Markers
- A copy of Trainer's Resource Sheet 6: Examples of Different Types of RH Information to Provide to Married Youth
- Three flipchart pages with one of the following written on each:
 - ◆ Family Planning
 - ◆ Safe Motherhood and Newborn Care
 - ◆ STIs/HIV and AIDS

Facilitator's Notes

It may be helpful to collect information about local or national government laws and regulations related to reproductive health to share with your participants.

Steps

1. Share the three flipchart pages with the three reproductive health concepts and explain that many issues of reproductive health fall under these broad categories. Post these flipcharts on the wall with plenty of space between them.
2. Divide the participants into three groups and assign each one a category. Ask each group to brainstorm types of information that they would need to share with community peers in their assigned subject area. Have them write each idea on one index card. Let them work as a group for 20 minutes. If they are stuck, help out each group by offering some ideas from the Trainer' Resource Sheet for this activity.
3. After 20 minutes ask each group to post their index cards on the wall below their assigned topic.
4. Bring the group back together and ask them to develop an agreed upon definition of reproductive health based on the ideas collected on index cards. The facilitator should write out the final definition and post it on the wall.

For the definition, the following key ideas about reproductive health should be included:
Reproductive Health:

- Is linked to physical, mental, and social well-being.
- Relates to the reproductive system of men and women.
- Plays a part in maintaining a safe and satisfying sex life.
- Includes the capability to reproduce and the freedom to decide if, when, and how often to do so.
- Includes access to information about family planning methods.
- Includes access to health professionals to stay healthy.

NOTE: Please keep the Family Planning, Safe Motherhood and STIs/HIV flipcharts and index cards on the wall for use in the following activity.

Trainer's Resource Sheet 6: Examples of Different Types of RH Information to Provide to Married Youth

Family Planning	Safe Motherhood and Newborn Care	STIs/HIV and AIDS
Importance of delaying first birth	Risk of early pregnancy	Information about transmission and prevention of various STIs
Information on family planning methods	Detailed information—including danger signs—related to pregnancy, labor and delivery, and the postpartum period	Importance of dual protection
Importance of protecting against unwanted pregnancy and HIV/STIs	Developing a safe delivery plan	Negotiating condom use and safer sex
Importance of engaging men in family planning	Care of mother after birth	Basic information on HIV testing
Detailed information on family planning methods	Care of baby after birth	Prevention of mother-to-child transmission of HIV
Importance of using a postpartum family planning method	Family planning after birth	Sexual responsibility
Healthy timing and spacing of children	Breastfeeding	Trafficking of adolescents
Gender	Nutrition and care in pregnancy	Sex in exchange for goods or money
	Cervical/breast cancer	Gender
	Female Genital Cutting	
	Gender	

4.3 Reproductive Health Needs of Married Youth

Objective

1. To identify the various reproductive health needs of young married people

Time

45 to 60 minutes

Materials and Advance Preparation

- Flipchart paper
- Markers and tape
- Prepare a flip chart with information contained in Trainer's Resource Sheet 7: Categories of Married Youth
- Sufficient copies of Handout 8: Reproductive Health Needs of Married Youth for all participants

Facilitator's Notes

You may need to change the age ranges below, depending on what is considered "young" or "adolescent" in the country or community in which you work.

Steps

1. Show participants the "Categories of Married Youth" chart written earlier on flipchart paper and explain the five categories for both young married men and women.
2. Explain that many young people have the same reproductive health needs, even though they fall into different categories. Others' needs might be different because they want to have children, are pregnant, or have just given birth. It is therefore important to explore the reproductive health needs of young couples at different points in their lives. Remind participants that they will be using the definition and ideas from the last activity to guide them.
3. Divide everyone into four groups: two will focus on married young women and two will focus on married young men. Hand all groups copies of the worksheet, flipchart paper, and markers. Give the groups 15-20 minutes to identify the family planning, maternal health, HIV, and other reproductive health needs of the young men or women in each category. Ask them to record their information on flipchart paper.
4. Have one person from each group present its work. Ask the rest of the room if they want to add any other reproductive health needs.

Handout 8: Reproductive Health Needs of Married Youth

Categories of Young Females	Family Planning	Safe Motherhood and Newborn Care	STIs/HIV	Other RH Needs
Married/ engaged/ promised, but has not lived with spouse				
Recently married (under 1 year)				
Currently pregnant				
Married, recently given birth				

Reproductive Health Needs of Married Young Males

Categories of Young Males	Family Planning	Safe Motherhood and Newborn Care	STIs/HIV	Other RH Needs
Married/ engaged/ promised, but has not lived with spouse				
Recently married (under 1 year)				
Spouse currently pregnant				
Married, spouse recently given birth				

Reproductive Health Needs of Married Young Females

Trainer's Resource Sheet 7: Categories of Married Youth

Young Females	Young Males
Married/engaged/promised, but has not lived with partner yet	Married/engaged/promised, but has not lived with partner yet
Recently married (under 1 year)	Recently married (under 1 year)
Married, but not living with husband because one of them is away from home (for school/work)	Married, but not living with wife because he one of them is away from home (for school/work)
Married and pregnant	Married and wife pregnant
Married, has recently given birth	Married and wife has recently given birth

5. Family Planning

5.1 Family Planning Methods

Objective

1. To review different kinds of family planning methods

Time

60 minutes

Materials and Advance Preparation

- Collect samples of different family planning methods available in your country. If possible, provide each participant with his own demonstration kit of family planning methods
- Display the anatomical visuals (reproductive system pictures from Activity 4.1) so that you can refer back to parts of the body that are associated with these methods
- Sufficient copies of Handout 9: Family Planning Methods for all participants

Facilitator's Notes

Be sure to clearly display the female and male anatomy charts at the front of the room.

Steps

1. Ask the group to brainstorm all the family planning methods they can think of. Record these on a piece of flipchart paper.
2. After the brainstorm session, add any methods that are missing and clear up any myths or false methods (e.g., washing out vagina with water after sex). Be sure to explain why the method does not work.
3. Provide a general overview of all the methods on the list (using Handout 9 as a reference) passing around any samples, whenever available, for participants to see and handle. Encourage participants to ask questions during the presentation.

Handout 9:

Family Planning Methods

Male Condom

What is it?

A thin sheath made of latex that a man places over his erect penis.

How is it used?

The condom holds the semen so that it does not pass into the woman's vagina. The man puts the condom on his erect penis before sexual intercourse. After sex, the man carefully takes off the condom. Each condom can only be used once.

How effective is it?

Condoms are highly effective in preventing pregnancy and many sexually transmitted diseases when used correctly every time a couple has sexual intercourse.

What are some advantages to using it?

- Protection from pregnancy, HIV, and other sexually transmitted infections
- Easily available without a prescription
- An excellent option for someone who does not need ongoing contraception
- No hormonal side effects
- May prevent premature ejaculation in men
- Some people report that condoms increase pleasure when there is a drop of lubricant inside the tip of the condom.

What are some disadvantages to using it?

- Condoms sometimes break.
- Putting on a condom may interrupt sexual activity.
- May cause decreased sensitivity during sexual intercourse

What are the possible side effects?

- Rarely causes an allergic reaction (either to latex or a spermicidal lubricant)

Female Condom

What is it?

- A polyurethane pouch that a woman places inside her vagina.

How does it work?

- The condom holds the semen so that it does not pass into the woman's vagina. The woman inserts the female condom into her vagina before sexual intercourse. There is a small plastic ring in the back of the female condom that hooks onto the woman's cervix to keep it in place. Once inserted, the man puts his erect penis inside the female condom, which acts like a lining to the vaginal canal. After sex, the woman removes the condom, careful not to let any of the fluid leak out.

How effective is it?

- Female condoms are highly effective in preventing pregnancy and many sexually transmitted diseases when used correctly every time a couple has sexual intercourse. However, the female condom is not as effective in preventing pregnancy as some other methods.

What are the advantages to using it?

- Protection from pregnancy, HIV, and other sexually transmitted infections
- Provides women with a method they can use themselves to prevent pregnancy and sexually transmitted infections
- Available without a prescription
- An excellent option for someone who does not need ongoing contraception
- No hormonal side effects
- May prevent premature ejaculation in men

What are the disadvantages to using it?

- Putting on a condom may interrupt sexual activity
- May cause decreased sensitivity during sexual intercourse
- Some complain that it makes noise
- The female condom is difficult to find in some areas
- The female condom is more expensive than the male condom
- A girl must feel comfortable touching her vagina to be able to insert the condom

What are the possible side effects?

- None

Oral Contraceptive Pill

What is it?

- A pill that a woman takes daily by mouth.

How does it work?

- The pills stop the egg from leaving the ovary every month. It also makes it difficult for sperm to enter the uterus. The pill does this by thickening the mucus at the entrance of the uterus. The woman must take one pill every day according to instructions.

How effective is it?

- The pill is very effective when used correctly.

What are the advantages to using it?

- Usually makes menstrual periods more regular, with less bleeding
- May reduce premenstrual syndrome, endometriosis, and acne
- Does not disrupt sexual intercourse
- Can be discontinued by a woman on her own
- Allows women to control when they get pregnant

What are the disadvantages to using it?

- The woman must remember to take a pill every day.
- Does not provide protection from sexually transmitted infections

What are the possible side effects?

- Nausea
- Weight gain
- Spotting between periods
- Mood swings
- Decreased libido

Injectable

What is it?

The woman gets an injection in her arm or buttock.

How does it work?

The injectable stops the egg from leaving the ovary every month. It also makes it difficult for sperm to enter the uterus. The injectable does this by thickening the mucus at the entrance of the uterus. The woman must get an injection of Depo-Provera every three months (every two months for Noristerat).

How effective is it?

The injectable is one of the most effective methods.

What are the advantages to using it?

- Does not disrupt sexual intercourse
- Can be used without the knowledge of others
- The woman does not have to remember to do something every day.

What are the disadvantages to using it?

- It may take a while to get pregnant (6 to 12 months) after stopping injections.
- Causes changes in menstrual cycle, such as spotting or bleeding between periods, longer periods, or no periods at all
- Return visits required every three months (every two months for Noristerat)
- Does not provide protection from sexually transmitted infections

What are the possible side effects?

- Headache
- Weight gain
- Changes in menstrual periods

Implants

What are they?

Implants consist of matchstick-sized plastic capsules (the number varies depending on the type of implant). A trained doctor or nurse places implants under the skin of a woman's upper arm by making a very small cut. The capsules can stay in the arm for several years (again, depending on the type), but they can be taken out before if the woman wishes.

How do they work?

Implants stop the egg from leaving the ovary. They also make it difficult for sperm to enter the uterus. They do this by thickening the mucus at the entrance of the uterus.

How effective are they?

Implants are one of the most effective methods.

What are the advantages to using them?

- Implants are a long acting method.
- They do not disrupt sexual intercourse.
- The woman does not have to remember to do something every day.

What are the disadvantages to using them?

- Causes changes in the menstrual cycle, such as spotting or bleeding between periods, longer periods, or no periods at all
- Requires a small cut in the arm that may leave a tiny scar
- Does not provide protection from sexually transmitted infections

What are the possible side effects?

- Headache
- Weight gain
- Changes in menstrual periods

IUD (Intrauterine Device)

What is it?

An IUD is a small, t-shaped device that is made of either plastic or of plastic and copper (some also release hormones). A doctor or trained health worker places the IUD in the woman's uterus. The most commonly used copper IUD can be left in place for up to 10 years.

How does it work?

The IUD stops the man's sperm from meeting the woman's egg.

How effective is it?

The IUD is very effective.

What are the advantages to using it?

- Prevents pregnancy for a long time
- Does not disrupt sexual intercourse
- A woman does not need to remember to do something every day.

What are the disadvantages to using it?

- Does not protect against sexually transmitted infections
- There is a higher risk for pelvic inflammatory disease when using the IUD, so youth at risk for STIs should consider other methods, in addition to condoms.

What are the possible side effects?

- May cause spotting, heavy bleeding, or more menstrual cramping

Sterilization

What is it?

A surgical procedure that can be performed on either a man or a woman. For a man the procedure is called a vasectomy. For a woman, it is called a tubal ligation.

How does it work?

- For men, a doctor makes a small incision on either side of the scrotal area. The vas deferens is clamped and cut so that no sperm can pass from the testicles to the urethra. The man still produces sperm, his testes remain intact, and he still has ejaculations. There is just no sperm present in the ejaculation due to the procedure. The recovery period for this procedure tends to be quite short.
- For women, a doctor makes a small incision near the hips, below the waistline. The woman is given pain medicine, and in some cases, she becomes unconscious. The fallopian tube is clamped and cut so that the egg cannot pass and meet with any sperm. This is a more serious surgery than the one for men and recovery may take a few days or longer.

How effective is it?

Sterilization is highly effective.

What are the advantages to using it?

- Users do not need to concern themselves with family planning again.
- It is a relatively simple procedure, especially vasectomy.

What are the disadvantages to using it?

- It is permanent, so a person must be sure that they do not want any more children.
- Does not provide protection from sexually transmitted infections

What are the possible side effects?

- Some men complain of slight pain shortly after the procedure (this subsides after a few days).
- Women need a few days to recover.

Emergency Contraception

What is it?

If a woman has unprotected sex, or a condom breaks, she can take a regimen of pills within 72 hours of sexual intercourse that will prevent pregnancy. The sooner the pills are taken, the better.

How does it work?

Emergency contraception pills do not end a pregnancy that has already begun; it will only prevent a fertilized egg from being implanted in the uterus. The pills are a set of artificial hormones that make the uterus an unfriendly environment for the fertilized egg. The egg will not be able to implant and develop and a pregnancy will not occur.

How effective is it?

Studies have found that emergency contraception pill treatment reduces the risk of pregnancy by about 75%.

What are the advantages to using it?

It is the only readily option available to reduce pregnancy risk in cases of rape, mechanical failure of a contraceptive device, or after sex without the use of any pregnancy-prevention method.

What are the disadvantages to using it?

- No protection from sexually transmitted infections
- The side effects may be unpleasant.

What are the possible side effects?

- Nausea
- Vomiting
- Headache
- Dizziness
- Abdominal pain

Withdrawal

What is it?

A man removes his penis from the vagina during sexual intercourse before ejaculation occurs.

How does it work?

Removing the penis from the vagina before ejaculation reduces the chances that semen is released into the vagina.

How effective is it?

Withdrawal is not a very effective method. Sometimes men fail to withdraw the penis from the vagina before ejaculation. Other times, a small amount of sperm is passed into the vagina before ejaculation from a man's pre-ejaculatory fluid.

What are the advantages to using it?

- Men and women do not need to access service from a health facility.
- This may be the only option for someone who does not have access to FP services.

What are the disadvantages to using it?

- Does not protect against sexually transmitted infections
- It is not very effective.

Lactational amenorrhea method (LAM)

What is it?

By only feeding a new baby breast milk, a new mother can prevent pregnancy for up to six months as long as her period has not returned.

How does it work?

LAM prevents the ovaries from releasing eggs. For LAM to work, the baby must be exclusively breastfed on demand. The baby does not need any foods other than breast milk until he or she is six months old, as long as (1) the baby is growing well and gaining weight, and (2) the mother is eating a balanced diet and resting in order to have a good milk supply.

How effective is it?

For as long as the baby breastfeeds on demand (day and night), is less than six months old, and a woman's period has not returned, LAM is very effective when it is used correctly. LAM is less effective after the baby is six months old, after the baby begins taking other foods and drinks, or after the woman's period has returned—whichever comes first.

What are the advantages to using it?

- Men and women do not need to access a service from a health facility.
- This may be the only option for someone who does not have access to FP services.
- There are no side effects associated with it.

What are the disadvantages to using it?

- Does not protect against sexually transmitted infections
- Needs to be used correctly in order for it to be effective

Dual Protection

What is it?

Dual protection is not a method of family planning, but an approach used to prevent both pregnancy and disease.

How does it work?

Dual protection can be used in two ways:

1. Use of condoms in conjunction with another family planning method.
2. The use of condoms alone to prevent pregnancy and disease.

How effective is it?

As long as the methods are used correctly and consistently, the dual protection approach is very effective.

What are the advantages to using it?

- Protects against both pregnancy and sexually transmitted infections
- Women may be able to more easily convince their partners to use condoms from a pregnancy-prevention perspective than from a disease-protection perspective.

What are the disadvantages to using it?

- Needs to be used correctly in order for it to be effective.

5.2 The Importance of Delaying First Birth and Using Family Planning

Objective

1. To review the importance of delaying first birth

Time

75 minutes

Materials and Advance Preparation

None

Steps

1. Begin by asking participants to raise their hands if they know a young woman who has had one or more children before the age of 18. Explain that many people think young women should delay pregnancy for a variety of reasons, while others think women should have children early. In this activity, you will be discussing both of these perspectives.
2. Divide all but a few participants into two groups. Those not in the groups will serve as judges (there should not be more than five). Explain that you will hold a debate and one group will argue the pros of women bearing children at a young age, while the other will argue the cons. Each will get five minutes to make a case and another five to rebut the other side.
3. Allow the groups 10 minutes to formulate their arguments and to assign one or two people to present them. Instruct the judges to carefully listen to each side's arguments and rebuttals, because they will have to choose a winning side based on the quality of those arguments. To the extent possible, the judges need to put aside their own personal values and attitudes in order to remain unbiased.
4. To start the debate, have the first group present its case while the second group listens carefully, since they will have to rebut the first group. Then have the second group present its argument, while the first group listens. After both sides have presented, allow five minutes for them to prepare rebuttals or follow-up arguments.
5. Have the second group present its rebuttal to the first group, then the first group present its rebuttal to the second. The judges will then discuss among themselves for five minutes and decide who has "won" the argument and why. Remind the judges that their decision needs to be based on the quality of the arguments, not on the delivery of the presenters. The judges should share their thoughts on what arguments were the most convincing.
6. Once the winning side has been declared, debrief the participants with the following questions:
 - ▶ Was it hard to debate this issue? Why or why not?
 - ▶ Was it hard to debate an issue with which you don't agree, even if it has valid points?

- ▶ Was it hard for those who acted as judges to put aside their personal values and attitudes and make a ruling based on the arguments?
 - ▶ Who in your community might argue the “pro” side and who might argue the “con” side? Did this exercise make you better understand both sides?
7. Explain that although both sides of the debate have merit, there are genuine health reasons why a young woman, 18 or younger, should delay pregnancy. They are:
- If pregnancy occurs before adolescents are fully developed—especially in countries where anemia and malnutrition are common and where access to health care is poor—they can be exposed to particularly severe health risks, including damage to the reproductive health tract, delayed or obstructed labor, ruptures in the birth canal, and elevated risks of maternal death and injury.
 - Spacing pregnancies at least three years apart helps women have healthier children and improves the odds of infants’ survival by about 50%. Babies born to adolescents may experience more birth injuries, low birth weight, and stillbirth (where the baby is born dead); infant mortality is highest in those countries with the largest proportions of adolescent births.
 - For many women, controlling their own childbearing can open the door to education, employment, and community involvement. Also, couples with fewer children are more likely to send their daughters, and sons, to school.
8. If there is enough time, break the participants into groups of three. Ask one group to create a role-play illustrating negative consequences of an early first birth. Ask another group to create a role-play about communicating the benefits of delayed childbearing to young married couples and/or community members. Ask the final group to create a role-play about how young married couples can delay childbearing. Allow 10 minutes for them to do so.

Then ask each of the groups to act out their role-plays.

9. Use the last few minutes of the activity for discussion about the barriers that young, married couples face if they want to delay childbearing and brainstorm some of the ways these barriers can be addressed. Summarize the activity by reviewing the reasons why it is important to delay first birth and use family planning.

5.3 Partner, Family, and Community Support for Family Planning

Objectives

1. To review the role of men in family planning
2. To review the roles of family and community members in young married couples' decision-making about family planning

Time

30 minutes

Materials and Advance Planning

- Flipchart
- Markers

Steps

1. Divide the participants into three groups.
2. Tell the members of group one that they will develop a list of all the ways a partner, family and community can support FP use among young married couples. Each group should record their ideas on flipchart paper and choose one person to present its information.
3. Tell the members of group two that they will develop a list of all the ways a partner, family and community can hinder or stand in the way of FP use among young married couples.
4. Tell the members of group three that they will develop a list of all the ways a peer educator can support men's engagement in family planning and all the ways a peer educator can encourage family and community members to support FP use among young married couples.
5. Ask the groups to draw a line down the center of the flipchart and put the points related to men on one side and points related to family/community on the other.
6. Bring the participants back to plenary and have each group share its list. Invite everyone to add to the lists. Discuss the ideas presented and how the role of the peer educator is important in supporting men's engagement in family planning and to increase family/community support of family planning among young married couples.

5.4 Practicing Communication Skills

Objective

1. To help participants practice communication skills and problem-solving with others

Time

75 minutes

Materials and Advance Preparation

- Small pieces of paper, each printed with a role-play (from options shown below). There should be several copies of at least three different role-plays to hand out to the volunteers enacting them. If you choose one of the three role-plays for which discussion questions are provided, only write the description of the role-play, not the questions.
- If you choose one for which discussion questions aren't included, adapt the questions from the other role-plays for the one you have chosen to use (for discussion later).
- Prepare a flipchart with the following information:

Communication Styles

- **Passive:** Passive communication is not expressing your own needs and feelings, or expressing them so weakly that they will not be heard.
- **Aggressive:** Aggressive communication is asking for what you want or saying how you feel in a threatening, sarcastic, or humiliating way that may offend other people.
- **Assertive:** Assertive communication is asking for what you want or saying how you feel in an honest and respectful way, so that it does not violate another person's rights or put the individual down.

Facilitator's Notes

You should choose the role-play topics that reflect the most important issues facing young married couples in the communities and/or countries in which you are implementing your project. If there are issues with literacy, you can read the role-play assignments to each group.

Steps

1. Before moving in to the role-play, it is important to talk with the group about communication. Begin by sharing the flipchart you prepared with the three different styles of communication. Ask the group which type of communication they believe is most useful. Stress that assertive communication is the most effective because it uses a respectful approach to communicating our feelings without hurting or offending others. Introduce the idea of using "I" statements instead of "You" statements:

"I" statements, as opposed to "You" statements, are very useful in communication because they focus the attention on the person speaking instead of the person who they are speaking to. For example, a woman speaking to her husband may say "I feel

like when you tell me I can't go to the clinic for prenatal care, it is bad for the baby," as opposed to "You should let me go to the clinic for prenatal care because it is better for the baby," it is often easier for the husband to receive. The "You" statements can sound accusatory and can make people feel like they are being attacked.

2. Ask for volunteers to share examples of when they or someone they know used these styles of communication. If the person gives an example of aggressive or passive communication, ask them how they might have changed it so it would have been more assertive. Allow 10 minutes for sharing of examples and discussion.
3. Ask for two or more volunteers and assign them a role-play topic from attached examples or ones that you create. After a few minutes of preparation, ask them to act out their role-play in front of the rest of the participants, making sure to speak in loud voices so everyone in the room can hear. These role-plays should take no more than five minutes each. The audience should closely observe and be ready to discuss them.
4. After each role-play is completed, facilitate a discussion about what happened by asking the questions listed after each scenario.
5. Continue asking for volunteers to role-play, until all the selected role-plays have been completed.
6. Close by talking about the importance of communication skills in these situations. Mention some of the keys to communication: not yelling or arguing, getting the other person to see your point of view, listening to the other person and respecting them while trying to get your point across, know the facts etc. Emphasize assertive communication and the use of "I" statements. Close with a discussion about the importance of communication skills in these situations.

Role-Play 1: Negotiating Condom Use

A young married man and woman want to have sex. They have not used any family planning methods so far and the woman suggests using condoms, but the man does not want to. The woman explains that it is not a matter of trust, but safety. The woman encourages her partner, saying that they can make it enjoyable. The man agrees to try it.

Questions for Discussion

- ▶ Did the couple take time to think about their opinions before having sex, get advice from each other, and consider the consequences of their different options?
- ▶ Did they listen to and respect one another?
- ▶ Is faithfulness (or trust or honesty) enough to protect people?
- ▶ How did the woman suggest using condoms? Do you think this was a good approach?
- ▶ What worked well in resolving the problem?
- ▶ Ask the participants to list the excuses people make for not using condoms.
- ▶ What other ways can a person persuade his/her partner to use condoms?

Role-Play 2: Negotiating “Safe Delivery at a Hospital”

A young husband is talking to his wife who is three months pregnant. She wants to deliver at the hospital because she feels that it will be better for her and the baby. Her husband doesn't want to because he feels that all the women in his family have delivered at home and his mother won't agree. He also thinks it will be too expensive. After some discussion, he agrees to consider it.

Questions for Discussion

- ▶ Did the couple take time to think about their opinions before delivery, get advice from each other, and consider the consequences of their different options?
- ▶ Did they listen to and respect one another?
- ▶ How did the woman suggest going to the hospital to deliver? Do you think this was a good approach?
- ▶ What worked well in resolving the problem?
- ▶ What other ways can a person persuade his/her partner to go to a hospital for safe delivery?

Role-Play 3: Negotiating “Family Planning Use”

A recently married husband is talking to his wife about using family planning methods. She wants to have a baby right away but her husband feels that they should wait. She feels that if she doesn't have a child right away, people will talk about her and call her infertile. She is also worried about what her in-laws and parents might say. Her husband is able to convince her and they decide to use a family planning method.

Questions for Discussion

- ▶ Did the couple take time to think about their opinions about family planning, get advice from each other, and consider the consequences of their different options?
- ▶ Did they listen to and respect one another?
- ▶ How did the man suggest they use a method? Do you think this was a good approach?
- ▶ What worked well in resolving the problem?
- ▶ What other ways can a person persuade his/her partner to use family planning methods?

More Role-Play Topics

- A young husband tries to convince his mother that he shouldn't start a family right away.
- A young wife tries to convince her husband, who is a seasonal migrant worker, to use condoms after he returns after months away.
- A young woman tries to convince her peer that she should wait at least three years before having a second child.

- A woman tries to convince her husband to accompany her to ANC visits.
- A young woman tries to convince her mother-in-law that she should deliver at a hospital.
- A young engaged woman tries to convince her parents that she should go to a health center to get information about family planning before marriage.
- One religious worker challenges another, who believes that young married couples should have children right away and not be given family planning methods.

6. STIs and HIV

6.1 Burning Questions about Sexually Transmitted Infections (STIs)

Objectives

1. To answer questions about STIs
2. To correct any misinformation about STIs

Time

30 minutes

Materials and Advance Preparation

- Trainer's Resource Sheet 8: Talking Points for Answering Burning Questions about Sexually Transmitted Infections (STIs)
- Print each of the following questions in large letters on flipchart paper.
 - ▶ What are STIs and how do people get them?
 - ▶ How do I know if I have an STI?
 - ▶ How can I protect myself from STIs during sexual activity?
 - ▶ What should I do if I think I might have an STI?
 - ▶ Can STIs be cured?
 - ▶ If I ignore my symptoms, will the STI go away?
 - ▶ What harm can STIs cause if not treated?
 - ▶ How do STIs affect pregnant women and their babies?

Steps

1. From the STI questions you prepared earlier, ask participants one question at a time and have the participants try to answer each question as a group. Correct any misinformation by using the talking points in the Trainer's Resource Sheet 8.

Trainer's Resource Sheet 8: Talking Points for Answering Burning Questions about Sexually Transmitted Infections (STIs)

1. What are STIs and how do people get them?

- STI stands for sexually transmitted infections. STIs are a group of infections that are passed from one person to another through sexual contact.
- STIs are most often passed via oral sex, vaginal sex, or anal sex.
- Some STIs, including HIV and syphilis, can be passed from a mother to her child during pregnancy, delivery, or breastfeeding.
- In order for an infection to be passed between partners, one person must be infected and pass the infection to his or her partner.
- HIV and some other STIs can also be passed through unclean injection needles, skin-cutting tools, and blood transfusions (when the blood is not tested).

2. How do I know if I have an STI?

It is very important to stress that many people who have STIs have no symptoms.

When symptoms appear, they may include:

- Abnormal discharge from the vagina or penis
- Pain or burning with urination
- Itching or irritation of the genitals
- Sores or bumps on the genitals
- Rashes, including rashes on the palms of hands and soles of feet
- In women, pelvic pain (pain below the belly button)

The only way to know for sure that someone has an STI is to go to the clinic or health center for testing.

3. How can I protect myself from STIs during sexual activity?

- Have sex only with an uninfected partner who has sex only with you.
- Know your status and get tested for STIs often (if you are sexually active with a number of partners, get tested once every six months).
- If this is not possible, or if you do not know if your partner is infected:
 - ◆ For vaginal or anal sex, use condoms each and every time.
 - ◆ For oral sex, use a condom over the penis, or plastic wrap or a condom cut open to cover the vagina or anus.
 - ◆ Engage in other forms of sexual activity, such as using your hand to stimulate your partner (always wash your hand immediately afterward).

4. What should I do if I think I might have an STI?

- Go to a clinic, and have a medical professional check you as soon as possible. Do not wait and hope the STI will go away (It may only get worse).
- If you have an STI, it is important to tell your most recent sexual partners, if possible, so they can also get treatment.

5. Can STIs be cured?

- Many STIs can be treated with antibiotics. However, viruses like HIV, hepatitis B & C, and genital herpes cannot be cured. Genital warts can be removed, but they can return. It is important to get STIs treated. Curable STIs like gonorrhea and chlamydia can cause infertility if left untreated for too long.
- It is important to remember that if just one of the partners in a relationship is treated, it is likely that the person who received treatment will be re-infected. Therefore, if one person is treated for an STI, it is essential that the partner be tested and treated as well, to prevent re-infection.

6. If I ignore my symptoms, will the STI go away?

- No. The symptoms may go away, but the STI will remain. If the STI is left untreated, it will continue to harm the body.

7. What harm can STIs cause if not treated?

If STIs are left untreated, some of the consequences can include:

- Infertility in women and men
- Increased risk for HIV infection
- Increased risk for cervical cancer (for women)
- Chronic pain
- Pelvic Inflammatory Disease (in women)
- Death

Some of the most serious consequences of STI infection affect both women and children (see below).

8. How do STIs affect pregnant women and their babies?

- Some STIs can be passed from a mother to a child during pregnancy, such as HIV, because they can enter the placenta that holds the baby and infect them. Other STIs, also including HIV, gonorrhea, and herpes, can be passed from parent to child during childbirth through the vaginal birth canal. Because of this, if a doctor knows about a woman's STI status, they can decide together to have a cesarean birth to reduce this risk.
- STIs can cause ectopic pregnancy, where the fetus dangerously develops outside of the uterus, typically in the fallopian tubes.
- STIs may also cause the water to break early, trigger early labor, or cause infection in the uterus after the birth.
- Babies who are infected can be born at a low weight, be born blind or deaf, suffer brain damage, or be generally weaker than a healthy baby.

Prenatal care can help to reduce the chances of infection to the child.

6.2 Finding the Gaps in HIV Knowledge

Objective

1. To help the participants identify their own gaps in knowledge about how HIV is transmitted

Time

45 minutes

Materials and Advance Preparation

- Sufficient copies of Handout 10: How HIV Affects the Body for all participants
- Trainer's Resource Sheet 9: HIV and AIDS: Some Basic Questions
- Copies of a brochure on HIV (if available)

Steps

1. Begin the session by asking the participants the questions in the Trainer's Resource Sheet 9: HIV and AIDS: Some Basic Questions on the next page. As the participants provide their answers be sure to clarify any misconceptions that may come up.
2. After the discussion, pass out the handout as well as a resource or brochure with basic information on HIV (if available) so that the participants have an accurate source of information to refer to.

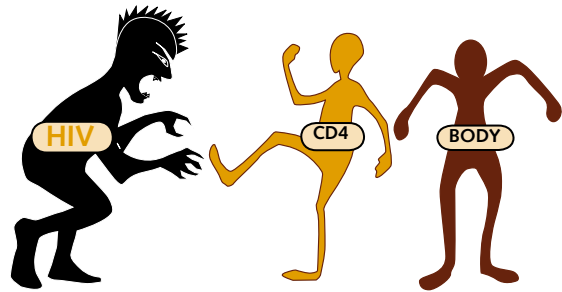
Handout 10:

How HIV Affects the Body

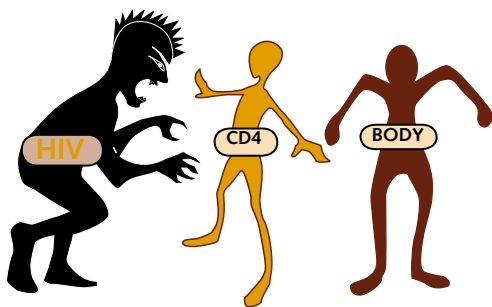
1. CD4 cells are types of white blood cells. CD4 cells are friends of our body because they protect us from infection and illness such as pneumonia or the flu.



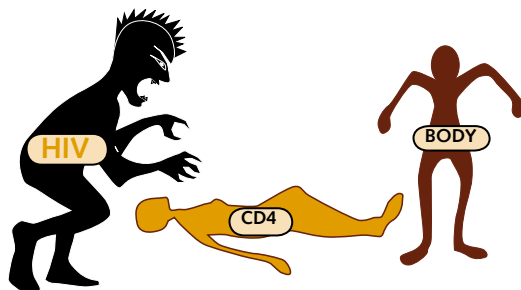
2. When a person gets the HIV virus, the virus starts attacking the CD4 cells.



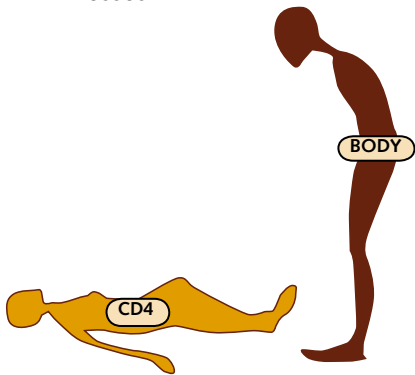
3. The CD4 cells have a hard time fighting the HIV virus.



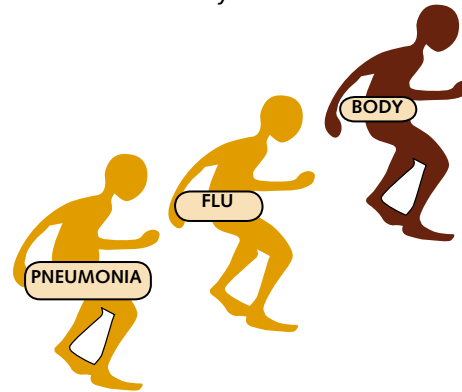
4. Soon, CD4 loses its force against HIV.



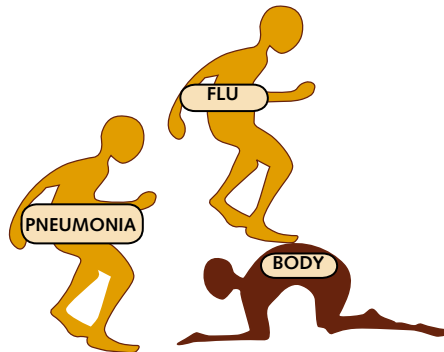
5. CD4 cells lose the fight. The body remains without a defence system to fight off infection and illnesses.



6. Now, the body is all alone, without a defence system. All kinds of illnesses such as pneumonia or the flu start to attack the body.



7. In the end, the body is so weak that infection and illnesses can attack it without difficulty.



Trainer's Resource Sheet 9:

HIV and AIDS: Some Basic Questions

How is HIV transmitted and NOT transmitted?

The HIV virus can be passed from an infected person to another person through the exchange of four different infected bodily fluids, including semen, vaginal fluid, blood and breast milk. The HIV virus can not be passed through casual, everyday contact such as shaking hands, sitting on the same toilet seat, kissing, hugging or sharing a fork. HIV is also not transmitted through mosquitoes.

Is there a link between HIV and other STIs?

Yes. Because some STIs can cause open sores, this leaves a direct opening for HIV to get into the bloodstream. It is also believed that even if there are no open sores, STIs can make a person more at risk for infection.

Are there some people who are at greater risk for contracting HIV?

As mentioned above, people with STIs can be at greater risk for contracting HIV. But remember that HIV does not discriminate. Infection rates, even among women without STIs, is increasing in many places. This is likely due to widespread lack of control over sexual and reproductive health (e.g., lack of access to condoms) and because many women's sexual rights are not upheld (e.g., inability to negotiate condom use, coercion, rape). It is also important to note that young people (under the age of 25) are at great risk, and now account for more than half of all new HIV cases every year.

What is VCT (Voluntary Counseling and Testing)?

Voluntary Counseling and Testing for HIV is a holistic process for testing for HIV. It involves providing clients with pretest counseling, testing (as desired by the client and after informed consent is provided), and posttest counseling (which may involve one or more sessions, depending on the client's needs). Individual risk assessment and risk-reduction planning are integral components of pre and posttest counseling. If the client tests positive, posttest counseling should also facilitate early referral for care and support, including access to anti-retroviral therapy (drugs that can help an HIV-positive person's immune system and allow them to live a longer, healthier life).

What is PPTCT (Preventing Parent to Child Transmission) of HIV?

PPTCT is a process for preventing parent to child transmission of HIV. A comprehensive PPTCT program involves (1) preventing HIV infection among women of childbearing age; (2) preventing unwanted pregnancy among HIV-positive women; and (3) preventing MTCT (mother-to-child transmission) during pregnancy, labor and delivery, and breastfeeding; and (4) assuring that sexual partners are also tested to avoid infection in pregnant women. Most programs only focus on the third component.

With the last component in mind, PPTCT is sometimes referred to as PMTCT, Prevention of Mother-to-Child Transmission.

For a woman who tests positive for HIV during pregnancy, PMTCT can involve taking drugs called antiretrovirals during pregnancy and the time around delivery.

At the time of delivery, a woman can opt to have a Caesarean section, which has been proven to have a more protective effect against MTCT than vaginal delivery.

After the baby is born, avoiding breastfeeding can help to prevent postnatal MTCT. Exclusive breastfeeding is also believed to be associated with lower risk than mixed feeding.

(Information Adapted from FHI Information Sheets and UNAIDS sources)

6.3 Men's Role in HIV Prevention

Objective

1. To review men's roles in HIV prevention

Time

30 minutes

Materials and Advance Preparation

- Flipchart paper
- Markers

Steps

1. Divide the participants into three groups.
2. Tell the members of group one that their assignment is to develop a list of all the ways a man can support HIV prevention.
3. Tell the members of group two that their assignment is to develop a list of all the ways a man can hinder HIV prevention.
4. Tell the members of group three that their assignment is to develop a list of all the ways a peer educator can support men's involvement in HIV prevention.
5. Bring the groups back together, and ask each group to share its list. Then discuss.

6.4 Steps to Using a Condom Correctly

Objectives

1. To examine the correct steps for using a condom
2. To identify places where people make mistakes using condoms

Time

30 minutes

Materials and Advance Preparation

Cards (or pieces of paper) with steps for condom use written on them (see below)

Steps

1. In large letters, print the following 16 steps for proper condom use on the cards, one step per card. Be sure they are in the correct order.

Condoms: Steps for Use

- Talk about condom use with partner.
 - Buy or get condoms.
 - Store the condoms in a cool, dry place.
 - Check the date made or expiration date.
 - Establish consent and readiness for sex and wait until the man has an erection.
 - Open the condom package.
 - Unroll the condom slightly to make sure it faces the correct direction over the penis.
 - Place the condom on the tip of the penis. If the condom is placed on the penis backwards, do not turn the condom around; throw it away and start with a new one.
 - Squeeze the air out of the tip of the condom while leaving two fingertips of space at the top to hold the semen.
 - Roll the condom down to the base of the penis as you hold the tip of the condom.
 - The man inserts his penis for intercourse.
 - The man ejaculates.
 - After ejaculation, hold the condom at the base of the penis while still erect.
 - The man removes his penis from his partner.
 - Take the condom off and tie it to prevent spills.
 - Throw the condom away in the trash (do not flush it, it will float back up!).
2. Randomly hand out the cards to the participants. (If there are more than 16 people, hand out one card each until they run out; if there are fewer than 16 people, give two cards to some people.)

3. Ask the participants to arrange themselves in the correct order of the steps. If the group consists of more than 16 participants and some do not have a card or piece of paper, they can help the others arrange themselves in the correct order. If the group consists of fewer than 16 participants, ask them to place the cards on the floor in order (from first step to last).
4. Process the activity with the following questions:
 - ▶ What was challenging about this activity?
 - ▶ Were you unsure of the order of any steps? Why? Could some of the steps have gone in more than one place?
 - ▶ Do you think most people who use condoms follow these steps? Why or why not?
 - ▶ What are some of the most important steps to remember when using condoms?
 - ▶ In what ways, if any, is condom use important to young married couples?

6.5 Condom Demonstration

Objective

1. To review the proper steps of condom use

Time

30 minutes

Materials and Advance Preparation

- Condoms
- Penis model (if available)

Facilitator's Notes

During this session be sure to:

- Provide information about the effective use of condoms. Emphasize what to do if a condom breaks or slips during sex (immediately remove the penis and use a new condom; if there is fear of pregnancy, get emergency contraception if available in your country).
- Highlight the fact that because breakage is often due to condoms wearing down, clients need to pay particular attention to using lubricants that are safe to use with condoms. Explain that “unsafe lubricants” are oil based and will damage the condom. Safe lubricants are ones that are water based.
- Point out that condoms need to be stored properly to remain effective. A condom may be left in a wallet for a day, but it should not be kept there over an extended period of time.
- Explain that if the condom is initially placed on the penis backwards, it should not be turned around. Throw it away and use a new one. This will prevent pre-ejaculatory fluid from coming into contact with the partner's genital area.
- Always use the correct words for body parts (e.g., penis and vagina) so people get used to the proper words and do not get confused.

Steps

1. Using a penis model and the steps from the last activity, demonstrate and explain how to properly put a condom on a penis.
2. After the facilitator has demonstrated this, ask a volunteer to repeat the demonstration. Allow others who are interested to try as well.
3. Facilitate a discussion by asking the questions below.
 - ▶ What mistakes do people make when using condoms? Which steps are sometimes forgotten or performed incorrectly?
 - ▶ Where should condoms be stored?
 - ▶ When demonstrating how to use a condom, what is the key information you need to impart to people?
 - ▶ What problems, if any, do you anticipate when demonstrating proper condom use?

7. Safe Motherhood

7.1 Understanding and Ensuring Safe Motherhood

Objectives

1. To review the dangers that may face a woman during pregnancy, labor & delivery, and postpartum period
2. To emphasize what needs to be done to ensure safe motherhood
3. To understand the roles that family and community members can play to ensure safe pregnancy, labor and delivery, and improved health in the postpartum period, including links to family planning

Time

75 minutes

Materials and Advance Preparation

- Flipchart paper and markers
- Flipcharts with descriptions of the four delays on them, as listed below
- Sufficient copies of Handout 11: Essential Actions a Woman and Her Family Must Take During Pregnancy, Labor and Delivery, and the Postpartum Period to Ensure a Healthy Pregnancy and Birth for all participants

Facilitator's Notes

Research maternal mortality and morbidity rates in the country and/or community in which you are conducting the training. It is important for participants to know the scope of the problem in their country and/or community.

Steps

1. Explain that unfortunately, many women still die or are injured during pregnancy, labor, and delivery (PLD). When a woman dies during pregnancy, labor, or delivery, we call that a maternal mortality; when she is injured as a result of PLD, we call that maternal morbidity.
2. Explain that many of the reasons women die or are injured during PLD are completely preventable. There are four main factors—or delays—contributing to maternal mortality and morbidity:
 - Delay in recognizing there is a problem (person or persons assisting during the PLD are unaware of an issue requiring the help of a trained provider)
 - Delay in seeking care after recognizing the problem (person or persons assisting during PLD recognize that there is an emergency, but delay in seeking care)
 - Delay in arranging transportation to a medical facility when necessary (person or persons assisting during PLD recognize that there is an emergency, but cannot find and/or do not have the funds for appropriate transport)
 - Delay in obtaining care after reaching the medical facility (upon arrival at the medical facility, there is a delay in being seen and treated by medical professionals)

Explain that the first three delays are delays that can be addressed and planned for by individuals and family members. After outlining the four delays, ask participants what they think are some of the reasons for each of the delays. Note their responses on flipchart paper. Be sure to emphasize that quality health care during the critical period of PLD is the single most important intervention for preventing maternal and newborn mortality and morbidity. This includes ensuring that a health worker with midwifery skills is present at every birth; preventing and treating complications during pregnancy, delivery, and after birth; as well as postpartum family planning and basic neonatal care.

3. Divide the participants into three groups and have them to brainstorm the actions a woman, her partner, her family, and her community can take during pregnancy, labor and delivery, and the postpartum period, to ensure a safe and healthy delivery and continued good health for the mother and the child. One group should focus on pregnancy, another on labor and delivery, and the third on the postpartum period. Give the members of each group 15 minutes to transform their ideas into a role-play.
4. Have each group enact its role-play. Once all role-plays have been completed, review Handout 11 with participants to ensure that they know the danger signs during PLD. Address any misconceptions or questions participants may have.

Handout 11:

Essential Actions a Woman and Her Family Must Take During Pregnancy, Labor and Delivery, and the Postpartum Period to Ensure a Healthy Pregnancy and Birth

During Pregnancy

- Ensure that the pregnant woman gets good nutrition, which includes plenty of fruits and vegetables and plenty of rest
- Attend at least four antenatal care visits:
 - ◆ as soon as she is pregnant
 - ◆ between the fifth and seventh months
 - ◆ during the ninth month
 - ◆ during the week of delivery
- Know the danger signs of trouble during pregnancy
 - ◆ severe headache
 - ◆ clouding of vision
 - ◆ swelling of hands and face
 - ◆ lower abdominal pain
 - ◆ fits or convulsions or loss of consciousness
 - ◆ any amount of bleeding
- Arrange for a skilled health provider (someone who can manage obstetrical emergencies) and necessary supplies to be available for the delivery
- Make plans to deliver at a hospital in case of emergency:
 - ◆ Arrange the quickest means of transportation to the hospital
 - ◆ Find the closest hospital where blood transfusion and emergency obstetric services are available
 - ◆ Find three people, before delivery, who can donate blood
 - ◆ Gather enough money, before delivery, for treatment

During Labor and Delivery

- Support should be given to the mother. Encouragement and support should include:
 - ◆ Emotional support – help her to relax, encourage her that she is doing a great job and provide her with encouragement
 - ◆ Physical support – help in any way you can to relieve her pain and make her more comfortable (for example, bring her water if she is thirsty or help her walk if she feels the need to move around)
- Obtain a clean home delivery kit or prepare one, by assembling a new blade, string, coin, plastic sheets, soap, and water.
- Provide water, soup, or another drink to the mother during labor.
- Request the assistance of a skilled healthcare provider (someone who can manage obstetrical emergencies).
- Those assisting at the birth should know the danger signs during delivery. If any of the following occur, rush the woman to a hospital that can manage emergencies:
 - ◆ Long labor (lasting more than eight to 12 hours) without any progress
 - ◆ Appearance of the baby's hand first
 - ◆ Appearance of the baby's leg first
 - ◆ Appearance of the baby's umbilical cord first
 - ◆ Excessive bleeding before and after delivery

During the Postpartum Period

Immediate Postnatal Care

- ◆ Baby should be cleaned and wrapped in a blanket or cloth.
- ◆ Breastfeeding should be started within an hour of delivery, after cleaning the breast of the mother.
- ◆ Family and friends should provide nutritious food, emotional support, and affection to the mother.
- ◆ The new mother should be given plenty of time to rest.
- The mother and baby should receive at least three postnatal check-ups from a skilled healthcare provider:
 - ◆ In the first 24 hours
 - ◆ After seven days
 - ◆ On the 42nd day after delivery
- Those attending to the mother should know the danger signs during the postpartum period. If any of these occur, IMMEDIATELY rush the mother to a hospital that can manage emergencies:
 - ◆ High fever

- ◆ Smelly discharge and lower abdominal pain
- ◆ Heavy bleeding
- ◆ Severe headache, convulsions and fits, or loss of consciousness
- The mother and those attending to her and the baby should know the danger signs affecting the NEWBORN. If any of these occur, IMMEDIATELY rush the baby to a hospital that can manage emergencies.
 - ◆ High fever or cold and clammy hands and feet
 - ◆ Unable to suckle
 - ◆ Rapid breathing
 - ◆ Infection around the umbilical cord area
 - ◆ Yellowish discoloration of the conjunctiva of the eye

7.2 Partner, Family, and Community Support for Safe Motherhood

Objective

1. To review partner, family, and/or community support for Safe Motherhood

Time

30 minutes

Materials and Advance Preparation

Flipchart paper and markers

Steps

1. Divide the participants into groups of four.
2. Give each group flipchart paper and markers. Assign one of the following topics to each:
 - Ways men can support safe pregnancy, labor, and delivery
 - Ways men can hinder or stand in the way of safe pregnancy, labor and delivery
 - Ways family and/or community members can support safe pregnancy, labor and delivery
 - Ways family and/or community members can hinder or stand in the way of safe pregnancy, labor and delivery

Ask each group to illustrate their assigned topic through drawings. Allow 15 minutes for them to complete their drawings.

3. Have each group explain their drawings. Ask the group to identify the specific things that were identified in the drawings that illustrated how men, family and/or community members could support safe pregnancy, labor and delivery. List these on flipchart paper.
4. In closing, be sure to emphasize that men, family, and community members should be aware of potential risks involved in pregnancy, birth, and at the post-partum stage, and be attentive to a woman's health and needs during these stages.

8. Violence

8.1 Types of Violence and Abuse

Objective

1. To help participants identify different forms of violence against women

Time

45 minutes

Materials and Advance Preparation

- Develop a list of community resources related to gender-based violence for all participants. This should include a list of resources in the community for women facing abuse and a list of resources in the community where men can get help to stop their abusive behavior (if available)
- A few copies of Trainer's Resource Sheet 10: Example of a GBV Role-Play

Facilitator's Notes

If you would like to draft another role-play that is more appropriate for the community context, make copies for the actors to use.

Steps

1. Tell participants that the following activity will help them identify various forms of violence against women through a role-play depicting a situation of abuse.
2. Remind participants that role-plays can bring up strong feelings and make people feel uncomfortable. Let them know that they are free to leave the room if they need to, and that if they do, someone will come check on them.
3. Ask participants to come up with the names of a husband and wife. They should not be the same as anyone in the room. Ask for two volunteers, one to play the husband and another to play the wife. Be sure to mention that the people doing the role-play will need to read a script.
4. The rest of the participants should imagine that they are neighbors observing this scene.
5. Set up the role-play, by saying, "This is the setting: It's the end of the day. The husband arrives home after a long, hard day of work. The ride home has been difficult and long. He's stressed out about the family expenses. The wife has also been working all day in the fields and house and is now taking care of the kids. She's getting ready to go out to participate in a women's group that is establishing a savings and credit program. The role-play begins as he arrives home."
6. Give the people doing the role-play a few minutes to review the script (Trainer's

Resource Sheet 10). Ask them to enact the role-play. Make sure it includes, or refers to several types of violence—physical, verbal, emotional, financial, and possibly sexual.

7. Explain that there are five main categories of abusive behavior: physical, sexual, emotional, financial, and verbal. Divide the participants into five groups and assign one category of abusive behavior to each. Ask them what from the case study fits into their category, in what other scenarios this abusive behavior might appear and how these behaviors/scenarios exist in their communities. Allow 10 minutes to complete the activity.
8. When they have finished, ask each group to quickly summarize its work. When each has done so, ask everyone if they can think of any other kinds of abusive behavior that do not fit into one of the five categories.
9. Discuss the following questions with the participants after the role-play:
 - ▶ What feelings came up for you as you watched the role-play?
 - ▶ What kinds of violence did you witness as this scene played out?
 - ▶ What are some other ways that this scene could have played out? What other types of violence may have appeared?
 - ▶ In what other situations might a man become abusive or violent with his partner?
 - ▶ What kinds of violence might she experience from other family members?
 - ▶ Were the scenes in the role-play reflective of what women in your community might have experienced?
 - ▶ What can family or community members do to support women in this type of a situation?
 - ▶ What is the relationship between violence and a person's reproductive health?

Tell the participants that gender-based violence, including domestic violence, can cause tremendous damage to both women and children, especially when not dealt with.

For children:

Domestic violence can leave children confused, angry, depressed, and fearful. Witnessing domestic violence in the home can interfere with children's ability to succeed at school and can increase the likelihood that they will use drugs and alcohol, become involved in a gang, and/or commit crimes. Girls who live in homes where domestic violence occurs are at greater risk of being abused themselves. Young men who grow up in violent homes are much more likely to be perpetrators of domestic violence.

For women:

Women who are victims of gender-based violence often suffer on multiple levels. Physically, women not only suffer pain from injuries, but also are at increased risk for STI transmission and unplanned pregnancies. Emotionally, domestic violence can cause depression, anxiety, decreased self-esteem, and foster dependence on drugs and/or

alcohol. With domestic violence also comes the risk of death. Worldwide, it is estimated that 40–70% of all female murder victims are killed by intimate partners.¹⁴

10. Summarize the activity by explaining that gender-based violence occurs in all communities, regardless of race, class, nationality, religion, etc. Explain that people deliberately use violence and abuse to gain power and control over their partners. It is not a result of someone losing control. It is also important to mention that while we typically talk about women as the abused, they can also be the abusers. Though this tends to be much less common, it is important to be able to support and help men when they are in this situation.
11. Distribute the list of community resources that you prepared earlier to all participants.

¹⁴The Effects of Domestic Violence. 2003. Minnesota Advocates for Human Rights.

Trainer's Resource Sheet 10: Example of a GBV Role-Play

Husband (*Comes through door, banging it closed behind him, a scowl across his face*): I'm home. What's for dinner?

Wife: Hello. How was your day?

Husband: It was terrible. I don't want to talk about it.

Wife: What happened?

Husband: (*Crossly*) Didn't I tell you that I didn't want to talk about it?

Wife: (*Keeps quiet*)

Husband: What's for dinner anyway?

Wife: Dinner is on the stove. All you have to do is heat it up. Remember I'm going to the meeting for the savings and credit group.

Husband: You're going where?

Wife: I'm going to the group with the other women in the community. I told you about it last night.

Husband: Look, I've been working hard all day. The least I can expect is that you have dinner ready for me. And what's this business about the savings and credit group. I told you I didn't trust that type of project. Get into the kitchen and get dinner ready for me and the kids.

Wife: Please, I really have to go now. I'm already running late.

Husband: You're not going anywhere until you've served me dinner. Do you understand? Besides, I don't know why you bother with these programs. They are complicated and you are too stupid to understand them.

Wife: You don't need to talk to me like that.

Husband: You'd better not tell me what I can say in my own house.

Wife: I have to go. They are waiting for me at the community hall.

Husband (*Raising voice, he walks up to her and grabs her firmly by the arm*): You're going to get into the kitchen is what you're going to do. You remember what happened last time you talked back to me, don't you? Don't make me do that again.

Wife: If you hit me again I'll leave you. I promise.

Husband: Oh yeah? And where do you think you're going to go that I won't find you. You tell me? And who's going to take you anyway. You can't go back to your parent's

house. You think my parents will take your side? No one would want you. You're stupid, useless, ugly. You're lucky I haven't gotten rid of you yet. Besides, you don't have any money. I am the one who makes the money and supports you. What are you going to do if you run away? You think that I will let you take the children?

Wife (*On the verge of tears*): I can't believe you're treating me like this. I have done everything for you. All you have to do is heat up the food.

Husband: Are you talking back to me? I have had about enough of your back talk. (*He raises his hand to her, yelling into her face.*) Now get to the kitchen or else I'll teach you not to argue with me.

8.2 Sexual Consent

Objectives

1. To identify situations in which consent for sexual activity is not given
2. To identify ways men can better understand when consent for sex exists

Time

60 minutes

Materials and Advance preparation

- Two signs (one that says “Consent” and another that says “No Consent”).
- Review the scenarios provided below. Choose several that will produce the best discussion.

A man has married a woman after paying a dowry. They have had sex regularly, but the woman tells her husband that she does not want to have sex on this occasion. The man forces sex with his wife anyway. (*No consent*)

A young woman gets drunk at a party. She is flirting with and kissing a young man. After dancing with him, she passes out in a bedroom. The young man has sex with her while she is sleeping. (*No consent*)

A woman and man are kissing on a bed with their clothes off. They have never had sex before. The man inserts his penis inside her vagina and she asks him to stop. He doesn't, even after she continually tells him to stop. (*No consent*)

A woman and man are kissing on a bed with their clothes off. They have never had sex before. The man inserts his penis inside her vagina and she does not say anything. (*Not enough information—what would allow us to know that consent existed?*)

A woman does not want to have sex. Her partner threatens to beat her if she does not sleep with him. She does not say anything as her partner has sex with her. (*No consent*)

A woman and a man are kissing on a bed with their clothes off. They have never had sex before. The man asks if it is okay if he inserts his penis inside her vagina and she says it is okay. They continue and have intercourse. (*Consent*)

Steps

1. Before the activity begins, put up the two signs on either side of the room.
2. Tell the participants that the group will be discussing sexual consent. Review the definition of sexual consent: “Sexual activity that both people want and freely choose.”
3. Ask the group to share why it is important that every human being have the right to consent to sexual activity.

4. Explain that you will be sharing some scenarios where the group will have to decide if consent was present in the scenario.
5. Read aloud the first statement you have chosen. Ask participants to stand near the sign that says what they think about the statement. Then ask one or two participants beside each sign to explain why they are standing there. Ask them why they feel this way about the statement.
6. After a few participants have talked about their attitudes towards the statement, ask if anyone wants to change their mind and move to another sign. After each statement, share whether or not the scenario actually does demonstrate consent or not. The correct response is given in parentheses. Clarify any misconceptions from the participants.
7. Bring everyone back together and read the next statement. Do this for each of the statements you have chosen.
8. After discussing all of the statements, ask the discussion questions:
 - ▶ What statements were difficult to take a position on? Why?
 - ▶ What can men do in order to have a clear understanding of their partners' consent?
 - ▶ How can sex without consent contribute to the spread of HIV?
 - ▶ What are the effects on women if a man forces sex upon her?
 - ▶ What can a man do if it is unclear whether or not a woman wants to have sex with him?
 - ▶ What can be done to improve men's attitudes, understanding, and acceptance of a woman's right to say no to sex?
9. Close the discussion by saying that forcing someone to have sex against their will is against the law, is a gross violation of human rights, and has a devastating effect on the person being raped. It is important to remember that consent is necessary for every sexual contact, even if the partners are married or have had sex before. Respect and good communication are the best strategies to ensure that sexual relations are consensual and enjoyable for both partners.

9. How to Reach Married Youth

9.1 Reaching Married Youth and Influential Adults

Objectives

1. To understand the importance of working with married youth, their families and the community to help married youth reach their reproductive health goals
2. To brainstorm methods for reaching young couples and other influential community members

Time

30 minutes

Materials and Advance Preparation

- Flipchart
- Markers

Facilitator's Notes

Remind participants that in many programs for married youth, it is as important (at least in the beginning) to reach out to key adults (parents, in-laws, religious leaders, etc.) as it is to the young people, because of the amount of influence they exert.

Steps

1. Review the categories of married youth that this project is trying to reach (Activity 4.3). Ask participants to brainstorm and name adults that might have an influence in the lives of the young people. Some examples are:
 - Parents-In-Law
 - Parents
 - Other relatives/family
 - Teachers
 - Service Providers
 - Community Leaders
 - Religious Leaders

Explain that it is not enough for peer educators to reach out just to married youth, they must also reach the people who significantly influence their lives.

2. Divide the participants into three groups: Assign one group to focus on young women,

another group to focus on young men, and the third to focus on adults who have influence in the lives of young people. Ask them how they would reach married youth and adults in the community, both individually and as a group, in order to get them involved in educational activities.

Ask the groups focusing on young men and women to remember the various categories of young people mentioned in the training, since some, such as newly-married young women, may be more difficult to reach due to social restrictions. Ask the participants to also think about the different ethnic and socioeconomic groups in their community and how each group can be reached. Allow 15 minutes for this exercise.

3. Ask one person from each group to present the team's work to the rest of the group. After the three groups have presented, discuss, with these questions:
 - ▶ What were the similarities in all three groups' approaches?
 - ▶ What were the differences in approaches?
 - ▶ What group(s) were the most difficult to reach?
 - ▶ What would be the least costly ways to reach the groups?
 - ▶ What methods would be most effective?

9.2 Types of Peer Education Activities

Objective

1. To explore the various ways to reach out to young married women, men, and other adults who have influence in their lives.

Time

30 minutes

Materials and Advance Preparation

Flipchart and markers

Steps

1. Explain to the group that in this activity, they will focus on the methods they can use as peer educators to reach young people and other stakeholders.
2. Ask participants to form three groups. One will focus on the kinds of activities that would be best to reach young women, one for young men, and one for community members. Encourage groups to be as creative as possible. Ask them to identify the methods they will use to reach each of these groups.
3. Bring all the groups back to plenary and have one person from each group present the team's work. Add the following ideas, if they're not mentioned to the list:
 - Peer-to-Peer Conversations
 - Group Discussions
 - Community Fairs
 - Film Shows
 - Drama Shows
 - Home Visits
 - Poster Displays
 - Song Competitions
 - Messaging on Community Walls (Murals)
4. Discuss the ideas collected and identify whether any of the methods work better for one group than another.

9.3 Practicing Peer Education

Objective

1. To give peer educators an opportunity to practice peer education skills

Time

60 minutes

Materials and Advance Preparation

Trainer's Resource Sheet 11: Peer Education Role-Plays

Facilitators Notes

Additional role-plays can be created that better address local issues for married youth.

Steps

1. Ask the participants to brainstorm the skills necessary for conducting peer-education activities. Make sure the following are covered:
 - Listening well
 - Being respectful
 - Making others feel comfortable
 - Encouraging others to express their views
 - Providing clear, understandable explanations
 - Confidence
 - Knowledge of topics being discussed
2. Tell the group that they will be practicing some of these skills through the use of role-play. To the extent possible, everyone in the workshop should, at some point, be involved in the role-play portion of the activity. Some will perform the role-play, while others will observe and provide feedback. Participants should not feel shy, since this is a way to practice their skills. For every role-play scenario, the main goal is to make certain that young married individuals (or couples, depending on the role-play) have access to information and services and can make their own decisions about their reproductive health.
3. Ask volunteers for each role-play. Ask them to perform one of the role-plays listed in the Trainer's Resource Sheet 11. Allow five minutes for each. Then ask the observers for feedback, using the following questions:
 - ▶ What did the participants do well?
 - ▶ What could the participants have improved upon?
 - ▶ Did the "peer educators" address all the issues? Why or why not? If not, how could they have addressed them better?

4. Ask the participants playing the role of peer educators, the following questions:
 - ▶ What did they find difficult to do?
 - ▶ What skills would they like to practice more?
 - ▶ What issues were difficult to discuss?
 - ▶ What did they like about being a peer educator? What did they not like?

Trainer's Resource Sheet 11:

Peer Education Role-Plays

- A group of peer educators goes to a religious group gathering to discuss the benefits of delaying the first pregnancy. There are several mothers-in-law there who think that recently-married couples should have children right away.
- A young married couple visits a peer educator to get information about family planning methods. The wife wants to use a family planning method, but the husband does not.
- A peer educator makes a home visit to a young pregnant woman. The peer educator talks to the husband and wife and their parents as a group about delivering at the hospital. The wife wants to deliver at the hospital, but the husband is undecided. His parents think that their daughter-in-law should deliver at home because that is their custom.
- A peer educator makes a home visit to a girl who has recently gotten married, but has not moved to her husband's house. The peer educator wants to talk to her about reproductive health generally, including family planning. Her parents feel that it is unnecessary to talk to her about these things.
- A group of male peer educators has gone to talk to young married men about getting more involved in reproductive health issues and discussing these issues with their wives. The young married men think that reproductive health is a woman's responsibility and do not want to get involved.

10. Planning Ahead and Closing

10.1 Developing an Action Plan

Objective

1. To help participants prepare plans for training in their communities

Time

45 minutes

Materials and Advance Preparation

Sufficient copies of Handout 12: Personal Peer Education Action Plan for all participants

Facilitator's Notes

Remind participants that it is as important for them to reach out to key adults in the lives of the young couples as it is to reach out to young, married couples. For illiterate participants, explain the key elements of the plan to them and ask them to share their ideas in plenary. Note their ideas on flipchart paper.

Steps

1. Explain to the participants that they will be asked to reflect individually on this training and their role as a peer educator to develop an action plan detailing how they are going to reach out to married youth and others in their community over the next three months.
2. Remind them to target every category discussed in the training, especially marginalized groups. Pass out the handout to the participants and ask them to fill it in. Allow 20 minutes for the exercise.
3. Bring the participants back together and ask for a few volunteers to share their ideas.
4. Ask participants to break up into groups with others from the community/district where they live. Have them think about how they might work together.

Handout 12: Personal Peer Education Action Plan

Activity	Who will this activity reach?	How often will this activity be done?	Where will this activity be done?	By whom?	What resource(s), if any, will be needed?

10.2 Wrap-Up and Reflection

Objective

1. To reflect on the ideas and information exchanged during the day/training

Time

10 to 20 minutes

Materials and Advance Preparation

Paper and pencils for all participants

Facilitator's Note

If there are participants in the group who are illiterate you can ask people to share their ideas verbally and record them on a flipchart.

Steps

1. Give each participant a pencil and paper. Ask them to complete the following statements:
 - a. This training has taught me that...
 - b. I was most surprised that...
 - c. I want to think more about...
 - d. I hope that I can...
2. Ask a few participants to share what they wrote.
3. Close the session by thanking all of the participants for their time and energy. Assure them that there will be times designated in the future for continued learning and sharing, as well as support for peer educators.

The Ecological Model

This manual highlights the importance of linking education to action. As a tool for the trainer, the Ecological Model, often used during action-planning in workshops, can help you communicate to the participants how to turn the knowledge and skills developed in the workshop into action for social change

Introduction to the Ecological Model

The Ecological Model provides a conceptual framework for a more comprehensive approach to working with young married people. The model emphasizes that to change individual behavior, programs need to not only work with individuals, but to also address the systems and groups—peers, families, communities, media, policies—that influence individuals. This model encourages individuals and groups to think about:

- Changes that are needed across all sectors of society
- The range of strategies across different levels of action required to bring about these changes
- The roles of social actors involved in such changes

The Ecological Model underlines the different levels of action required to effect changes in the reproductive health of young married couples. These are:

The Levels of the Ecological Model

1. Strengthening Individual Knowledge and Skills

Provision of reproductive health information and skills to young married couples so they can make the best decisions for themselves. This also means helping them understand how gender and social norms can put them and their partners and families at risk and how to promote alternate, healthier behaviors.

2. Creating Supportive Peer and Family Structures

Educating peers and family members about health risks and the ways they can support young married couples to promote their reproductive health and safety.

3. Educating Health Service Providers

Informing and educating providers about the specific needs of young married couples so they can pass on their skills and knowledge to others. Providers can encourage and support young, married men and women who seek healthcare and want to support their partners' access to health information and services.

4. Mobilizing Community Members

Educating community members and groups about health risks and ways to support young married couples to take actions that promote their reproductive health and safety. Programs can also mobilize groups and individuals to develop coherent strategies for promoting the reproductive health of young married couples.

5. Influencing Policy Legislation at the Societal Level

Developing strategies to change laws and policies so that they promote and support the reproductive health of young married couples.

Working across levels

When using the Ecological Model, it is important to pay attention to the links between the various levels. In other words, no level should be seen as independent of any other. It should become clear, for instance, that policy work affects and is affected by community education. Community education, in turn, is affected by and impacts how individuals in a community regard a particular issue.

Information to be recorded

For each level, the model can help participants identify:

- WHAT actions to take
- WHO should take these actions
- HOW to assess the success of these actions (this final column provides a record of group suggestions for indicators of success. These “indicators” answer the question: How will we know if actions are being successful)

If you want to use the Ecological Model in action planning, put the following on a flipchart (see example below) or create a handout of the Model and pass it out to participants. Remember that you will probably need more than one sheet or handout during a workshop. If a particular training activity is intended to help participants think about ways to reach out to or support young married couples, ask them to use the Ecological Model to record those ideas. They can write each in the appropriate level of the Ecological Model. This will be useful for developing action plans after the training.

Example: The Ecological Model

	WHAT? Action	WHO? Person or organization
1. Strengthening Individual Knowledge and Skills		
2. Creating Supportive Peer and Family Structures		
3. Educating Health Service Providers		
4. Mobilizing Community Members		
5. Influencing Policy Legislation at the Societal Level		

