YOLO Facilitator's Manual

A programme for the reduction of HIV Infections, and teenage and unplanned pregnancy

Department of Social Development (DSD)

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Foreword by the Minister

South Africa's population is largely made up of young people. According to Statistics South Africa's 2014 Mid-year Population Estimates, 66 per cent of the total population (over 54 million South Africans) comprises people under the age of 35. Approximately 18.9 million in the country are youth between the ages of 15 and 35. Young people are the heartbeat and the future of the nation. While South Africa's history is built on young people's tenacity through the 16 June 1976 uprising, young people in modern-day society face many challenges, which, among others, include HIV and AIDS.

Young people are currently the most vulnerable population at risk of acquiring HIV. The 2014 Mid-year Population Estimates puts the population of people aged 15–24 years at over 10 million and, out of this number, 8.7 per cent are already living with HIV. Although the Human Sciences Research Council (HSRC) 2012 Survey shows a slight decrease in new HIV infections in this age group, the numbers are still high. This is a cause for concern among development workers, as this will impede youth contribution to the economy of the country. According to UNAIDS 2013, many new infections occur among young females, with an estimated number of 2 363 new infections per week among women aged 15–24 in South Africa.

Although biomedical interventions that help to prevent the spread of HIV, such as condoms, are available, HIV transmission among young people remains relatively high. This is attributed to the behavioural, social and structural drivers of HIV transmission, which render the youth vulnerable to HIV and AIDS. At the behaviour level, most young people are faced with challenges of low self-esteem, peer pressure and a sense of wanting to belong. Furthermore, young people increase their risk by being involved in multiple and concurrent sexual partnerships, engaging in early sexual debut (age at first sexual experience), involving themselves in intergenerational relationships without protection, abusing intoxicating substances and gender-based violence.

Compounding these behavioural and social drivers are structural elements such as unemployment, poverty and migration. The current National Strategic Plan for HIV, AIDS and TB 2012–2016 asserts the need for a combination prevention approach that addresses biomedical intervention as well as behavioural, social and structural drivers of HIV, which involves the Department of Social Development (DSD).

The DSD is committed to providing comprehensive social services to the poor and vulnerable members of our society and creating an enabling environment for sustainable development. Over the past two decades, the DSD has given priority to services for children and youth to improve prevention of social ills, and has done well in providing a safety net for the young people. To date, more than 12 million children receive income support, including the Child Support Grant (CSG) and the Foster Child Grant.

Evidence from the impact assessment on CSG conducted in 2010 shows that the provision of social grants has contributed significantly to the reduction of child poverty in South Africa. The impact assessment also found that the provision of the CSG to adolescents contributed to the reduction of risky sexual behaviours and teenage pregnancies, as well as alcohol and drug abuse – particularly among female adolescents. There are, however, emerging challenges on HIV and AIDS such as the new 'blesser/blessee' phenomenon, which calls for a definite action to protect our young people from contracting HIV.

The DSD has developed the YOLO programme to target young people aged 15–24, irrespective of their sex. The programme has been developed to respond to the social and behavioural drivers of HIV.

YOLO stands for 'you only live once'. This acronym is very popular on social media and young people themselves chose it because it resonates strongly with them. The YOLO acronym goes with the following tagline: 'It's your choice, it's your life … Behave responsibly'. YOLO is aimed at building the resilience among youth to enable them to withstand the pressures that lead to risk-taking. The modules are tailored to address behavioural traits that instil positive values among the youth.

Young persons will undergo sessions that are aimed at building them to become accountable and responsible citizens. The emphasis is on the developmental needs of young people, which include achieving a sense of identity, a need for positive social interaction and developing skills and attributes, including self-confidence, a positive self-image, assertiveness and decision-making skills. Evidence shows that young people with high levels of self-esteem and self-efficacy are less likely to be infected with HIV.

The implementation of this programme builds on the existing prevention interventions within the DSD and will be implemented, among others, in conjunction with the following programmes:

- comprehensive social protection services;
- psychosocial-support services;
- gender-based violence awareness;
- substance abuse prevention programmes;
- child protection services and community development programmes.

The YOLO programme recognises that behaviour change at an individual level is unlikely to occur without broader social change. Hence, it will be implemented within the socio-ecological model to target the different spheres of influence.

The continued partnership with our social partners in implementing this programme will contribute to our efforts of working towards an HIV- and AIDS-free generation and to contribute to the two government outcomes: 'A long and healthy life for all South Africans' and 'An inclusive and responsive social protection system'.

Ms BO Dlamini, MP
Minister of Social Development

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The GCBS Programme is managed by Pact Inc., in partnership with South African organisations Mott MacDonald Development South Africa, Isibani Development Partners (IDP) and Development and Training Services (DTS) in collaboration with the DSD.

The project seeks to enhance the capacity of the South African Government (SAG), specifically the DSD, in supporting orphans, vulnerable children and youth (OVCY) and focuses on strengthening the DSD's response in addressing social and structural barriers that increase the vulnerability of OVCY to human immunodeficiency virus (HIV), sexually transmitted infections (STIs) and tuberculosis (TB). It also aims to address specific constraints hampering the health and social development system to achieve better outcomes for OVCY and other vulnerable youth (e.g. those affected by poverty, child abuse, neglect and exploitation).

The Department would like thank the initial YOLO facilitators and programme beneficiaries for the invaluable feedback that they provided in enriching the YOLO manual and contributing to making it a user-friendly document suitable for young people. Lastly, our gratitude goes to GOLD Consulting for their support in the development of DSD Youth Social and Behaviour Change Communication guidelines, which served as a basis for the development of the YOLO programme.

Definitions and useful terminology guidelines

These definitions and terms are taken from the UNAID Terminology Guidelines (2015) and should be used in this programme when talking about and training YOLO content.

	Background	Preferred Term
AIDS carrier	This term is no longer used because it is incorrect, stigmatising and offensive to many people living with HIV.	Person living with HIV
AIDS infected; HIV infected; transmitters	No one is infected with AIDS; AIDS is not an infectious agent. AIDS describes a syndrome of opportunistic infections and diseases that can develop as immunosuppression deepens along the continuum of HIV infection (from acute infection to death) ….	Refer to people as being HIV positive or a person/people living with HIV …
AIDS orphans	This term not only stigmatises children, but it also labels them as HIV positive, which may be untrue. Identifying a human being by his or her social condition alone shows a lack of respect for the individual, in the same way as identifying a human being by his or her medical condition. Contrary to traditional usage (but consistent with the dictionary definition), UNAIDS sometimes uses orphan as a subset of orphans and other children made vulnerable by AIDS to describe children who have lost either one or both parents to HIV.	Orphans and other children made vulnerable by AIDS
AIDS test	There is no test for AIDS. The test is for HIV.	Use HIV test or HIV antibody test.
AIDS virus; HIV virus	AIDS is a clinical syndrome. Thus, it is incorrect to refer to an AIDS virus; HIV is what ultimately causes AIDS. Avoid using HIV virus, (HIV stands for human immunodeficiency virus, so there is no need to repeat 'virus').	HIV There is no need to define, nor add the word 'virus' after it.
Behavioural change	Behaviour change is usually defined as the adoption and maintenance of healthy behaviours (with respect to particular practices) that reduce the chances of acquiring HIV.	Behaviour change

	Background	Preferred Term
Commercial sex work; commercial sex worker	The words 'commercial' and 'work' imply the same thing, so one or the other can be used but not both together. The term sex worker is intended to be non-judgemental and focuses on the working conditions under which sexual services are sold. Sex workers include consenting female, male and transgender adults – as well as young people over the age of 18 years – who regularly or occasionally receive money or goods in exchange for sexual services. As sex work is defined as the consensual sale of sex between adults, children (people under 18 years) cannot be involved in sex work. Instead, children involved in sex work are considered to be victims of sexual exploitation.	sex work, commercial sex, the sale of sexual services It is also acceptable to say that sex workers are paid for sex. sex worker, women/men/people who sell sex Clients of sex workers may be called men/women/people who buy sex.
high(er)-risk group; vulnerable groups	These terms should be avoided because they imply that the risk is contained within the group, whereas all social groups are actually interrelated. The use of the term high-risk group may create a false sense of security in people who have risk behaviours but do not identify with such groups, and it can also increase stigma and discrimination against the designated groups. Membership of groups does not place individuals at risk; behaviours may. In the case of married and cohabiting people, particularly women, the risk behaviour of the sexual partner may place the partner, who is not engaged in risk behaviour, in a situation of risk.	Use key populations or young key populations (when applicable) (in the sense of being key to the epidemic's dynamics or key to the response). Key populations are distinct from vulnerable populations, which are subject to societal pressures or social circumstances that may make them more vulnerable to exposure to infections, including HIV.
HIV/AIDS	The expression HIV/AIDS should be avoided whenever possible because it can cause confusion. Most people with HIV do not have AIDS. The expression HIV/AIDS prevention is even more unacceptable because HIV prevention entails correct and consistent condom use, use of sterile injecting equipment, changes in social norms and so on, whereas AIDS prevention entails antiretroviral therapy, cotrimoxazole, good nutrition, isoniazid prophylaxis (INH), etc. It is preferable to use the term that is most specific and appropriate in the context.	People living with HIV, HIV prevalence, HIV prevention, HIV response, HIV testing, HIV-related disease, AIDS diagnosis, children made vulnerable by AIDS, national AIDS programme, AIDS service organisation HIV epidemic and AIDS epidemic are acceptable, but HIV epidemic is a more inclusive term.

	Background	Preferred Term
most at risk; most-at-risk adolescents (MARAs), most-at-risk young people (MARYP), most-at-risk populations (MARPs)	Such terms should be avoided because communities view them as stigmatising. In specific projects where such expressions continue to be used, it is important never to refer to a person (directly or indirectly) as a MARA, MARYP or MARP.	Describe the behaviour each population is engaged in that places individuals at risk of HIV exposure (e.g. unprotected sex among stable and discordant couples, sex work with low condom use, young people who use drugs and lack access to sterile injecting equipment, etc.).
people living with HIV and AIDS, PLWHA, PLWHIV, AIDS patient, AIDS victim, AIDS sufferer	With reference to people living with HIV, it is preferable to avoid certain terms. For instance, AIDS patient should only be used in a medical context (most of the time a person with AIDS is not in the role of a patient). These terms imply that the individual in question is powerless, with no control over his or her life. Referring to people living with HIV as innocent victims (which often is used to describe HIV-positive children or people who have acquired HIV medically) wrongly implies that people who acquire HIV in other ways are somehow deserving of punishment. People should never be referred to as an abbreviation, such as PLHIV, since this is dehumanising. Instead, the name or identity of the group should be written out in full.	The preferred terms are people living with HIV and children living with HIV as they reflect the fact that persons with HIV may continue to live well and productively for many years. The term 'people affected by HIV' encompasses family members and dependents who may be involved in caregiving or otherwise affected by the HIV-positive status of a person living with HIV.
prostitute; prostitution	A term that implies a person is in the business of selling sex. This is not to be used as it denotes value judgement.	For adults (18 years and older), use sex work, sex worker, commercial sex, or the sale of sexual services. For children (younger than 18 years old), use sexual exploitation of children.
Risk of AIDS	Do not use unless referring to behaviours or conditions that increase the risk of disease progression in an HIV-positive person.	Risk of acquiring HIV, risk of exposure to HIV

	Background	Preferred Term
Safe sex	This term may imply complete safety. The term safer sex more accurately reflects the idea that choices can be made and behaviours adopted to reduce or minimise the risk of HIV acquisition and infections. Safer sex strategies include postponing sexual debut, non-penetrative sex, correct and consistent use of male or female condoms, and reducing the number of sexual partners.	Safer sex

USEFUL BACKGROUND TO SELECTED TERMS – it is important to know and understand why we use certain words and terms

antiretroviral medicines/ antiretroviral (ARVs)/ antiretroviral therapy (ART)/ HIV treatment	Antiretroviral therapy is highly active in suppressing viral replication, reducing the amount of the virus in the blood to undetectable levels and slowing the progress of HIV disease.
behaviour change communication (BCC) (see also social change communication)	Behaviour change communication promotes tailored messages, personal risk assessment, greater dialogue and an increased sense of ownership of the response by the individual and the community. It is developed through an interactive process, and its messages and approaches use a mix of communication channels to encourage and sustain positive and healthy behaviour.
condomless sex	In condomless sex, the sex act is not protected by male nor female condoms. Previously known as unprotected sex, this is now increasingly referred to as condomless sex to avoid confusion with the protection from pregnancy that is provided by other means of contraception. As oral pre-exposure prophylaxis (PrEP) becomes more widespread (and if topical PrEP is introduced), it will become increasingly important to be clear about the different methods of protection against HIV and the other consequences of sex and how those methods might be used or combined.
HIV negative (sero-negative)	A person who is HIV negative (also known as sero-negative) shows no evidence of HIV in a blood test (e.g. there is an absence of antibodies against HIV). The test result of a person who has acquired HIV but is in the window period between HIV exposure and detection of antibodies will also be negative.
HIV positive (seropositive)	A person who is HIV positive (or seropositive) has had antibodies against HIV detected in a blood test or gingival exudate test (commonly known as a saliva test). Results may occasionally be false positive, especially in infants up to 18 months of age who are carrying maternal antibodies.

	USEFUL BACKGROUND TO SELECTED TERMS – it is important to know and understand why we use certain words and terms
HIV-related disease	Symptoms of HIV may occur both at the time of HIV infection and after immune compromise set in. When the virus comes into contact with mucosal surfaces during initial infection with HIV, it finds susceptible target cells and moves to draining lymph nodes, where massive production of the virus ensues. This leads to a burst of high-level viremia (virus in the bloodstream) with wide dissemination of the virus. Some people may have flu-like symptoms at this stage, but these are generally referred to as symptoms of primary infection or acute infection rather than HIV-related disease. The resulting immune response to suppress the virus is only partially successful and some virus will escape; it may remain undetectable, sequestered in reservoirs, for months or years. As crucial immune cells – called CD4+ T cells – are disabled and killed, their numbers progressively decline. In this manner, HIV-related disease is characterised by a gradual deterioration of immune function. Eventually, high viral turnover leads to destruction of the immune system; this is sometimes referred to as advanced HIV infection, which leads to the manifestation of AIDS.
post-exposure prophylaxis (PEP)	Post-exposure prophylaxis refers to antiretroviral medicines that are taken after exposure (or possible exposure) to HIV. The exposure may be occupational (e.g. a needle stick injury) or non-occupational (e.g. condomless sex with a seropositive partner). The latter is sometimes referred to as non-occupational post-exposure prophylaxis (N-PEP).

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
BCC	Behaviour Change Communication
CAPS	Curriculum and Assessment Policy Statement
CBO	Community Based Organisation
DBE	Department of Basic Education
DSD	Department of Social Development
FBOs	Faith Based Organisations
HIV	Human Immunodeficiency Virus
MTCT	Mother to Child Transmission
NPO	Non-profit organisation
OVC	Orphans, Vulnerable Children
OVCY	Orphans, Vulnerable Children and Youth
PMTCT	Prevention of Mother to Child Transmission
SANAC	South African National Aids Council
STI	Sexually Transmitted Infection
TB	Tuberculosis

Glossary

Using the Manual	The terms listed below are defined for the purpose of this material.
Building block	In the programme, a building block is a series of sessions and activities that helps to achieve various learning and expected behavioural outcomes. There are five building blocks in this manual and collectively they help participants understand more about how to reduce HIV infections and teenage and unplanned pregnancies.
Session	A session is made up of a range of activities to address a specific learning outcome. There are 12 sessions in this manual, and these sessions form part of the five building blocks. Each session has a broad objective, and this aligns with the aims of the various activities.
Activity	An activity is an exercise that takes the form of a discussion group, role play, game or participatory activity to help participants understand more about a specific issue. Each activity has an aim, and this aligns with the broader expected outcome of the session and the building block.
Facilitator reflection	The reflection sessions for the facilitator are included during the sessions to help facilitators make notes and write down ideas on how a session or activity has gone and to keep a record of the sessions for future training.
Participant reflection	The reflection sessions are included at the end of each session to help participants recap what they have learned, or to draw attention to a specific skill that the participant can develop or work on further. There are 12 reflection sessions.
Take-home work	The take-home work is designed to allow participants to work independently to explore how each of the skills relates to their own lives. There are take-home activities offered for the completion of each building block. These take-home activities will be part of the participant's workbook.
Definitions	The Facilitator's Manual offers definitions to all the key terms used in the YOLO Manual and YOLO Guide. These definitions are in alignment with the UNAIDS Terminology Guidelines (2015). The facilitator must read all information sheets in the Facilitator's Guide prior to training as the guide provides detailed information of definitions for the various sessions.
Facilitator note	Facilitator's notes appear in various sessions to help the facilitator with immediate basic information needed during the facilitation of the session. The facilitator's note does not substitute the use of the facilitation guide or information sheets but rather provides important information during the activities.
Short seminar	The manual is designed to encourage activity, group work and discussions. However, some information has to be offered to participants that may not arise during discussions. The short seminar is designed to help facilitators fill in the information gaps when working through the various activities.
Speech bubbles	These are scripted text (word for word) explanations that can help a facilitator if they are unsure of what to say. There are very few of these in the manual, as facilitators are encouraged to prepare before the session, and plan how to introduce the various sessions.

Chapter 1: Introduction to the DSD Social and Behaviour Change Communication Programme

The Department of Social Development (DSD) assists young people with comprehensive social services and recognises the importance of integrating a focus on the reduction of HIV infections, teenage and unplanned pregnancy.

Many of the young people accessing social services are faced with the risk of HIV infections, teenage and unplanned pregnancy. The DSD has therefore taken a step towards introducing a social and behaviour change communication (SBCC) programme to increase the autonomy, self-esteem and self-efficacy in young people and to minimise risky behaviours that expose them to HIV and the possibility of unplanned pregnancy. This SBCC programme, YOLO, seeks to create a safe and enabling environment in which young people can safely engage in discussions about preventing HIV infections, teenage and unplanned pregnancy. In addition, the YOLO programme will provide an environment where positive values and quality decisions related to the sexuality of young people can emerge.

YOLO has been developed for knowledge generation, skills development and the empowerment of young people, enabling them make more informed choices to reduce HIV infections and the prevention of teenage and unplanned pregnancies. The programme will be offered in various areas where the DSD is working to promote healthy sexual choices, to reduce unplanned pregnancies and to equip young people with important life skills.

The role of the Department of Social Development

The South African National Department of Social Development (the DSD) recognises and collaborates with structures at national, provincial and all other local government levels, including the Provincial, District, Local and Ward AIDS Councils among others. The DSD is also a key stakeholder in the implementation of the National Action Plan for orphans, vulnerable children

and youth affected by HIV and AIDS (2012–2016), and is a member of the National Action Committee for Children Affected by HIV and AIDS (NACCA), which works to accelerate and scale up the national orphan and vulnerable children and youth (OVCY) response.

The DSD recognises the social, behavioural and developmental challenges presented by the HIV and AIDS epidemic in South Africa. Studies conducted by bodies like UNAIDS and the Human Sciences Research Council (HSRC) have continually shown that the epidemic is largely fueled by sexual behaviour patterns. Closely linked to this is the persistent challenge of teenage and unplanned pregnancies that continues to have a significant impact on the quality of life and economic status of young people, especially young girls, and increases levels of dependency on child support grants.

The DSD, in its Framework of Positive Values, promotes positive values and a renewal of Africa's commitment to sound social, communal and individual value systems, based on the Constitution and the Charter of Positive Values. To this end, the Department focuses on:

- respect, human dignity and equality;
- freedom, the rule of law and democracy;
- honesty, integrity and loyalty;
- harmony in culture, belief and conscience;
- respect and concern for all people;
- prevention of factors that put families and communities at risk.

These values, particularly the ones that address the prevention of risk factors and increased personal and individual respect, can make a difference in reducing the infections of HIV and the number of teenage and unplanned pregnancies among South African youth. These values form the foundation on which this SBCC programme rests.

Department of Social Development interventions with key populations

The DSD focuses on social behaviour change communication (SBCC) so as to complement the biomedical interventions by other stakeholders such as the Department of Health and has adopted a socio-ecological model to involve all sectors of society. While much success has been achieved by the country's HIV treatment programme, with approximately 3.5 million people on HIV treatment today, HIV infections remains unacceptably high, with an estimated 340 000 new HIV infections in 2014 (USAID, 2016).

The model is used to illustrate the interwoven relationship that exists between individuals and their social networks, their communities and broader society.

According to the DSD Comprehensive HIV and AIDS, TB & STI Strategy 2013–2016, the socio-ecological model also allows for an understanding of the spheres of influence that need to be addressed to successfully bring about transformation in relation to HIV and AIDS, STIs and TB. It identifies the following as key populations:

- Orphans and vulnerable children and youth (OVCY)
- Out-of-school youth, aged 15–24
- Young women, aged 15–24, receiving child support grants (CSG)
- People who abuse alcohol and/or drugs
- Sex workers and their clients
- Persons with disabilities
- Farming communities
- Older persons

In this case, the socio-ecological model is applied with specific focus on youth (ages 15–24) with issues of HIV and teenage and unplanned pregnancy prevention as key focus areas. In addition, the DSD also strengthens families and communities and gives financial and technical support to a number of community-based organisations (CBOs) where vulnerable children receive assistance and support in a variety of ways. These include homework supervision, feeding programmes and other psychosocial interventions. Children coming from child-headed homes will have an opportunity to interact with other children in similar situations and with adult figures who will be able to provide support for them and are often their role models.

Facilitator note

The key objectives of the programme are directly linked to building the resilience, knowledge, skills and values of young people towards positive sexual choices. However, issues of gender norms and gender imbalances are prevalent and cannot be avoided or ignored. This programme does not intend to alter gender norms but the activities presented are hoped to create better gender awareness and understanding.

Introduction to YOLO

The Government Capacity Building and Support (GCBS) project seeks to strengthen societal and individual behaviour change to prevent HIV infections This project aims to strengthen the Department of Social Development (DSD)'s response to HIV and AIDS by ensuring that HIV prevention becomes institutionalised as a key element of their basket of services to children and their families. It supports the fulfilment of the DSD's mandate within the National Strategic Plan as articulated in the DSD Comprehensive Strategy on HIV, AIDS, TB and STIs to address the social drivers of the epidemic including gender-based violence (GBV).

One of the key objectives is to support the implementation of a social behaviour communication change (SBCC) programme through capacity building, mentoring and coaching of National, Provincial DSD and implementing partners (NPOs). This will include support on designing, implementing, managing, monitoring and evaluating sustainable high impact SBCC and HIV prevention programmes and reducing GBV among orphans, vulnerable children and youth (OVCY) including adolescent girls and boys and young women, aged 15–24 years.

This programme is the first step towards addressing reduction in HIV infections and teenage and unplanned pregnancies from a DSD perspective.

How YOLO came alive

The Government Capacity Building and Support (GCBS) project seeks to strengthen social and individual behaviour change to prevent HIV infections. YOLO aims to strengthen the DSD's response to HIV and AIDS by ensuring that HIV prevention becomes institutionalised as a key element of their basket of services to children, and their families. It supports the fulfilment of the DSD's mandate within the National Strategic Plan as articulated in the DSD Comprehensive Strategy on HIV, AIDS, TB and STIs to address the social drivers of the epidemic, including gender-based violence (GBV).

In line with the GCBS objective, a youth SBCC programme that was initially developed by the DSD went through a review and quality assurance process that resulted in an improved programme focusing on orphans, vulnerable children and youth (OVCY) between the ages of 15 and 24 years. The DSD SBCC Youth Programme, which was branded 'YOLO' (You Only Live Once) was developed through a systematic application of interactive, theory-based and research-driven communication processes and strategies to address 'tipping points' for change at the individual, community and social levels.

The aptly named programme, YOLO was then rolled out in all provinces through DSD service point social workers and NPOs presently being funded by DSD. The YOLO programme is run over twelve (12) sessions, and presented to small groups of 15–20 young people including OVCY. YOLO takes young people on a journey using participatory activities that allow them to reflect on themselves, their living circumstances and their communities and how these ultimately impact on their sexual behaviour and decisions.

YOLO facilitator package

YOLO offers three documents to facilitators to support the roll out of this programme:

Facilitator's Manual

This Facilitator's Manual provides 6 (six) sections to help facilitators adequately prepare for facilitating the sessions of the programme. The manual will enable facilitators to understand the overall objective of this SBCC youth initiative with specific information that facilitators need to know when engaging with youth. This facilitator manual provides necessary background information for facilitators before starting a workshop. In addition, the manual contains information regarding the five building blocks with a total of 12 sessions that are the YOLO programme. These building blocks are designed to address reduction of HIV infections among young people, and teenage and unplanned pregnancy.

Facilitator's Guide

The Facilitator's Guide will help you as the facilitator take participants through a range of participatory activities to enhance skills for behaviour change using SBCC skills and understanding towards the reduction of HIV infections, teenage and unplanned pregnancies. The guide leads facilitators through the YOLO programme and the five building blocks that need to be covered. The purpose of the guide is to help facilitators run the YOLO sessions to enhance and develop specific social and life skills among young people that can aid the process of decreasing risky sexual behaviours that lead to HIV infections, and teenage and unplanned pregnancies. The facilitator guide provides the actual activities to be facilitated with youth aged 15–24 in different social contexts, organisations and other community groups.

Participant's Workbook

These books will both be used in the programme and as 'take home' resources to help maintain the personal growth and individual work done on the YOLO programme and to facilitate the choosing of safer sexual behaviour and the reduction of risky practices after being on the YOLO programme.

The Workbook is aimed at providing young people with a space where they can write ideas, thoughts and content of things that they learned on the YOLO programme. In addition to containing content of knowledge learned in the YOLO sessions, the workbook will serve as a reflective journal for participants. The Workbook is a private resource for each participant.

It is imperative that the facilitator is knowledgeable about the contents of these three documents and is confident about the material.

How YOLO is delivered

The participatory approach, supporting programme activities and facilitation style of the programme have been designed to enhance personal growth and promote behaviour change with a view to reducing HIV infections, encouraging testing for HIV and the prevention of teenage and unplanned pregnancies. The programme further emphasises the importance of support from parents and communities to enable young people to make informed decisions.

In aligning the programme with present quality assured SBCC programmes from the DSD of a similar nature, the following five (5) building blocks are addressed:

Building Block One seeks to build young people's resilience, self-confidence and self-esteem

Building Block Two reaffirms young people's rights in terms of sexual and reproductive health

Building Block Three aims to minimise HIV infections among youth through skills development around risky sexual behaviour.

Building Block Four strengthens knowledge, attitudes and skills to voluntarily assume positive practices and sustain positive behaviour outcomes.

Building Block Five centres on investigating social skills in young people to build healthy relationships and communicate effectively about healthy sexual choices.

Introduction to the Facilitator's Manual

The purpose of this manual is to provide YOLO facilitators with the required background in sex communication and HIV knowledge and information to be an effective part of this DSD programme. In addition, the manual will provide facilitators with the ability to enhance and develop specific social and life skills among young people, which can aid the process of decreasing risky sexual behaviours that lead to HIV infections and teenage and unplanned pregnancies.

The (DSD) aims to work with facilitators within the various provinces, and use this manual as a tool to build resilience, increase the autonomy, self-esteem and self-efficacy of individuals, and to minimise risky behaviours that expose young people to HIV and unplanned pregnancy.

Structure of the Facilitator's Manual

The Facilitator's Manual is divided into 6 (six) sections which offer key information to provide background knowledge to social and behaviour change communication (SBCC), HIV and AIDS, participatory methodology, the role of the facilitator and the activities of the 12 training sessions through the five building blocks.

Chapter 1: Introduction to DSD Youth Social Behaviour Change Communication Programme
Provides an outline of the SBCC programme YOLO, what can be expected and a guideline to using this manual

Chapter 2: Understanding the HIV background with youth in SA

Chapter 3: Understanding social behaviour change communication

Chapter 4: Facilitating YOLO, an SBCC programme

Chapter 5: The YOLO SBCC programme

Chapter 6: Monitoring and Evaluation (M&E) of the YOLO programme

Chapter 1–4 can be read as stand-alone chapters and are there to prepare the facilitator in his/her own skills and knowledge development before the SBCC programme. These chapters are foundational and preparatory sections for the facilitator to feel empowered to be the facilitator.

Chapter 5 is structured to offer the 12 sessions with five building blocks. All sessions have compulsory activities with complimentary activities added to promote the learning outcome if time permits. Each of the 12 sessions has specific session outcomes and each activity within the sessions has specific aims. This is done to ensure that the learning outcomes and behaviour outcomes are continuously re-enforced throughout the programme.

A programme for the reduction of HIV and Teenage Pregnancy

Facilitator note

Some sessions that have a higher content to cover have compulsory and complimentary activities, and this is indicated at the beginning of the session. In the event that no indication is given of a compulsory activity, all activities must be completed.

Facilitator note

The term 'participants', 'youth' and 'young people' are used interchangeably in this manual.

Who should use the Manual

The sessions can be facilitated by people like social workers, community health workers, youth facilitators, teachers or anyone in the community working with young people.

The Facilitator's Manual will help you, as the facilitator, take participants through a range of participatory activities to enhance skills for behaviour change using SBCC skills and understanding towards the reduction of HIV infections and teenage and unplanned pregnancies.

This manual aims to have a positive influence on young people by complimenting other efforts by many role players towards remedying the devastating effects of HIV and teenage and unplanned pregnancy in South Africa. These sessions are designed to complement the support sessions from the DSD's list of referred service providers and resources.

How to use the Manual

Each of the 12 sessions is designed to be run over a two-hour period with a 15-minute break in between. Overall the facilitator needs 24 hours of contact time to complete the 12 sessions. It is recommended that no more than 2–3 sessions be completed per week.

Remember: it is important to finish in time to allow participants to get home safely after the training, i.e. before dark or while transport is still available.

It is compulsory for facilitators to spend a minimum of three days going through the facilitator manual and the facilitator guide with activities that will prepare him/her to facilitate the sessions with young people. Facilitators will be provided with three-day training on the programme. However, additional time will be needed to go through all the content in addition to the training.

Chapter 2: Understanding the HIV landscape of youth in SA

This section provides the facilitator with a very brief overview of what HIV is, HIV statistics, its effects on young people and the specific factors that place young people at risk of HIV infections. This section is not meant to provide detailed insight and it is advised that facilitators conduct their own research to be better informed about HIV and its impact on young people. This section provides facilitators with a bird's eye perspective and must be read several times prior to the facilitation of the actual sessions in the Facilitator's Guide.

A clear understanding of HIV and AIDS are critical in order to engage effectively with issues around them; therefore the background below should provide a basic understanding of the concepts.

What are HIV and AIDS?

The human immunodeficiency virus (HIV) is defined as a virus that gradually breaks down the body's immune system by destroying white blood cells, most particularly CD4 or T4 cells. When many of these cells have been destroyed, the body is no longer able to protect itself from infections or diseases, which then leads to Acquired Immune Deficiency Syndrome (AIDS), known as the clinical end stage of HIV (UNESCO, 2007). HIV makes a person vulnerable to various infections known as opportunistic infections, which would rarely occur in people with a strong immune system.

How do you contract HIV?

This virus is spread through body fluids such as blood, semen (the liquid that leaves the penis at orgasm or ejaculation), pre-seminal fluids, rectal fluids (from the anus), vaginal fluids and breast milk. A person can contract HIV when these body fluids come into contact with a mucous membrane, damaged tissue or are directly injected into the bloodstream by a needle or syringe from a person who is HIV positive.

Such fluids can be transmitted through unprotected sex with an HIV-positive partner; sharing of needles or drug equipment; pregnancy; breastfeeding and childbirth (mother-to-child transmission – MTCT) and blood transfusion. HIV preventative measures are dealt with in Information Sheet 4c.

Understanding HIV policy and goals for youth in South Africa

For the past four years, the National Strategic Plan (2012–2016) (NSP) has been the framework that outlined how South Africa sought to prevent and treat HIV, AIDS, TB and STIs. This NSP falls in line with long-term plans to eliminate HIV and AIDS, to promote healthy lives and to increase life expectancy among all who live in South Africa. HIV prevention is a key goal of the NSP. There is a new NSP being designed for 2017–2022 which aims to use a more SBCC-based approach to dealing with HIV, AIDS, STIs and TB.

Until the new NSP (2017–2022) is released, the NSP (2012–2016) is the current overarching framework for the country's response to these epidemics. It gives a mandate to all government departments to mainstream HIV and AIDS as a key focus in their social and development programmes.

The NSP (2012–2016) places significant emphasis on behaviour-change interventions for youth by:

- implementing tailored preventions for youth to facilitate the delay of sexual debut (time of first sex) and to encourage protective behaviours;
- implementing multi-level interventions that focus on sexual, social, cultural and gender norms and values to change young people's risky behaviours related to multiple concurrent sexual partners;
- targeting prevention strategies to change youth behaviour related to intergenerational sexual relationships (blessors);
- implementing behaviour-change interventions to decrease alcohol abuse and other substance abuse (including illegal substances);
- increasing knowledge, prevention and risk perception.

The South African government has made several programmes available towards HIV prevention, and teenage and unplanned pregnancy prevention, with the South African National AIDS Council (SANAC) being one of the key structures at national, provincial and district level. SANAC has set up AIDS councils to bring together government services, NGOs and community organisations. Local projects on HIV and AIDS include education and prevention, which are most effective when they include SBCC interventions.

The current HIV experience for youth

South Africa has a population of over 55 million people. Approximately 19 million people in the country comprise young people between the ages of 15–35 (Statistics SA, 2016). That means almost 35% of South Africa consists of young people between ages of 15 and 35. Of these 19 million young people, approximately 9 million are between the ages of 15 and 24. The South African National AIDS Council (SANAC) has established that this population group is currently the most vulnerable to HIV infections.

In South Africa, about 18.7% of people living with HIV are aged between 15 and 24. The increasing number of young people who are living with HIV affects the country's human resource capital and therefore more programmes are required involving young people to prevent HIV infections and promote safer sexual practices.

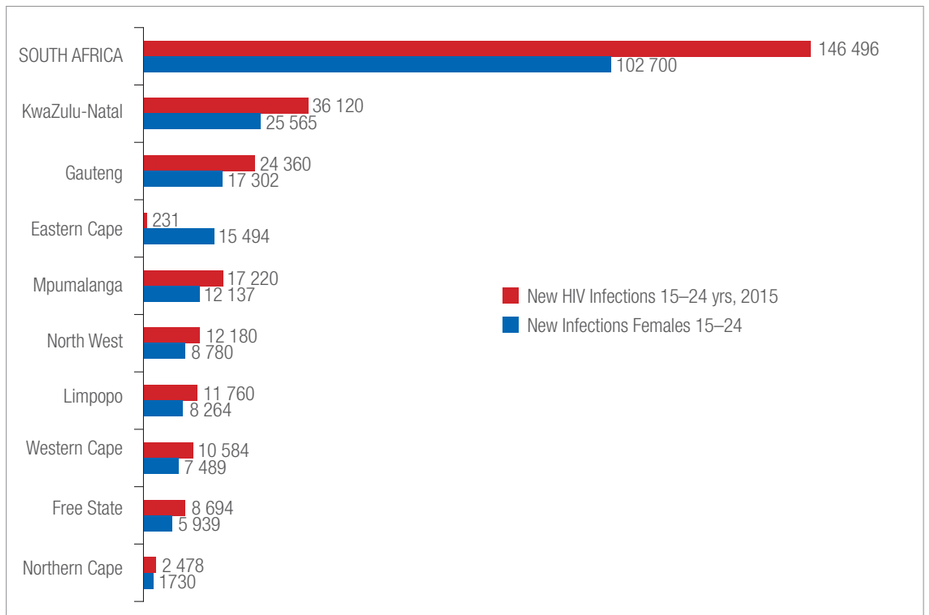
These young people are the future of our nation and it is important to ensure that they have the necessary skills, resources and good health to contribute to the next generation of leaders in our country. HIV testing and treatment programmes need to run in partnership with prevention of HIV infections as a priority, which is where this SBCC programme has importance.

UNAIDS HIV and AIDS estimates in South Africa from 2015, according to UNAIDS1

Number of people in South Africa living with HIV	Seven million (7 000 000)
Adults aged 15 to 49 prevalence rate (how many people are HIV positive)	Nearly 20%: 19.2% [18.4–20.0%], one person in every five people is HIV positive
Adults aged 15 and over living with HIV	Nearly 7 million (6 700 000)
Women aged 15 and over living with HIV	4 million (4 000 000)
Children aged 0 to 14 living with HIV	A quarter of a million (240 000)
Orphans due to AIDS aged 0 to 17	Over 2 million (2 100 000)
Deaths due to AIDS	Nearly 200 000 (180 000)

Source: http://www.UNAIDS.org/en/regionscountries/countries/southafrica

Estimated annual new HIV infections among 15–24 years by province, South Africa 2015



Source: Calculation based on Spectrum 2015 estimates

Knowledge Box 1
At the June 2012 plenary session of the HSRC, the following statistics were released

Statistics	What are the key issues?
In 2012, young males aged 15–24 years reported condom use at 67.4%. This is also the group that reported the highest proportion of multiple sexual partnerships at 34.6%.	Consistent condom use Concurrent partners (previously known as multiple and concurrent partners – MCP)
Females aged 15–24 have a four times higher incidence rate than males in this group.	Females are at higher risk of HIV infections
Female teenagers aged 15–19 years were more likely than their male counterparts to have sex with older sex partners than with their peers.	Intergenerational sex- 'Blessor and Blessee', transactional sex
In 2012, 19.9% of all respondents were involved in age-disparate relationships involving a sexual partner more than five years older than they were.	Sex for favours 'Blessor and blessee' relationship
One third of girls reported having had sex, but only 4.1% of boys.	Younger girls are more sexually active than young boys of the same age
One tenth (10.7%) of respondents aged 14–24 reported having sex for the first time before their 15th birthday.	Early sexual debut

Knowledge Box 1 At the June 2012 plenary session of the HSRC, the following statistics were released	
Statistics	What are the key issues?
12.6% of respondents aged 15 years and older reported that they had had more than one sexual partner in the last 12 months, with five times more males (20.1%) than females having had multiple partners.	Multiple and concurrent partners
Most respondents aged 15 and older (76.5%) believed they were at a low risk of getting infected with HIV. Yet about one in 10 who believed they were at low risk for acquiring HIV infections was already infected with HIV but didn't know it.	Low perceptions of risk
(Human Sciences Research Council, 2012, South African National HIV Prevalence, Incidence and Behaviour Survey, HSRC Press, Cape Town).	

Current school sexual and reproductive health programmes

School-based life skills orientation and sexual reproductive health programmes are available and helpful for young people in South Africa. These programmes introduce youth to accurate information about puberty, contraception, pregnancy and other aspects of reproductive health. However, the shortcomings of these programmes are that they often focus solely on the teaching of facts within the school context and give limited consideration to the developmental needs of young people, particularly in relation to social and behavioural issues and how these are worked out at an interpersonal, community and society level.

Many programmes are designed to relate knowledge and increase awareness, but few initiatives are geared towards translating knowledge and awareness to changing attitudes and perceptions and ultimately enhancing a positive behaviour change. Therefore, the DSD coordinates its efforts with the Department of Basic Education, which has implemented Curriculum and Assessment Policy Statement (CAPS) Life Orientation in schools.

Cultural and religious sensitivity

HIV and AIDS, sexual health, and reproductive health are all sensitive subjects. They are often mired in religious and socio-cultural taboos and beliefs. Therefore, it is very important that you, as facilitator, become aware of these dimensions. Religious beliefs are an important part of the cultural identity of many people. Freedom of thought and religion is a basic human right recognised in the Universal Declaration of Human Rights.

Most religions and cultures of the world promote tolerance and love. These should be used to help overcome the discrimination and stigmatisation associated with HIV and AIDS and other sexual and reproductive choices, such as homosexuality and use of family planning methods (contraception).

Understanding the social and cultural influences on youth sexual practices

Although HIV-prevention options are available for young people, HIV infections remains relatively high, as the reduction in HIV infections is a very complex process. There are various psychosocial, cultural, economic and structural factors that influence whether an HIV message is adhered to and if behaviour change can be achieved.

Young people have also become more vulnerable to the risk of HIV infections. Some factors that influence this vulnerability include:

- psychosocial issues such as low self-esteem, peer pressure and a sense of wanting to belong, which affect young people's decision-making capacity and compromise their ability to consider long-term consequences;
- engagement in concurrent partnerships (previously known as multiple and concurrent partners, MCP);
- early sexual debut with or without protection;
- intergenerational relationships where there is a big age gap between partners;
- transactional relationships – sugar daddy's and sugar mommy's or blessors;
- use of intoxicating substances;
- gender imbalances and gender-based violence;
- child-headed households; and
- poor family structures.

Apart from these behavioural and social factors, structural issues also play a role. These can include:

- culture: cultural norms affect sexual attitudes and behaviour;
- unemployment and low employability: erodes self-confidence, which in turn leads to poorer decision making;
- poverty: some young people view sex as a commodity or earn a living through sex; and
- poor information on HIV: some young people are not well informed or are unable to access information.

A programme for the reduction of HIV and Teenage Pregnancy

Many interacting individual and environmental factors influence high-risk behaviour among young people (Campbell and MacPhail 2002; Eaton et al 2003; Harrison et al 2005). These include:

- low levels of perceived risk;
- negative peer pressure;
- gender norms that place young men under pressure to have unprotected sex and that limit women's power to make independent decisions;
- lack of positive role models;
- poverty that can result in transactional sex; and
- inadequate support structures.

Young women are more vulnerable to HIV infections than their male counterparts due to cultural and social factors. Almost 2000 new HIV infections occur among young women and adolescent girls (aged 15–24) in South Africa each week, a rate two and a half times that among males of the same age.

However, the greater concern is the increased biological factors that place women at greater risk of infection. Hence in some cases, programmes can be adopted to target young women in particular, as they are most vulnerable to HIV infections. However, it is important to remember to talk to young men as well as young women because in most cases HIV is being transmitted to women from men and we can't leave men out of programmes to reduce HIV infections.

Knowledge box 2	
What is the research saying	What does this mean?
'The disproportionately high HIV prevalence levels among females in the country and high prevalence in unmarried, cohabitating people … require a rethinking of conventional approaches of HIV prevention towards strategies that address the underlying socio-cultural norms in the affected communities.' (Olive Shisana, chief executive and principal investigator of HSRC 2012 survey)	• More HIV intervention is required for young people, particularly young women. • Behaviour change is complex. • Behaviour change involves and understanding of the various psychosocial, cultural, structural and biological influences when developing HIV programmes.

Research is also highlighting the importance of communication between caregivers and children about sex, sexuality and HIV and AIDS. Caregivers include parents and grandparents.

Current prevention options for young people

The HIV prevention messaging in the past that many South African young people have been exposed to is often called ABCC.

'A': Abstinence from sexual intercourse, or a delay of early sexual debut

'B': Be faithful to your partner and do not have concurrent sexual partners (more than one sexual partner at the same time)

'C:' Condom use – male or female condom

'C': Circumcision – Voluntary Medical Male Circumcision (VMMC)

Additional prevention options are available and include the following:

Pre-exposure prophylaxis

Current research in pre-exposure prophylaxis (PrEP) studies has also demonstrated some hope for biomedical HIV-prevention options that can empowerment women to protect themselves against HIV. According to the USAID Terminology Guidelines (2015), 'pre-exposure prophylaxis (PrEP) refers to antiretroviral medicines prescribed before exposure (or possible exposure) to HIV. Several studies have demonstrated that a daily oral dose of appropriate antiretroviral medicines is effective in both men and women for reducing the risk of acquiring HIV infection through sexual or injection transmission.'

Currently PrEP is being rolled out to sex workers and to homosexual individuals but there are moves to make it available on demand. This will be dealt with in the new NSP. Sex workers and homosexual individuals have been identified as having a high risk of HIV infections and are subsequently the current target.

In addition to PrEP antiretroviral medicines, there are other PrEP products still in the clinical trial phase. These include the use of vaginal rings, vaginal gels, oral pills and long-acting injectables. However, none of these products are available for public use currently.

Post-exposure prophylaxis (PEP)

Another HIV-transmission-prevention option is post-exposure prophylaxis. Post-exposure prophylaxis 'refers to antiretroviral medicines that are taken after exposure (or possible exposure) to HIV' (USAID Terminology Guidelines, 2015). PEP is a short-term anti-retroviral (ARV) treatment that reduces the likelihood of HIV infection after exposure to HIV-infected blood or sexual contact with an HIV-positive person. The exposure to HIV may happen during work (e.g. a needle stick injury for doctors and nurses), after sex without a condom or after rape.

However, no matter what communication strategy is developed (ABCC strategy) or which biomedical HIV intervention becomes available, one step is key for any HIV-prevention strategy and that is behaviour change. Behaviour change is a complex process and will be discussed further in this manual and the YOLO guide.

There are a number of myths or beliefs about HIV and AIDS that are common in South Africa. As a facilitator in YOLO, it is important that you know how to deal with these myths with correct factual information. Here are some myths.

Myth 1: *'If I had HIV, I'd feel sick' or 'I could tell if my partner was HIV positive'*

There is the misconception that an HIV-positive person will have certain symptoms that indicate that they have HIV. If a person does not have any symptoms then they may not expect to be HIV positive.

Fact: A person can have HIV without showing any symptoms of the disease and the only way to know if you or your partner is HIV positive is to get tested (CDC, 2011; AIDS Foundation of South Africa, 2014; UNESCO, 2007).

Myth 2: *'A diagnosis of HIV is a death sentence.'*

Many people learn about their HIV status long after they have contracted the virus, resulting in cases where people have become very ill, or having a short life span after diagnosis.

Fact: Although HIV is serious and there is no cure, early detection and ARV drugs allow HIV-positive people to live longer, healthier lives (CDC, 2011; AIDS Foundation of South Africa, 2014).

Myth 3: *'If I'm receiving treatment, I can't spread HIV.'*

When HIV treatments work well, they can reduce the amount of virus in your blood to a level so low that it doesn't show up in blood tests therefore people may think that they can stop practicing safer sex.

Fact: ARV treatment does not cure HIV and the virus is always in the bloodstream. Therefore, it is still essential to use a condom to prevent transmitting HIV and getting re-infected (AIDS Foundation of South Africa, 2014).

Myth 4: *'My partner and I are both HIV positive – there's no reason for us to practice safe sex.'*

HIV-positive partners may think that their level of HIV transmission is the same and that there is no need to use protection during sex because they are both diagnosed with HIV.

Fact: Two sexual partners who are both HIV positive could have different strains of the virus and, if they have unprotected sex, they could infect one another with another strain, leading to their immune systems being attacked by two different forms of the virus (AIDS Foundation of South Africa, 2014).

Remember, pregnancy and other STIs can also result from not using condoms.

Myth 5: *'Male circumcision prevents HIV transmission.'*

Young people may think that it is safe to have unprotected sex when the male partner is circumcised because their foreskin, the part of the penis that makes them more susceptible to HIV transmission, is removed.

Fact: Male circumcision reduces HIV transmission among males by up to 60% but it does not prevent HIV transmission completely (AIDS Foundation of South Africa, 2014).

Myth 6: *'ARVs disfigure you.'*

In the past, people who were on ARV treatment experienced side effects that included fat loss in the legs, arms and face, while developing more fat in the stomach and the breasts. This made people's bodies look unbalanced.

Fact: Nowadays there is a range of drugs to choose from and doctors are better equipped to monitor side effects (AIDS Foundation of South Africa, 2014). Being very sick from AIDS will also negatively affect how you look.

Myth 7: *'Only people with multiple sexual partners are vulnerable to HIV transmission.'*

People believe that because they have one sexual partner they are not risk of HIV transmission therefore there is no need for a condom during sex.

Fact: Although it is true that people with multiple sexual partners are at a high risk of acquiring HIV, everyone who engages in unprotected sex is at risk of getting HIV, whether they have one or multiple sexual partners (UNESCO, 2007; CDC, 2011).

Chapter 3: Understanding social behaviour change communication (SBCC) in the social behaviour change framework

This section provides an introduction to understanding social behaviour change communication (SBCC) processes. This background is important for all facilitators as it provides an in-depth understanding of the key outcomes of the programme. Formal training is strongly recommended for people who will facilitate these SBCC programmes.

Overall this section offers facilitators a quick introduction to understand how behaviour change and social change intersect. Facilitators must keep in mind that the YOLO training, regardless of the duration, cannot achieve behaviour change, but it can catalyse (start) a process of decisions, choices and skills development.

In public health communication, there are four key intervention approaches:

- Biomedical approach (medicines and treatment)
- Behaviour change communication approach (BCC)
- Social behaviour change communication approach (SBCC)
- Structural change approach

Research has shown that integrated approaches to health education, and HIV in particular, work best for reducing HIV transmission. Adopting an approach that brings together social change and behaviour change is key to HIV prevention. In order to understand HIV prevention approaches better, we first need to understand what social behaviour change communication is.

What is behaviour change communication?

Over the years, there has been a shift in thinking about behaviour change communication (BCC): simply giving correct information – while this is important – does not change behaviour by itself. Only addressing individual behaviour is often not enough either. Behaviour change can refer to any transformation or modification of human behaviour.

- Young people don't change with information alone but are inspired to make positive choices when others around them change.
- The term 'behaviour change' should be understood as a move from practices that are risky and harmful to young people to practices that lead to better long-term health and wellness.
- This process of personal change that leads on to influence change in peer groups is often only possible when the facilitators themselves model the message that they are delivering.
- This is one of the key methodologies in the delivery of an effective behaviour change intervention with youth.
- In public health, BCC often refers to a broad range of activities and approaches, which focus on the individual, community, and environmental influences on behaviour.
- Effective behaviour change therefore promotes positive choices that result in individual health and wellness, which in turn affect the health and wellness of the community and society as a whole.

According to the UNAIDS Terminology Guidelines of 2015, behaviour change communication 'promotes tailored messages, personal risk assessment, greater dialogue and an increased sense of ownership of the response by the individual and the community. It is developed through an interactive process, and its messages and approaches use a mix of communication channels to encourage and sustain positive, healthy behaviours' (UNAIDS Terminology Guidelines 2015).

Behaviour change interventions mean that there is a systematic attempt to influence behaviour. This is usually achieved through a focus on how an individual can change behaviour.

Behaviour change on its own assumes that individuals can change if:

- knowledge increases;
- attitudes and perceptions are changed to encourage the positive behaviour; and
- practice (change of the behaviour) will be the outcome of knowledge and attitudinal change.

This approach has been used extensively in HIV communication and has unfortunately failed in many instances as it assumes that individuals are in control of their environment/context and could make decisions of their own free will. Here are some key facts about human behaviour:

- People interpret and make meaning of information based on their own context.
- Culture, norms, and networks influence people's behaviour.
- People can't always control the issues that create their behaviour.;
- People's decisions about health and wellbeing compete with other priorities.

The limitations of a focus on behaviour change communication (BCC) have caused a revisit of the influence of social change in HIV prevention.

What is a social behaviour change communication approach?

While risky individual behavioural patterns can cause HIV transmission, the key drivers of this epidemic in South Africa are deep-rooted institutional problems of poverty, underdevelopment and gender-based violence (HIV and AIDS Strategic plan for South Africa 2007–2011: 2006).

Individual behaviour change does not occur in a vacuum and therefore looking at the multiple social determinants that influence behaviour is important. These social determinants are defined by the World Health Organization (WHO) 'as the conditions in which people are born, grow, live, work and age.' According to the UNAID Terminology Guidelines, 'these circumstances (which include the health system) are shaped by the distribution of money, power and resources at the global, national and local levels, and these factors are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities –– the unfair and avoidable differences in health status that are seen within (and between) countries. It is common practice in public health to use the term as an umbrella concept that incorporates not only social factors influencing health but also economic, cultural or environmental factors (including those codified in laws and policies) and those operating through community norms' (UNAID Terminology Guidelines 2015).

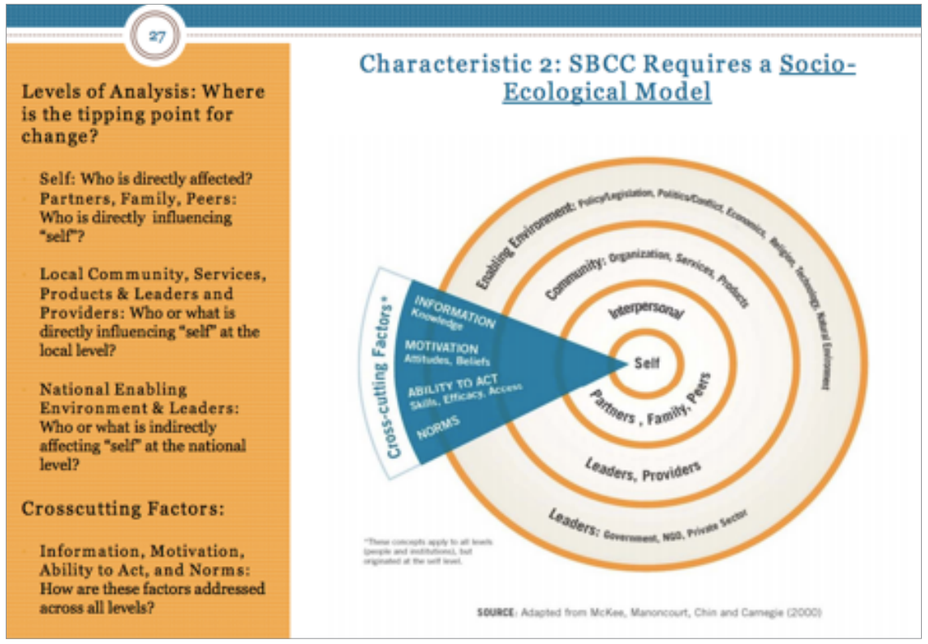
As a result of research and new understanding of HIV and behaviour, HIV is now identified as a social condition rather than an individual behavioural problem. A multi-faceted approach is needed to address HIV prevention.

Social behaviour change communication (SBCC) is an aspect of SBC and sees people and communities as agents of their own change. SCC 'is the strategic use of advocacy, communication and social mobilisation to systematically facilitate and accelerate change in the underlying determinants of HIV risk, vulnerability and impact. It enables communities and national AIDS programmes to tackle structural barriers to effective AIDS responses, such as gender inequality, violation of human rights and HIV-related stigma. SCC programmes act as catalysts for action at the individual, community and policy levels' (UNAID Terminology Guidelines, 2015).

Social behaviour change communication is a combination of BCC and SCC and provides individuals and communities with the relevant skills development and empowers them to deal effectively with issues such as HIV. SBCC works with what is known as the socio-ecological model.

Take a look at the diagram below. What does it mean and how can we use it? The diagram shows all the levels in society that have an impact on individual behaviour and choices.

A programme for the reduction of HIV and Teenage Pregnancy



Source: https://c-changeprogram.org/focus-areas/capacity-strengthening/SBCC-Toolkit

Below is a table explaining the same idea.

Level of Change Process	Targets of Change
Individual	Personal behaviours
Interpersonal	How the person interacts with his or her social network
Community	Dominant norms at community levels
Society	Dominant norms societal levels

Source: Adapted from McKee, Manoncourt, Yoon, and Carnegie (2000)

Source: https://c-changeprogram.org/focus-areas/capacity-strengthening/SBCC-Toolkit

So how does this diagram, and the accompanying table, help us understand SBCC and changes in behaviour? Let's look at using condoms as a behaviour that an individual wants to put in place.

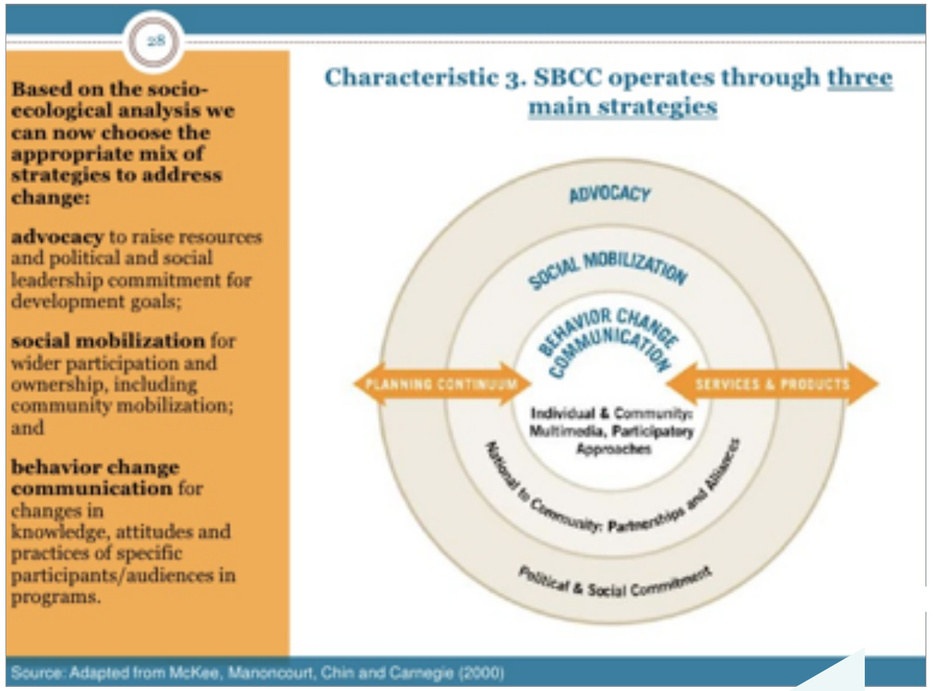
A person can decide to use condoms when she or he has sex. This is an individual decision on the individual level. This decision on the personal level to use condoms then needs to be communicated to his or her partner as people do not have sex alone. This is a joint decision, which is on the interpersonal (between people) level and both partners will need to agree. If both partners agree to use condoms, then they need to be able to get condoms. This is the community level and means the condoms need to be available in the community if they are going to use them. These are places like clinics, taxi ranks, public toilets, work places, shebeens, etc. The final level is the political, legislative and societal level, which makes free condoms available to the population. If government does not provide these condoms, then all the levels within will not be possible. Individuals will not be able to use condoms even if they choose to and if their partners agree to using condoms and if there are places in the community where they can get condoms. The surrounding environment influences the individuals and at the same time individuals, couples and communities can influence the more external environments. Thus, all of these levels need to work together all of the time in order for behaviour to change and for this changed behaviour to be sustained and maintained.

Facilitator note

SBCC is an interactive, researched and planned process.

- SBCC requires a socio-ecological model for analysis to find the tipping point for change.
- SBCC operates through three main strategies, namely
  a) advocacy;
  b) social mobilization; and
  c) behaviour change communication

Below is a slide from the UNAIDS SBCC toolkit to show how SBCC programmes rely on an interaction of advocacy, social mobilisation, and behaviour change communication to create and sustain changes in behaviour. Advocacy is raising support for a particular change in behaviour for leadership; social mobilisation is creating a demand in communities and society for a change in behaviour; and behaviour change involves the content and knowledge needed to change behaviour.[5]



Source: https://c-changeprogram.org/focus-areas/capacity-strengthening/SBCC-Toolkit

Remember the following things about SBCC:

- The socio-ecological framework considers an individual as a product of the context such as culture, socio-economic status, government policy, gender and spirituality (UNAIDS, 1999).
- Social behaviour change is best understood within a socio-ecological framework that takes into account the interconnected influences of family, peers, community and society on behaviour (Sallis and Owen, 2002).
- Social ecology is the study of people in an environment and the influences each has on one another.
- SBCC merges social change, behavioural change and structural change in a network.
- It takes a systems approach to understand HIV complexity and interrelatedness of the components of a complex adaptive system rather than just one isolated component.

Knowledge box 3

Characteristics of YOLO as a social behaviour change communication programme

- YOLO aims to support young people to reach their goals and fulfil their developmental needs in order to minimise HIV transmission and teenage and unwanted pregnancy.
- YOLO is participatory in nature. Young people are involved in the dialogues and are given every opportunity for applying the content to their own context.
- Change is agreed from within; young people are not to be lectured to or told what to do.
- YOLO provides an opportunity for young people to determine what they think they need to do and to support them to make it happen.
- The YOLO messages are culturally relevant to the local community and community knowledge is used to develop solutions. The community is involved in and owns the process.

Why choose the social and behaviour change communication approach?

A combination of strategies is the best approach.

- Research shows that the only hope for the reversal of the HIV epidemic lies in effective behaviour change, regardless of the difficulty of attempting to change human behaviour. A realisation and enactment of positive sexual practices is the only approach to reduce HIV transmission.
- Biomedical HIV-prevention methods such as microbicides and vaccines are still undergoing clinical trials and if/when they do become available, product uptake, consistent product adherence and consistent use is key (behaviour change is needed).
- Behaviour change interventions also promote consistency (for example, from not using condoms every time you have sex during sexual encounters to consistent condom use).

- However, widespread and consistent behaviour change is often difficult to achieve because human behaviour is complex and depends on the realities and experiences that individuals find themselves in. Circumstances and contexts change, making behaviour change difficult to sustain.
- Many HIV-prevention strategies include a specific behaviour change message. Whatever the specific message is, it must always be clear and be something that young people are able to do or negotiate. It must recognise the daily life experiences and realities of individuals trying to implement the change.
- Examples of effective behaviour communication change messaging might include:
  - encouraging youth to delay sexual debut;
  - empowering female sex workers to ask clients to use condoms; and/or
  - promoting HIV testing.

However, other points to consider when working in social behaviour change communication are:

- Providing 'head' knowledge or information alone is not enough.
- Social and behaviour change communication is a preferred strategy because 'head' knowledge or information about HIV and AIDS does not always result in appropriate behaviour.
- Research shows that many young people practice risky sexual behaviour even though they know about the HIV epidemic. Therefore, a programme that merely presents facts is generally not sufficient to change young people's behaviour.
- Behavioural changes are often only possible in a supported context where they can discuss consequences and think through the issues that affect them.

The SBCC approach considers context and encourages application

A behaviour programme is significantly more likely to succeed if young people adopt a change of behaviour together and hold one another accountable. The behaviour change must make sense to them in the context and environment in which they live. This includes cultural and economic issues. This makes it easier to sustain the chosen 'new' behaviour.

So what does this all really mean? What does an SBCC project need to do to facilitate behaviour change?

In order to change behaviour, people require:

- Information – timely, accessible, and relevant. Some individuals, groups, or communities may be empowered to act. For most people, information is not enough to prompt change.

- Motivation – determined by their attitudes, beliefs, or perceptions of the benefits, risks, or seriousness of the issues that programmes are trying to change. However, even motivation may not be enough. They need the ability to act in particular circumstances.
- Self-efficacy (or collective efficacy) – psychosocial life skills: problem-solving, decision-making, negotiation, critical and creative thinking, interpersonal communication;
- Access – financial, geographical, or transport issues that affect access to services and ability to buy products.

Critical to SBCC is the notion of self-efficacy, which is a person's belief in their ability to achieve a desired outcome. Self-efficacy is perceived regardless of one's actual ability. If a person sees someone else performing behaviour, but doubts his or her own ability to copy it, it's not likely that the new behaviour will be adopted.

This manual therefore forms an essential component of the DSD's efforts to reduce the spread of HIV and teenage and unwanted pregnancies among the youth.

Chapter 4: Facilitating YOLO, an SBCC programme

YOLO is an exciting and dynamic SBCC programme. One of the core principles of YOLO is the way it is going to be rolled out, implemented and facilitated. It is important to be familiar with participatory training and facilitation.

YOLO as an SBCC programme will reach youth both formally and informally using participatory models of training and facilitation.

- YOLO reaches youth formally when planned and structured educational sessions are run. These sessions are prepared in advance and offer youth opportunities for interactive discussion and reflection.
- YOLO reaches youth informally when young people become aware of the key issues raised, think through the issues and discuss them with others in their peer group and community. Knowledge and skills might be transferred whenever young people talk about what they've learned and start to show signs of genuine change in their own lives.
- Relevant referral support must be arranged before YOLO is implemented. For example, linkages with a social worker or counselling services within the community in case young people are affected emotionally during sessions.

What is participation?

Participation will be dealt with in far more detail in the YOLO guide but here are some pointers relevant to the manual.

- Participation is a process through which young people of a community or organisation become involved in, and have influence on, decisions related to activities that will affect them.
- Participation often involves a dialogue, a two-way flow of communication, with the idea that young people will collectively identify a situation they are faced with and decide what needs to be done to improve that

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situation and then take action to address it.

- Participation can also be described as the involvement of young people through a dialogue and collective action process to bring about change to an issue.

Why is it important to encourage participation?

Participation means young people can be agents of change. This is critical to an SBCC programme like YOLO.

If young people feel they can be participants of change, they will experience ownership and empowerment relating to the change. By participating in YOLO, young people feel ownership or responsibility for, and control over, the process of change. Behaviour change is more likely to be successful and permanent when people who are wanting to change behaviour initiate and promote the behaviour change and feel empowered. Feeling empowered provides young people with the opportunity to take ownership of their behaviour change. This results in them addressing their own needs and advocating behaviour change to address an old behaviour

When presenting YOLO training, you as facilitator are going to use a participatory approach to interact with the participants. This means the training will take a youth-centred approach. This is a bottom-up method and uses a collective learning process where everyone is an active participant and engages in the issue at present. The opinions of the youth participants in this approach are given value and recognition.

The role of the facilitator

It is compulsory for trained facilitators to spend a minimum of three days going through the Facilitator Manual and the Facilitator Guide with activities that will prepare you to facilitate the sessions with the participants. However, additional time will be needed to go through all the content in addition to the training. Facilitation skills will be explained in more detail in the YOLO Guide but here are some pointers.

How to reach youth as a facilitator

This youth SBCC programme is designed to target young people, specifically adolescent girls and boys and young men and women aged 15–24 years. In order to reach people with a specific programme as a facilitator, the programmes must be effectively advertised. It helps to have a marketing and visibility plan in place from the start so that the targeted youth are attracted to the programme (see Facilitator's Guide pg xx).

It may be necessary to make this a closed group, so that participants are increasingly comfortable sharing their stories with the others, particularly the more sensitive topics.

Facilitator note

The term 'facilitate' is a verb and means 'to make an action or process easy.' A facilitator is someone who adopts certain actions or processes to help a group of people understand their common objectives and assist them to plan how to achieve these objectives. The facilitator must remain neutral during this process and not take a particular position in the discussion.

Remember: you are a facilitator in an SBCC programme. That means you have to acknowledge and recognise the structural, social, community, interpersonal and individual realities of your participants.

Skills for facilitators

A good facilitator needs to be able to work with individuals, a group and several teams. Facilitation is a skill that develops over time, but it is important to be mindful of some of the key facilitation skills, and work on improving them over time. Don't put pressure on participants to share; if they are unwilling, respect their privacy.

Self-evaluation by facilitators

It is very important for facilitators to think about themselves as such especially in terms of an SBCC programme facilitator. YOLO is relying on you to share the content on this programme in an effective way. By thinking about the YOLO training from the perspective of a facilitator, you will improve their facilitation skills and the outcomes of YOLO. This will be explained further in the Facilitators Guide.

Remember: your contribution forms part of a large effort to change youth behaviour in South Africa. You are part of an important and worthwhile endeavour! You are not alone.

Chapter 5: The YOLO programme

You now have a large amount of information and knowledge about SBCC programmes, the HIV situation in South Africa, participatory learning and facilitation techniques. Now you are ready to start the YOLO programme.

The YOLO programme has been developed in FIVE Building Blocks, namely:

- **Building Block One: 'I am important': building social skills**
- **Building Block Two: Understanding sexual health**
- **Building Block Three: My rights and responsibilities**
- **Building Block Four: Taking chances and dealing with consequences**
- **Building Block Five: 'Others are important': improving my relationships**

These five building blocks form part of the foundational knowledge and skills that each young person needs to build capacity and resilience in approaching sexual and other relationships and in approaching adulthood with responsibility. In a sense, these are the building blocks for building a strong 'house' (or strong person). There are many building blocks that can develop young people's skills and knowledge in HIV prevention, but for the purpose of this manual, we will only focus on the five discussed above.

Specific learning outcomes of YOLO

Each of the five building blocks has various learning and expected behavioural outcomes. The table below presents the key learning outcomes for the various building blocks:

Building block	Learning outcome	Expected behaviour outcome
Building Block One I am important: building social skills	• Have a better knowledge of their self-identity. • Understand what social skills are. • Learn how to use or improve the use of their social skills.	• Exercise their self-esteem and confidence more through positive self-talk. • Demonstrate the ability to show assertiveness and placement of boundaries.
Building Block Two Understanding sexual health	• Understand sexual health and guidelines on when to have sex. • Learn more about teenage pregnancy and the risk of STIs and HIV transmission. • Understand how to prevent HIV infection, teenage and unplanned pregnancy. • Understanding HIV related stigma and discrimination.	• Use improved knowledge about sex, teenage pregnancy and HIV to make safer sexual choices, e.g. delayed sexual debut; consistent condom use; avoidance of concurrent partners; reduced intergenerational or transactional sex. • Identify when is the 'right' or appropriate time to have sex. • Use increased knowledge to prevent HIV infection, teenage and unplanned pregnancy.
Building Block Three My rights and responsibilities	• Basic understanding of the provisions of the South African Constitution and law concerning their sexual and reproductive rights. • Understand more about human value and responsibilities and what sexual violations are.	• Increased knowledge about sexual and reproductive rights. • Ability to identify sexual violations and responsibility to respect human rights of others. • Take action if sexual assault or rape is experienced.
Building Block Four Taking chances and dealing with consequences	• Understand the consequences of certain risky sexual behaviours. • Awareness of how to deal with the consequences of risky behaviour.	• Identify the effects and consequences of sexual behaviour practices. • Practice safer sex. • Make healthy lifestyle choices. • Deal with adverse situations and challenges. • Access PrEP and PEP. • Negotiate condom use.

Building block	Learning outcome	Expected behaviour outcome
Building Block Five 'Others are important': improving my relationships	• Learn about the importance of healthy relationships. • Understand what is effective communication and the importance of saying no when you do not want to do something. • Learn more about effective and ineffective decisions, healthy or unhealthy decisions or informed and uninformed decisions. • Understand stigma and discrimination	• Have healthy relationships. • Understand body language and understand communication through body language. • Make better decisions about sexual health. • Be accepting/tolerant towards others.

Facilitator note

It is advised that the building block activities are followed in a sequential format. You should start with Building Block One and move through Building Blocks Two, Three, Four and Five as the manual has been developed to take participants through a process of skills development, knowledge generation and information sharing towards the promotion of positive behaviour change in sexual decision.

Structure of the building blocks

Each building block has:

- outcomes;
- time allocated for activities;
- facilitator notes;
- short seminars where relevant;
- end-of-session reflections; and
- take-home activities.

The following icons provide a quick and easy way to highlight the various aspects of the sessions:

GROUP DIALOGUE

FACILITATOR NOTES

FACILITATOR REFLECTION / PARTICIPANT REFLECTION

TAKE-HOME ACTIVITY

SHORT SEMINAR

PREPARATION

Following these building blocks in sequential order is important but being flexible and adaptable as you facilitate each activity is also very important. For example, some activities may go quicker and others may take longer. Be flexible and adapt accordingly.

Caution: However, when being flexible, always ensure that you still work towards your learning outcome within the restricted time.

BUILDING BLOCK ONE: 'I am important': building social skills

Young people are the leaders of tomorrow and it's important for them to have a sense of identity and a sense of belonging. Young people are also very resilient and have the ability to overcome adverse (difficult) situations. Building Block One is designed to help young people understand their importance, to understand who they are (self-identity) and later, through other building blocks, to develop their social skills.

Building Block One lays a foundation of self-identity, understanding who they are and why they are important. It then builds on three key individual skills through three sessions.

Learning outcomes

The main learning outcome for this building block is for participants to become aware of their positive qualities.

By the end of this building block, participants must:

- have a better knowledge of their self-identity;
- identify their ability to increase their self-esteem and self-confidence; and
- know more about setting personal boundaries.

Expected behavioural outcome

By the end of Building Block One, participants should be able to:

- identify things about themselves that can be improved;
- exercise their self-esteem and confidence through positive self-talk; and
- demonstrate the ability to show assertiveness and establishment of boundaries.

SESSION 1

Self Identity

Expected session outcomes

By the end of this session, participants should have a self-identity and know what makes them who they are.

Information Sheet 1a: What is self-identity?

Definition: Self-identity is the recognition of one's potential and qualities as an individual, especially in relation to social context

Everybody has a sense of personal or self-identity. Young people have a number of important ways of thinking about themselves. Self-identities, especially those of young people, are dynamic or in flux. Our self-identity includes characteristics, roles, behaviours and associations. Self-identities are associated with status, success, talent and interest.

Some common attributes to our self-identity are:

- Occupations (e.g. a student, leader in your community, teacher, volunteer)
- Social and family relationships (e.g. sister, brother, mum, dad, friend, cousin)
- Abilities (e.g. intelligent, smart, high achiever, adaptable, patient)

Self-identities are constructed over time. For example, early in life, a sense of self is associated with the security, protection and acceptance that infants, toddlers, and preschoolers feel when effectively cared for by adults to whom they feel an attachment.

By the late preschool years and early school years, a sense of self is associated – positively or negatively – with attributes that parents value and model for their children in the way they live their lives.

Over the school years, peer values and peer pressure come to play an increasingly influential role in how older children and young adolescents think about themselves. However, a confident person is not always influenced by peer pressure and stands up for what they think even if others do not agree with them.

Sense of self-identification is often associated with physical attributes (e.g. physical attractiveness), physical prowess (e.g. athletic accomplishments) or physical possessions during the primary and high school years.

By late adolescence, mature students are moving beyond peer pressure, group norm and predominately physical associations, and come to think about the sort of person they want to be based on their most deeply held values.

Self-identity is therefore constantly changing through the various stages of life. It is important for young people to maintain a positive self-identity and realise that they are important, no matter how they may feel or what they may think at times.

Information Sheet 1b: Why am I important?

Definition: Important is the state or fact of being of great significance or value.

Remind participants that there is no one more important or significant than them; because they are important, they can bring value to so many others.

There is only ONE you

No matter who you are, there will never be another you. Remind participants that there are billions of people in the world, but no two people have the same thumbprint. You are uniquely created, and there will never be another you.

You are unique

Because there is only one you, you bring specific values, characteristics, ideas, purpose and value to others. No other person can be exactly the same or do exactly the same as you would. You are unique.

You have a purpose

We all have a purpose in life. At times, it may not always seem like things are going well, but we have a purpose, and when life becomes challenging, it is important to remind yourself of what you would like your life to achieve.

You bring value

No matter what life circumstances can be, your life is of value, you can bring value to people around you because you have a purpose. Remind participants of the purpose they identified in Activity 2.

You have many abilities

You are able to love, learn, teach, be happy and inspire others. No matter what happens in your life, you can choose how you have to deal with those situations. You have the ability to change negative situations into positive learning experiences.

You can be a good example

You can be a role model to others based on the choices and decisions you make. Don't allow yourself to be easily influenced by others. Rather think through your actions carefully, and question if this behaviour or action would be a positive influence to others.

You are a leader

Leaders are people who can positively influence others. You can be a leader, even if it's in a small area in your life. You are important, because you are you.

SESSION 2

Building self-esteem and self-confidence

Expected session outcomes

This session builds on the previous session of understanding self-identity. The main focus of the next three activities is on skills identification and development. The first skill is self-esteem. Self-esteem is made up of various elements, but for the purpose of this session, we will only focus on self-confidence. Because this is an SBCC programme, we will also look at self-efficacy while we look at self-confidence. Facilitators can explain self-efficacy to participants in terms of what they have learned in the training and in this manual.

Remember: self-efficacy is a person's belief in their ability to achieve a desired outcome.

The purpose of this session is to explore how to build self-esteem and self-confidence/self-efficacy in young people, which overall should increase their self-worth.

Expected session outcomes

By the end of this session, participants should have a better understanding of self-esteem and self-efficacy; and know how to increase their self-esteem.

Information Sheet 2a: Self-esteem

Definition: Self-esteem is feeling good about yourself, feeling that you are a worthwhile person.

Self-esteem is how you feel about yourself as a person and knowing that there are things that you are good at.

While we all have doubts at times, a healthy self-esteem enables a person to try new things without too much fear of failing, to reach out and make friends, and to manage problems they are likely to meet along the way.

Facilitator to keep in mind the following points:

- Emphasise the fact that engaging in sex to be popular is high risk behaviour. Sex must not be used in order to be seen to 'fit in' with others.
- Help them to recognise that a good friend, boyfriend or girlfriend won't ask them to do things that make them feel uncomfortable. True friends are concerned about them and their future, and want them to stay healthy.
- Many young people often go too far in order to fit in, and may disregard their own boundaries for the sake of popularity.
- Self-esteem is connected to boundaries. It is important to ask participants to think about how they relate to pressure from their peers to fit in.
- Sustainable behaviour change is hard for people who have low self-esteem.
- Many young people who severely lack confidence will do almost anything to experience love and acceptance from others.
- Their own sense of worthlessness makes it hard for them to say no to peer pressure. This makes them highly vulnerable to contracting HIV or becoming teenage parents or having an unplanned pregnancy.
- Building young people's self-esteem is therefore crucial in enabling them to put essential boundaries in place.

Elements of self-esteem

1. *Self-knowledge*
   - I know who I am, where I come from.
2. *Self-awareness*
   - I have choices about how I think, feel and behave.
3. *Self-acceptance*
   - I accept who I am and I feel OK about my body.
4. *Self-reliance*
   - I understand how to make decisions and how to motivate myself.
5. *Self-expression*
   - I understand the importance of expressing myself in a socially acceptable way.
6. *Self-confidence*
   - My thoughts and opinions are of value, and I believe in my ability to overcome obstacles.
7. *Self and others*
   - I know about friendships, respect and tolerance.
8. *Beyond self*
   - I am able to connect with the wider world; I can cope with a degree of uncertainty in life.

Information Sheet 2b: Gender and self-esteem

Definition: Gender defines the norms and expectations about appropriate male and female behaviour and the interaction between the sexes.

Self-esteem and how we see ourselves is also influenced by gender.

We are born as males and females, but becoming girls, boys, women and men is something that we learn from our families, friends, communities and society.

Young women and men learn from experiences around them what the expected way to behave, achieve, participate and engage with others is.

These expectations are often gender-specific, and can prevent the self-confidence of young people.

It is important to recognise these roles, and take pride in being a young man or young woman.

Gender – young women

Young women are affected and influenced by:

- Friendship, groupings, education, childcare. However, many women have low self-esteem because of domestic responsibilities, traditional values, limited employment opportunities and social exclusion.

Gender – young men

Young men are affected and influenced by:

- Different issues to young women such as masculinity, violence, health, cultural identity, sex and sexuality that all directly have an impact on their development. Young men, as a result, can also have self-esteem issues, and therefore building self-esteem and confidence in young men is very important.

There are a number of concepts to help to understand self-identity. These include sex, sexuality, sexual orientation and gender. Here are some definitions to help participants understand more about who they are:

- **Sex (biological sex):** The physical and biological characteristics that distinguish males and female.
- **Gender:** The roles, behaviours, activities and attributes that a given society at a given time considers appropriate for men and women. In addition to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, gender also refers to the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialisation processes. They are context/time-specific and changeable. Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access

to and control over resources, as well as decision-making opportunities. Gender is part of the broader socio-cultural context, as are other important criteria for socio-cultural analysis, including class, race, poverty level, ethnic group, sexual orientation, age, etc.

- **Sexuality:** This is much more than sexual feelings or sexual intercourse. It is an important part of who a person is and what she/he will become. It includes all the feelings, thoughts, and behaviours associated with being female or male, being attractive and being in love, as well as being in relationships that include sexual intimacy and sensual and sexual activity.

LGBTI *– an umbrella term to describe the members of the different communities below:*

Lesbian *– A female- identified person who is attracted romantically, physically, or emotionally to another female-identified person.*

Gay *– A person, mainly a male-identified person, who is attracted romantically, physically, or emotionally to another a person of the same sex.*

Bisexual *– A person who is attracted romantically, physically, or emotionally to both men and women.*

Transgender *– A person who is a member of a gender other than that expected based on anatomical sex.*

Queer *– An umbrella term which embraces a variety of sexual preferences, orientations, and habits of those who do not adhere to the heterosexual and cisgender majority. The term queer includes, but is not exclusive to lesbians, gay men, bisexuals, trans-people, and intersex persons, traditionally, this term is derogatory and hurtful, however, many people who do not adhere to sexual and/or gender norms use it to self-identify in a positive way.*

Intersex *– Someone who's physical sex characteristics are not categorized as exclusively male or exclusively female.*

Asexual *– A person who does not have a sexual orientation. A person that does not experience a sexual attraction but can experience a romantic, emotional, or aesthetic attraction to another person.*

Source: tahoesafealliance.org

SESSION 3

Assertiveness and personal boundaries

Session One and Two have taken young people through a journey of setting a foundation of understanding who they are (a self-identity) and building their self-esteem and self-confidence. This important foundation helps them to become more assertive in situations relating to health and wellbeing. Setting personal boundaries is one way of exercising assertiveness or personal confidence. This session takes participants through three key activities to introduce them to assertiveness and personal boundaries.

Expected session outcomes

By the end of the session, participants should be able to identify their personal boundaries and have improved their assertive communication skills.

Information Sheet 3: Assertiveness

Definition: Being assertive means that you are able to say what you think or what you want clearly and without being aggressive or rude.

Being assertive is stating your opinion in a confident and respectful way to others.

Definition: Being aggressive is stating your opinion in a forceful, confrontational way which does not show respect for others.

Definition: Boundaries are the limits we set in relationships that allow us to protect ourselves, they make it possible for us to separate our own thoughts and feelings from those of others and to take responsibility for what we think, feel and do.

Personal boundaries make you feel safe. Inside your boundaries, you feel comfortable.

For example, a young woman might set a boundary such as, 'I do not like to be touched by someone of the opposite sex unless he is my partner.' She should be comfortable to communicate that to those around her.

Many people have weak boundaries. They might believe that their role is to please others or that they have no right to set boundaries. Some people grow up in homes where they are told that setting boundaries is not their right. Others are able to set boundaries but struggle to maintain them because they are abused, or because they have low self-esteem.

The first step in setting boundaries is to figure out what you want. The second step is to communicate it clearly. Many people need to practice doing this.

When people set boundaries, they often find that others react negatively. Young people should be prepared to deal with some of these reactions when they set boundaries. For example, they might find that people react in the following ways:

- Who do you think you are? You're getting too big for your boots!
- Don't you care about me? I thought you loved me.
- You always want everything your way.
- You are so selfish. Why won't you compromise on this?
- I am sorry that you don't want to be in a relationship with someone who cares about you.
- I'm not going to change, everyone does it like this – you're the one who is being different.
- I don't want to talk about this.
- Don't make such a big deal out of nothing. You are overreacting.

However, it is important to stand your ground. If you have made a positive decision for your own sexual wellbeing, set a personal boundary and stick to it. Do not allow yourself to be influenced by what others think or say.

BUILDING BLOCK TWO: Understanding sexual health

The previous building block looked at self-identity, self-esteem, self-confidence and assertiveness. The previous block also introduces the concepts of sex, sexuality, gender and sexual orientation, which are important in understanding who we are. However, in order to reduce new HIV infections and teenage and unplanned pregnancies, we need to understand what sex is; how we fall pregnant and how HIV is transmitted. This block looks at different aspects of sexual information and knowledge and sexual behaviour, including when is the 'right' time to have sex; taking responsibility for our actions and the consequences of unprotected sex through understanding pregnancy, STIs and HIV and AIDS.

Learning outcomes

- Understand sex, sexuality, gender and sexual orientation.
- Understand timing and the 'right' time to have sex.
- Understand that only you can take action.
- Learn about the implications of sexual actions (unplanned pregnancy, STIs and HIV).
- Understand HIV-related stigma and discrimination.

Expected behavioural outcomes

- Use improved knowledge about sex, teenage pregnancy and HIV to make safer sexual choices, e.g. delayed sexual debut; consistent condom use; avoidance of concurrent partners; reduced intergenerational or transactional sex.
- Identify when is the 'right' or appropriate time to have sex.
- Use increased knowledge to prevent teenage and unplanned pregnancy as well as HIV infection.
- Be accepting/tolerant towards others.

SESSION 4

Healthy sexual behaviour and good attitudes about sex

Expected session outcomes

By the end of this session, participants should know what healthy sexuality is and they would have explored different attitudes towards sex and have increased sexual knowledge and information.

Information Sheet 4a: Sex and sexual health

Definition: Sex refers to the biological characteristics that define humans as female or male.

Definition: The term 'sex' is also often used to mean sexual activity.

Understanding 'sex' and 'sexuality'

- Sexuality is more than simply sex.
- Sexuality is about many things such as emotions, beliefs, relationships and self-image.
- All human beings are sexual and develop their sexuality from a number of influences. These include social, cultural, biological, economic and educational factors. Sexuality can be a sensitive issue, and there is often confusion about how best to address it.
- Remember, sex is a natural and biologically important act. Without sex, there would be no children and humans would die out. So, sex is important and something our bodies are driven to have. Sex is meant to be enjoyable so that people will have it. It is how we choose to have sex to keep ourselves safe, and to have children when we are ready for them, which is for us to decide.
- Notions of sexuality, sexual education, sexual health and rights have different meanings in different contexts. Therefore, sexuality must be understood in the broader context of culture, tradition, religion and morals.

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What is sexual health?

Definition: sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality.

Sexual health requires a positive and respectful approach to sex, sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences free of coercion (force), discrimination and violence (WHO, 2006).

According to the USAID Terminology Guidelines (2015), sexual health is 'not merely the absence of disease, dysfunction or infirmity – it is a state of physical, emotional, mental and social wellbeing in relation to sexuality. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.'

What is reproductive health?

Reproductive health is defined as the wellbeing of the reproductive system and its functions and processes. According to the USAID Terminology Guidelines (2015), reproductive health 'is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility that are not against the law, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.'

People have the freedom to decide if, when and how often to reproduce. Reproductive health requires men and women to be informed about and have access to safe, effective, affordable, and acceptable methods of family planning of their choice.

Information Sheet 4b: Teenage and unplanned pregnancies and contraception

Teenage and unplanned pregnancies are a significant problem in South Africa. According to 2013 statistics from the Department of Health, there were 89 000 legal abortions in 2013 and teenage pregnancy contributes to 8% of all pregnancies.

More than 99 000 schoolgirls in South Africa fell pregnant in 2013 – a rate of about 271 for every day of that year. This is a dramatic increase of nearly 20 000 girls from the 81 000 pupils who fell pregnant the previous year and 30 000 more girls from the 68 000 who fell pregnant in 2011.

The SA Council for Educators (SACE), the Department of Basic Education and Gauteng Education MEC Panyaza Lesufi have labelled the figure a 'crisis' and 'unheard of'. They have emphasised the need for drastic improvement in sexual education and access to contraceptives such as condoms.

Contraception is a pillar in reducing adolescent pregnancy rates.

- Contraception is available to help adolescents reduce risks of and negative health consequences related to unintended pregnancy.
- Over the past 10 years, a number of new contraceptive methods have become available to adolescents. Contraception methods include:

'Natural' methods: These methods do not make use of any contraceptive devices or medications.

- Abstinence: this means you don't have any sex at all.
- Natural rhythm method: this method means you abstain during ovulation. It is a very risky method of contraception because you can never be sure when a woman ovulates.
- Withdrawal method: this method involves pulling the penis out of the vagina before ejaculation. It is not a reliable contraceptive method as sperm can be released before ejaculation.

Barrier methods: Barrier contraceptive devices physically prevent the sperm reaching the egg in the uterus or fallopian tubes of the woman.

- Male and female condoms: condoms are freely available at a number of places. These include clinics, work places, universities, bars, clubs and shebeens.
- Diaphragm and cervical cap
- Spermicides ('sperm killers') in the form of foams, creams and gels.

Hormone methods: These methods work by stopping the ovaries from releasing an egg each month (and/or keeping the cervical mucus thick so that sperm cannot easily pass through it). They all contain synthetic hormones. Hormonal methods require visiting a doctor or clinic for a prescription, injection or placement of implants/rings.

- Oral contraceptives: the Pill, taken daily
- Hormonal injections: lasts 8–12 weeks
- Implants: placed under the skin of the arm
- Vaginal rings: placed into the vagina

Other methods:

- • IUD – (intra-uterine device): the 'loop' fitted inside a woman's uterus by a doctor.
- • Emergency contraception: the 'morning after pill' is emergency contraception to be used within 72 hours of unprotected sex to prevent pregnancy.

Counselling about abstinence and contraception

Counselling about abstinence and postponement of sexual intercourse is an important aspect of adolescent sexual healthcare. Abstinence is 100% effective in preventing pregnancy and STIs and is

an important part of contraceptive counselling. Adolescents should be encouraged to delay sexual onset until they are ready. However, existing data suggests that, over time, many adolescents planning on abstinence do not remain abstinent.

Adolescent sex and contraceptive experiences: Perspectives of teenagers and clinic nurses in the Northern Province, South Africa Published by: Health Systems Trust

- The researchers found that teenagers had been provided with virtually no useful information about menstruation or sexual matters by older relatives or teachers.
- Some discussed contraception with their friends, but others did not, perceiving sexual matters to be secret.
- First contraceptive use was commonly initiated by mothers, once daughters started to menstruate.
- Some adolescents decided to start contraception themselves because they perceived that sexual initiation was imminent and often because their peers used contraception.
- Others only began using contraception after they had their first baby, which was often conceived in response to pressure from their families, as well as boyfriends.
- Teenage pregnancy was largely socially sanctioned and regarded as infinitely preferable to the threat of contraceptive-induced infertility.
- Nuristerate was the preferred method for most teenagers and all the nurses as Depo was perceived sometimes to cause permanent infertility.
- Oral contraceptives were regarded as inconvenient and easily forgettable.
- Nurses were generally unfamiliar with emergency contraception.
- Condoms were rarely perceived to be a contraceptive and were often not offered to girls in clinics.

Facilitator note

In South Africa, many young men must pay inhlawulo/intlawulo yesisu (damages) to their girlfriend's family if she becomes pregnant.

- Some pay 'damages' but then won't pay maintenance as well.
- Some families deny the father access to his child until he has paid damages.
- However, the law in South Africa states the following:
  - It is a criminal offence to deny a parent reasonable access to his child.
  - He can apply to the High Court for a court order.
  - All parents must contribute financially to the care of their children.
- In South Africa, maintenance default stays on a parent's credit record for five years.
- For a variety of reasons, 48% of children in South Africa have absent but living fathers.

Information Sheet 4c: What is HIV and AIDS?

Definition: HIV (Human Immunodeficiency Virus) is the virus that causes AIDS (Acquired Immune Deficiency Syndrome).

HIV attacks the human body and makes it weak and open to infection. AIDS is a collection of different illnesses. These can include pneumonia, tuberculosis, cancer or many other complex illnesses. A person does not die from HIV itself, but from the different illnesses which are able to attack the body as a result of the effects of HIV.

How is HIV transmitted and how to stay HIV negative

People can get HIV through three ways: sexual intercourse, blood and mother-to-child transmission (MTCT). The most common way for HIV to be transmitted is through heterosexual sex (sex between males and females). For HIV to be transmitted, there has to be HIV present. You cannot acquire HIV from someone who doesn't have it. The difficult thing is to know if someone has HIV. You need to make safer choices.

Unsafe sexual behaviour

- If you have unprotected sex with someone who has HIV. This means sex without a condom or condomless sex
- Anal sex without condoms
- Unprotected sex when you have STIs
- 'Dry' sex (drying out the vagina)
- Unprotected sex with sex workers
- Multiple partners
- Concurrent partners (different partners at the same time)
- Sharing sex toys

Remember: You cannot get HIV from kissing, masturbation or mutual masturbation. There is a low risk of getting HIV from oral sex.

You can make choices to have safer sex: use condoms EVERY time you have sex; don't drink too much or take drugs as this lowers self-control; have only one sexual partner at a time; have a partner who is in the same age group as you – avoid Blessor relationships.

Blood

- Touching blood from someone who has HIV with open cuts on your hands
- Sharing razors
- From a blood transfusion with HIV-contaminated blood
- Sharing a needle with someone who has HIV when using drugs
- A needle-stick injury in the medical profession

Remember: You can take measures to protect yourself from acquiring HIV from blood:

- Do not touch anyone else's blood.
- Always wear gloves or wrap your hands in a plastic bag if it is an emergency and there are no gloves.
- Don't share razors and toothbrushes.
- Use tested blood in blood transfusions (there is very low risk with blood transfusions).
- Use new needles if you inject drugs.
- Use new razors for circumcision and ritual scarring.

Mother-to-child-transmission (MTCT). There are three ways a mother can transmit HIV to her child. However, South Africa has made great advances in reducing MTCT through providing ARVs to pregnant women and breastfeeding mothers and there is a real possibility of no children acquiring HIV from their mothers anymore if the mothers are on ARVs.

- A mother can transmit HIV to her baby while she is pregnant as the mother's blood mixes with the baby's blood. *It is very important to have an HIV test as soon as you find out you are pregnant and to go for antenatal testing so you can get ARVs to take while you are pregnant to protect your child*.
- During childbirth, there is a lot of blood and a mother needs to be on ARVs during labour to reduce the chances of transmitting HIV to her baby during the birth.
- An HIV-positive mother can pass the virus on to her baby from breastfeeding as HIV is found in breast milk. However, according to the World Health Organization, breastfeeding is best for babies. If the mother is HIV positive, she can safely breastfeed her baby if she is on ARVs. It is not safe to breastfeed your baby if you are HIV positive and are not taking ARVs. If you are not taking ARVs, you can breast feed your baby for six months but this must be exclusive breast feeding with no mixed feeding.

Are there any medicines that can help an HIV-positive person? Yes.

Antiretroviral therapy (ART) stops the virus from multiplying in the body, and allows the person's immune cells to live longer. ART can't cure HIV. Once a person is HIV positive, he or she is HIV positive for life, but he or she can still live a long, productive life on ART.

If you are on ART, you are taking ARVs. ARVs are antiretroviral medicines that you take when you are on antiretroviral therapy (ART). ARVs are the medicines themselves and should not be confused with ART which relates to therapy of taking ARVs. Some people don't like taking ARVs or being on ART because they experience side effects from the medicine.

Often teenage pregnancies are unplanned and unwanted. There are a number of problems that are related to teenage pregnancy or pregnancy at an early age:

- Lower birth weights for the babies of young mothers
- Mental anguish and trauma
- Social exclusion
- Discontinued education
- Society and her family may look down on her
- Parents may try to force her to marry the father of the expected child, or someone else, to avoid shame and ridicule
- Unprepared parenthood
- Lack of a job or finances

Sometimes young girls are frightened of the consequences and attempt unsafe abortions. This can damage their uterus, resulting in problems with future pregnancies. It is important for young women to seek professional help in these cases.

The best way of avoiding teenage pregnancy is to either abstain from sexual intercourse or practice safer sex. If two people do decide to have sex, they should discuss the means of birth control and protection. They might use a condom or female condom, the pill or injectables.

Remember: only condoms prevent STIs, HIV and pregnancy. The pill and injectables do not protect you from HIV and STIs. Usually men and women choose different kinds of contraceptives for different reasons.

Gender and HIV and AIDS

- There are three times more women than men of the global population living with HIV and AIDS.
- Many women experience sexual and economic subordination and inequality in their marriages or relationships and are therefore unable to negotiate safer sex or refuse unsafe sex.
- The power imbalance in the work place exposes women to the threat of sexual harassment.
- Women's access to prevention messages and services is hampered by illiteracy and cultural/religious taboos.
- Studies show the heightened vulnerability of women, compared to men, as part of the social stigma and ostracism associated with AIDS, thus leaving them marginalised and neglected.
- It is therefore important for young people to recognise that issues of gender can make addressing HIV more complex.

It is important to remind young people that engaging in sex increases their exposure to HIV transmission, engaging in risky sexual behaviour further increases their risk of infection.

A programme for the reduction of HIV and Teenage Pregnancy

Information Sheet 4d: HIV and HCT

What to do if you become HIV positive

Whether a person feels sick or not, the first step after you have been diagnosed with HIV is to see a healthcare provider to assess the progress of the virus and to determine whether one needs to start taking antiretroviral treatment immediately (AIDS Info, 2015).

According to press releases in May 2016, from 1 September 2016, any person in South Africa who tests positive for HIV should be entitled to government provided ARVs. This programme is referred to as 'Test and Treat'.

Daily News

No.1 TODAY EDITION Rands

South Africa takes bold step to provide HIV treatment for all

Antiretroviral therapy to be offered to all people living with HIV as soon as possible after HIV-positive diagnosis

GENEVA, 13 May 2016 – The Government of South Africa has announced a major policy shift that will move the world faster towards the global 90–90–90 treatment target. On 10 May 2016, the South African Minister of Health, Aaron Motsoaledi, announced in his Health Budget Vote Speech to the Parliament of South Africa that the country will implement a new evidence-based policy of offering HIV treatment to all people living with HIV by September 2016. This ground-breaking announcement brings South Africa, which already has the world's largest HIV treatment programme, in line with the latest World Health Organization guidelines on HIV treatment. South Africa is among the first countries in Africa to formally adopt this policy.

[illegible]frica already encourages everyone who is H[illegible] negative or who does not know their HIV sta[illegible]s to be tested for HIV at least once a year. However, instead of having to undergo an additional test of the immune system (the CD4 cell count) to determine eligibility for treatment, people who are diagnosed HIV positive will be offered HIV treatment as soon as possible after diagnosis …

… South Africa is also considering whether to expand the offer of PrEP to prevent HIV in vulnerable young women, based on the lessons learned from demonstration projects.

These combined efforts demonstrate the South African Government's commitment to maximising the benefits of antiretroviral medicines for both the prevention and treatment of HIV. This approach has proved to be highly effective in reducing new HIV infections and AIDS-related deaths in high-prevalence settings, such as South Africa.'

If an individual is HIV positive, he/she should:

- go for post-counselling, or join support groups in their community for ongoing emotional support (UNAIDS, 2000);
- adopt a healthy and active life, always use a condom correctly and consistently to avoid getting re-infected and spreading the virus to other people (AIDS Foundation of South Africa, 2014); and
- take ARVs as prescribed to keep healthy and prevent the onset of AIDS.

Why is it important to get tested if you are sexually active?

It is important for sexually active people to go for regular HIV tests because reports show that HIV is transmitted mainly through sexual intercourse. Therefore, people should get tested if they are having unprotected sex before starting a new relationship, if the condom broke or if they haven't been using a condom consistently. **Remember:** regular testing does not keep you HIV negative, it only tells you when you have HIV so you can take care not to infect anyone else and start treatment.

Testing for HIV is the only way to know if you have HIV or not, and regular tests ensure that a person is always up to date with their HIV status (Avert, 2015).

Most importantly, if detected at an early stage, one can learn more about the virus, how it affects the body and what measures need to be taken in order to remain healthy for a long time. This can also help in monitoring the disease and determining when one needs to start taking antiretroviral treatment.

Knowing your HIV status also helps a person not get re-infected and/or transmit HIV to another person or to acquire other STIs, which can weaken the immune system by continuous engagement in risky sexual behaviours.

If a person is HIV negative, they can be motivated to continue or adopt a positive lifestyle that ensures that they stay HIV negative. Men can go for a voluntary medical male circumcision (MMC) which reduces chance of acquiring HIV by 60%.

Facilitator note

Everyone who engages in unprotected (or condomless) sex is at risk of acquiring HIV or transmitting HIV, whether they have one or multiple sexual partners.

How do you get tested?

Government health facilities offer free HIV testing. To get tested, visit your local doctor, community-based organisation, clinics, AIDS services organisations, etc. (AIDS.gov. 2014). This helps the person who wants an HIV test to cope with stress and to be able to make informed decisions regarding HIV and AIDS (UNAIDS, 2000).

A programme for the reduction of HIV and Teenage Pregnancy

Young people can ago through a process called Voluntary Counselling and Testing (VCT), which includes voluntary pre- and post-test counselling and voluntary HIV testing. This process is now called HCT – HIV Counselling and Testing. According to the National HIV Counselling and Testing Policy Guidelines this South African-government-based campaign encourages people to access health and wellness units or to contact their nearest public health facilities for free HIV counselling and testing. (May 2015):

'The National HCT Programme will provide an integrated service at all levels of the public health service delivery system. It encourages and supports formal collaboration among public, private and non-governmental sectors. The programme seeks to ensure that people who test HIV negative are encouraged and motivated to maintain their negative status, and those who test positive are supported in living long healthy lives through positive health-seeking behaviour and the provision of appropriate service'

Core principles of HIV counselling and testing in South Africa

The HCT campaign provides opportunities for individuals to:

- be counselled, and informed on the nature of HIV and AIDS, STIs and TB;
- be encouraged to adopt a healthy lifestyle to prevent development of other non-communicable diseases;
- get tested for HIV and screened for TB and other non-communicable diseases;
- know that TB can be cured even if you are HIV-positive;
- get treated for HIV and AIDS and TB before your immune system is too weak;
- prevent AIDS and TB related deaths; and
- prevent HIV transmission and new TB infections.

For further information on HCT, there is National HIV Counselling and Testing (HCT) Policy Guidelines 2015 available at health-e.org.za/2015/07/09/guidelines-national-hiv-counselling-and-testing-hct-policy-guidelines-2015/. The guidelines cover the provision of HCT in different settings, to different populations, as well as strengthening couples and children's HCT.

HCT target groups: Men, couples, children, adolescents, prisoners, migrant workers and closed communities unlikely to seek HCT on their own.

Age of consent: Any person above 12 years of age with sufficient maturity and mental capacity to understand the benefits, risks, social and other implications of HIV testing may give consent for HIV counselling and testing (HCT) services in South Africa. (See Information Sheet 5 for addition content)

Health facility-based HCT approaches

Provider-Initiated Counselling and Testing (PICT)

PICT refers to HIV counselling and testing which is routinely offered by healthcare providers to persons attending healthcare facilities as a standard component of medical care.

Provider-initiated HIV counselling and testing (PICT) should be offered to all persons attending clinical services in both public and private sector. Healthcare providers should recommend HCT to all patients in a health facility, regardless of whether they show signs or symptoms of HIV infection. This allows the healthcare provider to make specific medical decisions that would not be possible without knowledge of the patient's HIV status. Additionally, PICT contributes to increased rates of HIV testing and early identification of HIV-infected persons who may not otherwise know their HIV status.

Client initiated Counselling and Testing (CICT)

Client initiated counselling and testing also referred to as VCT are HCT services provided within health facilities for clients who present specifically for HCT services. Client(s) may voluntarily make the decision to learn their HIV status as an individual, couple or family.

Community-based HCT approaches

The focus of HCT in these settings is for properly trained healthcare providers to reach out to communities outside of the health facility to increase access to HCT and normalise HCT services. Examples of community-based settings include:

Stand-alone HCT

Stand-alone HCT sites are located within the community with the primary function of providing HCT services to individuals, couples or families within the community. These are not attached to a health facility.

Home-based HCT (including door-to-door and index case testing)

Home-based HIV counselling and testing (HBHCT) is testing offered in the homes by a trained healthcare worker. It is provided in two ways – either systematic door-to-door HCT services or services to households with a known index HIV positive or TB patient, with consent obtained from the index patient prior to a home visit.

Mobile/outreach services

Mobile or outreach HCT services are provided through vans or tents in the community to increase access to hard-to-reach populations such as rural communities, men, mobile populations or key populations.

Workplace and education institution HCT services

HCT services may also be offered in school, higher education and workplace (public and private) settings.

- School-based testing increases access to HCT for sexually active youth who are at least 12 years old. School-based settings may also be targeted as part of a national HCT campaign.

Self-testing

HIV self-testing is when a person conducts an HIV test on him or herself. HIV self-testing is currently not recommended and supported in South Africa. Further research is still required to support the implementation of self-testing. However, it appears that self-testing will be addressed in the new National Strategic Plan (2017–2022) and will become available throughout South Africa.

Information Sheet 4e: HIV-related stigma and discrimination

Stigma and discrimination are among the foremost barriers to HIV prevention, treatment, care, and support. This calls for remedial interventions to achieve higher levels of prevention, treatment, care and support. HIV-related stigma refers to the negative beliefs, feelings and attitudes towards people living with HIV, groups associated with people living with HIV (e.g. the families of people living with HIV) and other key populations at higher risk of HIV infection, such as people who inject drugs, sex workers, homosexual individuals and transgender people.

HIV-related discrimination refers to the unfair and unjust treatment (act of omission) of an individual based on his or her real or perceived HIV status. Discrimination in the context of HIV also includes the unfair treatment of other key populations, such as some social contexts, women, sex workers, people who inject drugs, homosexual individuals, transgender people, people in prison and other closed settings. HIV-related discrimination is usually based on stigmatising attitudes and beliefs about populations, behaviours, sex, illness and death.

Stigma can be disguised in two ways, enacted stigma and felt stigma. Felt stigma is more prevalent than enacted stigma. Felt stigmas are the feelings that individuals have about their condition and the likely reactions of others. Enacted stigma refers to the actual experiences of stigmatisation and discrimination. Stigma can be experienced and felt at different levels, these include societal and community levels and at the individual level.

Societally, laws, rules, policies and procedures may result in the stigmatisation of people living with HIV. These include laws such as:

- the compulsory screening and testing of groups and individuals;
- the prohibition of people living with HIV from certain occupations and types of employment;
- the medical examination, isolation, detention, and compulsory treatment of infected persons; or
- limitations on international travel.

These measures serve only to increase and reinforce the stigmatisation of people living with HIV and those at greater risk of contracting the virus.

People's experiences of HIV-related stigmatisation and discrimination can be caused by commonly held believes which are forms of societal stigmatisation. These may hinder the individual's ability to access supportive networks of peers, family and kin. Overall the negative depiction of people living with HIV, reinforced by the language and metaphors used to talk and think about the disease, has reinforced fear to disclose status.

The stigmatisation and discrimination of people living with HIV can be reduced by various interventions which can be classified as information-based intervention, skills-building intervention, counselling interventions, contacting stigmatised groups, structural interventions and biomedical interventions. These interventions can be used jointly to intervene ***to reduce stigma and discrimination***.

- An *information-based approach* to stigma reduction consists of the provision of fact-based information, which can be conveyed through written or verbal communication.
- *Skills-based interventions* teach people in the general population and people living with HIV coping skills for resolving conflicts such as being excluded or coming into contact with people living with HIV.
- *Counselling interventions* provide information about HIV, discussions on concerns and providing support for behaviour change.
- The contact with stigmatised groups intervention consists of interactions that are direct, for example speaking to a group of persons.

BUILDING BLOCK THREE: My rights and my responsibilities

This session builds on the preceding blocks and explores the importance of understanding your rights, responsibilities and your needs as a young person. We all have rights. Some of the rights we have included:

- the right to education;
- the right to social welfare;
- the right to participate;
- the right to say NO;
- the right to sexual and reproductive choices.

This building block will focus on sexual and reproductive rights and will help participants to understand what their roles and responsibilities in relationships are.

Learning outcomes

By the end of the sessions, participants should have:

- a basic understanding of the provisions of the South African Constitution and law concerning their sexual and reproductive rights; and
- about a better understanding of sexual assault and how to address a violation of sexual and reproductive rights.

Specific session outcomes

- Increased knowledge about sexual and reproductive rights;
- Ability to identify sexual violations and the responsibility to respect human rights of others;
- Identify what a 'need' is and a 'want' is.

A programme for the reduction of HIV and Teenage Pregnancy

SESSION 5

My sexual and reproductive rights and responsibilities

Expected session outcomes

By the end of this session, participants should know about their sexual rights, sexual responsibilities and developmental needs.

Information Sheet 5: Human Rights

Definition: A human right is a right that is believed to belong justifiably to every person.

Definition: Sexual rights are the application of existing human rights to sexuality and sexual health.

Sexual rights protect all people's rights to fulfill and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination (WHO, 2006, updated 2010).

Our Constitution and the Bill of Rights

The Bill of Rights sets out the fundamental rights of all South Africans.

According to the Bill of Rights, everyone is equal before the law and has the right to equal protection and benefit of the law. Furthermore, nobody may discriminate against you on the grounds of race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth. You have the right to dignity and to have your dignity respected and protected.

Reproductive and sexual rights are linked to human rights

Reproductive (and sexual) rights are linked to human rights, such as the rights to equality, non-discrimination, dignity and privacy. Therefore, every South African has reproductive and sexual rights under the Constitution. According to the USAID Terminology Guidelines (2015), sexual rights embrace 'human rights that already are recognised in many national laws, international human rights documents and other consensus statements: the right of all persons to the highest attainable standard of sexual health, free of coercion, discrimination and violence. This includes the following: accessing sexual and reproductive healthcare services; seeking, receiving and imparting information related to sexuality; obtaining sexuality education; enjoying respect for bodily integrity; choosing a partner; deciding to be sexually active or not; participating in consensual sexual relations; engaging in consensual marriage; determining whether or not (and when) to have children; and pursuing a satisfying, safe and pleasurable sexual life'

Sexual rights in South Africa

- You may decide for yourself how many children you want to have, and whether you want to be a parent at all;
- When you are old enough, you may decide for yourself whether you want to have sex or not, and you can insist on using contraceptives to prevent having a baby and condoms to protect yourself from falling pregnant, getting HIV, or other sexually transmitted infections. The age of consent in South Africa is **16**, as specified by sections **15** and **16** of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 and Amendment Bill 2015. It states that children between the ages of 12 and 15 can consent to sexual acts with each other.
- You may decide for yourself if you want to get married or not.
- You may marry someone with any gender or sexual orientation (and you may choose to use the wording 'marriage' or 'civil partnership' to describe your union).
- You may adopt a child if you are an adult, regardless of your sexual orientation.
- You may have your sex status altered in the population registry (you'll be issued a new identity document) if you have received hormone replacement therapy (you need not have undergone sex reassignment surgery).
- Under Customary Law, you may marry more than one person (in this case, traditional practices such as paying lobola, bogadi, bohali, xuma, lumalo, thaka, ikhazi, magadi or emabheka will form part of the negotiations).

What is a sexual act?

In South Africa, a sexual act is considered any act that can cause sexual stimulation, such as kissing to the point of arousal or touching a person's genitals.

What is consensual sex?

Consensual sex occurs when both parties agree to have sex and conform to all the legal requirements. The status of the relationship – whether the people are married, boyfriend and girlfriend, or whether they are friendly with one another – does not make the act consensual. Non-consensual sex is rape no matter who it happens between. In other words, sex between married people that is non-consensual is rape. Both parties must give explicit permission before every sexual act whether it is kissing to the point of arousal or touching a person's genitals. Sex with a child younger than 16 is considered statutory rape, a criminal offense – regardless of consent.

Responsibilities: On the other side of these rights are responsibilities related to sex and sexuality.

Responsibilities mean we have to show respect to others and not violate their rights.

Sexual violation

In South Africa, (according to the Sexual Offenses Act), you may NOT:

- discriminate against a person who has a different sexual orientation to you (for example, someone who is heterosexual, homosexual, and bisexual, asexual, pansexual or polysexual) or a transgender person;
- have sex with a child younger than 16 if you are an adult (over 18) (statutory rape);
- watch pornography if you are younger than 18;
- have sex with a family member (called incest);
- share photos or films of someone's sexual parts or them performing a sexual act without their permission ever;
- share photos or films of someone's sexual parts or them performing a sexual act if they are under the age of 18 even if you have their permission – this is regarded as owning and distributing child pornography; or
- show your sexual parts to someone without their consent.

The Act also states that a child under the age of 12 is too young to give permission to any sexual act. Therefore a sexual act with a child under the age of 12 is automatically a crime. However, changes to the Criminal Law (Sexual Offences and Related Matters) Amendment Bill were adopted by the National Assembly in 2015. It states that children between the ages of 12 and 15 can consent to sexual acts with each other.

Who can help if your human rights are violated?

If your human rights have been violated, you can ask the SA Human Rights Commission to help you by emailing them at sahrcinfo@sahrc.org.za or phoning them on 011 484 8300.

The Aids Legal Network also helps people whose human rights have been violated. Their legal aid desk can be contacted at: Tel: +27 21 447 8435 / lad@aln.org.za. If you have been unfairly treated because of your gender, the Commission for Gender Equality can help: cgeinfo@cge.org.za / Tel: +27 11 403 7182.

Stigma

Although the Constitution allows South Africans the freedom of choice regarding their sexual orientation, a survey in 2013 showed that 61% of South Africans think that society should not accept homosexuality (in 2008, the percentage was 84 %). There is a high level of stigma against homosexual individuals and transgender people in South Africa (see **Information Sheet: 4e** for additional content).

Why are human values important?

Because we are part of a community, we must not only focus on our rights, but also on those values that our communities hold as being important. The way we treat other people reflects on us and affects our lives. Ubuntu is the belief that we are all connected, so, when we exercise our rights, we keep in mind the context of community and the basic human values of Ubuntu. For example, greeting our elders when we meet them, respecting the environment and the law of the country and other people's property, as well as behaving with dignity in public (e.g. like not urinating in public).

What is the Children's Act?

The Children's Act serves to enforce principles relating to care and protection of children's rights as contained on the Constitution. The Children's Act 38 of 2005 states that children 12 years and older have rights relating to reproductive health, this including access to contraceptives and information on sexuality and reproduction, and the right of consent to HIV and AIDS testing and treatment. Children under the age of 12 years old can also give consent to the above, provided they are of sufficient maturity to understand the benefits, risks and social implications of the test. It further states that children, 12 years and above, may not be refused access to condoms, either through sale or where condoms are distributed free of charge. They are also entitled to confidentiality regarding this matter (Juliana Han and Michael Bennish, 2009 Children's Act of 2005).

What is the Domestic Violence Act?

Gender-based violence, also known as intimate partner violence (Jen Thorpe, 2014), is addressed under the Domestic Violence Act. This Act 116 of 1998 seeks to strengthen protection for domestic violence victims who are normally women and children. The Act considers domestic violence to include physical abuse, sexual abuse, economic, emotional, verbal and psychological abuse, stalking, entry to a complainant's residence without their consent, or any other controlling or abusive behaviour towards a complainant. The Act aims to provide victims with legal protection against domestic violence and to ensure that the provisions of this Act are enforced by various bodies of the state (Domestic Violence Act 116 of 2008).

SESSION 6

Goals in sexual and reproductive health

This session is about goal setting, but with a particular focus on sexual and reproductive health. Remind participants that goal setting is a choice and everyone must choose to make a decision about their sexual choices and reproductive health. This session will help participants to think about their goals in life and how they relate to reproductive choices. Remember, however, that sometimes choice is restricted by the situations people find themselves in.

Expected session outcomes

By the end of this session, participants will have an increased self-awareness, and be able to identify their goals, strengths and weaknesses.

Information Sheet 6: Goal-setting

Definition: A goal is the object of a person's ambition or effort; an aim or desired result.

- Human situations are dynamic and they can change. Human beings can change too.
- Knowing our goals helps us to move forward positively and to make 'good' choices.
- It is difficult to define a 'good' choice and a 'bad' choice as many people aren't always able to make the choice they want. As a facilitator, be careful of using words like 'good' and 'bad' as these imply judgement and that something is either wrong or right. Rather use words like 'effective' or 'ineffective'; 'informed' or 'uninformed' and 'empowered' or 'disempowered'. Remember, sometimes people have chosen the only option they have or what they see as the 'best' choice in the situation they find themselves in.
- 'Good' and informed choices usually have good and healthy consequences; 'bad' and uninformed choices usually have bad and unhealthy consequences in the long run. We can influence the path our lives take by making effective choices.
- Once we know what our goals are and have become convinced that good choices will help us achieve those goals, we can also consider the elements of our character/personality that aid or hinder our progress.
- Each person has a unique set of strengths and weaknesses. Building on our strengths helps us to achieve our goals. Learning about our strengths and weaknesses is a life-long task.
- Remember some participants may already be teenage parents or have STIs or HIV. Use appropriate language to avoid making them feel guilty or left out.

Remind participants that even if they have made ineffective choices (don't judge people's decisions by calling them 'bad' decisions) that have negative or ineffective consequences, they can still set other goals and work towards it (for example, if a young woman has an early unplanned pregnancy, she can still decide to complete her education, or she can set a goal for a better lifestyle for her child).

BUILDING BLOCK FOUR: Taking chances and dealing with consequences

The previous building block explored the rights we have as young people and also demonstrated the importance of identifying when our rights are violated. Building Block Four helps participants identify that while they have skills and resources, some decisions can lead to negative consequences. Sexual behaviour in Building Block Two is further expanded in these sessions to help participants understand their risk and risky behaviour. The block also deals with PrEP and PEP, the importance of making healthy choices, the consequences of teenage pregnancy and how to deal with emotional stress and challenges that may arise from teenage and unplanned pregnancies as well as HIV infection.

Learning outcomes

- Understand risky behaviour.
- Identify the consequences of negative sexual behaviour.
- Awareness of how to deal with consequences of behaviour.
- Learn how to handle emotional stress and challenges.

Expected behavioural outcomes

- Identify the effects and consequences of sexual behaviour practices.
- Practice safer sex.
- Make healthy lifestyle choices.
- Deal with adverse situations and challenges.
- Access PrEP and PEP.
- Negotiate condom use.

SESSION 7

Risky behaviour

Expected session outcomes

By the end of this session, participants should have a clear perception of the behaviours that place them at high risk of unplanned and teenage pregnancy and contracting HIV

Information Sheet 7a: Risky behaviour

Definition: Risky behaviours are actions that potentially expose young people to harm, or significant risk of harm, which will prevent them reaching their potential.

While some risky behaviour is normal and part of growing up, not all risky behaviour is good or safe. Risky sexual behaviour in particular can have life-threatening consequences for young people. Remember: be careful of judging sexual behaviour as 'good' or 'bad'. Some sexual behaviour is more risky than other sexual behaviour and can be seen as 'bad', but sometimes, choosing and having safer sex is not easy.

Research shows that people increase their risk of acquiring HIV when one or more of the following are true for them:[14]

- **Having sex for the first time at a young age:** Starting to have sex at a younger age increases the risk of HIV transmission. People who start having sex at a young age expose themselves to a longer period of time for potential infection than those who choose to have sex later in life. Also, statistically, these people are more likely to have many, and multiple, sexual partners and are less likely to use a condom the first time they have sex.
- **Teenage pregnancy** is a major challenge in South Africa. Statistics South Africa (StatsSA) shows that 1% of female learners (89 390 girls) attending school fell pregnant in 2009/10. One in five teenagers attending antenatal clinics (and therefore presumably pregnant) are HIV-positive (SANAC, 2011). Pregnancy increases the chance of HIV transmission and the incidence of HIV among pregnant women in South Africa is noted to be high (Mugo et al., 2011; Rehle et al., 2007; Moodley et al., 2009).
- **Intergenerational sexual relationships:** Large age-gaps between sexual partners contribute to a greater chance of HIV transmission. This is because the younger partner is exposed to older age groups who statistically have higher HIV prevalence (Katz and Low-Beer, 2008; SADC, 2006). Younger women who have sexual relationships with older men have more chance of contracting HIV – particularly when the age difference is ten years or more (Kelly et al., 2003).

- **Transactional sex:** Transactional sex is sex that has financial benefits for one of the partners, usually the younger partner. This is commonly called a relationship with a 'Blessor' and 'Blessee.' Relationships with older men may be seen to provide social, physical and psychological benefits for younger women (Leclerc-Madlala, 2008). Economic benefits of such relationships include receiving cash, food, cosmetics, clothing, transportation or schooling. Young women who manage to avoid such intergenerational relationships generally have a stronger sense of self-worth, are accepting of their economic circumstances and desire to maintain a sense of decision-making power (Nkosana and Rosenthal, 2007).
- **Intimate partner violence (IPV):** Intimate partner violence includes sexual violence and psychological abuse by intimate partners. Research shows a strong association between intimate partner violence (IPV) and HIV transmission for women (Jewkes et al, 2010; 2006; Dunkle et al, 2004). It has also been estimated that HIV transmission could have been prevented in almost one in seven young women if she had not been subjected to intimate partner violence (Jewkes et al., 2010).
- **Sexual violence:** Childhood sexual abuse is noted to increase the chances of HIV transmission (Dunkle et al, 2004). Recent studies report that experiences of forms of sexual violence, such as coerced sex and rape, are high in South Africa (Jewkes et al 2006; Pettiford et al, 2005; Jewkes and Abrahams 2002).
- **Alcohol and substance abuse:** Alcohol consumption is associated with risky sexual behaviour, which contributes to HIV transmission risk (SANAC, 2011b). In many countries, injecting-drug use poses risks for HIV transmission, but this is not a widespread practice in South Africa. However, abuse of drugs, including marijuana (known as weed, grass or ganja) and methamphetamine (known as 'tik') is more common in South Africa. The use of these drugs makes the user more likely to behave without thinking clearly, and therefore HIV risk is increased (Parry and Pithey, 2006).

Information Sheet 7b: PrEP and PEP: Pre-exposure prophylaxis and post-exposure prophylaxis

PrEP

Research in pre-exposure prophylaxis (PrEP) studies is currently showing some hope for biomedical HIV-prevention options that can empower men and women to protect themselves against HIV. According to the USAID Terminology Guidelines (2015), 'pre-exposure prophylaxis (PrEP) refers to antiretroviral medicines prescribed before exposure (or possible exposure) to HIV. Several studies have demonstrated that a daily oral dose of appropriate antiretroviral medicines is effective in both men and women for reducing the risk of acquiring HIV infection through sexual or injection transmission.'

In South Africa, the Medicines Control Council (MCC) has officially registered the use of a combination of two antiretroviral drugs as a form of pre-exposure prophylaxis (PrEP) medication. People who are HIV negative can take a pill every day to significantly reduce HIV transmission.

According to Prof. James McIntyre, CEO of Anova, 'This is a major advance in HIV prevention in South Africa, with the potential to save many lives. The evidence is clear; PrEP works if you take it. Not everyone will need or want PrEP, or require it forever, but it can provide almost complete protection against infection if taken consistently. Our challenge is to educate users and move rapidly to ensure access for those who need it.'

Dr Kevin Rebe, Specialist Medical Consultant at Anova's Health4Men said that the use of PrEP is a 'major step forward in the fight against HIV. It is extremely effective and safe to use. It can reduce the risk of HIV by more than 90% in HIV-negative people who use it correctly … Our challenge now is to create demand for PrEP and to work towards removing barriers to access.'

Five (5) things you need to know about PrEP

What is PrEP?

'PrEP provides an additional prevention option for those who are at high risk for HIV,' explains Dr Saiqa Mullick, director of implementation science at the Wits Reproductive Health and HIV Institute.

'It's an ARV drug in the form of a tablet and it's for HIV-negative people. It needs to be taken daily to significantly reduce the chances of getting HIV,' she tells Health-e News. 'It works if people are taking it every day but they don't need to take PrEP for the rest of their lives – only during the period of their life when they are at a significant risk for HIV'.

It's important to note that the ARVs used in Truvada also form part of standard HIV treatment when combined with a third ARV. Truvada is a type of medicine used to treat HIV-1 infection in adults and teenagers. People who use PrEP will have to regularly test for HIV to ensure that they are switched onto a three-drug regimen should they contract HIV to avoid developing drug resistance.

What's the evidence that PrEP works?

According to the South African National AIDS Council, 12 clinical trials have tested the effectiveness of oral tablets for PrEP in Africa, Asia, Europe, South America and the United States. Daily PrEP has been shown to lower a person's risk of sexually contracting HIV by more than 90 percent.

Is it safe?

The efficacy and safety of Truvada as PrEP has been tested in 10 randomised clinical trials, according to the Southern African HIV Clinicians Society. PrEP can cause initial side effects like nausea in some people, according to the US Centres for Disease Control, but side effects are rare.

'There's a lot of myths that the drug is toxic and that there are side effects,' said Dr Kevin Rebe, specialist medical consultant for the Anova Health Institute. Rebe runs a small programme offering PrEP homosexual individuals in Cape Town. 'Side effects are only present in one in 10 patients.'

Some patients have experienced moderate declines in kidney function associated with higher doses and older age, according to two major studies presented at the recent Conference on Retroviruses and Opportunistic Infection. According to researchers, the findings indicate that while PrEP is generally safe, clinicians may ask to monitor a patient's kidney function to catch any problems early.

The Southern African HIV Clinicians Society currently recommends that PrEP only be given to people with normal kidney function. 'PrEP isn't for everyone but it might be for quite a lot of us,' Rebe said.

Is it only available for sex workers?

South African drug regulatory body the Medicines Control Council (MCC) approved Truvada for use as PrEP in December. According to Rebe, the MCC's approval means that anyone is free to ask their doctor if PrEP is right for them.

'In reality, PrEP has been available for years,' said Rebe, stressing that HIV-negative people at high risk of contracting HIV who are interested in PrEP must be tested for HIV and kidney function first.' Any general practitioner (GP) who is savvy really could just write a script for this.'

Medical aid Fedhealth has said it will cover at least six months of PrEP for medical scheme members who are at a high risk of HIV as well those who are in relationships with HIV-positive partners.

To qualify for this benefit, doctors must register members on Fedhealth's Aid for AIDS PrEP Programme, according to a statement issued by the company.

How much does it cost?

A monthly course of PrEP ranges from about R200 to R550.

Post-exposure prophylaxis (PEP)

Another HIV-transmission prevention option is post-exposure prophylaxis. Post-exposure prophylaxis 'refers to antiretroviral medicines that are taken after exposure (or possible exposure) to HIV' (USAID Terminology Guidelines, 2015). The exposure to HIV may happen during work (e.g. a needle stick injury for doctors and nurses) or after sex without a condom or after rape.

What is PEP?

Post-exposure prophylaxis is a short-term anti-retroviral (ARV) treatment that reduces the likelihood of HIV infection after exposure to HIV-infected blood or sexual contact with an HIV-positive person. PEP consists of a combination of ARV medications that are taken for a period of four weeks. Some healthcare workers suggest beginning PEP 24–36 hours after possible exposure to HIV through rape or unprotected sex. South African policy advises that PEP should be administered within 72 hours after the potential exposure to HIV.

Who is PEP for?

PEP is available to any person following either:

- intentional exposure to HIV (e.g. unprotected sex, sharing injecting equipment, etc.);
- accidental exposure to HIV (e.g. condom failure); or
- forced exposure to HIV (e.g. sexual abuse, sexual assault or rape).

Under which circumstances can PEP be considered?

PEP may be considered where there is potential risk that HIV-infected bodily fluids (i.e. blood, semen or vaginal fluids) have entered the bloodstream through direct contact, including any of the following:

- Anal or vaginal sex without a condom
- Anal or vaginal sex where the condom slipped off or broke
- Sharing injecting equipment

You can't be given PEP treatment if you are already HIV positive. You won't be given PEP treatment if you refuse to take an HIV test. Tests that are positive immediately after exposure mean that you were already infected with HIV before the exposure and you will be referred for counselling about living with HIV and to a clinic to monitor your health.

What the laws regarding PEP?

The government is required to provide PEP free of charge without a case number.

- Rape victims do not have to report the rape to police to get PEP.
- Healthcare workers do not have to report rape to the police if the victim is over 16 years of age.
- By law, a rape victim may ask the police to test a rape suspect for HIV if he is arrested.
- A court will order a rape suspect to go for an HIV test.
- A rape suspect can only be tested up to 90 days after the rape occurred.
- If a rape suspect tests HIV negative, you should still complete the PEP treatment and go for follow-up HIV tests as the doctor suggests.
- If a rape suspect tests HIV positive, it is very important to take PEP medicines properly, and to take more HIV tests to be sure that you have not contracted HIV.
- Even if you feel very angry, you are not allowed to tell others that a rape suspect has HIV, whether by writing to a newspaper or publishing on social networks like Facebook or Twitter.

SESSION 8

Playing it safe and making changes for a healthier lifestyle

Expected session outcomes

By the end of the session, participants should understand the consequences to HIV infections, teenage and unplanned pregnancy and the importance of making healthy lifestyle choices. They will also have information about the transmission and prevention of HIV, teenage and unplanned pregnancies including condom use, contraception and prevention strategies.

Information Sheet 8a: Being responsible

Definition: Being responsible means that others can depend on us and we are accountable for our actions. We keep to our agreements and give our best to any activity, relationship and job.

Definition: Taking responsibility means accepting our role in whether things go well or badly. It means taking control of a situation rather than letting things just happen to us.

- Responsibilities are linked to rights. If we have the right to decide on whether to have sex or not, we also have the responsibility to make sure that if we do decide to have sex, we have safer sex; we do it with the full agreement of the other person and do not harm ourselves or anyone else.
- When things go wrong, we are responsible if we acknowledge our mistakes and make amends (apologise or try to fix things) instead of making excuses and blaming.
- We should not take responsibility for things that are not our fault. For example, when children are abused, they often blame themselves, but it is never their responsibility.
- We can encourage each other to act responsibly and also ask adults to take up their responsibilities for protecting and supporting young people.

- Men often expect women to take responsibility for preventing pregnancy, STIs, including HIV and AIDS infection, even though men tend to make the decisions about sex and whether they are going to wear condoms.
- Young men and women need to share responsibility for their behaviour and what happens in relationships.

How to stay HIV negative

Although abstinence from sexual intercourse is a way to stay HIV negative, this is not an effective long term option as just about everyone eventually has sex some time in their lives. It is a better option to become informed about safer sex practices, to be empowered to make informed decisions and to reduce risky sexual behaviour. In the case where one is sexually active, consistent and proper condom usage is the most effective form of preventing HIV transmission during sexual intercourse (see Information Sheet 4c).

Other ways to reduce the chances of HIV transmission are to be faithful to your partner, get tested regularly and limit the number of sexual partners that you have. Men can undergo voluntary medical male circumcision (VMMC) to reduce their chances of contracting HIV during sexual intercourse (see Information Sheet 8c). However, this only reduces chances of HIV transmission and HIV transmission is still possible. Use sterile needles and syringes to inject drugs and never share drug equipment. (AIDS Info, 2015). Regular healthcare visits ensure early detection of HIV and treatment.

Information Sheet 8b: Using contraceptives to avoid pregnancy

Definition: Contraception is a method or device used to prevent pregnancy

Abstinence is the safest way to avoid pregnancy. But, as we have mentioned, abstinence is not a long-term solution. The vast majority of people will have sex at some stage in their lives, whether it is as teenagers, young adults or older adults. Remember, sex can be risky at any age and no one is unlikely to abstain for their whole life. Even unprotected sex at 70 with a new partner or HIV-positive partner is risky.

Young people can obtain safe methods of contraception that work well from family planning service providers, clinics, doctors and pharmacies (see **Information Sheet 4b**)

The condom gives between 80 and 90% protection against pregnancy. It has no chemical effect on the body and is available in the community free or at a low cost.

If a person has had sex without using contraception, or a condom has broken, or the person has been raped, they can go to the nearest clinic, within 72 hours, for emergency contraception. These special pills will prevent conception. The sooner the person takes the medication, preferably within 24 hours, the more effective it will be.

Information Sheet 8c: Voluntary Medical Male Circumcision (VMMC)

Trials of male circumcision in South Africa have proven that circumcision reduces the risk of HIV acquisition by up to 60%. The South African national strategy aims to reach 80% of males aged 15–49 with circumcision services during 2016, new goals are set on an annual basis. This is 4.3 million people and, if successful, South Africa would prevent more than 1.2 million HIV infections between 2009 and 2025.

The VMMC programme has the following aims:

- immediate catch-up phase to rapidly achieve optimal coverage among adult men in age groups that are most likely to be, or soon become, sexually active, and
- sustainability phase which will focus on efforts to reach adolescents and introducing MMC for new born babies.

The immediate priority is reaching men aged 15–49, who are currently most at risk of HIV exposure during heterosexual intercourse;

VMMC is available at a number of service providers. These include hospitals, clinics and mobile services. Some clinics perform up to 50 circumcisions per day. During school holidays and the winter months (June, July and August) over 100 clients per day get circumcised.

A programme for the reduction of HIV and Teenage Pregnancy

SESSION 9

Dealing with emotional and social challenges

Expected session outcome

By the end of this session, participants should know more about dealing with challenges such as making difficult choices, handling emotions, peer pressure, stress, change and feedback.

Information Sheet 9: Managing stress and dealing with challenges

Definition: Stress is a state of mental tension, anxiety and worry caused by circumstances or events in your life, your health, your relationships, work, etc.

Stress is something that causes strong feelings of worry or anxiety. It is important to distinguish between good stress and bad stress. Being stressed about an exam, for example, can be a positive stress. Not all stress is bad, but stress must be managed.

- Every human being has challenges in their life.
- The first step towards managing challenges in one's life is to have the right attitude.
- The attitude that says, 'This shall pass, there will be a way out' is always a great attitude that can help one face difficult situations.
- Positive self-talk always helps, including phrases like: 'I will get through this.'
- When faced with a challenge, young people must always find someone to talk to, and find out where they can get assistance without giving up their dreams.
- Consider stories of other public figures that overcame great difficulties in their lives but made it through.
- There are also other ways of dealing with stress such as reading, spending time doing something you enjoy and playing a sport.
- Seek professional help from a social worker, health worker, counsellor, religious leader or family and community members.
- The following number are available to provide help:

Department of Social Development Substance Abuse Line 24hr helpline
0800 12 13 14, SMS 32312

Suicide Crisis Line
0800 567 567
SMS 31393

SADAG Mental Health Line
011 234 4837

Depression and Anxiety Helpline
0800 70 80 90

BUILDING BLOCK FIVE: Others are important: Improving my relationships

This fifth building block continues to highlight that young people are not alone, but can have good quality relationships with others. Young people do not experience life on their own, but with the people they interact, communicate, socialise and live with. Understanding that life choices and decisions about sexual and reproductive health are not independent decisions means that we have to continue to build strong, healthy relationships that have open two-way flows of communication. We need to recognise that as young people we are able to make effective decisions about our own lives. This building block helps to identify what makes a good relationship and further aids to build better communication skills and the ability to ask quality decisions about HIV prevention and teenage pregnancy.

Learning outcomes

- Learn about the importance of healthy relationships.
- Understand what is effective communication, and the importance of saying NO when you do not want to do something.
- Learn more about effective and ineffective decisions.

Expected behavioural outcomes

- Have healthy relationships;.
- Understand body language and understand communication through body language.
- Make better decisions about sexual health.

SESSION 10

Healthy relationships

Expected session outcomes

By the end of this session, participants should know that a healthy relationship involves respect and trust, as well as being equipped to improve their relationships by developing empathy and accepting diversity.

Information Sheet 10: Healthy relationships

Definition: area relationship is the connection between two or more people. It also refers to the way two or more people relate or behave towards each other.

Definition: A healthy romantic relationship is when there is a high level of trust, respect, open communication and partners who are fairly close in age.

Definition: An unhealthy relationship is when there is abuse, mistrust, no or poor communication, a power imbalance and lack of trust and respect.

Young people might not be in a position to recognise or get out from unhealthy family relationships. However, if they are being abused, they must seek help. This means finding someone to tell and telling until someone listens. Young people can usually disengage from social relationships that are unhealthy if they have confidence and a strong self-identity and if they have support from family, friends and other adults. It is an important first step to show young people that unhealthy relationships change them and can have a negative impact on them and their lives.

Many young people don't take the time to evaluate whether their relationships are healthy or unhealthy because their need for acceptance overrides personal protection or they need the relationship and do not have the choice to end it. Even when they realise that a relationship is unhealthy, they don't always realise the negative impact it can have on them in the long term.

Adults often undervalue the importance of teenage romantic relationships. Although these relationships usually don't last very long, they can affect a person for life, influencing self-esteem, identity and sexual relationships in the future. They can also help a person to develop resilience for later life and offer opportunities to develop negotiation skills and empathy (kindness).

For young people whose sexual orientation is in the minority category, i.e. they are homosexual or lesbian or uncertain of their sexual identity, romantic partners might be the only people with whom they can reveal their true identity. Young people who are homosexual or lesbian are statistically more likely than their peers to experience violence in romantic relationships.

Young people often stay in unhealthy relationships because:

- they might not yet have the capacity to see long-term consequences;

- they have a strong need for acceptance;
- the idea of a romantic relationship is new and therefore very exciting;
- media romanticises special relationships to the point where expectations are unrealistic and confusing;
- the friends who counsel young people do not yet have the experience and wisdom in this area to always offer useful advice; or
- young people might like the idea of doing something risky because it affirms their feelings of independence.

Many young people are abused in relationships and become confused about whether the abuse is normal or not. This puts teens at risk of HIV transmission as well as unplanned pregnancy. Adolescents who are physically abused by their partners are more likely to be accepting of abuse later on in life.

Other unhealthy relationships are transactional sex relationships, where young people engage in sex for the exchange of basic needs (food, shelter, and clothing) or for luxury items (cellphones, branded clothing, etc.). These are commonly called 'Blessor' relationships. Transactional and intergenerational sex relationships can also expose young people to further vulnerabilities, STIs, HIV and abuse. Identifying these relationships as unhealthy, and in some cases abusive, is the first step towards getting help.

Talk to someone at social services about your situation – there is always help and a way out.

It is important to identify and distinguish between healthy and unhealthy relationships as early as possible.

SESSION 11

Communication skills and reading the signs

Expected session outcomes

By the end of this session, participants should be able to start to communicate clearly and assertively, understand how to communicate effectively and be able to use risk-avoidance communication skills.

Information Sheet 11: Communication

Definition: Communication can be verbal or non-verbal. People speak to communicate or use gestures and facial expressions to communicate without saying a word.

Communication is an essential skill for every human being. If one is unable to communicate clearly, they can be misunderstood or taken advantage of.

Understanding body language helps us to gain a deeper sense of what people are thinking or feeling, and can also give us an indication of whether we are in danger or in a risky situation.

Sometimes we don't like the way someone is behaving towards us, but we don't know how to tell him or her to stop or to say 'no' without offending them or making them angry.

A boy must not assume that because a girl said yes to sex once, then it means that he can now have sex with her all the time. A boy can be accused of rape even if he had consensual sex with a girl in the past. She must say yes every time. If she is drunk or under the influence of drugs, the boy can still be accused of rape. The same is true for boys. Boys need to consent to having sex with a girl or another boy. A girl must also consent to having sex before another girl has sex with her. No one can have sex with anyone, whether it is a boy and a girl, two boys or two girls or a group of boys and girls, without giving consent first.

The bottom line is: **When someone says NO, it means NO**.

SESSION 12

Making effective decisions and taking responsibility

Expected session outcomes

By the end of this session, participants should be able to evaluate whether a decision is effective or ineffective, and be more able to take responsibility for their decisions.

Information Sheet 12: Decision-making

Definition: Decision-making is the process of selecting a specific course of action from more than one possibility or option

A study by the HSRC showed that adolescents take longer than adults to reach a decision, even when the decision is obvious (for example, 'is it a good idea to set your hair on fire?').

Adults rely more on a general understanding from their experience – the essence of the matter – while adolescents tend to use facts, details and their reasoning abilities in the absence of experience.

Adolescents might make ineffective decisions because they do not have the life experience to accurately judge consequences. It is important to note that the problem is not that they don't reason things through or that they think they are indestructible, but that they don't have experience in making decisions.

The more experience we have, the less we rely on facts and detail. Research shows that better, more mature decisions are made when people are able to rely more on their intuition.

The part of the brain that deals with intuitive decision-making (the frontal lobe) is only fully developed for most people when they reach their mid-twenties. Adolescents are therefore at a biological disadvantage when it comes to effective decision-making.

Giving adolescents lots of facts to persuade them to make effective choices often doesn't work because the problem is not that they lack information. What works better is to model positive choices and make healthy living seem desirable such as engaging in safe, fun activities, and building their sense of self-value. You can, however, help young people make effective decisions by personalising risk and helping them to think critically.

Ways of justifying ineffective or 'bad' behaviour

'Everybody does it' is a justification for behaviour that includes not taking responsibility for one's actions. People who say 'everybody does it' excuse their own behaviour and usually think that they are the innocent victims of circumstances. In their own eyes, they have done nothing wrong. When we say that we are a mere victim of circumstances (such as a disadvantaged background or absent/unloving parents), we deny that our actions affect our lives. The first step in dealing with any problem is to take our fair share of responsibility for it even though this can seem difficult or even impossible.

Young people also sometimes justify violent sexual behaviour, lying and cheating by minimising the damage they've done. They might say that they know the difference between behaviour that causes injury and behaviour that doesn't cause real injury, and their behaviour falls in the latter category. They will say that nobody *really* got hurt.

It is also common to blame the victim when they have acted in a violent or unkind way towards someone else. In their own minds, he or she deserved the way they were treated.

Another possibility is that young people blame those who judge their behaviour. For example, they will say that they are acting in accordance with their culture, and people who judge them can't know or understand anything about this. Young people are able to make safe, effective, empowered and informed decisions. Young people can do this with the support of their partners, friends, families and communities. **'You only live once … Live responsibly'**.

Chapter 6: How to **monitor** and **evaluate** the programme (in the Facilitator's Guide)

Monitoring and evaluating (M&E) are key to SBCC programmes. The diagram below illustrates how an SBCC programme is created. This will help you put YOLO in place effectively. Step 1–3 of the diagram below have been done by the DSD but the facilitator is required to help with steps 4 and 5. The facilitator needs to implement the YOLO programme (that has been discussed in the guide in the previous sections) and then monitor and evaluate it in order to give feedback for re-planning to ensure the continued success of YOLO. Remember, SBCC programmes are grounded in the real experiences of individuals and these realities change all the time, which is why re-planning needs to happen after monitoring and evaluation.

By monitoring and evaluating your programme, you can find out:

a) whether or not your programme is being conducted as planned;

b) what you are doing well and what you need to do to improve your programme implementation and learn from experience – both positively and negatively; and

c) the extent to which your programme's objectives are being met.

Monitoring and evaluating (M&E) can help you to improve your YOLO programme. M&E also builds accountability and transparency into your programme because it enables you to give feedback. Anyone can see at any time what you are doing and how you are using resources for the programme (if applicable). Your M&E also helps YOLO and the DSD keep this programme effective and working. You will be given M&E tools to complete to guide future YOLO roll outs and give the DSD feedback.

Monitoring your YOLO sessions and programme will help DSD determine if your programme is on track and if you are making progress towards meeting the YOLO objectives. It will help you to measure **what** has been done, **when** it was done, **how** it was done, and **who** has been reached. M&E can also help you as a facilitator, your NPO and the DSD identify any problems in the YOLO programmes so that changes can be made.

Some useful numbers also include:

Condom distribution at clinics

- Organisation: Society for Family Health
  Tel: 011 484 5320

Early detection and treatment of STIs and management of pregnancy

- Organisation: Marie Stopes South Africa
  Tel: 0800 11 77 85
- Organisation: Better2Know
  Tel: 0800 999 276
- Organisation: Rabie Ridge Thusong Service Centre (Clinic)
  Tel: 011 310 1977

Voluntary testing and counselling

- Organisation: Right to Care
  Tel: Gauteng 011 276 8850
- Organisation: AIDS Training and Treatment Centre.
  Tel: 021 763 5320
- Organisation: AIDS Law Project
  Tel: 011 356 4100
- Organisation: Treatment Action Campaign
  Tel: 021 422 1700

Prevention of mother to child transmission advice

- 24-hour National Aids Helpline 0800 012 322
- Organisation: Rabie Ridge Thusong Service Centre (Clinic)
  Tel: 011 310 1977

Contact number for orphans and vulnerable children

- Organisation: Child Line South Africa
  Tel: 08000 55555
- Organisation: Department of Social Development
  Tel: 012 312 750

National number for social work

- Organisation: National Association of Social Work
  Tel: 011 463 5085
- Organisation: Department of Social Development
  Tel: 012 312 750

Sexual reproductive health, contraceptives

- Organisation: Rabie Ridge Thusong Service Centre (Clinic)
  Tel: 011 310 1977

Male Medical Services

- Organisation: Men's Clinic South Africa
  Tel: 0860 362 867 / +27 11 523 5100

Termination of pregnancy

- Organisation: Abortion Clinic Johannesburg
  Tel: 076 903 9340
- Organisation: Marie Stopes Clinic (termination of pregnancy)
  Tel: 0800 11 77 85

Endnotes

1 Source: http://www.UNAIDS.org/en/resources/presscentre/featurestories/2016/june/20160624_south-africa
2 Source: https://www.health-e.org.za/2016/03/15/5-things-you-should-know-about-hiv-pre-exposure-prophylaxis/
3 See www.caprisa.org
4 Source: https://c-changeprogram.org/focus-areas/capacity-strengthening/SBCC-Toolkit
5 Source: https://c-changeprogram.org/focus-areas/capacity-strengthening/SBCC-Toolkit
6 Adapted from Albert Bandura, *Psychology Review* 1977, Vol. 84, No. 2, 191-215; and https://c-changeprogram.org/focus-areas/capacity-strengthening/SBCC-Toolkit
7 UN Women, OSAGI Gender Mainstreaming - Concepts and definitions
8 Source: http://www.advocatesforyouth.org/for-professionals/lesson-plans-professionals/200.
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