Pack Two—Programming for Behavior Change and Development

1. Introducing Pack Two

Pack Two is designed for frontline staff and managers working on programs that aim to develop healthy behaviors and reduce risk behaviors among young people. With social and behavioral change at the heart of most programs, staff need an in-depth understanding of: sexual and reproductive health behaviors and outcomes; principles of effective programs with youth; behavioral and social change theories and approaches; and intervention design and implementation.

Framing the Issues

In section 2, “Addressing Issues in YSRH,” participants will consider key YSRH outcomes and behaviors, and the social influences that shape those behaviors. Priority outcomes and behaviors differ significantly according to sociocultural context and economic and political conditions. Principles and lessons learned from effective programs for behavior change are introduced.

Exploring the Principles

Principles of effective programs include understanding and working with youth, clarifying values about sexuality, and encouraging a participatory learning process. In section 3 (“Understanding and Working with Youth, Sexuality, and Values”) and section 4 (“Skills for Working with Youth and Adults”) participatory skills-building activities are introduced to build knowledge of factual information and improve communication with young people. These activities can be used with adults working with youth and some may also be appropriate to use directly with youth.
Understanding Behavior Change and Social Learning

In section 5, “Behavior Change: Theories, Processes, and Applications” are presented. In section 6, “Social Learning: Theory, Processes, and Applications” are introduced. Both types of approaches are widely used in youth behavior change programs, and concentrate on change at the individual and interpersonal levels.

Designing Programs

In section 7, “BCC Interventions: Diagnosis, Development, and Delivery,” participants apply what they have learned in the previous sections to design a behavior change communication (BCC) intervention for youth. Participants will identify key goals and outcomes, influencing factors, and program activities to address those factors.

Developing Knowledge, Skills, Behaviors, and Relationships among Youth

Three types of programs are commonly used to develop and promote healthy behaviors among young people. In section 8, programs in “Sexuality, HIV, and Life-skills Education” are discussed. Section 9 focuses on “Peer Education” approaches. Section 10 illustrates models of “Parent Education.” In each of these three sections, participants discuss and share experiences of designing and implementing these types of programs in different settings.

Activities

3. Understanding and Working with Youth, Sexuality, and Values
   Activity 3.1—Understanding Youth
   Activity 3.2—My Own Adolescence
   Activity 3.3—Values Clarification on Sexuality
   Activity 3.4—Understanding Sexuality
   Activity 3.5—Sexuality through the Life Cycle

4. Skills for Working with Youth and Adults
   Activity 4.1—“Down There” Bingo
   Activity 4.2—Body Mapping
   Activity 4.3—Myths and Facts
   Activity 4.4—Sexual Jeopardy
   Activity 4.5—Safari of Life
   Activity 4.6—Life Behaviors for a Sexually Healthy Adult

5. Behavior Change: Theories, Processes, and Applications
   Activity 5.1—Risk Assessment: Wearing a Helmet or Seatbelt
   Activity 5.2—Key Concepts of Comprehensive Sexuality Education
   Activity 5.3—Identifying the Six Stages of Behavior Change

   Activity 6.1—Orientation to Social Learning Theory
7. BCC Interventions: Diagnosis, Development, and Delivery
   Activity 7.1—Identifying Youth Problems and Healthy Sexuality Outcomes
   Activity 7.2—Case Studies of Katbang and Talipo
   Activity 7.3—Designing Behavior Change Programs

8. Sexuality, HIV, and Life-skills Education
   Activity 8.1—Who’s at Risk? – Revealing and Analyzing Stereotypes
   Activity 8.2—Risk Behaviors
   Activity 8.3—Decisions and Consequences

9. Peer Education
   Activity 9.1—Role-Play – How Peers Influence Each Other
   Activity 9.2—Designing a Peer Program
   Activity 9.3—Implementation Issues in Peer Programs

10. Parent Education
    Activity 10.1—Where Did I Learn about Sex?
    Activity 10.2—Messages about Sexuality

---

**Framework for Pack Two**

1. Framing the Issues
   - 2. Addressing Issues in YSRH

2. Exploring the Principles
   - 3. Understanding and Working with Youth, Sexuality, and Values
     - 4. Skills for Working with Youth and Adults

3. Understanding Behavior Change and Social Learning
   - 5. Behavior Change: Theories, Processes, Stages, and Applications
   - 6. Social Learning: Theories, Processes, and Applications

4. Designing Programs
   - 7. BCC Interventions: Diagnosis, Development, and Delivery

5. Developing Knowledge, Skills, Behaviors, and Relationships Among Youth
   - 8. Sexuality, HIV, and Life-skills Education
   - 9. Peer Education
   - 10. Parent Education
2. Addressing Issues in YSRH

Introduction

This section provides an overview of issues related to social and behavioral change to improve YSRH health. We review some of the key points from Pack One regarding behaviors and outcomes, and individual and social factors that influence decision-making and behaviors. We then review intervention strategies for bringing about changes in individuals, and relationships and groups that support healthy youth development. The contents of this section are divided into four parts:

• YSRH outcomes and behaviors
• Individual behavioral factors
• Social influences
• Intervention strategies

Issues

With social and behavioral change at the heart of YSRH programs, staff needs to acquire an in-depth understanding of sexual and reproductive health program outcomes that relate to adolescent development, behavior, and decision-making. In this pack, participants will discuss broad issues related to individual, interpersonal, household, and institutional-level change.

To build on the assets of youth while reducing their vulnerabilities, we need to influence the many transitions that mark adolescence and have consequences in adulthood. These key transitions include the onset of puberty, first sexual intercourse, marriage, childbirth, leaving school, separation from parents and beginning employment. Influencing these transitions requires an understanding of sociocultural and gender factors that create diversity in the reproductive health needs of adolescents.

YSRH Outcomes and Behaviors

Individual health and health behavior are influenced by culture, and social norms and interactions. Indeed, the primary causes of morbidity and mortality among youth are rooted in behaviors and social environments (Blum 1999). In working with youth, we want to prevent unwanted health outcomes and behaviors such as:

• Unwanted pregnancies.
• STIs, including HIV.
• Alcohol and other substance abuse that leads to addiction, injuries, unsafe sexual behavior, and HIV/AIDS transmission.
• Injuries and mortality due to violence.

We also want to promote positive and healthy development in terms of:

• Improved nutritional status.
• Improved educational and vocational opportunities.

• Increased sense of safety, belonging, self-esteem, and caring relationships (WHO/UNFPA/UNICEF 1999).

• Positive development, which includes participating as citizens; responsible decision-making; assessing risks and consequences; assessing costs and benefits of decisions and actions; and forming positive relationships and communication with peers, partners, and adults (Blum 1999).

Specific behaviors associated with undesirable or negative sexual and reproductive health outcomes include the following:

• Early sexual activity

• Multiple sexual partners

• Unwanted and unprotected sex

The behaviors, attitudes, values, skills, and information that lead to unhealthy outcomes or to positive development occur within a complex set of factors at individual, interpersonal, community, and societal levels.

**Individual Behavioral Factors**

Multiple factors influence whether or not individual youth engage in behaviors that put them at risk for unwanted health outcomes. **Risk factors**—those that increase the likelihood of unwanted health outcomes and behaviors—including biological factors such as older age, physical maturity, and higher hormone levels. They also include related risk behaviors such as alcohol or drug abuse, and emotional distress such as depression and higher levels of stress. Family background and history, such as a history of sexual abuse, may also contribute to early or unprotected sexual behavior. It is important to note that many of these factors fall outside the realm of YSRH programs, and therefore cannot be addressed by them.

**Protective factors** increase the likelihood of positive behaviors, including health and well being, and decrease the likelihood of negative behaviors. These may include good school performance, hope for the future and strong religious ties. Other factors relate to sexual beliefs, attitudes, and skills, and these include the following:

• Greater perceived susceptibility to and awareness of pregnancy, STIs, and HIV.

• A sense of importance in avoiding unwanted health outcomes.

• Knowledge of and positive attitudes toward condoms and contraception.

• A greater sense of self-efficacy, or sense of confidence in one’s ability to use condoms and contraception (Kirby 2001).

All of these factors can be strengthened through sexuality and life-skills education programs.

**Social Influences**

Social structure, kinship, family relationships, and peer networks define the social norms that shape how young people are socialized into adult roles. At the household level,
family and kin expectations reflect broader cultural ideals for age at marriage and childbearing, selection of partners, and ideal family size. Often, it is within the extended family that information about sex and reproductive behavior is communicated, and in which rites of passage from childhood to adulthood are performed.

Connections, positive relationships with adults and institutions, help protect young people from risky behaviors. Adults play a key role in teaching gender roles and making decisions on behalf of young people, while connections with institutions, such as schools, and nonformal organizations, such as sports groups, are also important. “In the absence of positive relationships with adults, young people, especially girls, are more likely to report having early sexual activity, being approached for unwanted sex, or experiencing some form of sexual coercion or exchange” (FOCUS 2000).

Peer influences can both negatively and positively influence health outcomes. Negative peer influences include encouraging the use of alcohol and drugs, or pressuring others to engage in early sexual activity. Peers can also positively influence friends to protect themselves by:

- Controlling the consumption of alcohol or drugs.
- Delaying onset of sexual activity.
- Promoting the use of condoms and contraceptives.
- Sticking to one partner.
- Seeking health services.

Indeed, peers can be a source of support and encouragement, particularly when family members are not. Research has found that if youth believe their friends are having sex and/or using alcohol, drugs or tobacco, they are more likely to engage in those behaviors themselves (Kirby 1999; Bond and Magnani 2000). In fact, perceptions regarding peers’ behavior and attitudes toward sex are among the strongest indicators of whether or not a young person is sexually active. Because of the importance of friends in the lives of young adults, many YSRH programs put an emphasis on peer education or peer promotion.

Although the decision to engage in sexual activity or to use a contraceptive method ideally occurs between two individuals, in reality the situation is often more complex and may involve more people. Gender norms and expectations, as well as power differentials between partners, may play a significant role in sexual and reproductive health behaviors. Many women experience sexual coercion or engage in deliberate sexual exchange due to economic need and/or perceived benefits from their sexual partners. Young and older men report believing in different levels of risk for disease transmission with different types of partners, which ultimately affects their behavior. Partner communication, relationship type and age differences between partners are important correlates of condom or contraceptive use.

Although the sex ratio at birth slightly favors boys, they are more likely to die at every age than girls (WHO 1999). Socialization into traditional masculine roles promotes greater risk-taking among boys, along with the accompanying consequences: infection, disease, injury, and death from accidents, violence, homicide and substance abuse. Moreover, boys’ greater access to power does not prevent depression, as reflected by their higher suicide rates.
Girls experience a distinct set of vulnerabilities very different from their male counterparts. As they reach adolescence, girls are often under pressure to marry; as a result, their social movement is frequently limited to protect their reputation and eligibility for marriage. Access to schooling may also be limited. Marriage is often followed quickly by pregnancy, thereby increasing girls’ biological, social, and economic vulnerabilities. Girls are vulnerable not simply because they reach adolescence—they are vulnerable because of the social norms that limit their power and ability to control their own sexual activity and reproductive health once they reach puberty.

Clearly, boys and men need to be engaged in changing gender norms, not only for the benefit of girls and women, but also for themselves. Though the specific implications differ, prevailing gender and social norms undoubtedly negatively influence both boys and girls.

**Intervention Strategies**

Programs need to pay attention to young people not only as individuals, but also as part of a larger social network. Interventions have the greatest impact when they not only provide information and services, but address both individual behaviors and the social and contextual dimensions of adolescence.

In Pack One, section 3, we introduced the key elements of YSRH programs (see the table, next page). This pack’s focus is developing the strategies and skills necessary to conduct quality programs that: develop knowledge; skills; attitudes; and healthy behaviors among youth through sexuality and life-skills education, peer education, and parent education programs.

There are several points to keep in mind that contribute to the success or effectiveness of a program. These will be emphasized through a series of participatory learning activities that can be performed with other programmers or youth and are briefly outlined below.

**Building supportive partnerships between youth and adults is key.**

Youth and adult caregivers require clear and accurate information about sexuality and reproductive health. In most countries, issues surrounding adolescent sexuality and reproductive health needs are still sensitive, if not taboo. The first step in addressing this sensitivity is to facilitate dialogue among adults and young people to generate a better understanding of young people’s needs and concerns, and to encourage adults to consider their roles, responsibilities, and contributions to the welfare of youth. This requires that adults be aware of their own values and learn to communicate with youth in an open, non-judgmental manner.

**Providing information alone is not sufficient in addressing behaviors.**

There is strong evidence to suggest that information alone is not enough to change behavior. Young people are often not aware of risks and consequences, and thus their attitudes, intentions, and motivations to avoid unwanted health outcomes should be strengthened.
There is no evidence that providing information about sexuality and reproductive health increases sexual activity.

**Addressing peer social norms and perceptions and building social support for youth are essential.**

Programs need to make better use of natural channels of communication and influence among youth. This includes identifying and using different modes of influence in order to accommodate the diversity of youth groups and networks. It also requires that peer programs choose peer leaders carefully, and encourage them to present curricula and messages about social situations. Finally, it is important to identify characteristics that youth relate to.

By addressing these points, we will be able to pioneer a second generation of programs that:

- Create community support by working with adults.
- Strengthen positive relationships or connections.
- Promote autonomy and skill building.
- Modify social norms that put young people at risk.

**Incorporating social learning theory into sexuality education is crucial.**

Elements of successful sexuality education are based in social learning theory (Kirby 1997, 2001). These elements include the following:

---

• Focusing objectives on reducing one or more sexual behaviors that lead to STIs, HIV, or unintended pregnancies.
• Using methods that are appropriate to age, sexual experience, and culture.
• Basing programs on theoretical approaches.
• Designing programs to last a sufficient length of time.
• Using a variety of teaching methods.
• Providing basic and accurate information.
• Addressing social pressures.
• Using a skills-based approach.
• Selecting and training teachers and peers carefully.
• Using clear messages that are continually reinforced.

By drawing on these frameworks and lessons, we can avoid replicating approaches that have not been successful in leading to positive development and behavior change. We can also implement and test new approaches that address the social and behavioral factors that affect the health of young people. Throughout this pack, additional theories, frameworks, and activities will be introduced to facilitate this process.

References
Introduction

It is well recognized that young people should be involved in every aspect of YSRH programs. At the same time, it is important to acknowledge that adults will usually be the ones involved in the management of a program, from its initial conceptualization to its final evaluation. Therefore it is essential that adults working in the YSRH field have a solid understanding of youth and sexuality. It is also important that adults have an opportunity to explore their values and attitudes towards young people and sexuality.

A program has a much greater chance of success if it takes the time and effort necessary to improve staff knowledge and attitudes towards youth and sexuality. If adults learn that human sexuality is a natural life-long process then they are more likely to understand the need to provide healthy messages about sexuality from an early age. If they see human sexuality in a positive light, they can develop YSRH programs that carry positive messages, rather than simply focusing on problematic behaviors. By developing a better understanding of youth, adults can create programs that are not judgmental and respect young people’s rights and their ability to make healthy, informed decisions.

In short, we must first work with adults before asking them to work with youth. Helping adults better understand young people, human sexuality, and their own values and attitudes, will have a significant impact on a program’s success.

Issues

Understanding Youth

It is important for adults to recognize the many significant changes that young people experience. Adolescence is a complex transition from childhood to adulthood that involves a multitude of challenges. These include numerous physical and interpersonal changes as well as significant cognitive development. All of these changes are important to understand and respect when working with youth. Since all adults have also experienced these changes themselves, insight and empathy towards youth can be gained by asking adults to reflect on their own adolescent experiences.

Understanding Sexuality

It is important that those working in the sexual and reproductive health field develop a solid understanding of human sexuality. Many people equate the term “sexuality” with sexual activity. In reality, sexuality is much more than sex. Sexuality includes all the feelings, thoughts, and behaviors of being male or female; being attractive; and being in love; as well as being in relationships that include intimacy and physical sexual activity.
Sexuality begins before birth and lasts throughout the life span.

Understanding sexuality in such a comprehensive manner helps staff understand the importance of exploring a variety of issues in sexuality education. Issues such as relationships, gender, and sexual identity are often left out of sexuality education programs, yet such concepts are crucial for young people to explore in order to help them have sexually healthy lives.

**Recognizing Our Own Values about Sexuality**

A person’s sexuality is unique. It is shaped by his or her values, attitudes, behaviors, physical appearance, beliefs, emotions, personality, likes and dislikes, spirituality, and all the ways in which he or she has been socialized. Consequently, the ways in which individuals express their sexuality are influenced by ethical, spiritual, cultural, and moral factors. Because of this, it is extremely important to allow adults and youth an opportunity to reflect on their own personal values concerning sexuality. In doing so, individuals begin to recognize their own values and attitudes, while respecting those that are different from their own.

**References**


**Activities**

Activities in this section are designed for use with adults who are either working in or about to begin a YSRH program. The first two activities allow participants to reflect on their own personal experiences in an attempt to build empathy for youth. In the third activity, participants are asked to explore their own values and attitudes about human sexuality. This is done in a participatory manner that allows them to hear from other participants who may have perspectives different from their own. The final two activities in this section help participants understand a broader definition of human sexuality that will guide them as they develop comprehensive sexual and reproductive health programs.

- **Activity 3.1—Understanding Youth**
- **Activity 3.2—My Own Adolescence**
- **Activity 3.3—Values Clarification on Sexuality**
- **Activity 3.4—Understanding Sexuality**
- **Activity 3.5—Sexuality through the Life Cycle**
Activity 3.1—Understanding Youth

Time Estimate

75 minutes

Objectives

- Reflect on what we think about today’s youth
- Reflect on our experiences as youth compared with the experience of youth today.

Materials

- Sets of six cards with one statement on each (see below).

Method

1. Divide participants into groups of six people.

2. Give each group a set of cards with the following statements written on them:
   - Something that young people today do that I don’t like.
   - Something that I did during my teens that challenged adults.
   - Something that young people today do that I would never have done.
   - Something about young people today that I really admire.
   - Things that youth today have to face that I did not have to during my youth.
   - The youth spirit that I wish I could have kept (and regret that I couldn’t).

3. Ask each participant to take one of the six cards. Ask them to read their card and share their response with the rest of the group. After each participant shares their answer, other participants can add additional responses. Provide three minutes for discussion of each card.

4. After all the cards have been read and answered, ask participants to return to the large group and discuss these questions:
   - What did you learn from doing this activity?
   - Were there any questions you found difficult to answer? Why?
   - Why would this activity be helpful for staff working on YSRH programs?
Reflection Points

- It is important for staff to recognize that it is normal to be bothered by some things that youth do, while there are other things to admire. Youth are not perfect and neither are we.
- When we were youth, we may have felt disconnected from adults, just as many youth feel today.
- Although we were once young, today’s world may look different from the one we grew up in.

Suggestions for Facilitators

- Asking each person in the group to respond to each of the six questions can extend this activity.
- Ask participants to share memories of their own youth, including the context of these events, and encourage them to compare these experiences with the challenges faced by youth today.

Activity 3.2—My Own Adolescence

Time Estimate

1 hour

Objective

- Through reflection on personal adolescent experiences, develop a better understanding of and empathy for today’s youth.

Materials

- Flip-charts
- Markers

Pass out sheets of paper for participants to write on.

List the following questions on a flip-chart:

- What were the most important things in your life?
- What did you like to do in your free time?
- What adults played a significant role in your life?
Method

1. Tell participants that in this activity they will explore their own experiences of adolescence. Tell them that each person will be assigned a particular age. Divide the room into thirds. Tell the first group that they will be reflecting on when they were 12 years old. The second group will think back to when they were 16 years old. The third group will think back to when they were 19 years old.

2. Show the participants the six questions on the flip-chart and tell them to think about and answer each one. Read the questions out loud and ask participants to write their answers to the six questions on a sheet of paper, based on the age they were assigned. Give participants 15 minutes to complete the questions.

3. After 15 minutes, invite them to share their answers with one person in the same age group. Divide the participants into pairs. Explain that each pair will have ten minutes to share their answers to the questions. Assure them that they only have to share what they feel comfortable discussing.

4. After ten minutes, reconvene the group and ask various participants to share some of the things that the activity made them think about. Begin by taking comments from the 12-year-old group, followed by the 16-year-old group, and finally the 19-year-old group.

5. Conclude the activity with a discussion that includes the following questions:
   - What did you learn from this activity?
   - Was it easy or difficult to remember what it was like to be an adolescent? Why?
   - Would you consider the issues that we just discussed at ages 12, 16, and 19 similar or different? What does this mean in terms of the needs and concerns of young health clients at various stages of adolescence?
   - How can this activity improve the way you interact with adolescents?

Reflection Points

- It is important to reflect on our past to remember some of the positive and negative experiences we had as adolescents. This may help us to understand that youth today may have similar needs, concerns and experiences. It may also help us to be empathetic to youth when they seek sexual and reproductive health services.
Suggestions For Facilitators

- Encourage participants to explore their own youth experiences, including feelings and attitudes that they may have had. It may help to be a little dramatic or provocative to bring memories to life. A humorous approach may be useful in leading the story-telling session.

Activity 3.3—Values Clarification on Sexuality

Time Estimate

45 minutes

Objectives

- Explore attitudes about human sexuality.
- Reflect on the impact personal attitudes have on the development of YSRH programs.

Materials

- Flip-charts
- Markers

Write the following terms on cards—one term per card: Strongly Agree; Agree; Disagree; and Strongly Disagree.

Display the cards around the room, leaving enough space between them for participants to stand near each one.

Write some of the following statements on a flip-chart:

- Sex is more important to men than women.
- Men in a heterosexual relationship should make the first move.
- Sexual faithfulness is part of a successful relationship.
- A person can trust a partner to be honest about past relationships.
- People should have sexual intercourse only if they are in love.
- It is best if people younger than 17 do not have intercourse.
- If abortion is illegal, people are more careful about using a reliable method of contraception.
- I can accept if someone in my family has a homosexual relationship.
- Using contraception is the woman’s responsibility.
**Method**

1. Explain that this activity is designed to give participants a general understanding of their own and each other’s values and attitudes about sexuality issues.

2. Explain that you will read a statement. They are to decide what they think about it and stand by the card that represents their opinion. After all have decided where they will stand, several people will be asked to share their opinions with the rest of the group. Remind them that everyone has a right to his or her own opinion, and no response is right or wrong.

3. Ask participants to listen to each other, explaining that this activity is not about debate, but rather dialogue. Ask them to state their personal opinions to support their agreement or disagreement with each statement and not to rebut other participants’ opinions.

4. Read aloud the first statement you selected and ask participants to stand near the card that most closely represents their opinion. After the participants have made their decisions, ask for one or two volunteers from each group to explain why they feel the way they do. Continue for each of the statements you selected.

5. After all the statements have been read, have the participants return to their seats.

6. At the end, facilitate a discussion by asking the following questions:
   - Which statements did you find challenging to form an opinion about? Why?
   - How did it feel to express an opinion that was different from those of other participants?
   - How do you think people’s attitudes about some of the statements might affect their interactions with young people or their ability to provide sexual and reproductive health services to youth?

**Reflection Points**

- It is normal to have strong feelings and values about these topics. Learning to be aware of our own values helps us be more open to listening to different points of view. When youth notice that providers are more accepting of differences, they more openly and honestly assess and express their own values. This in turn helps them assess the attitudes and beliefs that lead to high-risk behavior.

**Suggestions for Facilitators**

- For the sake of discussion, if the participants express a unanimous opinion about any of the statements, ask a volunteer to play the role of “devil’s advocate” by expressing an opinion that is different from the rest of the group.
Activity 3.4—Understanding Sexuality

**Time Estimate**

1 hour

**Objective**

- Gain an understanding of the broad concept of sexuality and how it influences many areas of our lives.

**Materials**

- Flip-chart
- Markers

**Method**

1. Write “Sex” and “Sexuality” in separate columns on a piece of flip-chart paper.
2. Ask the participants what the term sex means to them. Allow participants to share their thoughts and record their responses in the “Sex” column on the flip-chart. Then read the following definitions of sex and sexual intercourse out loud and ask the participants for any comments on the definitions.

   **Sex** refers to the biological or anatomical characteristics (e.g., breasts, vagina, penis, testes) of men and women. Sex is also a synonym for **sexual intercourse**, which includes penile-vaginal, oral, and anal sex.

3. Ask participants what the term **sexuality** means to them. Allow participants to share their thoughts and record their responses in the “Sexuality” column on the flip-chart. Then read aloud the following definitions and ask the participants for any comments on them.

   **Sexuality** is an expression of who we are as human beings. Sexuality includes all the feelings, thoughts, and behaviors of being male or female; being attractive; and being in love; as well as being in relationships that include intimacy and physical sexual activity.

   **Sexuality** begins before birth and lasts throughout our life span. A person’s sexuality is shaped by his or her values, attitudes, behaviors, physical appearance, beliefs, emotions, personality, likes and dislikes, spiritual self, and all the ways in which he or she has been socialized. Consequently, the ways in which individuals express their sexuality are influenced by ethical, spiritual, cultural, and moral factors.

---

4. Explain that while many people often associate the term sexuality with the terms sex or sexual intercourse, it encompasses much more than that. To help the group understand the complexity of sexuality, discuss four different aspects of sexuality in a brief presentation. One way to present these is to draw four circles that all touch each other (see the diagram at the end of this activity). Each circle represents one of the elements of sexuality. When all four circles are placed together, they suggest a definition of sexuality. In this diagram there is a space in the middle of the circles where the words “values, spirituality, and culture” are written. These factors may all play a role in how an individual experiences the four components of sexuality. After each concept is described to the participants, see if they have any examples to demonstrate their understanding of each element:

- **Sensuality** is how our bodies derive pleasure. It is the part of our body that deals with the five senses: touch, sight, hearing, smell, and taste. When enjoyed, any of these senses can be sensual. Ask participants to provide examples of how a person might enjoy each of the five senses in a sensual manner. The sexual response cycle is also part of our sensuality because it is the mechanism that enables us to enjoy and respond to sexual pleasure.
  - Our body image is part of our sensuality. Whether we feel attractive and proud of our bodies influences many aspects of our lives.
  - Our need to be touched and held by others in loving and caring ways is called skin hunger. Adolescents typically receive less touching from family members than do young children. Therefore, many adolescents satisfy their skin hunger through close physical contact with a peer. Sexual intercourse may result from an adolescent’s need to be held, rather than from sexual desire.

- **Fantasy** is part of sensuality. Our brain gives us the capacity to fantasize about sexual behaviors and experiences, without having to act upon them.

- **Intimacy** is the part of sexuality that deals with relationships. Our ability to love, trust, and care for others is based on our levels of intimacy. We learn about intimacy from relationships around us, particularly those within our families.

  - Emotional risk-taking is part of intimacy. In order to have true intimacy with others, a person must open up, share feelings, and personal information. We take a risk when we do this, but intimacy is not possible otherwise.
Sexual identity can be thought of in four ways:

- **Biological sex** is based on our physical status of being either male or female.

- **Gender identity** is how we feel about being male or female. Gender identity starts to form around age two, when a little boy or girl realizes that he/she is different from the opposite sex. If a person feels like he or she identifies with the opposite biological sex, he/she often considers him/herself transgender. In the most extreme cases, a transgender person will have an operation to change biological sex so that it can correspond to his/her gender identity.

- **Gender roles** are society’s expectations of appropriate behavior for women and men. Ask the group to think about what behaviors we expect of men and what behaviors we expect of women. These expectations are gender roles.

- **Sexual orientation** is the final element of sexual identity. Sexual orientation refers to the biological sex that we are attracted to romantically. Our orientation can be heterosexual (attracted to the opposite sex), bisexual (attracted to both sexes), or homosexual (attracted to the same sex). People often confuse sexual orientation and gender roles. For example, if a man is feminine or a woman is masculine, people often assume that these individuals are homosexual. They are actually expressing different gender roles and their masculine or feminine behavior has nothing to do with their sexual orientation. A gay man may be feminine, masculine, or neither. The same applies to heterosexual men. A person may also engage in same-sex behavior and not consider him- or herself homosexual. For example, men in prison may have sex with other men but may consider themselves heterosexual.

Sexual health involves our behavior related to producing children, enjoying sexual behaviors, and maintaining our sexual and reproductive organs. Issues like sexual intercourse, pregnancy, and STIs are part of our sexual health. Ask the group to identify as many aspects of sexual health as possible.

After discussing the four circles of sexuality, draw an octagon that is disconnected from the four circles. This octagon illustrates the negative aspect of sexuality that can inhibit an individual from living a sexually healthy life. Say that the octagon can cast a shadow on the other four circles of sexuality.

**Using sexuality to control others is not healthy.** Unfortunately, many people use sexuality to violate someone else or get something from another person. Rape is a clear example of sex being used to control somebody else. Sexual abuse and prostitution are others. Even advertising uses sexual messages to sell products.
Discussion Questions

- Where is “sexual intercourse” included within the definition of sexuality? Does the term play a large or small role in the definition?
- How does culture influence the various circles of sexuality?
- Which circles of sexuality are different for males and females? Do men and women experience sensuality the same way? Do men and women view relationships the same way? Do men and women have the same sexual health needs?

Reflection Points

- Terms like sex; sexuality; sexual intercourse; sensuality; intimacy; sexual identity; sexual orientation; and gender are often misused. As a result, it is useful to see on the diagram how these various aspects of sexuality relate and connect to one another.

Suggestions for Facilitators

- This exercise may appear to be complicated, but participants value the opportunity to discuss their own interpretations of the terms.
- It is not necessary to “pin down” the definitions, but make it clear how the terms refer to particular facets of sexuality.

Activity 3.5—Sexuality Through the Life Cycle

Time Estimate

45 minutes

Objective

- Review and understand the milestones of human sexual development from birth to death.

Materials

- “Milestones in Male and Female Sexual and Social Development” hand-out. p. 395

Write each of the following milestones of sexual development on a card large enough to be read from a distance:

---

110

• Begins to have sexual responses.
• Explores own genitals for the first time.
• Shows an understanding of gender identity.
• Shows an understanding of gender roles.
• Asks questions about where babies come from.
• Begins to show romantic interest.
• Shows the first physical signs of puberty.
• Begins to produce sperm (boys).
• Begins to menstruate (girls).
• Begins to engage in romantic activity.
• Has sex for the first time.
• Gets married.
• Begins to bear children.
• Experiences menopause or male climacteric (decreased male hormone levels).
• Experiences sexuality in later life.

Method

1. Tell participants that they are going to participate in an activity to determine when certain aspects of sexual development occur in a person’s life. The participants will be given cards with milestones of sexual development. Participants will be asked to tape their card to their chest so that the rest of the group can see it. On one side of the room, a sign will be placed that says “birth.” On the other side of the room, a sign will be placed that says “death.” These two signs will represent the two ends of a life-span continuum. The participants will be asked to stand in the place on the continuum that is most appropriate for their card. Participants will need to look at the other cards to make sure they are in the correct order. Encourage the participants to seek help from or to discuss their placement with others.

2. Once all the cards are placed on the time-line, ask the participants whether or not they agree with where each card was placed. After they have discussed each card, provide the answers by referring to the hand-out on “Milestones in Male and Female Sexual and Social Development.”

3. Explain that the onset of the milestones may be different between individuals and are affected by a variety of factors. Hence, these milestones occur within a range of years. For example, questions about where babies come from generally occur between ages 3 to 5 but can also occur at an older age.
4. Reconvene the group and have a discussion using these questions:
   - Where on the time-line does most sexual development occur?
   - At what age do most youth receive sexuality education? Does this happen before or after most sexual development?
   - Were you surprised about where any of the cards were placed? Which ones?
   - How is this information helpful when working with adolescents?

**Reflection Points**

- This activity gives us a glimpse of the sexual and social development people experience in their lifetime. Viewing sexual development in this manner helps us understand that we are all sexual beings, from birth until death. Because of this, people have a right to sexuality education beginning at an early age. Realizing that many developmental milestones occur during adolescence helps us understand the challenges young people face during their physical, emotional, and social development.
- It is important to note that due to many factors, individuals may reach particular milestones at different ages than what are listed on the hand-out.

**Suggestions for Facilitators**

- For a variation of this activity, the cards can be pinned on a piece of string that is tied across a wall.
Milestones in Male and Female Sexual and Social Development

Some of these items should be checked for accuracy and relevance to the particular country where training occurs.

- **Begins to have sexual responses.** Occurs before birth. A male fetus achieves genital erections in utero; some males are even born with erections. Sexual responses in females also occur before birth.

- **Explores own genitals for the first time.** Occurs between 6 months to 1 year of age. As soon as babies can touch their genitals, they begin to explore their bodies.

- **Shows an understanding of gender identity.** Occurs by age 2. Children are aware of their biological sex.

- **Shows an understanding of gender roles.** Occurs between ages 3 to 5. Children begin to conform to society’s messages about how males and females should act.

- **Asks questions about where babies come from.** Occurs between ages 3 to 5.

- **Begins to show romantic interest.** Occurs by ages 5 to 12, though may vary by culture. At this stage, children show the first signs of sexual orientation (sexual preference toward males or females).

- **Shows the first physical signs of puberty (the transition from childhood to maturation).** Occurs by ages 8 to 13. This usually occurs slightly earlier for girls than boys.

- **Begins to produce sperm (boys).** Occurs between ages 11 to 18. This milestone depends in part on the child’s nutrition and may be delayed where nutrition is severely compromised.

- **Begins to menstruate (girls).** Occurs between ages 9 to 16. This milestone depends in part on the child’s nutrition and may be delayed where nutrition is severely compromised.

- **Begins to engage in romantic activity.** Occurs by ages 10 to 15. This milestone depends heavily on cultural factors.

- **Has sex for the first time.** This varies greatly by individual and culture, but mid- to late adolescence is fairly common.

- **Gets married.** Varies based on individual and cultural factors.

- **Begins to bear children.** Varies based on individual and cultural factors.

- **Experiences menopause or male climacteric (decreased male hormone levels).** Menopause usually occurs in women at around age 50 (it can also start in the late 30s or early 40s), when women go through a process of physiological changes characterized by the end of ovulation, menstruation, and the capacity to reproduce. Male climacteric occurs between ages 45 to 65 and is characterized by a decrease in testosterone production.

- **Experiences sexuality in later life.** Older adults (those aged 50 to 60 or beyond) can remain sexually active to the end of their lives. Although some age-related changes in sexuality take place, the total loss of sexual functioning is not a part of the normal aging process.
**Introduction**

In the previous section, we looked at the importance of understanding human sexuality and examining values and attitudes associated with sexuality. Adults working in the field of sexual and reproductive health must have a solid base of information and knowledge related to these issues. This includes information on reproductive anatomy and physiology, pregnancy prevention, STIs, HIV/AIDS, and other health issues.

Training workshops are often one of the few opportunities to pass on basic reproductive health information. As a result, many workshop trainers provide lectures on sexual and reproductive health. However, this widely practiced method of training is not particularly effective. Research indicates that individuals learn best in an environment of active involvement and participation.

The principles of participatory learning apply for both adults and youth. Many of the participatory activities that are used for training adults in sexual and reproductive health can also be used for helping youth acquire the basic knowledge and skills they need to protect themselves from STIs, HIV, and unintended pregnancy.

**Concepts of Participatory Learning**

Effective training on sexual and reproductive health is an experiential process that involves learners and facilitates dialogue and collaboration. To achieve this, trainers must use participatory training methodologies that actively involve the learner in his or her growth (Hedgepeth and Helmich 1996). Participatory learning approaches embrace these beliefs:

- Participants learn best in an atmosphere of active involvement and participation.
- Participants tend to retain 10 percent of what they read, 20 percent of what they hear, 30 percent of what they see, 50 percent of what they hear and see, 70 percent of what they are asked to say themselves, and 90 percent of what they are asked to say and do themselves (Wiman and Merheney 1969).
- Learners are a knowledgeable group who should be used as a resource in a learning environment.
- Learning is not usually an outcome of formal teaching. It comes from a process of self-development through experience.

**References**


Activities

The activities in this section are designed to use with youth. The first two activities involve talking about the body and sexuality; the third and fourth are about sharing basic reproductive health information; the fifth is about making reproductive health decisions; and the last one deals with views on sexuality.

Activity 4.1—“Down There” Bingo
Activity 4.2—Body Mapping
Activity 4.3—Myths and Facts
Activity 4.4—Sexual Jeopardy
Activity 4.5—Safari of Life
Activity 4.6—Life Behaviors of a Sexually Healthy Adult

Activity 4.1—“Down There” Bingo

Time Estimate

45 minutes

Objective

• Discuss different sexual issues and commonly held beliefs.

Materials

• “Down There” Bingo hand-out

Method

1. Give each participant a copy of the hand-out “Down There” Bingo.

2. Ask participants to read through the boxes on the hand-out and ask if they have any questions.

3. Instruct participants to walk around the room and randomly ask other people the questions on the hand-out. Explain that when they find someone who
answers “yes” to a question, they should write that person’s name in the box. That question is then considered completed.

4. Give participants about 15 minutes to interact and fill in the hand-out.

5. When the hand-outs are filled in, ask participants to take their seats.

6. Go through each question on the form asking, “Who ...(e.g., was taught when you were little that it’s not O.K. to touch your genitals?),” and ask the respondents to share with the group and to elaborate.

**Reflection Points**

- We must be able to feel comfortable discussing these issues.
- We need to be able to discuss condom use using common references, not just using anatomy and physiology terms. This is not easy to do and it can expose you to dilemmas about sexuality.
- We need to face the issues and explore why they make us uncomfortable.
- Some people in the group are comfortable reading about sex, but may still not want to talk about it.

**“Down There” Bingo**

<table>
<thead>
<tr>
<th>Are you someone who ...?</th>
</tr>
</thead>
<tbody>
<tr>
<td>...learned the correct names for the genital organs when you were a small child?</td>
</tr>
<tr>
<td>...knows how many openings a woman has “down there”?</td>
</tr>
<tr>
<td>...never learned or heard about contraceptives before engaging in sex?</td>
</tr>
<tr>
<td>...has heard that men have more sexual desires than women?</td>
</tr>
</tbody>
</table>
Suggestions for Facilitators

- Additional boxes in the worksheet may be added for less-covered topics, such as issues about the penis.

Activity 4.2—Body Mapping

Time Estimate

45 minutes

Objectives

- Provide participants with an opportunity to share their knowledge of female and male anatomy.
- Encourage participants to feel comfortable in discussing their bodies, particularly sexual organs.

Materials

- Flip-chart paper
- Markers
- Tape

Method

1. Explain that we are going to share what we know about how our bodies work.

2. Divide participants into groups of four to five people of the same sex.

3. Ask each group to take a few pieces of flip-chart paper and draw an outline of a body. The easiest way to do this is to ask one participant to lie down on the sheets of paper, while another member draws an outline of his/her body.

4. On one set of flip-chart paper, the group can work together to draw the outline of a woman’s body, and on the other they can outline a man’s body.

5. Once the outlines have been drawn, ask participants to add visible body parts and those covered by clothes, including the sexual and reproductive parts of the bodies.

6. Ask the groups to especially focus on the changes that young people experience in their bodies during puberty.

During a Body Mapping activity, a facilitator was working with boys who were feeling intimidated. He told them: “Close your eyes, imagine someone with no clothes on, on a faraway planet. What would he or she look like? Like someone from a neighboring country? Someone from here?”
7. Bring all of the participants together into a big group and ask each small group to present their body maps. Encourage people to ask questions about the body maps and use this as a way of encouraging the groups to share some of what they discussed.

8. Discuss these questions with participants:
   • What did you learn from doing this exercise?
   • What do you think the purpose of the body mapping exercise is?
   • What are the advantages of doing this?
   • As a trainer using this methodology, what challenges do you think you could face?
   • How could you use this training methodology in your work?

Reflection Points

• The value of Body Mapping is in the discussion it generates. It provides rich information about people's perceptions of the body.

• Body Mapping provides a visual representation of how young people talk about bodies. It can capture verbal and non-verbal communication.

• Engaging decision-makers in this process, by showing them what young people know about bodies, can be a convincing way of building support for YRSH programs.

• Body Mapping can also be used as an assessment or teaching tool.

Suggestions for Facilitators

• Facilitators should be sensitive to the discomfort that some participants feel when discussing body parts.

• This is a good activity to use at the beginning of a program since young people will frequently use their own local terms for body parts. Program designers can learn these words and use them instead of more clinical terms.

• The activity can be modified. For example, groups can draw “before and after” puberty body images.

• If time is limited, the facilitator can ask each group to draw only one of the two sexes.

• If the group is comfortable with each other, it may be possible to have men and women work together. This can provide an opportunity for dialogue between the sexes about bodies, and further break down barriers caused by embarrassment.

• Some people may feel uncomfortable lying down on the sheet of paper. If participants appear reluctant, allow them to choose another way to draw the shape.
Activity 4.3—Myths and Facts

Time Estimate

30 minutes

Objectives

• Provide factual information about sexual and reproductive health.
• Correct misinformation about sexual and reproductive health.

Materials

• Pencils or pens
• “Myths and Facts” hand-out  p. 397-399

Method

1. Distribute the hand-out “Myths and Facts” to all participants.
2. Divide the participants into four groups, and ask them to work together on the statements before reviewing the answers.
3. Ask each group to read each statement to themselves, and write M (for myth) or F (for fact) next to each one as appropriate. Tell participants not to spend a lot of time on each statement; if they are unsure of an answer, they should guess and move on to the next statement. Allow ten minutes for completion.
4. Rotate from group to group asking different participants to read the statements and their responses and explanations to them. After a participant responds, ask the other participants whether they agree with the response. Allow them to discuss their views.
5. Provide any required answers or clarifications.
6. Ask the group to discuss these questions:
   • What are some other commonly held myths about sexual and reproductive health that you have heard?
   • What self-treatment practices have you heard of people using to address pregnancy prevention, unwanted pregnancy, menstrual problems, and STIs?
   • Why do you think so much misinformation exists about sexual and reproductive health?
Reflection Points

- It may be disturbing to note that some reproductive health myths endure, even among program staff.
- In order to pass on correct information to youth, it is important for service providers to provide accurate and up-to-date information.

Suggestions for Facilitators

- Since some participants may be embarrassed to ask, be sure to clarify the meanings of certain terms.
- There are several alternative ways you can facilitate this activity:
  - You could begin the activity by having one participant at a time read a statement aloud, and then have that participant and the large group respond.
  - You could ask each participant to fill out the hand-out on their own and then discuss it as a group.
  - You could break the group into teams and have them compete to see which team has the most correct answers.
  - If time is limited, you could choose and read select statements aloud, and ask the participants to respond to them.

Myths and Facts

1. A man cannot impregnate a woman while she is menstruating.
2. Anal sex is a risk-free way for women to avoid pregnancy.
3. The best way to use a condom is to pull it on tight.
4. A woman is protected against pregnancy the day she begins taking the pill.
5. Aside from abstinence, male and female condoms are the only contraceptive methods that can protect against STIs.
6. A woman can take emergency contraception pills to reduce the risk of pregnancy after having unprotected sex.
7. Withdrawal is an effective method of preventing pregnancy for a man who has never had sex before.
8. A longer penis is more likely to satisfy a woman than a shorter one.
9. A man cannot transmit an STI if he withdraws before ejaculation.
10. It is possible to get an STI from having oral sex.
11. A monogamous person cannot contract an STI.
12. You can always tell if someone has an STI by his or her appearance.
13. While latex condoms are not 100 percent effective, reports suggesting that HIV can pass through latex condoms are untrue. In fact, condoms reduce the risk of contracting STIs, including HIV infection.

14. A person infected with an STI has a higher risk of contracting HIV infection.

15. Abstinence is the only 100 percent effective safeguard against the spread of STIs.

**Answers for Myths and Facts**

1. A man cannot impregnate a woman while she is menstruating. *(MYTH)*

   Even when a woman is menstruating, it is possible for her to ovulate (release an egg) and become pregnant. However, a woman is most likely to become pregnant right after ovulation, which usually occurs in the middle of her menstrual cycle, when she is not menstruating.

2. Anal sex is a risk-free way for women to avoid pregnancy. *(MYTH)*

   Anal sex holds risks for both pregnancy and STI transmission. A woman can become pregnant from anal sex if semen from the man’s ejaculation seeps out of her anus and enters the opening of her vagina. Anal sex is also one of the easiest ways to spread HIV infection and some other STIs.

3. The best way to use a condom is to pull it on tight. *(MYTH)*

   The best way to use a condom is to leave some space at the tip to hold the semen after ejaculation. Some condoms have reservoir tips for this purpose; however, even if such a tip exists, some space should be left at the tip when the condom is put on.

4. A woman is protected against pregnancy the day she begins taking the pill. *(MYTH)*

   Most doctors recommend that women either abstain from penile-vaginal sex or use another method of contraception for seven days after they begin using the pill. After this time, a woman is protected from pregnancy every day, including during her period.

5. Aside from abstinence, male and female condoms are the only contraceptive methods that can protect against STIs. *(FACT)*

   Male and female condoms made of latex or polyurethane are the only contraceptive methods that protect against all STIs; no other methods offer such protection. Lambskin condoms do not protect against all STIs. A couple should always use condoms made of latex or polyurethane during sex if the partners are at risk for STIs.

6. A woman can take emergency contraception pills to reduce the risk of pregnancy after having unprotected sex. *(FACT)*

   Emergency contraception is an effective mechanism for reducing the risk of pregnancy when contraception fails or is not used. Emergency contraception should be used when a couple forgets to use contraception, a condom breaks, a diaphragm becomes dislodged, an IUD is expelled, a woman forgets to take her birth control pills, or a woman is raped. Emergency contraceptive pills do not protect against STIs including HIV.

7. Withdrawal is an effective method of preventing pregnancy for a man who has never had sex before. *(MYTH)*

   A man who is inexperienced in penile-vaginal sex will likely have difficulty removing his penis from the vagina in sufficient time before ejaculating.
8. A longer penis is more likely to satisfy a woman than a shorter one. (MYTH)
   A woman’s vagina is most sensitive in the first third of its length. Therefore, many women report that the length of the penis does not affect their sexual stimulation or satisfaction during vaginal penetration.

9. A man cannot transmit an STI if he withdraws before ejaculation. (MYTH)
   Withdrawal does not eliminate the risk of STIs. Pre-ejaculatory fluid from the penis can contain infectious organisms, and organisms on the skin of a man’s genitals can be transmitted to another person.

10. It is possible to get an STI from having oral sex. (FACT)
    The person performing the oral sex have different risks. The person receiving oral sex is only at risk if his or her partner has a sore or ulcer in the mouth, on the face, or has an STI in the throat. The person performing oral sex is at high risk if he or she has open sores on the lips or face, or if he or she has ejaculate or vaginal fluids in the mouth. To protect against STIs, an individual should always use a latex or plastic barrier (such as a male or female condom, or dental dam) when having oral sex.

11. A monogamous person cannot contract an STI. (MYTH)
    A person who has sex with only one partner may still be at risk for STIs if his or her partner has sex with other people. In addition, individuals who are currently monogamous with their partner may have contracted an STI from someone else in the past, and may have the disease without knowing it and/or without telling their current partner.

12. You can always tell if someone has an STI by his or her appearance. (MYTH)
    Sometimes STIs produce no symptoms or no visible symptoms. In fact, many people carry STIs for long periods of time without having any idea that they are infected. In addition, STIs affect all people; no type of person is immune from STIs. People of different races, sexes, religions, socioeconomic classes, and sexual orientations are all affected.

13. Condoms reduce the risk of contracting STIs, including HIV infection. (FACT)
    After abstinence, proper use of latex condoms is the most effective way of preventing STIs, including HIV infection. Some groups have reported inaccurate research that suggests that HIV can pass through latex condoms, but that is not true. In fact, standard tests show that water molecules, which are five times smaller than HIV, cannot pass through latex condoms.

14. A person infected with an STI has a higher risk of contracting HIV infection. (FACT)
    Both ulcerative STIs (those that cause sores) and nonulcerative STIs increase the risk for transmitting and contracting HIV infection. Ulcerative STIs increase the risk of HIV infection because the ulcer provides easy entry into the body via the HIV virus. Nonulcerative STIs may enhance HIV transmission for two reasons: they increase the number of white blood cells in the genital tract, and genital inflammation may cause microscopic cuts that can allow HIV infection to enter the body.

15. Abstinence is the only 100% effective safeguard against the spread of STIs. (FACT)
    Abstinence from penile-vaginal sex is the best way to prevent the transmission of STIs, including HIV. However, latex condoms are the next best option. When used consistently and correctly, latex condoms are very effective at preventing the transmission of STIs.
Activity 4.4—Sexual Jeopardy

Time Estimate

60 minutes per game

Objective

• Offer participants a fun, nontraditional format in which to learn information about sexual and reproductive health.

Materials

• “Sexual Jeopardy” board made with an easel, flip-chart paper, Post-It© notes, and markers. You can also use a chalkboard, chalk, and eraser.
• Prepared questions.

Make a “Sexual Jeopardy” board on flip-chart paper and use Post-It© notes for the numbers. Remove the Post-It© notes when the number is picked. See the following diagram for a board example.

Method

1. Explain that participants are going to play a game called “Sexual Jeopardy,” which is based on a popular television game show in the United States called “Jeopardy.” Unlike the television game show, this game discusses issues around sexual and reproductive health.

2. Decide which four categories will be included in the “Sexual Jeopardy” game. Each category has a list of five questions. The easier questions are worth fewer points (the easiest is 100 points), and the more difficult ones are worth more (the hardest is worth 500 points).

3. Divide participants into two teams. Each team should designate a spokesperson. This individual is responsible for giving the team’s final answer. The team members should discuss their answer together, and then have the spokesperson present it. Any other answers that other team members shout out will not be accepted.

4. Take turns giving each team an opportunity to select from the board. Allow the team to select categories and question values from the board. For example, “I’ll take STIs for 300 please.” Ask the question. If the team answers correctly, it gets the points. If the team is incorrect, it loses half of the question’s points. For example, if a team answers a 300-point question incorrectly, it loses 150 points.
5. Continue to play until all of the questions are answered.

6. After all of the questions have been answered, you can opt to provide a “Final Jeopardy” question. Present this question to both teams. Each team develops its own answer quietly, so the other team cannot hear it. Both teams also decide how many points they want to risk on their answer. The team can bet as little or as much as it wishes. Remind the teams that if their answer is incorrect, they will lose all of the points they bet, not just half of them! The winner is the team with the most points after the “Final Jeopardy” question.

### Example of a “Sexual Jeopardy” Board

<table>
<thead>
<tr>
<th>Adolescent Development</th>
<th>Family Planning</th>
<th>STIs</th>
<th>Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>300</td>
<td>300</td>
<td>300</td>
<td>300</td>
</tr>
<tr>
<td>400</td>
<td>400</td>
<td>400</td>
<td>400</td>
</tr>
<tr>
<td>500</td>
<td>500</td>
<td>500</td>
<td>500</td>
</tr>
</tbody>
</table>

### Reflection Points

- After finishing the game, remind the participants that everybody ends up winning because they are all having fun and learning important information from each other at the same time.

- This activity is a lively way to present information that works well with various audiences. By involving team members, it solicits information from peers, not just the instructor. Incorrect answers help you quickly identify major gaps in knowledge within the group, and enables you to focus on problem areas when you plan future workshops.

### Suggestions for Facilitators

- This quiz format is popular and can be adapted for any topic.

- Try making up other questions that relate to the specific situation within your own country.
Sexual Jeopardy Categories and Questions

Adolescent Development

100 True/False: Young people lose their ability to think abstractly as they grow older.  
Answer: False

200 True/False: By the end of adolescence, young people are less influenced by peers.  
Answer: True

300 True/False: It is normal for young men, especially teenagers, to have spontaneous erections that occur for no reason at inconvenient times of the day.  
Answer: True (Note: This is a common occurrence during puberty and will occur less often as teenagers get older.)

400 At what age is an adolescent usually most uncomfortable with his/her body:  
a) 11-13, b) 14-16, c) 17-19.  
Answer: a) 11-13

500 Identify at least two protective factors for adolescents.  
Answer: Supportive relationships, open communication with parents, trusting relationship with partners, strong self-esteem.

Family Planning

100 Name one reason why sterilization may not be appropriate for youth.  
Answer: Risk of future regret is much higher in young clients.

200 Name one reason why an intrauterine device (IUD) may not be a good choice of family planning for an adolescent girl.  
Answer: 1) If the adolescent is at risk for STIs, because an IUD may increase the likelihood of Pelvic Inflammatory Disease (PID).  
2) IUD expulsion rates are higher in users under 20 years.

300 How should a woman taking oral contraceptive pills begin the first packet of pills?  
Answer: Start on the first day of the menstrual cycle and use condoms or another contraceptive method for the first two weeks. Follow the instructions.

400 How long after sexual intercourse can emergency contraception be used?  
Answer: Up to 72 hours

500 Which method of birth control has WHO deemed medically unsafe for adolescents:  
a) sterilization, b) IUD, c) oral contraceptive pills, d) Norplant® implants, e) none of the above.  
Answer: e) none of the above.

Sexually Transmitted Infections

100 Name two signs that a man has gonorrhea or chlamydia.  
Answer: Burning sensation when the man urinates, a discharge from the penis.

200 True/False: Female adolescents are more susceptible to some STIs than older women.  
Answer: True. Cervical ectopy, cells that line the inside of the cervical canal, extend to the outer surface of the cervix, which allows for infection.
What is the difference between HIV and AIDS?

**Answer:** HIV is the virus that causes AIDS. HIV may live in a person for over ten years without that person showing any signs of illness. Eventually, the HIV virus destroys a person’s immune system, which causes AIDS. When a person has AIDS he or she gets sick easily and eventually dies.

How long must a person wait after possible HIV infection until a blood test will tell them if they are infected or not?

**Answer:** Three months: this is how long it takes for our blood to develop enough detectable antibodies to the HIV virus, which is what an HIV test looks for to see if someone is HIV positive or negative.

Name three STIs with no known cure.

**Answer:** HIV; genital herpes; genital warts (warts can be removed but might grow back); and hepatitis B.

### Pregnancy

The main cause of death for 15-19 year old girls worldwide is: a) road traffic accidents, b) pregnancy-related complications, c) AIDS, d) malaria.

**Answer:** b) pregnancy-related complications.

Each year, the number of young women ages 15-19 reported as having induced abortions is: a) five million, b) one million, c) two million.

**Answer:** a) The reported number is five million induced abortions worldwide. The actual number is probably higher.

True/False: Children born to adolescent mothers are more at risk of death than children born to older women.

**Answer:** True. A recent comparative study using demographic and health surveys data from 20 countries showed that the risk of death by age five was 28 percent higher for children born to adolescent mothers than for those born to women ages 20-29 (Bicego, et al. 1996).

Although most adolescent women are physiologically mature enough to become pregnant, their bodies are often not sufficiently developed to carry a pregnancy to term safely. Name at least two pregnancy-related complications they are most at risk of:

**Answers:**

- **Pre-eclampsia.** Pre-eclampsia, which is also called toxemia, is a problem that occurs in some women during the second half of pregnancy. The following are signs of pre-eclampsia: high blood pressure; swelling that doesn’t go away; and large amounts of protein in the urine.

- **Anemia.** This is a result of iron deficiency. Being tired, weak, or pale are some of the symptoms of anemia.

- **Obstructed labor due to cephalopelvic disproportion.** This is a medical term that means that the baby’s head cannot pass through the mother’s pelvis. This may be because the mother’s pelvis is too small or sometimes it is because the baby’s head is not in the best position. It usually means that a Caesarean section is necessary.
• **Obstetric fistulae.** Obstetric fistula occurs when labor is obstructed, that is, the baby is unable to pass through the birth canal despite strong labor. As a result of the pressure of the baby bearing down on the soft tissues of the pelvis, a hole in the wall between the vagina and the rectum or urethra develops. The mother may lose control of her bladder and/or bowels if the fistula is not repaired.

500 Which clinical health services must be available to youth to reduce the largest numbers of maternal deaths?

*Answer:* Most deaths occur either during labor and delivery or within the first week following delivery. So we need to focus on providing quality **emergency obstetric care** and increasing access to these services (250 points), as well as providing effective **contraceptive services** to reduce unwanted pregnancy (250 points).

**Final Jeopardy Question**

Name three bodily fluids that can pass the HIV virus from one person to another.

*Answer:* Blood, semen, vaginal fluid, or breast milk.

---

**Activity 4.5—Safari of Life**

**Introduction**

The *Safari of Life* game was designed by PATH to promote reproductive health. It focuses on increasing communication, providing information, and strengthening social skills. Originally developed for use in Africa, this game has been successfully adapted for use in Asia. Following the seminar series, one group in Cambodia adapted it to their context, redesigning the board and developing culturally-specific questions and language.

The teams race around the game board on a stepping stone path. Whoever reaches the end first, is the winner. The game includes a board, rolling dice, tokens, and two sets of cards. *Facts cards*, which contain closed-ended questions with the correct answer printed on the reverse side of the card, and *Feelings cards*, which contain open-ended questions designed to foster meaningful communication, critical thinking, and increased self-esteem. Topics covered include male and female physiology, STIs, HIV/AIDS, contraception, and sexual activity including intercourse. The game encourages discussion of relationships between genders, parent-child communication, friendship, values, and self-esteem.

**Time Estimate**

• The game can be demonstrated as a 45-minute skill station, but when young people play it timing will depend on the generated discussion, the number of players, and how long they want to continue playing.
Objectives

- Demonstrate increased ease of communication about sexuality topics.
- Demonstrate increased knowledge about sexuality and health.
- Engage in discussions about personal sexuality values and attitudes.
- Demonstrate critical thinking, as solutions and reactions to questions are discussed and refined.

Materials

- One Safari of Life board game for 4-10 players, forming teams of two players, up to five pairs. The games are available from Learning Zone Express, Box 1022, Owatonna, Minnesota, USA, 55060. To inquire about this game, write to: publications@path.org.

Method

1. All teams put their tokens on the space at the beginning of the game board.
2. Each team throws the dice in turn. The highest score starts first, the lowest starts last.
3. Each team throws the dice in turn and advances its token the number of spaces indicated on the dice.
4. The team follows the instructions on the space where the token lands.
5. When the token lands on either a Facts or Feelings card, the next player in line draws the appropriate card and asks the question on the card. The team briefly discusses the question and then tells the other players its answer. There is no penalty for answering incorrectly, but if the question on the Facts card is answered correctly, that team gets another turn.
6. The team that reaches the end of the game board first wins.

Reflection Points

Over the course of fifteen months, PATH has evaluated the game by playing it with over 550 players in 11 countries. Qualitative methods were used to assess the game’s ability to fulfil the objectives of improved communication, knowledge, and skills. The main findings of their evaluation were similar to comments made by seminar participants, and included the following:

- The game is simple to use, innovative, fun, and light-hearted.
- The most immediate uses of the game are as an icebreaker, to clarify values, and as a formative research tool.
• Players achieved the game’s objectives, in particular, increased ease of communication about sexuality topics, and increased knowledge about sexuality and health. The game successfully fostered constructive discussion about personal sexuality values and attitudes. Although more difficult to measure, critical thinking was demonstrated as players discussed and refined their solutions and reactions to questions.

• Although no particular age range is specified, players from ten years old and up evaluated the game. The evaluation revealed that the content of *Safari of Life* was too easy for some older teen audiences, especially those in high school.

To read the full evaluation and a report about another of PATH’S board games, *Young Man’s Journey*, visit the PATH website at www.path.org/materials.

### Suggestions for Facilitators

• While young people can play the game independently, a skilled facilitator can enhance their experience by stimulating discussion, managing content, correcting misconceptions and misinformation, or offering guidance.

• If you are introducing the game to program staff and partners, you may want to discuss its possible uses and even conduct a small field test to see what changes need to be made to adapt it to their environment.

### Activity 4.6—Life Behaviors of a Sexually Healthy Adult

#### Time Estimate

45 minutes

#### Objectives

• Discuss the life behaviors of a sexually healthy adult.

• Reflect on our own values regarding sexuality.

#### Materials

• “Becoming Aware of Your Own Values Regarding Sexuality” worksheet  p. 400

• “Life Behaviors of a Sexually Healthy Adult” hand-out (National Guidelines Task Force 1996)  p. 401
**Method**

1. Provide participants with a copy of the worksheet on “Becoming Aware of Your Own Values Regarding Sexuality.”
2. Ask them to read through the statements and indicate their own values.
3. When participants have completed their worksheets, go through the statements one by one and ask people about their responses.
4. Now give each participant a hand-out on “Life Behaviors of a Sexually Healthy Adult.”
5. Facilitate a group discussion about values, and relate the participant values from the previous worksheet (“Becoming Aware of Your Own Values Regarding Sexuality”) to the statements on the “Life Behaviors of a Sexually Healthy Adult” hand-out.

**Reflection Points**

- There may be some gaps between personal and professional values regarding sexuality and the life behaviors of a sexually healthy adult.
- People naturally hold a range of differing values and these should be respected. The discussions around each statement are helpful for understanding misconceptions.

**Suggestions for Facilitators**

- Encourage participants to honestly answer the questions according to their personal values.
- Be diplomatic and sensitive to differing values when facilitating these discussions.
1. Sexuality is a natural and healthy part of living.
2. All persons are sexual.
3. Sexuality includes physical, ethical, social, spiritual, psychological, and emotional dimensions.
4. Every person has dignity and self-worth.
5. Young people should view themselves as unique and worthwhile individuals within the context of their cultural heritage.
6. Individuals express their sexuality in varied ways.
7. Parents should be the primary sexuality educators of their children.
8. Families provide children’s first education about sexuality.
9. Families share their values about sexuality with their children.
10. In a pluralistic society, people should respect and accept the diversity of values and beliefs about sexuality that exist in a community.
11. Sexual relationships should never be coercive or exploitative.
12. All children should be loved and cared for.
13. All sexual decisions have effects or consequences.
14. All persons have the right and the obligation to make responsible sexual choices.
15. Individuals, families, and society benefit when children are able to discuss sexuality with their parents and/or other trusted adults.
16. Young people develop their values about sexuality as part of becoming adults.
17. Young people explore their sexuality as a natural process of achieving sexual maturity.
18. Premature involvement in sexual behaviors poses risks.
19. Abstaining from sexual intercourse is the most effective method of preventing pregnancy and STI/HIV.
20. Young people who are involved in sexual relationships need access to information about health care services.

<table>
<thead>
<tr>
<th>Becoming Aware of Your Own Values Regarding Sexuality</th>
<th>I am likely to agree with this statement</th>
<th>I can completely accept this statement</th>
<th>I have some reservation about this statement</th>
<th>I completely disagree with this statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sexuality is a natural and healthy part of living.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>2. All persons are sexual.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>3. Sexuality includes physical, ethical, social, spiritual, psychological, and emotional dimensions.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>4. Every person has dignity and self-worth.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>5. Young people should view themselves as unique and worthwhile individuals within the context of their cultural heritage.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>6. Individuals express their sexuality in varied ways.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>7. Parents should be the primary sexuality educators of their children.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>8. Families provide children’s first education about sexuality.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>9. Families share their values about sexuality with their children.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>10. In a pluralistic society, people should respect and accept the diversity of values and beliefs about sexuality that exist in a community.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>11. Sexual relationships should never be coercive or exploitative.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>12. All children should be loved and cared for.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>13. All sexual decisions have effects or consequences.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>14. All persons have the right and the obligation to make responsible sexual choices.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>15. Individuals, families, and society benefit when children are able to discuss sexuality with their parents and/or other trusted adults.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>16. Young people develop their values about sexuality as part of becoming adults.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>17. Young people explore their sexuality as a natural process of achieving sexual maturity.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>18. Premature involvement in sexual behaviors poses risks.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>19. Abstaining from sexual intercourse is the most effective method of preventing pregnancy and STI/HIV.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>20. Young people who are involved in sexual relationships need access to information about health care services.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>
Life Behaviors of a Sexually Healthy Adult

The goal of a comprehensive sexuality education program is to facilitate sexual health. After learning the six key concepts and associated topics, sub-concepts, and developmental messages, at an appropriate age the student will demonstrate certain life behaviors.

A sexually healthy adult will:

**Human Development**
- Appreciate one’s own body.
- Seek further information about reproduction as needed.
- Affirm that human development includes sexual development that may or may not include reproduction or genital sexual experience.
- Interact with both genders in respectful and appropriate ways.
- Affirm one’s own sexual orientation and respect the sexual orientation of others.

**Relationships**
- View family as a valuable source of support.
- Express love and intimacy in appropriate ways.
- Develop and maintain meaningful relationships.
- Avoid exploitative or manipulative relationships.
- Make informed choices about family options and relationships.
- Exhibit skills that enhance personal relationships.
- Understand how cultural heritage affects ideas about family, interpersonal relationships, and ethics.

**Personal Skills**
- Identify and live according to one’s values.
- Take responsibility for one’s own behavior.
- Practice effective decision-making.
- Communicate effectively with family, peers, and partners.

**Sexual Behavior**
- Enjoy and express one’s sexuality throughout life.
- Express one’s sexuality in ways congruent with one’s values.
- Enjoy sexual feelings without necessarily acting on them.
- Discriminate between life-enhancing sexual behaviors and those that are harmful to the self and/or others.
- Express one’s sexuality while respecting the rights of others.
- Seek new information to enhance one’s sexuality.
- Engage in sexual relationships that are consensual, non-exploitative, honest, pleasurable, and protected against disease and unintended pregnancy.

**Sexual Health**
- Use contraception effectively to avoid unintended pregnancy.
- Prevent sexual abuse.
- Act consistently with one’s own values in dealing with an unintended pregnancy.
- Seek early prenatal care.
- Avoid contracting or transmitting a sexually transmitted disease, including HIV.
- Practice health-promoting behaviors, such as regular check-ups, breast and testicular self-exam, and early identification of potential problems.

**Society and Culture**
- Demonstrate respect for people with different sexual values.
- Exercise democratic responsibility to influence legislation dealing with sexual issues.
- Assess the impact of family, cultural, religious, media, and societal messages on one’s thoughts, feelings, values and behaviors related to sexuality.
- Promote the rights of all people to accurate sexuality information.
- Avoid behaviors that exhibit prejudice and bigotry.
- Reject stereotypes about the sexuality of diverse populations.
- Educate others about sexuality.

---

Behavior Change: Theories, Processes, and Applications

Introduction

Throughout this pack, we have emphasized numerous factors that shape or determine behaviors. Many of these factors are internal to the individual, such as knowledge, perceptions, attitudes, values, beliefs, feelings, self-esteem, personality, and skills, among other things. Other factors are external to the individual such as socioeconomic conditions, availability of and access to services and information, quality of services and programs, and the policy environment. There are other factors that occur among individuals, such as communication, relationships, and expectations of self and others. In this section, we will discuss the importance of change theories to interventions, and introduce several theories of behavior change that address internal factors and processes of change. These include the following:

- Internal factors.
- Personal behavior change in the context of the environment.
- Stages of change and interventions to address them.

Issues

In order to design interventions and programs that effectively address behaviors, we must have an in-depth understanding of the different processes that occur in forming and changing behaviors. There are many theories and intervention approaches to behavior change. This section will help participants discern what change processes occur within an individual, and how to support or intervene in these processes, and how to begin placing those processes in a broader context.

Let’s begin by asking: What is “theory”?

Participants can brainstorm a number of ideas:

- A formula; a statement; an idea; a principle; certain rules; a framework; a scientifically proven fact; evidence-based guidelines; or an educated guess based on certain findings. It could be a way of systematically organizing what we observe, or a statement.

Why do we need theory in programs?

- Individuals’ behaviors are shaped by their social environment.
- All prevention programs are based on theory, whether we recognize them or not.
- Theories help us think about why, what, and how.
- Theories¹ explain behavior and suggest ways to change.

---

¹ Theories of behavior are often referred to as “models” of behavior.
Prevention programs based on theory are more effective.

- **The checklist effect.** Theories include a detailed list of elements that need to be considered in designing and implementing interventions. These programs make fewer mistakes, and are more effective and efficient.

- **The thoughtfulness effect.** Having a theory implies you have thought about why the intervention might work. This consideration leads to a more detailed plan of action and reproduces the checklist effect. Your intervention is more intentional about expected achievements.

- **The Hawthorne effect.** Having to prove a theory to justify your intervention ensures you work harder at the intervention. In some cases, people know they are being observed, so they try harder.

- **The donor effect.** Sometimes donors demand a theory to ensure that the program design is optimally effective and efficient. This contributes to a learning agenda. We want to ensure that we are accountable and that we share what we are learning (Houvras and Kendall 1997).

**References**


**Activities**

The activities in this section are designed to introduce key concepts related to risk, sexuality education, and behavior change.

Activity 5.1—Risk Assessment: Wearing a Helmet or Seatbelt

Activity 5.2—Key Concepts of Comprehensive Sexuality Education

Activity 5.3—Identifying the Six Stages of Behavior Change
Activity 5.1—Risk Assessment: Wearing a Helmet or Seatbelt

**Time Estimate**
30 minutes

**Objectives**
- Reflect on the concepts of risk and protective factors.
- Explore individual and environmental influences on risk behaviors.
- Relate the exercise to other risk behaviors relevant to young people.

**Materials**
Four signs created by writing each of the following on a piece of paper: 100%; 80%; 50%; and Rarely.

**Method**
1. Place the four signs in different corners of the room.
2. Read the following statement out loud:

   *When riding a motorcycle (or in a car), how often do you wear a helmet (or seat belt)? 100% of the time? 80% of the time? 50% of the time? Rarely?*

3. Ask participants to stand in the corner of the room that reflects their helmet wearing (or seat belt wearing) habit or behavior.
4. Ask participants to give their reasons for why they do or do not wear a helmet or seatbelt.

Participant responses may include, for example:

**100%**
*It’s the law. It’s important. It protects our lives. Accidents can happen anytime. I like to use it. At first we didn’t have a law but I wore it anyway, as it protects me from dust.*

**80%**
*If it’s far, I will use it. If the motorbike taxi provides one, I will use it. I wear it during the week but not on weekends. I had an accident when I didn’t wear a helmet and I nearly lost my teeth – but you know I don’t change my behavior. When I drive across the highway I wear the helmet, but when I go to the village I don’t.*
I am always a passenger as I don’t know how to drive and if the police say I have to wear it I do. When I ride I ask the driver to drive slowly. I think helmets are important for our life, but for short distances I don’t wear one and sometimes I am in a hurry. Helmets can protect the head but not the body. It depends on the availability. If the helmet smells or looks dirty I don’t wear it even though I should. We know where the police are – we either don’t go there or we wear helmets when we go there.

Rarely
It’s uncomfortable and it’s too hot. My hair gets messed up which is no good when I need to stand in front of my boss. I don’t like it. In the city I don’t wear it because other people don’t wear it. Not many people do it – if I wear it I feel odd. I wore it one time but only because the motorcycle guy offered it to me. It’s a short time and short distance so I think nothing can happen to me. I don’t wear one because I don’t know how to ride – if I travel with other people I tell them to go slowly. I work in remote areas and mountains and there is no road so we walk.

Reflection Points

• There are many influences on risk behavior, at the individual, interpersonal, and policy or regulatory levels.

• This example can also be a metaphor for using condoms or engaging in other types of protective behaviors. People know that helmets (condoms) can prevent health problems and save lives, but their attitudes and knowledge are not necessarily reflected in their behaviors.

• Knowledgeable people are not necessarily practitioners.

• People give many different reasons for what determines their behavior. However, there may be other things that people are not explicitly aware of or don’t mention. Some determinants may relate to the circumstances or conditions in which they live. Others relate to experiences much earlier in life or in their families. Individuals may also not explicitly recognize the extent to which others influence what they do.

Suggestions for Facilitators

• The “helmet” or “seatbelt” exercise can be used in a large group (up to 30 people) as a way to encourage participants to think about risk and protective factors by taking a public position about their own personal behaviors.

• Allow plenty of time for all participants to share their opinions.

• Encourage reflection about the gaps or inconsistencies between knowledge, attitudes, and behavior, and encourage discussions about interpersonal influences (e.g. peer norms, family pressures) and laws.
Stages of Individual Behavior Change

The following diagram illustrates stages of change. There are several stages, or steps, to individual behavior change; beginning with being unaware of the risks or consequences of a given behavior, to becoming aware, and then motivated to change. New behaviors are then tried and if they are successful, they may be sustained. To sustain new behaviors a person needs skills, practice, and constant reminders of the behaviors’ benefits, and access to services that support the change. (e.g., in the workplace, in gathering places). We need to help create an environment of social support and positive feedback in order to sustain healthy behaviors.

If you know what stage people are in, you can design an appropriate program for them. Every step has specific suggestions as to how to support or help sustain the behavior change process. In these steps, sometimes people fall back down, or drop out.

Questions for Discussion

• How can you sustain the desired behavior step by step?

• Whose change is it? Is it their goals or our goals? How do you define the common ground?

• How can you help move people to the next step, or help them sustain a desired behavior?

• How do human beings rationalize their actions? There are similar components involved in the use of helmets and condoms, such as availability or disliking their use.
• A different set of conditions may be needed to achieve behavior change and another set is necessary to achieve and sustain the behavior. Can you think of some examples?

• For sustained behavior change, the linkages and connections with others are most important. What kind and with whom?

**Reflection Points**

• We have to learn alongside our audience. We must create a positive environment for change, and know what clients need every step of the way. It is important to listen to, respect, and respond to beneficiaries.

• Audience analysis is most important. What stage are the members of the target audience at and what do they want? How can we help them through the stages of behavior change? Be realistic.

• We have to recognize their achievements at every step along the way. This will help keep them motivated.

• Sustained behavior is a continuous process. Continuous reinforcement is needed.

• Because there are so many things involved in the behavior change process, we need to be specific about what changes we want to occur.

• Make sure that people have enough analytical and decision-making tools and information. You don’t need to say “Do this.” Instead, give them analytical tools to help them form their own decision.

**Participant Reflections**

I am curious to know if we can add one step more to that model. If people have achieved the sustained behavior, they move on to advocacy (like ex-smokers).

Part of the shortcoming is from us as external change agents and how serious we are. Sometimes we are just interested in the behavior – we take photos and submit reports and then it’s finished. And then people go back to their old ways. And we say “I don’t know what happened – when we were working there…”

I first started working with 10-year-old children to educate them about safe sex. In some countries they learn from previous generations. The issue is to sustain safe sex from one generation to another. How can we create a safe sex cycle? We need to integrate with other stages, e.g., when young women start to menstruate, they learn about how to use cotton pads. The private companies can add reproductive health messages to these pads. We can create a network of change agents, e.g., when I was breastfeeding, I learned a lot more from the milk company than from the health sector.
Activity 5.2—Key Concepts of Comprehensive Sexuality Education

Time Estimate

45 minutes

Objective

• Analyze important skills in behavior change areas.

Materials

• Large “Key Concepts of Comprehensive Sexuality Education” matrix posted on a wall.
• Green dots.

Method

1. Introduce the participants to the “Key Concepts of Comprehensive Sexuality Education” matrix.

2. Ask them to form small groups and give each group six small green stickers (dots).

3. Ask the groups to discuss the following question:
   If you want a person to change behavior, what kinds of skills do they need?

4. Ask the groups to decide what priority areas are involved in the behavior change and to stick the green dots in these key areas of the matrix.

Reflection Points

• Responses from participants may include, for example:

   Our group tried to put equal weight on each area. We decided that all three should be given equal emphasis if we are to achieve that behavior.

   There were not many green dots on two important areas: express love and intimacy in appropriate way and exhibit skills that enhance personal relationships. These are individual choices. Making informed choices (about contraceptives for example) generally get more dots. These two important areas are not often addressed in the programs, so that’s a challenge for program planners and educators.
We understand that people have knowledge and now we need to emphasize attitudes. We knew that the person had already gone through that stage of learning.

In the Sexual Behavior group, I put all my dots on Attitudes/Perceptions/Behavior because in programs we often focus on the skills, practice, and knowledge issues, but attitudes are crucial.

In my group I was confused about the small differences between knowledge, attitude/behavior/practice, and skills.

It’s more than knowledge and skills. Attitude is most important. For example, I know if I have unprotected sex I can get HIV and I know how to use condoms. But risky or unprotected sex still happens.

In Nepal, the son does what the father does. They don’t have formal knowledge but it’s learned behavior from generation to generation. Some skills are learned without knowledge. It’s a form of knowledge but not necessarily the kind of knowledge we are promoting.

---

Key Concepts of Comprehensive Sexuality Education

**Concept 1: Human Development**
- Reproductive Anatomy and Physiology
- Reproduction
- Puberty
- Body Image
- Sexual Identity and Orientation

**Concept 2: Relationships**
- Families
- Friendship
- Love
- Dating
- Marriage and Lifetime Commitments
- Raising Children

**Concept 3: Personal Skills**
- Values
- Decision-making
- Communication
- Assertiveness
- Negotiation
- Help-seeking Behavior

**Concept 4: Sexual Behavior**
- Sexuality throughout the Life Cycle
- Masturbation
- Shared Sexual Behaviors
- Abstinence
- Human Sexual Response
- Fantasy
- Sexual Dysfunction

**Concept 5: Sexual Health**
- Contraception
- Abortion
- Sexually Transmitted Diseases, including HIV Infection
- Sexual Abuse
- Reproductive Health

**Concept 6: Society and Culture**
- Sexuality and Society
- Gender Roles
- Sexuality and the Law
- Sexuality and Religion
- Diversity
- Sexuality and the Arts
- Sexuality and the Media

---

Suggestions for Facilitators

• This exercise helps us to look at these things critically and encourages healthy debate. It’s a tool for looking at components analytically.

• It may be different in different settings and with different targets.

• This activity can get participants excited and may get a bit chaotic.

• Participants may want more direction and definitions on the terms, but allow time for them to sort these out themselves.

Activity 5.3—Identifying the Six Stages of Behavior Change

Time Estimate

90 minutes

Objectives

• Define the six stages of behavior change.

• Identify what stage of behavior change a client is in so that a provider can help him or her move towards the next stage.

Materials

• “Six Stages of Behavior Change” hand-out p. 402

Method

1. Give each participant a copy of the hand-out on “Six Stages of Behavior Change.”

2. After reviewing each of the six stages, ask participants to give examples of people who have moved through this process when trying to change a particular behavior. (Examples may include a person trying to stop smoking, a person trying to cure his/her tuberculosis, or a person trying to eat a healthier diet.)

3. Ask the participants to form six groups. Explain that each group will be assigned one stage of change, and should create two-minute role-plays of a young man talking about condom use with his peer, based on the stage that he is in. They may take 15 minutes.

4. Assign groups a stage of change and ask them not to reveal it to other groups.
5. When the groups present, the audience will not know what stage the role-play is based on. After the role-play is completed, the audience will be asked to identify the stage that was portrayed. Continue until all six stages have been portrayed and identified.

6. Conclude the activity with a group discussion using these questions:
   - How can counselors and health educators benefit from understanding the six stages of behavior change when working with clients?
   - What are some limitations to models that focus only on individual change?

**Reflection Points**

- It is interesting to see what the groups come up with in the role-plays.

**Suggestions for Facilitators**

- It may be difficult for participants to pinpoint which particular stage of change the role-play is referring to, but encourage them to guess and discuss.

**Six Stages of Behavior Change**

Prevention often requires drastic changes in behavior that may not be realistic for clients to successfully implement right away. Clients should be encouraged to take whatever incremental steps they can to alter their behavior.

The Transtheoretical Model construes behavior change as a process involving progress through a series of five stages, and a sixth potential stage:

![Six Stages of Behavior Change Diagram](image_url)

**Precontemplation** is the stage in which people are not intending to take action in the foreseeable future, usually measured as the next six months. People may be in this stage because they are uninformed or under-informed about the consequences of their behavior. Or they may have tried to change a number of times and had become demoralized about their ability to change. Both groups tend to avoid reading, talking, or thinking about their high-risk behaviors.

**Contemplation** is the stage in which people are intending to change in the next six months. They are more aware of the pros of changing but are also acutely aware of the cons. This balance between the costs and benefits of changing can produce profound ambivalence that can keep people stuck in this stage for long periods of time.

**Preparation** is the stage in which people are intending to take action in the immediate future, usually measured as the next month. They have typically taken some significant action in the past year. These individuals have a plan of action, such as joining a health education class, consulting a counselor, talking to their physician, reading a brochure, or relying on a self-change approach.

**Action** is the stage in which people have made specific modifications in their lifestyles within the past six months. This change may be temporary and the risk for relapse is high.

**Maintenance** is the stage in which people are less tempted to relapse and increasingly more confidant that they can continue their change.

**Relapse** is the stage in which failure has occurred. When this occurs, a person may return to any of the previous stages.
Introduction

In this section, we continue discussing the importance of change theories to interventions, and introduce several theories of behavior change that address social and interpersonal factors that influence behaviors and processes of social change. These include the following:

- Peer and other forms of social influences on behaviors.
- Theories and models of social change and examples of types of interventions based on the theories.
- An activity to help understand social learning theory.
- A participatory assessment of the strengths and limitations of different intervention strategies.

Issues

In order to design interventions and programs that effectively address behaviors, we must have an in-depth understanding of the different processes that occur in forming and changing behavior. There are many theories and intervention approaches to behavior change. This section will help participants discern the levels of social influence on behaviors and what change processes occur within the broader social environment.

Social Learning Theory

Now that we have covered individual processes of change, let’s discuss models of social learning. Social learning theory (Bandura 1994) describes the processes in which individuals interact with each other and their social environment. It addresses the interaction between an individual and the interpersonal environment, for example, friends, parents, and community. Interventions based on social learning theory encourage the following:

- Understanding risks and benefits.
- Focusing on social or behavioral outcomes and expectations.
- Self-efficacy in carrying out behaviors.
- Recognizing social influences.
- Changing individual values.
- Changing group norms.
- Building social skills.

Many sexuality and health promotion programs design activities based on the principles of social learning theory. These programs can effectively demonstrate changes in values,
attitudes, norms, skills, and behaviors. Peer programs that try to influence norms and behaviors are also based on social learning theory.

**References**


**Activity**

The activity in this section is designed to give participants an opportunity to consider the multiple components of social learning and their effects on behavior.

**Activity 6.1—Orientation to Social Learning Theory**

**Time Estimate**

45 minutes

**Objective**

- Identify ways that programs can help clients address the six components of social learning theory.

**Materials**

- “Behavior Change: An Orientation to Social Learning Theory” hand-out
- “Social Learning Theory” worksheet

**Method**

1. Introduce social learning theory by presenting the information on the “Behavior Change: An Orientation to Social Learning” hand-out.

2. After reviewing the six components of social learning theory, ask participants to form six small groups. Give each group a “Social Learning Theory” worksheet, and ask them to think about how a program could address each of the components of social learning theory when addressing HIV prevention. Give groups no more than five minutes to discuss their answer.
3. Bring the groups together and ask a participant from each group to present the findings. Encourage other participants to add additional thoughts.

Reflection Points

- Changing behavior is more than just getting knowledge. It is a process requiring skills, positive examples, and support.
- The process of change may be fast or slow, depending on many factors.

Suggestion for Facilitators

- Encourage other groups to provide feedback on each presentation.
- Make sure groups try to provide specific suggestions to answer the questions.

Behavior Change: An Orientation to Social Learning Theory

Many communication approaches are used to change individuals’ complex behaviors. However, simply providing information on harmful behaviors is not enough to create positive behavior change. Various behavior change theories suggest that programs must address many psychological, sociocultural, and structural factors to successfully change human behavior. The following six elements of behavior change are based on Albert Bandura’s Social Learning Theory. All six of these factors play a role in determining whether or not a person is able to change his or her behavior.

Knowledge – People need to receive consistent factual messages about health issues. Individuals also need to identify myths and misconceptions that may exist about a particular health issue. Through knowledge, an individual should feel that he/she knows how to effectively avoid a health problem.

Skills – People must be able to apply knowledge to their own lives. Individuals require communication skills to express their health concerns and needs to a partner. They also need practical skills such as the ability to use condoms correctly.

Benefits – People must understand and believe that there are benefits to a particular behavior. People are often more influenced by the benefits they receive from a particular behavior rather than the negative consequences a behavior might cause.

Modeling – Social norms or “rules” influence behavior. We are more likely to behave in a certain way if others that we associate with also behave that way. Therefore, modeling can either support healthy behavior change or hinder it. For example, a person is more likely to use drugs if his friends use them. A person is less likely to use drugs if his friends are opposed to drug use.

**Self-efficacy** – A person needs to believe that he/she can actually control his/her behavior and effectively perform the desired behavior. For example, a young man needs to know that he has the knowledge to effectively and correctly use a condom.

**Support** – A person needs help, support, or encouragement to maintain his or her health. Services must be provided so that a person can prevent health problems from occurring. Families can also provide emotional, physical, or economic support to an individual.

The diagram illustrates how the six components of social learning theory all influence behavior change. The mountain range in the diagram represents reproductive health problems that an individual would want to avoid such as HIV, STIs, unwanted pregnancy, and maternal mortality.

To the left of the mountain range is a person. The person’s task is to pass over this mountain of challenges and arrive at “health” on the other side. To achieve this, the person will need balloons to carry him or her over the mountain range. Just having one balloon will not suffice. The individual needs most, if not all, of the balloons to cross the mountains.

---

**Social Learning Theory**

In order to help change a young person’s behavior around HIV prevention, a program will need to help address all six components of the social learning theory. Review each component below and identify ways that a counselor could address these issues with a male client.

**Group 1**

**Knowledge** – People need consistent factual messages about health issues. They also need to identify myths and misconceptions that may exist about a particular health issue. Through knowledge, an individual should feel that they know how to effectively avoid a health problem.

*What key pieces of knowledge would a young person need to prevent getting HIV?*

*How could this knowledge be shared in a YSRH program?*
**Group 2**

*Skills* – Youth must be able to apply knowledge to their own lives. This requires skills. Individuals require communication skills to express their health concerns and needs to a partner. They also need practical skills such as the ability to use condoms correctly.

> What types of skills are needed for a young person to prevent HIV infection and prevent passing it on to others? How could these skills be developed in a YSRH program?

**Group 3**

*Benefits* – Youth must understand that there are benefits to a particular behavior. The behavior has to be worth doing. Youth are often more influenced by the potential benefits from a particular behavior rather than the negative consequences it might cause.

> What are all the benefits a young person gains by delaying sex? What are the benefits of a young person having only one partner? What are the benefits that would come from a young person using condoms? What are the benefits of HIV prevention for a young person?

**Group 4**

*Modeling* – Social norms influence our behavior. We are more likely to choose a certain behavior if others that we associate with also perform that behavior. Therefore, modeling can either support healthy behavior change or hinder it. For example, a person is more likely to use drugs if his friends use them. A person is less likely to use drugs if his friends are opposed to drug use.

> How could a program work with youth to model behaviors that prevent HIV infection?

**Group 5**

*Self-efficacy* – A person needs to feel confident in his/her ability to change behavior.

> How could a program support a young person’s sense of control and self-efficacy in preventing HIV infection?

**Group 6**

*Support* – A person needs help to maintain his or her health. Services must be provided so that a person can prevent health problems from occurring. Families can also provide emotional, physical, or economic support to an individual.

> What type of support and services should a YSRH program focus on to help youth prevent HIV infection?
Introduction

In section 6 of Pack One, we introduced key issues related to program design, including the Logic Model framework. In this section, participants are encouraged to practice applying the principles from previous sections on behavioral and social influence theories to develop interventions that are specific to different contexts. This is done through the process of diagnosis, development, and delivery.

Issues

As stated previously, one of the most important factors to program success is its design, strategy, stated outcomes, and activities that are clearly linked to those outcomes. In this session we review some of the key definitions presented in section 6 of Pack One.

Defining the Goal

A goal states the impact a program intends to have on a target population, the specific group the program is trying to effect. Goals can focus on health issues such as reduction of STIs and HIV among youth, or on social or development aspects such as increasing girls’ education. In some cases, we are trying to prevent negative outcomes or health problems, while in others, we are trying to promote positive outcomes and development.

Defining Behavioral Outcomes

Behaviors largely determine or contribute to health and development goals. They may be enacted by groups or individuals. Positive behaviors contribute to the improvement of a health goal, while negative behaviors impede the goal or contribute to health or development problems. The majority of youth programs focus on developing or changing behaviors, whether implicitly or explicitly.

Defining Protective and Risk Factors

We typically cannot directly shape or change behaviors. Rather, we must try to identify what determines or influences behavior and then affect those determinants. There are a number of reasons people give for engaging in particular behaviors, for example, using condoms, using drugs or alcohol, or not wearing a helmet or seatbelt in traffic. Most behaviors are determined or influenced by a variety of factors, and these depend on differences in settings, cultures, religious beliefs, and political and economic conditions. For young people especially, the influence on what they do depends a lot on who is involved in their lives and decisions, and the nature and quality of these relationships, the values they express, the behaviors they model, and the opportunities they provide. This is true for family, peers, health providers, teachers, or others.
Protective factors increase the likelihood of positive behaviors and decrease the likelihood of negative behaviors. Protective factors may be directly related to health outcomes, such as valuing condoms in the prevention of HIV, or they may be more general, such as a youth’s perception that he or she is cared for by parents.

Risk factors, in contrast, increase the likelihood that young people will engage in negative or health-compromising behaviors, or reduce their involvement in positive behaviors.

Because both protective and risk factors affect behavior, it is important to consider both types of factors.

Identifying the Interventions

We can change these determinants or factors by developing groups of activities, or interventions. Interventions can help to provide alternatives, address the perceived risks of unsafe behaviors, change social and cultural norms, make products more accessible, and promote institutional changes.

Activities

The following activities are designed for participants to practice applying the principles of behavior change and social learning to diagnosing and developing interventions.

Activity 7.1—Identifying Youth Problems and Healthy Sexuality Outcomes

Activity 7.2—Case Studies of Katbang and Talipo

Activity 7.3—Designing Behavior Change Programs

Activity 7.1—Identifying Youth Problems and Healthy Sexuality Outcomes

<table>
<thead>
<tr>
<th>Time Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>45 minutes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Practice identifying YSRH problems and healthy sexuality outcomes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Flip-charts</td>
</tr>
<tr>
<td>• Markers</td>
</tr>
</tbody>
</table>
Method

1. Ask participants to form small groups to discuss and respond to the following three tasks:
   - Identify youth problems (at individual and social levels).
   - Identify desired healthy behavioral outcomes (at individual and social levels).
   - Identify risk factors and protective factors.

2. Invite a representative from each group to share the group’s ideas.

3. Discuss which factors are amenable to change by program interventions and which are not. Why not?

Reflection Points

- This activity relates to the Logic Model in that it looks at youth problems, desired behavioral outcomes, and risk and protective factors.

Examples of group feedback might include:

Youth Problems

- Increased sexual activity among adolescents.
- Increased drug use.
- Dropping out of school.
- Lack of jobs.

Desired Healthy Sexuality Outcomes at the Individual (adolescent) Level

Sexual Activity

- Practice safe sex (promote condom use), decrease unwanted pregnancy, abortion, STIs, HIV.
- Delay sexual initiation or abstain from sex.
- Have only one partner (monogamy) or no partner.
- Demonstrate life skills (e.g., use critical analysis skills, make a decision).
- Seek healthy behaviors.

Drug Use

- Youth not using drugs and able to resist peer pressure.
- Youth avoiding alcohol or engaged in responsible drinking and able to resist peer pressure.
School Drop-out

- Youth should at least complete high school.
- Support for pregnant youth to stay in school.

Desired Healthy Sexuality Outcomes at the Social Level

Parents:

- Are aware that they are the primary sexual educators for youth and know how to talk with their children, especially about sexuality.
- Improve and increase communication between parents and their children.
- Spend more time with their children.
- Encourage and support children to complete their education.
- Guide and demonstrate what they (parents) teach their children.

School and Teachers:

- Increase communication and coordination between school and family, or teachers and parents.
- Improve sexual education curriculum in school.
- Refer students who need help to qualified health providers.
- Spend more time with students during consultations.
- Develop a school policy to support young people.

Friends:

- Help their friends get help from qualified health personnel.
- Have same desirable behaviors as other youth (e.g., safe sex) or have a positive attitude towards condom use and abstinence.

Media:

- Be more socially responsible; focus more on social issues than profits.
- Allocate resources for both commercial and social issues.

Community:

- Set appropriate standards, regulations, or norms.
- Set policies and programs in support of YSRH.
- Provide adolescent-friendly services.

Nongovernmental Organizations:

- Provide more help and commitment in working on YSRH.

Risk Factors

- Too many entertainment options—easy access to alcohol, drugs, and sexual contact.
• No comprehensive sex education in school.
• Materialism.
• Migration and weakening of family bonds.
• Incomplete education.
• No youth-friendly services.

**Protective Factors**

• Supportive media.
• Healthy economy.
• Secure resources.
• Parenting associations that promote communication.
• Industries that provide information and services to employed young adults.

**Suggestions for Facilitators**

• It is useful to do Activities 7.1 and 7.2 during the same session though this is not necessary.
• The case studies in the next activity will help participants think comprehensively about each of the desirable outcomes. The next step is to focus selectively and intensively on outcomes.

**Activity 7.2—Case Studies of Katbang and Talipo**

**Time Estimate**

1 hour

**Objective**

• Practice identifying YSRH problems and healthy sexuality outcomes.

**Materials**

• Hand-outs of case studies on Katbang and Talipo.  

**Method**

1. Distribute the Katbang case study and ask participants to read it.
2. Ask participants to form small discussion groups to identify the following:
   - Problems related to YSRH.
   - Desirable healthy sexuality outcomes at individual and social levels.
   - Factors promoting or hindering the desirable outcomes.
3. Ask the groups to analyze (or make assumptions) about what stage(s) the intended audience is at for each of the desirable behaviors or outcomes.
4. Ask the groups to suggest some possible interventions and rationales.
5. Invite a representative from each group to present their ideas and invite discussion.
6. Repeat this process for the second case study on Talipo.

**Reflection Points**

Group output for the Katbang case study may include:

**Identify Youth Behaviors**

Reproductive health problems: unwanted pregnancy, unsafe abortion, misuse of contraceptive pills, maternal morbidity, post-abortion complications, emotional problems, stigma, depression, criticism, isolation.

**Desirable Healthy Outcomes**

Individual: practice safe and protected sex, use skilled care providers, use contraception correctly, use youth-friendly services.

Social: positive role models, encouragement from friends, social support from community and factory, healthy entertainment, advocacy for changing policy in factory.

**Risk Factors**

Peer pressure to have sex, isolated (away from family support), difficult availability and accessibility to health services, unsupportive managers, power imbalances within male-female relations, unsafe healthcare, providers who act punitively or stigmatize youth seeking services.

**Protective Factors**

Adequate information, trusting relationships, money management, ability to share experiences or opinions with friends.

**Interventions**

Life-skills training.
Group output for the Talipo case study may include:

**Identify Problems**

**Individual:** increasing sexual activity, increasing drug use, increasing drop-out rate.

**Social:** no sex education in school, increased advertisements targeting students.

**Desirable Healthy Outcomes**

**Individual:** increased safe sex, increased condom use, delayed sexual initiation, monogamous partnership, health-seeking behavior, ability to demonstrate life skills, ability to resist drug use due to peer pressure, ability to practice responsible drinking, and high school completion.

**Risk factors**

Too many entertainment places, no sex education in schools, materialism promoted by media, migration weakening family ties, incomplete education, and lack of youth-friendly services.

**Protective factors**

**Parents:** improved and increased parent communication with children, more time with children, supportive encouragement for children to finish high school, and to guide children and to practice with they preach.

**Schools:** supportive school policies, increased communication and coordination, sexuality education curriculum development, and more time for communicating with students.

**Peers:** same as individual.

**Media:** more responsible emphasis on and resources for social issues (not just commercial advertising and reporting).

**Community:** appropriate norms and programs to promote adolescent reproductive health and youth-friendly services.

**NGOs:** participatory behavior in community programs.

**Interventions**

Media strategies, institutional pressure from NGOs, and economic development can help provide resources for workplace youth-friendly services. Parents and Teachers Association (PTA) support for improving YSRH services and getting sex education into the school curriculum.

**Suggestions for Facilitators**

- It may be effective to project the case study onto a screen, as well as giving it to participants as a hand-out.
Case Study—Katbang

Katbang is the capital city of Ottagon, an Asian country with a population of 3 million, of which more than 80 percent are Muslim. Ottagon is predominantly agricultural. The textile industry is rapidly expanding as a result of substantial overseas investment, stimulated by the large pool of low-cost labor the country offers. This rapid growth draws many young men and women ages 15 - 25 years from rural areas to Katbang, looking for jobs in factories and the growing service sectors. The increasing urban workforce gives rise to rental houses and dormitories for workers as well as restaurants, cafes, mini-theaters, and other youth-targeted entertainment businesses in the vicinity of the industrial zone.

These developments produce circumstances leading to an increase in sexual activity resulting in unwanted pregnancies. Abortion is illegal and strongly punished in Katbang. Nevertheless, many young women seek this alternative and arrange abortions with unqualified providers. Consequently, morbidity due to unsafe abortion is increasing. Drugstores in Ottagon report high sales of contraceptives and abortifacients. Emergency contraceptives are also popular. However, staff in drugstores and other sources of these products lack information about their correct use. Generally, the population can access government and private hospitals, and there are polyclinics in the industrial zones. Most workers have workplace health insurance coverage. However, this health package usually excludes reproductive health services, such as contraceptives or pre- and post-natal care, as the factories prefer to hire unmarried workers and try to avoid paying the expenses of maternity leave.

Case Study—Talipo

Talipo is a country of 80 million people. Catholicism and Buddhism are the predominant religions. Talipo’s economy is booming, and all the major cities are growing rapidly. Foreign investment has led to the establishment of many large industries in cities outside the capital. The subsequent growth of services has filled these cities with entertainment places such as pubs, bars, and karaoke rooms. The job opportunities attract young people, who tend to leave school after finishing eight years of education.

The media is full of advertisements for products that specifically target young people. Seeking to establish good images for their businesses among the youth market, companies use creative promotional strategies with elements of pop culture to draw youth attention and reach the school-aged population.

There is growing concern about increased sexual activity among adolescents. Parent associations complain that schools have not done their job of disciplining students and preventing sexual activity and drug abuse. NGOs and media are demanding that schools include sex education in the curriculum. However, the Ministry of Education still resists the idea of providing sex education and insists that biology and health education classes at all levels already give the basic information. Several religious organizations are pressuring the government to issue a law to prevent youth under the age of 18 from going out after 10 pm.
Activity 7.3—Designing Behavior Change Programs

Time Estimate

2 hours

Objective

• Clarify behavior objectives for target groups and design activities that will address them.

Materials

• Flip-chart
• Marker

Method

1. Let participants know that in this activity they are going to formulate detailed action plans.
2. Ask participants to form discussion groups and select an objective for a target audience.
3. Ask participants to consider learning, knowledge, and skills, and to design program activities accordingly.
4. When groups are ready, invite them to present their programs.

Reflection Points

• Responses from the groups will vary according to the target group and objectives they have selected.

Suggestions for Facilitators

• Participants should use the steps from Activities 7.1 and 7.2 as a guide.
• This is an involved activity requiring groups to work systematically to outline their programs. Encourage the groups to think specifically and to provide as much detail as possible.
Introduction

Promoting healthy decision-making and safe behaviors among young people is at the heart of most youth programs. A number of education approaches have been developed for youth, ranging from life-skills education that emphasizes refusal skills, to basic anatomy and physiology, to HIV prevention. Approaches that offer the greatest promise for promoting healthy development and preventing unwanted sexual and reproductive health consequences, address the developmental, emotional, physical, and social elements of sexual development in a holistic manner.

This section introduces definitions and concepts of new generation approaches to education, including sexuality, HIV, and life-skills education. Building on activities and exercises in previous sections, we introduce additional training activities that promote:

- Risk assessment
- Decision making
- Communication

Issues

**Sexuality education emphasizes holistic development.**

Departing from more traditional approaches that teach only about anatomy and physiology, sexuality education curricula usually address the following content:

- Sexual development
- Reproductive health
- Interpersonal relationships
- Body image
- Gender roles

The Sexual Information and Education Counsel of the United States (SIECUS) has developed a long list of criteria, entitled “Life Behaviors of a Sexually Healthy Adult,” (SIECUS 1996) recognizing sexuality education as a life-long process of discovery and interconnectedness.

**HIV prevention focuses on preventing specific behaviors.**

The urgent need for HIV education has stimulated concerns about sexual risks among young people, and allowed the introduction of more explicit approaches to teaching about sexuality. HIV education provides information on risks of HIV transmission, methods of prevention, condom promotion, and in some cases, caring for people with HIV/AIDS.
and reducing stigma. HIV education programs have been found to help decrease the number of sexual partners and increase condom use.

**New generation approaches to sexuality education incorporate life-skills education and HIV prevention.**

This approach combines learning experiences that develop knowledge and attitudes, and especially skills needed to make healthy decisions, and take positive actions to promote health and safety and reduce disease. The five foundation skill areas include:

- Decision-making and problem-solving.
- Critical thinking and creative thinking.
- Communication and interpersonal skills.
- Self-awareness and empathy.
- Coping with emotions and stress.

Skills-based approaches are gaining recognition because they teach young people alternatives for action.

**Sexuality, HIV/AIDS, and life-skills education programs can increase levels of knowledge, change attitudes, and promote positive behaviors.**

Reviews of evaluations and studies from the U.S. and developing countries indicate that school-based sexuality education programs can increase knowledge, change attitudes, and promote behaviors such as delayed sexual initiation and increased condom use among sexually active youth.

As mentioned in section 2, a number of characteristics of successful programs have been identified. These elements include:

- Focusing objectives on reducing one or more sexual behaviors that lead to STIs, including HIV, or unintended pregnancies.
- Using methods that are appropriate to age, sexual experience, and culture.
- Basing programs on theoretical approaches.
- Designing programs to last a sufficient length of time.
- Using a variety of teaching methods.
- Providing basic and accurate information.
- Addressing social pressures.
- Using a skills-based approach.
- Selecting and training teachers, peers, or both, carefully.
- Using clear messages that are continually reinforced.

**Sustaining behavior change remains a challenge.**

While there have been a number of successful programs that change behavior in the short term, there is still a question of how to sustain behavior change through these programs.
Institutionalizing sexuality, HIV, and life-skills education requires commitment and resources.

Education programs in school settings can reach a large number of youth where school enrollment rates are high. There are a number of implementation challenges to introducing and implementing such programs, including:

- Gaining commitment and support from policy-makers.
- Establishing ownership by and confidence in teachers.
- Developing and adapting curricula for different ages and local socio-cultural conditions.
- Setting minimum training requirements.
- Organizing a structure of master trainers.
- Testing and adapting training techniques and content to achieve high quality and performance by trainers.

References


Activities

In this section, the activities promote knowledge and shape attitudes to address skills such as assessing risk (including risks of specific sexual behaviors) making healthy decisions, and communicating.

Activity 8.1—Who’s at Risk? – Revealing and Analyzing Stereotypes

Activity 8.2—Risk Behaviors

Activity 8.3—Decisions and Consequences
Activity 8.1—Who's at Risk?  
Revealing and Analyzing Stereotypes

**Time Estimate**
90 minutes

**Objective**
- Reflect on stereotypes regarding HIV infection risks.

**Materials**
- Cards with “types” written on them (see next page).

**Method**
1. Ask participants to arrange the chairs in a horseshoe shape.
2. Hand each participant a small card with a “type” written on it (see list on the next page).
3. Tell participants that one end of the horseshoe represents High Risk and the other end is Low Risk.
4. Ask participants to sit according to how they assess the risk of the “type” on the card.
5. Tell them that if someone is sitting on the seat they think they should occupy, they should negotiate with that person. Allow ten minutes for participants to reorganize themselves and negotiate.
6. After the group reorganizes itself, start at the High Risk end and ask participants to reveal the “type” written on their card and to give reasons for choosing that seat.
7. The group should debate the risk assessment according to the “type” of person.

**Reflection Points**
- We must be careful not to make generalizations. We should not stereotype. Risk depends on behavior, habits, and will power. Emphasize explicitly to participants that this exercise should not reinforce the use of stereotypes. While “types” are used as examples, stress that it is the behavior choice that produces risk, not how a particular individual is classified by “type.”

**Thailand**
In the early 90s all the campaigns stamped letters with “If you go to prostitutes, you will get AIDS.” This became a problem later when trying to educate people about the disease because they would say, “I’m not sleeping with prostitute, so I’m not at risk.”
• We are all at risk. These are our own ideas about stereotypes. Even though we have been trained, we can still have stereotypical thoughts (like calling people in this exercise “types”). So we must think about how we educate youth.

• Behavior change messages must be carefully chosen. This exercise focuses on knowledge and perceptions.

**Suggestions for Facilitators**

• This activity is most powerful at the end when participants conclude that it is not the job title that indicates risk, but actual behavior. Let participants reach this point through the process of the activity. Do not tell them this up front. Allow them to realize it through their own discussions. If they do not draw this conclusion, bring it to their attention.

<table>
<thead>
<tr>
<th>Teacher</th>
<th>Salesman</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGO worker</td>
<td>Hotel worker</td>
</tr>
<tr>
<td>Doctor</td>
<td>Politician</td>
</tr>
<tr>
<td>Nurse</td>
<td>Athlete</td>
</tr>
<tr>
<td>Village headman</td>
<td>Construction worker</td>
</tr>
<tr>
<td>Housewife</td>
<td>Factory worker</td>
</tr>
<tr>
<td>Widow</td>
<td>Single man</td>
</tr>
<tr>
<td>Young secretary</td>
<td>Single woman</td>
</tr>
<tr>
<td>Government official</td>
<td>High school student</td>
</tr>
<tr>
<td>Priest</td>
<td>One with multiple partners</td>
</tr>
<tr>
<td>Drug user</td>
<td>Caretaker of people living with HIV and AIDS</td>
</tr>
<tr>
<td>Banker</td>
<td>Taxi driver</td>
</tr>
<tr>
<td>Truck driver</td>
<td>Married monogamous woman</td>
</tr>
<tr>
<td>Singer</td>
<td></td>
</tr>
<tr>
<td>Massage girl</td>
<td></td>
</tr>
</tbody>
</table>
Activity 8.2—Risk Behaviors

Time Estimate

30 minutes

Objectives

- Provide information and understanding of the risks of HIV infection.
- Become aware of the importance of clear and correct information.
- Strengthen understanding of risk behavior.

Materials

- Sets of “Risk Level” cards (one per group)

Method

1. Explain that this activity is to help understand risk behavior.
2. Ask participants to form discussion groups.
3. Distribute a set of “Risk Behavior” cards to the groups and ask them to divide the cards into four sets according to the level of risk behavior: “High Risk;” “Moderate Risk;” “Low Risk;” and “No Risk.”
4. Allow time for the groups to discuss and complete the task. Go around to clarify any issues, but let the participants make their own decisions.
5. When all the groups have completed the task, go through each of the risk behaviors one by one and invite the groups to give their assessments.
6. Discuss any points of confusion and have an open discussion.

Reflection Points

- It is confusing to decide into which level of risk some of the behaviors fit.
- Questions on HIV arise from lack of information, personal anxiety, or attitudes toward sex and HIV. When providing information, full and clear explanations are needed. Unclear or vague information will affect the target groups’ ability to protect themselves and their acceptance of people living with HIV and AIDS.
**Suggestions for Facilitators**

- This activity is not simple and there may be some disagreements about risk level. Clarify misunderstandings by referring to fact sheets and recent data.
- “High Risk” behaviors include: penetrative (vaginal and/or anal) sex without using a condom, intravenous drug use with shared needles, and sexual intercourse during menstruation.
- “Moderate Risk” behaviors include: performing oral sex and mother-to-baby HIV transmission during pregnancy.
- “Low Risk” behaviors include: getting needle pricks, providing treatment and care to people living with HIV and AIDS (PLHAs), and contact with wounds, blood, and plasma of infected persons.
- “No Risk” behaviors include: getting mosquito bites, and performing daily activities, and working with HIV/AIDS-infected persons.

---

**Note: For HIV to be transmitted from one person to another there must be:**

**Quantity**
- The virus must be present in sufficient quantity and concentration in the body fluid being passed (blood, semen, vaginal fluid or breast milk).

**Quality**
- The virus must be of sufficient quality. Saliva, stomach and other acids, bleach, heat and air can reduce the quality of the virus.

**Route of Transmission**
- The virus must be passed directly into the bloodstream in a drop or more of blood, semen, vaginal fluid, or breast milk. Skin, thick membranes, condoms, and scabs are effective barriers to transmission.

*Without sufficient quantity, quality, and an effective route of transmission, the virus cannot be passed on.*

*Common causes of transmission include having unprotected sex, receiving infected blood, needle sharing, mother-to-baby transmission (in the womb, at birth, or through breastfeeding).*

---

**“Risk Level” Cards**

- Having penetrative vaginal sex without using a condom
- Using intravenous drugs and sharing needles
- Having sexual intercourse during menstruation
- Treating and taking care for PLHAs
- Having contact with wound, blood, or plasma of PLHAs
- Performing daily activities or working with PLHAs
- Inserting fingers into sexual organs
- Caressing or using the tongue on body parts other than genital organs
- Inserting sexual pleasure enhancement equipment into sexual organs
- Masturbating
- Getting a blood transfusion with HIV-contaminated blood
- Getting needle pricks
- Performing oral sex
- Getting mosquito bites
- Using condoms during sexual intercourse
- Eating food prepared by someone who is HIV infected.
Activity 8.3—Decisions and Consequences

Time Estimate

1 hour

Objective

• Identify the consequences of personal decisions.

Materials

• Three signs for the corners of the room, indicating: Decision 1: Go ahead and have intercourse without a condom; Decision 2: Have sexual contact that excludes intercourse; and Decision 3: Decide not to have sexual contact.
• Slides with the text described in the “Method.”

Method

Prior to this exercise, put color-coded cards (blue, green, yellow, and pink) in the center of the room. Have as many cards as there are participants.

1. Show the first slide that says:

Roy really likes Emily, the girl he has been dating for more than a month. He meets her almost every day. On Friday night, Emily and Roy go to her room where they spend time talking and watching a movie together. They start touching and hugging and then Emily says she would like to have sex with him. She explains that he does not have to worry about birth control because she is on the pill. Roy knows that HIV is a big risk today and that pills do not prevent HIV. Emily is so concerned about pregnancy and so trusting of Roy, that she forgets to think about STIs, including HIV, and AIDS.

2. Ask: “What would you do if you were Roy or Emily?”

3. Show the decisions on the second slide:

1. Go ahead and have intercourse without using a condom.
2. Have sexual contact that excludes intercourse.
3. Decide not to have sexual contact.

4. Ask participants to stand in a part of the room according to their decision (1, 2 or 3).

5. Ask participants to explain how they made their decision.
6. Then ask each participant to take one card of any color they like from the many cards of four colors (blue, green, yellow, pink) on the floor in the center of the room.

7. Explain that decisions are followed by behaviors and consequences.

8. Ask whether they expect any consequences from their decision.

9. Show the remaining slides in turn, which describe the consequences of each of the three decisions. Explain to the participants that the specific consequence for each decision will correspond to the color card they have chosen.

**Decision 1: Go ahead and have intercourse with no condom.**

**BLUE:** Emily did not get pregnant and Roy did not give her a disease.

**GREEN:** Emily forgot to take her pill for two days and became pregnant.

**YELLOW:** Emily did not get pregnant but Roy had asymptomatic gonorrhea, which he transmitted to Emily.

**PINK:** Roy, who did not know he was HIV positive, transmitted HIV to Emily and we do not know if she is pregnant yet.

---

**Decision 2: Have sexual contact that excludes intercourse.**

**BLUE:** Everything works out okay. They are both a little nervous, but they enjoy the touching.

**GREEN:** Roy and Emily start a conversation about what they are comfortable doing. They have a really good, honest talk, and feel closer to each other. They decide not to do anything yet but to keep talking.

**YELLOW:** They agree to be sexual without having intercourse but then get carried away and have intercourse without using a condom. Roy ends up with a sexually transmitted disease and Emily gets pregnant.

**PINK:** Roy and Emily end up talking and being very sensual together, but they do not have intercourse. Emily enjoys the contact very much and has her first orgasm.

---

**Decision 3: Decide not to have sexual contact.**

**BLUE:** Emily is very understanding and does not feel rejected.

**GREEN:** Although Emily agreed not to have sexual contact, she is upset and keeps on pressuring Roy. She makes fun of him, questioning his manhood. Later, she apologizes.

**YELLOW:** Emily suggests they make each other feel good without having intercourse. The two of them give each other a sensual massage. It is very playful and feels great. They both enjoy the experience and do not have to worry about pregnancy or disease.

**PINK:** Emily does not get upset but wants to know why Roy will not have intercourse with her. When Roy tells her his reasons for wanting to wait, she is really impressed. She tells him that he is very special. The two make a date for the next night.
10. Ask participants: “Now that you are aware of the possible consequences, would you make the same decision?”

**Reflection Points**

- Stress that neither Emily nor Roy should be considered villains in this story. Avoid reinforcing stereotypes—that Roy is a Casanova or Emily is a deceptive, villainous girl.
- Whatever we teach youth invariably affects the way they relate to themselves and others.
- This is one way of developing creative thinking. Once people go through the exercise they are more prepared to think about consequences.
- It is a good exercise for youth that allows them to participate in decision-making.

**Suggestions for Facilitators**

- Encourage participants to discuss their decision choice within their small group.
Peer Education

Introduction

Because young people have a great deal of influence on each other, especially during middle to later adolescent years, many programs involve peer education. As we have seen earlier, a young person’s perception of what his or her friends do may be one of the most important factors to decision making. Peer programs are based on the assumption that relationships among young people influence what they learn and how they behave. Peer programmers also assume that peers get information about sexuality and reproductive health from each other. In this section, we cover:

- Key issues in peer programs
- Assessing peer influence
- Designing peer programs

Issues

Peers influence each other in different ways.

Peer influences can both positively and negatively affect behaviors and health outcomes. Negative influences include encouraging the use of alcohol and drugs, or pressuring someone to engage in early sexual activity. More positively, peers can influence friends to protect themselves by controlling their alcohol or drug consumption, delaying the onset of sexual activity, promoting the use of condoms and contraceptives, being faithful to one partner, and seeking health services. Peers can be a source of support and encouragement, particularly when family members are not. Research has found that if youth perceive their friends as having sex, using alcohol or drugs, or smoking, they are more likely to engage in those behaviors as well.

The ways that peers influence each other may be quite complicated, depending on whom young people select as their friends, what type of interests and values they share, what behaviors they model, and how they communicate.

Peer programs aim to influence norms and behaviors among friends.

Because teens feel the need to fit in with friends, they often conform to the norms and values of a group. Young people may be more or less influenced by these group norms depending on their age, their relationships with siblings and parents, and other choices and opportunities available to them. Peer programs should help young people recognize the norms and influences in a group, consider whom they choose to spend time with, and learn to differentiate between positive and negative influences. Peer programs may also have a positive effect on the peer promoters by strengthening their self-esteem and providing positive role models.
Peer programs are not a substitute for adult responsibility and involvement.

There is a connection between how young people choose their friends, and the influence exerted on them, and their existing relationships with parents and other family members. Young people may be more susceptible to negative peer pressure when they lack positive connections with their parents or other adults. They may turn to peers for information and values when they do not get this from their family. Just because peers talk to each other about sex does not mean that youth programs should rely only on peer education efforts to impart information and values about sexuality. In fact, peer programs are more effective when they receive adequate adult supervision, mentoring, and support.

Peer programs consist of many possible activities.

Building on young people’s existing social networks, peer programs generally include one or more of the following activities:

- Providing counseling.
- Holding group activities.
- Exchanging coping and communication skills in small groups.
- Learning to model or role-play behaviors.
- Building communication, negotiation, and refusal skills.
- Engaging in interactive techniques like media, puppetry, and simulation exercises.
- Providing commodities.
- Making referrals for services.

Peer educators and counselors are not usually health professionals, but they receive special training for conducting their activities. Peer programs may be located at schools, youth centers and youth organizations, community centers, or as outreach from health facilities (Senderowitz 1997).

Evidence of the effectiveness of peer programs is still relatively weak.

Peer programs have been described anecdotally as effective in creating a demand for family planning and HIV/STI prevention services, distributing contraceptives and referring youth to other services, and changing social and cultural norms that reduce risk behaviors. However, evidence about how to make peer programs effective is still weak, and only a limited number of peer programs have undergone systematic evaluations. As our understanding of peer and adult influences on youth grows, it is important to increase our knowledge of what features of these programs are important, and to create localized programs that build on those influences. A commitment of resources and effort to conduct thorough evaluations is needed in order to draw conclusions about what really works.

In a UNAIDS needs assessment conducted among peer education program managers around the world, managers stated that, among other things, they wanted more information concerning how to select peer educators and how to measure program effectiveness (Kerrigan 1999).
**Implementation and management in peer programs is critical to their effectiveness.**

Seeking to identify the elements that contribute to effective peer programs, the U.S. Campaign to Prevent Teen Pregnancy reviewed peer programs and documented its findings (Philliber 1999). Although the majority of reviewed peer programs were conducted in the U.S., the findings are also relevant to peer programs in developing countries. In general, the review found that peer programs need to more strategically consider how peers influence each other and identify the conditions under which peer programs are most effective (Philliber 1999). Programs can be strengthened if, when developing their strategies, they:

- Identify and use multiple modes of influence. Programs should be aware of multiple types of influences on youth, and should target and involve youth appropriately.
- Recognize that young people operate in different group “sub-cultures,” and these groups are heterogeneous.
- Consider using naturally-occurring peer groups and networks in productive ways.
- Choose peer leaders carefully and encourage them to present curricula and messages about social situations and peer group pressures.
- Identify important characteristics that peers relate to.

In managing and implementing programs, we should also consider implementation issues such as:

- Training
- Mentoring, coaching, and supervision
- Attrition
- Incentives

Management can be made easier when clear and realistic expectations are established and communicated, roles and responsibilities are determined, and activities are consistent with training and demonstrated competencies. Monitoring activities by peer educators also provides an opportunity for discussion with adult mentors or supervisors, allowing adults to recognize the types of situations encountered by peer educators, and their ability to respond.

**References**


Activities

The activities in this section are designed to illustrate peer influence and communication, discuss implementation challenges and solutions related to peer programs, and how to consider designing an effective peer program.

Activity 9.1—Role-play: How Peers Influence Each Other

Activity 9.2—Designing a Peer Program

Activity 9.3—Implementation Issues in Peer Programs

Activity 9.1—Role-play: How Peers Influence Each Other

Time Estimate

40 minutes

Objective

• Think about how, when, and where peer influence occurs.

Materials

• None

Method

1. Explain that this activity focuses on the how, when, and where of peer influence.

2. Ask participants to form pairs or groups of three for role-plays.

3. Ask the groups to discuss and select a situation where peer influence is a factor affecting behavior and decisions (e.g., using drugs, going out at night).

4. Ask pairs or groups to prepare a short role-play to highlight the issues and conditions of peer influence.

5. Invite the pairs or groups to perform their role-plays and have an open discussion with other participants.
Reflection Points

- There are many situations where peer pressure is present. Sometimes it is greater than others, but it is often a major factor in youth behavior.

Suggestions for Facilitators

- Encourage groups to be realistic in their performances.
- This role-play activity can be taken a step further; after the first performance, ask the groups to reformulate the script to show how negative influences of peer pressure can be deflected or avoided.

Activity 9.2—Designing a Peer Program

Time Estimate

1 hour

Objective

- Design the core components of a peer program.

Materials

- Flip-chart
- Markers

Method

1. Tell participants that in this activity they are going to formulate a detailed intervention program and action plan.
2. Ask participants to form discussion groups and select a topic to address in a peer program.
3. Ask them to consider principles of peer influence, activities, and implementation issues when designing activities for the program.
4. Get different ideas from different groups. For example, what should go in a training program. Topics, exercises, objectives the exercises will achieve, etc.
5. Ask one or two groups to present their detailed plan and encourage the large group to provide feedback.
Reflection Points

- Responses from the groups will vary according to the program’s target group and objectives.

Suggestions for Facilitators

- Supervise the groups as they work on their peer interventions, posing questions that will help them be more specific in the intervention design.
- Allow plenty of time for the groups to describe their interventions and for group feedback and discussion.

Activity 9.3—Implementation Issues in Peer Programs

Time Estimate

1 hour

Objective

- Share experiences in implementing peer programs.
- Identify challenges and solutions to strengthen implementation.

Materials

- Flip-chart
- Pens

Method

1. Tell participants that they will be asked to share experiences about their organization’s peer programs. Ask participants to form small groups.

2. Assign each group a topic for discussion. These could include:
   - How do young people influence each other and where can we reach them?
   - What expectations should we have from peer programs? What expectations should participants in peer programs have from adults?
   - What types of activities are popular and effective among peers? What can they achieve?
• How should we select and recruit young people to participate in peer programs?
• What type, level, and content of training and support do peer educators need?
• What management, supervision, motivation, and incentives are needed for peer programs?
• How do we maintain peer educators or develop systems to account for high turnover?

3. Give the small groups 20 minutes to discuss the topics and exchange strategies.
4. Ask a representative from each small group to report back on the key issues shared during the discussion.

Reflection Points
• Reflect further on the challenges and limitations of working with peer educators.

Suggestions for Facilitators
• Allow extra time to share strategies for working with peer educators as this is a central component of YSRH programming.
Parent Education

Introduction

Parents are the ideal sexuality educators for their children. They are their children’s most influential source of knowledge, beliefs, attitudes, and values. Unfortunately, many parents are reluctant to embrace the opportunity to provide healthy messages about human sexuality. This is caused by many factors including a parent’s own lack of knowledge regarding sexuality issues, embarrassment in discussing sensitive topics, and the fear that talking with children about sex will lead to sexual experimentation.

In reality, when parents do not discuss sex with children, they put them at risk. Left to their own devices, youth will seek out such information from other sources. The messages they are most likely to receive include misinformation from peers and unhealthy messages from the media. Meanwhile, when parents do not discuss sexuality they are also sending a message to their children that it is something taboo and not to be discussed. Therefore, when children need the information, they cannot get it, and if they need help, they feel they cannot ask for it.

Because of this parents need help communicating with their children. Programs can provide parents with: facts; opportunities to clarify values and practice discussing these with peers; and ways to recognize and pass on healthy messages to their children.

Parent programs should not be viewed in isolation. They will be most effective if included as part of a comprehensive effort to build a safe and supportive environment for youth. At the same time, involving parents directly in a comprehensive initiative can help mobilize adults in a community to advocate for YSRH.

Helping Parents Talk about Sexuality Issues with Their Children

There are many guidelines that professionals can offer parents when talking to their children about sex. Here are a few to consider:

- **Parents do not need to be experts on sexual and reproductive health**—Many parents do not discuss issues of sexuality because they feel that they lack adequate information. In reality, what parents know is much less important than their attitude about discussing the issue. If a parent is asked a question he or she can always search for the answer. However, if a parent is unapproachable, he or she will never be asked a question, even if he or she knows the answer.

- **Parents can use “teachable moments”**—Parents can take advantage of everyday situations, such as a television show, a newspaper article on AIDS, or a friend’s pregnancy. If a television show sends a questionable message, then parents can use that opportunity to share their own values.
• **It is no unusual for parents to feel uncomfortable discussing sexual issues**—Most parents can expect to feel uncomfortable discussing sex. Parents should try to relax and tell their children that they are going to talk to them because they care. Parents may also want to seek help in getting correct information.

• **If a child is old enough to ask a question, he or she is old enough to get the correct answer**—The amount of detail in an answer can depend on the child’s age.

• **Parents should listen and be aware of the question behind the question**—Sometimes the question a child asks may not always be what he or she really wants to know. It sometimes helps to ask clarifying questions. Many times there is an unspoken question of “Am I normal?” hiding behind questions of sexual development, thoughts, and feelings. Parents should reassure children as often as possible.

• **Parents should be approachable**—Parents can reward a child’s question by saying “I’m glad you asked that.” It will encourage children to ask other questions in the future.

**Activities**

The following two activities look at roles that parents play in providing sexuality education to their children. The activities ask participants to reflect on their own experiences as youth to think about the messages that youth receive from parents today. These activities could be adapted for youth to help them reflect on what they presently learn from their parents and what they would like to learn.

Many of the other activities included in these packs can be used with parent groups. At the same time, the activities in this section can be useful when working with other groups besides parents. In any parent education program, participants should be given an opportunity to learn more about sexual and reproductive health issues, explore their values about sexuality, and practice necessary communication skills for talking with their children about sexuality.

**Activity 10.1—Where Did I Learn about Sex?**

**Activity 10.2—Messages about Sexuality**

---

**Activity 10.1—Where Did I Learn about Sex?**

- **Time Estimate**
  - 45 minutes

- **Objective**
  - Reflect on how, when, and from whom we learned about sex.
Materials

• “ME” worksheet projected onto a wall or whiteboard, or drawn on large paper
• Post-It® notes
• Pens or markers

Method

1. Show the image of the “ME” worksheet on a large wall.
2. Give each participant as many Post-It® notes as they need.
3. Ask participants to think about where they learned about sex. Ask them to use Post-It® notes to share different experiences of learning about sex. For each experience, ask groups to share how old they were at the time of the experience, the information that they got, and its source.
4. Ask all participants to come up to the worksheet image, and place any Post-It® notes that they feel comfortable sharing with the group.
5. Ask each participant to talk briefly about at least one experience with the whole group.
6. Lead a discussion using these questions:
   • Where did the group learn most of its information about sex? Why do you think that is?
   • How prominent were parents’ roles in comparison with other sources? Why do you think that is?
   • Where do you think you received the best messages and information about sex? Why?

Reflection Points

• There are various sources of information about sex, but youth often do not turn to parents for answers to these questions. They prefer to consult friends or learn from the media.
• This was the situation when adult service providers were young and it is partly so today, though media seems to be a greater influence now.

Suggestions for Facilitators

• Pieces of large colored paper can make this activity look more interesting and attractive.
• Encourage all participants to walk up and post their card on the appropriate area or color.
• Distribute extra cards and encourage each participant to post more than one.

Activity 10.2—Messages About Sexuality

Time Estimate

45 minutes

Objective

• Think about the messages we received from our parents about sex.

Materials

• Cards

Method

1. Tell participants that in this activity they will explore the messages that they received about sexuality from their parents, as well as the messages that they would like to pass on to their own children.

2. Explain that you have two questions that you want them to think about. The first is:

   What are three messages about sexuality that you received from your parents?

3. Ask each participant to write his or her answer on the front side of the card. Give participants a few minutes to complete the task.

4. After the group has completed this, ask them to think about the second question:

   What are three messages about sexuality that you want to pass on to your children?
5. Ask each participant to write his/her answer on the front side of the card. Give participants a few minutes to complete the second question.

6. Once the cards have been completed, ask participants to pair up with someone with whom they feel comfortable discussing these issues. Explain that in their pairs, each person will have five minutes to share answers to the questions and discuss them. In particular, encourage participants to explore how the messages that they received about sexuality from their parents affected them. Assure the participants that they only have to share what they feel comfortable discussing.

7. After ten minutes, reconvene the group and ask various participants to share some of the things that the activity made them think about.

8. Conclude the activity with a discussion, including these questions:
   - What did you learn from this activity?
   - How can this activity improve the way you interact with your child?

Reflection Points

- It is important for parents to remember that many of our parenting skills are learned from the ways our parents raised us as children. If a parent was raised in a family in which sexuality issues were not discussed, it may be challenging to begin doing this. However, it is possible to change. Parent programs can help parents provide messages that they wish they had received as children.

Suggestions for Facilitators

- Participants could do the sharing as a stand-up activity or they might move chairs to form discussion pairs. Usually the best format for a large group discussion is a full circle or horseshoe shape.