

Program M:

Young Men's Manual

**A Training Manual
for Educators and
Youth Workers**

The M Manual is a tool that developed out of the Young Men Initiative; a program by CARE International NW Balkans and its collaborative partners focused on addressing gender inequalities, harmful health practices and violence in everyday life with young men in schools and the community.

M Manual is a training manual that aims to promote gender equality and promote healthy lifestyles with young men by addressing some of the social constructions of masculinity (ies) as a strategy for building important life skills in young men as they emerge into young adulthood.

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Program M:

Young Men's Manual
A Training Manual for Edu-
cators and Youth Workers



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Young Men Manual (M Manual): A Gendered Approach to Building Life Skills for a Healthy Transition to Manhood, a training manual developed by CARE International in collaboration with Instituto Promundo, Status: M, Center E8, Perpetuum Mobile, Association XY and Initiatives for use by educators, youth workers and other professionals working with young men is an important contribution to those working to support the healthy development of young people. Using a gender lens by focusing on masculinity (ies) we seek to deconstruct some of the challenges, young men face in adolescence. The manual seeks to build the skills necessary for young men to develop healthy relationships based on gender equality, to understand their physical, sexual and emotional development and to address all forms of violence in their everyday life.

This manual is an important resource for governments and nongovernmental organizations (including Ministries dealing with Education and Youth) that understand the importance of how gender social constructions around masculinity affect the attitudes and behaviors of boys and young men. This manual seeks to build skills and competencies of young men to face some of the life course challenges that are often a part of the transition period of adolescence. We believe by working in a more comprehensive approach than addressing just a single issue we can achieve more positive results. A significant feature of this Manual is that it has been tested and validated through research and evaluation in schools in Bosnia and Herzegovina, Croatia and Serbia.

The research conducted as part of the young men initiative (and research conducted by others) has clearly demonstrated the need to address the diverse topics covered in this manual. During adolescence young men are often engaged in a variety of risky behaviors. This ranges from binge drinking (drinking alcohol until they are drunk), experimenting with drugs and exposure to violence either as a victim or a perpetrator. This is a time of experimentation as they try to figure

out the type of man they want to be. Many young men start to date and develop their first sexual relationships. Lacking knowledge and skills to deal with these experiences put them at risk. We know from research at the European level that the leading causes of death for young men in this age group are traffic accidents, suicide and interpersonal violence. Gender norms and social constructions of masculinity often contribute to these harmful behaviors and practices.

Young people adopt their personal lifestyle during the transition from family and home to adulthood under the influence of a complex mixture of economic, social, cultural and educational processes. The impact of inequalities (gender, social and/or health) may be immediate, with poor outcomes being apparent in a range of indicators and behaviors during childhood and adolescence. These may reduce young people's ability to participate fully in many aspects of life and affect, for example, school attendance and academic achievement, social functioning, sports participation and uptake of employment opportunities. Quality of life and mental well-being may consequently be affected. Life skills education can be a protective factor against some of these challenges.

The Manual has been prepared through a three-year long participatory process. It is published in English and Croatian/Serbian/Bosnian/Albanian to encourage wide-spread use in the region. The manual was designed to work alongside a lifestyle campaign at the school and community level that promotes a more positive and healthier version of what it means to be a man. For resources around the campaign please consult with the local partner(s) in each country. CARE and its partners encourage government and nongovernmental organizations to adopt this manual as part of their comprehensive efforts around life skills education. Any approach must bring schools, community, families and other important civil society actors together to support young people as they emerge into young adults. We wish you success in using this manual!

The Program H (H stands for “hombre” which means “man” in the Portuguese language) Working with Young Men Series was originally developed in 1999 by four Latin American organizations with significant experience in working with young men:

Instituto Promundo (coordinator of the initiative, based in Rio de Janeiro, Brazil); ECOS (São Paulo, Brazil); Instituto PAPAI (Recife, Brazil); and Salud y Género (Mexico).

The adaptation of Program H to the Western Balkans/Southeast Europe context is called the Program M Manual (M means “man” in the local languages) and was produced by CARE International and Promundo, in collaboration with local partner organizations and their adaptation coordinators:

Perpetuum Mobile Banja Luka (Saša Ostoji), Status M Zagreb (Natko Gereš, MD), Association XY Sarajevo (Adnan Cviko), Center E8 Belgrade (Vojislav Arsić) and Initiatives Prokuplje (Miloš Kostić). John Crownover coordinated the effort for CARE International together with CARE staff – Saša Petković, Marina Starčević and Miroslav Blagojević. Christine Ricardo coordinated the efforts of Promundo together with Gary Barker, Fabio Verani, and interns Caitlin Bryan and Kylene Guse.

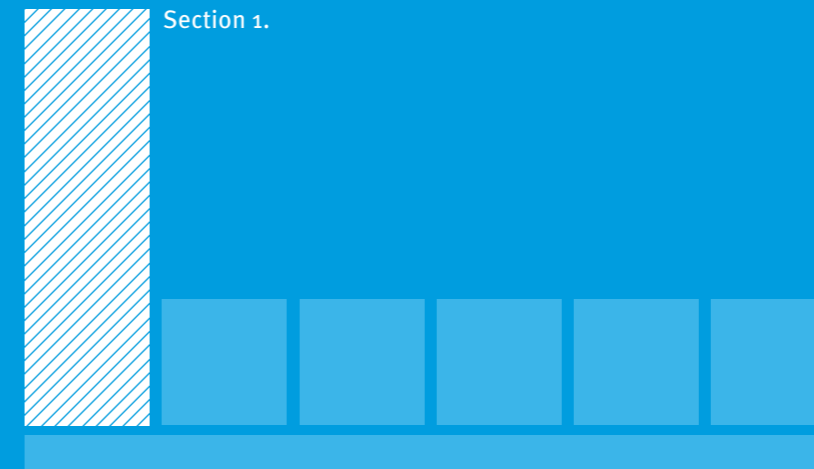
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Finally, Care International and Instituto Promundo are grateful to the Ellen Beate Langehaug from CARE Norway and Norwegian Ministry of Foreign Affairs for its generous support and funding of this project.

Section 1:

Introduction



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1. Why a Focus on Young Men?
 2. From Young Men as Obstacles to Young Men as Allies
 3. About the Manual
 4. Using the Manual
 5. The Video: "Once upon a Boy"
 6. Reprinting the manual

— WORKSHOPS —

1. Talking stick – opening session

Section 1:

Introduction

1. Why a Focus on Young Men?

For many years, we have made assumptions about the health and development of young men¹ – Most often, we have assumed they are doing well and have fewer needs than young women. Other times we have assumed that they are difficult to work with, aggressive, or not concerned with their health. We have often seen them as the perpetrators of violence against other young men, against themselves and against women – without stopping to also recognize the ways in which society often condones young men's use of violence. New research and perspectives are calling for a more careful understanding of how young men are socialized, what they need in terms of healthy development and how health educators and others can engage them in more appropriate and effective ways.

Furthermore, while numerous initiatives have historically sought to redress gender inequities by empowering women, there is an increasing consensus that promoting gender equity and improving women's health and well-being also requires engaging men, of all ages. The 1994 International Conference on Population and Development (ICDP) in Cairo and the 1995 Fourth World Conference on Women in Beijing provided a foundation for including men in efforts to improve the status of women and girls. The ICPD Programme of Action, for example, seeks to "promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behavior and their social and family roles."

Since the Cairo and Beijing conferences, numerous UN agencies, governments, and civil society

organizations have affirmed the need to work with men and boys. In 1998, the World Health Organization decided to pay special attention to the needs of adolescent boys, recognizing that they had too often been overlooked in adolescent health programming. In 2000-1, UNAIDS devoted the World AIDS Campaign to men and boys, recognizing that the behavior of many men puts themselves and their partners at risk, and that men need to be engaged in more thoughtful ways as partners in HIV/AIDS prevention and the support of persons living with AIDS. More recently, governments from around the world made a formal commitment at the 48th session of the Commission on the Status of Women (CSW) in 2004 to implement a range of actions to involve men and boys in efforts to achieve gender equality.

In addition to the growing recognition that working with men and boys to challenge gender inequities can have a positive impact on the health and well-being of women and girls, there is also an increased understanding of how rigid ideals of gender and masculinities can also lead to specific vulnerabilities among men and boys. This is evidenced by their higher rates of death by traffic accidents, their higher rates of suicide and violence, and their higher rates of alcohol and substance use than women and girls. Thus, for the sake of both young men's and young women's well-being, it is essential that programs seek to incorporate a gender perspective into work with youth.

But, what does it mean to apply a "gender perspective" to working with young men? Gender – as opposed to sex – refers to the different ways in which men and women are socialized to think, behave, and dress; it is the way these

¹ – "Young men" refers to males between the ages of 15 and 24, corresponding to the "youth" age group defined by the World Health Organization (WHO).

roles, usually stereotyped, are taught, reinforced, and internalized. We sometimes assume that the way that boys and men behave is "natural" - that "boys will be boys." However, the roots of many of boys' and men's behaviors including, whether they negotiate with partners about condom use, whether they take care of children they father, or whether they use violence against a partner are found in the way boys are raised. To change how we raise and view boys is not easy. However, it has the potential to transform gendered relations, as well as reduce many of the health and social vulnerabilities that both women and men face.

Throughout many societies there are often one or more versions of masculinity, or ways of being a man, that are accepted as the "right" or dominant way of being a man. This is generally termed hegemonic masculinity. In most settings, this hegemonic masculinity is idealized and becomes a way to subordinate or marginalize men who are different. Looking across diverse settings, in fact, we often see many similarities in definitions of manhood and how men are expected to behave. For example, many cultures uphold the idea that being a "real man" means being a provider for and protector of one's family and community. Boys are often raised to be aggressive and competitive - skills considered useful for their roles as providers and protectors. They are also often raised to believe in rigid codes of "honor" that obligate them to compete or use violence to prove themselves as "real men". Those boys who show interest in domestic tasks such as cooking, cleaning, or caring for younger siblings, or who easily display their emotions, or who have not yet had sexual relations, may be ridiculed by their families and peers as being "sissies", or not real men.

In terms of health-seeking behaviors, boys are often raised to be self-reliant, not to worry about their health and not to seek help when they face stress. But being able to talk about one's problems and to seek support is a protective factor against substance use, unsafe sexual practices

and involvement in violence. This could explain in part why boys are more likely than girls to be involved in violence and substance use. Indeed, there is a significant body of research that confirms that the ways in which boys are raised have direct consequences for their health. For example, a national survey of adolescent males aged 15-19 in the U.S. found that young men who had sexist or traditional views of manhood were more likely to report substance use, involvement in violence and delinquency and unsafe sexual practices than adolescent boys with more flexible views about what "real men" could do². Similar results have also been found in studies carried out with young men in various other settings, including Brazil, India, South Africa and the Western Balkans. Thus, applying a gender perspective to working with young men implies two major points:

(1) **GENDER SPECIFICITY:** Looking at the specific needs that boys have in terms of their health and development because of the way they are socialized. This means, for example, engaging boys in discussions about substance use or risky behavior and helping boys understand why they may feel pressured to behave in those ways.

(2) **GENDER EQUITY:** Engaging boys to discuss and reflect about gender inequities, to reflect about the ways that girls and women have often been at a disadvantage and have often been expected to take on a disproportionate share of child care, sexual and reproductive health matters and domestic tasks.

This manual series attempts to incorporate these two perspectives, seeking to both recognize the specific needs and realities of young men and engage them to challenge and transform gender relations. Evidence from around the world indicates that programs that apply this type of gender transformative approach are more likely to lead to changes in young men's attitudes and behaviors than programs that do not make an explicit attempt to address and challenge gender norms (Barker et. al. 2007).

2 — W.H. Courtenay, "Better to die than cry? A longitudinal and constructionist study of masculinity and the health risk behavior of young American men" (Doctoral dissertation, University of California at Berkeley, 1998)

2. From Young Men as Obstacles to Young Men as Allies

Discussions about young men have often focused on their problems – either their lack of positive participation in reproductive and sexual health matters or their sometimes violent behaviors. Some youth health initiatives approach young men as obstacles or aggressors. Indeed, some young men are violent toward their female partners. Some are also violent toward each other. And many young men – too many – do not participate in the care of the children and do not participate adequately in the sexual and reproductive health care needs of themselves and their partners. At the same time, there are many young men who are respectful in their relationships with their partners and each other, as well as many young fathers who participate in the care of their children.

It is clear from research and from our personal experiences as educators, parents, teachers and health professionals that young men respond to what we expect from them. From research on delinquency, we know that one of the main factors associated with delinquent behavior among young men is being labeled or identified as a delinquent by parents, teachers and other adults. Young men who feel they are categorized and/or treated as "delinquent" are more likely to become delinquent. If we expect young men to be violent, if we expect them not to be involved with the children they may father, if we expect them not to participate in reproductive and sexual health issues in a responsible way, then we are, in effect, contributing to the creation of self-fulfilling prophecies.

For all of these reasons and more, this manual and the activities contained within are grounded in the assumption that young men should be seen as allies – potential or actual – and not as obstacles. Some young men do in fact act in irresponsible and even violent ways. We do not condone their behavior. Rather, we believe it is imperative that we start from the things that many young men are doing right and believe in the potential of other young men to do the same.

”

... young men respond to what we expect from them...

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3. About the manual

The manual is comprised of five thematic sections:

1. Reasons and Emotions
2. Fatherhood and Caregiving
3. Sexuality and Reproductive Health
4. Preventing and Living with HIV/AIDS
5. From Violence to Peaceful Coexistence

Each of these sections contains an introduction to the theme, including a brief review of relevant literature, and a series of group educational activities for working with young men. The overall goal of the activities is to create dynamic discussion spaces in which young men can reflect critically about gender norms, relationships, and various health topics, as well as “rehearse” the skills and abilities necessary to reduce risk behavior and act in more equitable ways. Among other things, the activities encourage young men to:

- › Value dialogue and negotiation, not force or violence, as the basis for relationships and the resolution of conflicts, and to make use of dialogue and negotiations in their own interpersonal relationships;
- › Respect individuals and groups with different backgrounds and lifestyles, and to question those who do not show such respect;
- › Seek to maintain intimate relationships based on equality and mutual respect;
- › Talk with partners about safer sex and share the responsibility for obtaining and using safer sex methods;
- › Share reproductive decision-making with partners (in case of heterosexual relationships), including the responsibility for obtaining and using contraceptives to prevent unplanned pregnancies;
- › Reject the use of violence against intimate partners and others and;
- › Recognize that care-giving is also a male attribute and to seek to care for others, including friends, relatives, partners and their own children.

This manual is an adaptation of The Program H Working with Young Men Series, an educational curriculum originally developed and tested in Latin America and the Caribbean. The adaptation was a collaborative effort, involving staff and peer educators from several organizations working with youth in the Western Balkans. It was field-tested with 63 young men aged 15-24 in Bosnia and Herzegovina, Croatia, Montenegro and Serbia in 2007/2008 and later piloted in 2009 / 2010 with hundreds of young men in Bosnia and Herzegovina, Croatia and Serbia.

4. Using the manual

The manual is designed for use by educators and youth workers, health workers, and/or other professionals or volunteers who work with, or would like to work with, young men. Each activity is designed to last between 45 minutes and 2 hours, and can be carried out with young men in a diversity of settings, from schools, youth and sports clubs to military barracks and juvenile correction centers. While the activities were originally designed for use with groups of young men, they can also be adapted for use with mixed-sex groups (SEE BOX 2).

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...the goal of the
activities is to create
dynamic discussion.

“

The activities draw on an experiential learning model in which young men are encouraged to question and analyze their own experiences and lives to understand how gender can sometimes perpetuate unequal power in relationships and make both young men and women vulnerable.

Most importantly, the activities engage young men to think about how they can make positive changes in their lives and communities. This process of questioning and changes takes time. Experience in using this manual has shown that it is preferable to use the activities as a complete set (or selecting groups of activities from the different sections) rather than using just one or two activities. Many of the activities complement each other and when used together contribute to richer and more rewarding reflections than if used alone.

In general, the activities seem to work best with smaller groups (e.g. 8 – 20 individuals), although they can also be used with larger groups. A group that is too large, however, can make it difficult for all of the participants to contribute. It should also be remembered that physical contact for young men is not always easy – activities that require physical contact can and should be presented as optional for young men, respecting each individual's limits. In starting the work with this manual, the facilitator should also be aware that it will most likely be the first time that many of the young men participate in a male-only educational group discussion process. Although some young men might at first say that it is difficult or awkward, the facilitator should help the young men identify the possible benefits to working in male-only groups and be patient as the young men get accustomed to the idea.

While the activities were developed for young men between the ages of 15 and 24, we also recognize that there is a broad range of concerns and experiences among this group. While bringing them together can offer many advantages, it is also important to ensure that young men have the necessary spaces to focus on those issues most relevant to their lives and relationships – to this end, many organizations often work with young men in groups of 15 to 19 year olds and 20 to 24 year olds.

Working with young men is not always an easy task and not always predictable. Many of the activities included here deal with complex personal topics, such as sexuality, mental health, and experiences with violence. There may be young men who open up and express their feelings during the process, while others simply will not want to talk. While these activities are not intended to be used as group therapy, they should foster a sufficient level of self-reflection among participants for them to be able to learn from their own experiences, to question rigid ideals of gender and masculinities, and to change their attitudes and behaviors. It is up to the facilitator to gauge and promote the young men's comfort levels with the themes and to administer the activities in such a way that honest reflection is promoted, but without becoming a group therapy session. At the same time, the facilitator should remain alert to the possibility that some individuals may need specific attention and, in some cases, referral to professional services or counselling.

Skilled facilitators are a key part to the group educational process. Activities can be carried out by male or female facilitators (see Box 3), as well as by facilitators working alone or in pairs. Before starting the work with young men, it is critical that the facilitators feel comfortable dealing with the manual's themes, have experience working with young people and have support from their organizations and/or other adults to carry out such activities. The main role of the facilitators is to create an open, frank and respectful environment, where there are no a priori judgements or criticisms of the attitudes, language or behavior of the young men, and where the young men can feel comfortable moving beyond the “politically correct discourse” they may initially use. As conflicts may arise among the young men, it is also necessary for facilitators to have the necessary skills to intervene in such situations and to promote respect for different opinions.

Finally, the activities should be carried out in a private and comfortable space in which the young men can move around. Many young men like movement and it can be helpful for keeping them engaged. Similarly, young men require high caloric intake for growing and, when possible, it is recommended to provide snacks for participants.

BOX 2: Is it better to work with young men in male-only groups or in mixed-sex groups?

Our response is: each has their advantages and disadvantages. Some young men may feel more comfortable expressing their emotions or discussing topics like sexuality and violence in male-only groups. On the other hand, some young men complain or show little interest if there are no young women in the group. Of course, having young women in a group can make it more interesting. Nevertheless, we have also found that at times the presence of young women inhibits young men from "opening up." In some discussion groups, we have seen that young women sometimes act as the emotional "ambassadors" of young men, that is, the men do not express their emotions but instead delegate this role to women. Nonetheless, we recommend that at least part of the time, organizations should seek to bring young men and young women together to discuss gender and health as mixed groups allow men and women to hear each other's perspectives and to jointly explore and understand gender relations and attitudes.

BOX
2.*BOX 3: Men or Women Facilitators?*

A common question regarding facilitators for group activities with young men is whether men facilitators are more appropriate and effective than women facilitators. Male facilitators can serve as positive role models and young men may perceive them as easier to confide in and more persuasive. At the same time, experience has also shown that young men will also respond well to a female facilitator if she is informed and open-minded. Indeed, the qualities of the facilitator – the ability of a facilitator, man or woman, to engage a group, to listen to them, to inspire them – are far more important than the sex of the facilitator. A third possibility is to work with co-ed pairs of facilitators. In addition to bringing two gender perspectives to the discussion, this arrangement also has the benefit of providing the young men with an immediate model of equitable and respectful interactions between men and women.

BOX
3.*BOX 4: Lessons learned from working with young men*

Experiences in working with young men in diverse settings have confirmed the importance of carrying out multiple activities if we hope to promote true attitude and behavior change with young men. This includes:

BOX
4.

- › Carrying out broad-based informational and educational campaigns; Carrying out discussions with young men (and/or young men and young women in mixed groups) in health posts and other spaces;
- › Taking our activities to where young men are, including military barracks, schools, sports groups and facilities, bars, etc.
- › Designing strategies to attract men to use existing health services, including carrying out activities to train and sensitize public health staff on the needs and realities of young men;
- › Using and reinforcing non-sexist and non-discriminatory language, and considering the diversity of young men (in terms of sexual orientation, religion, social class, ethnicity, etc.);
- › Promoting integrated health services for young men, and not dividing their needs into various sectors;
- › Promoting or holding up examples of young men and adult men who demonstrate solidarity and more gender-equitable attitudes;
- › Demonstrating and modeling peaceful conflict resolution and alternative, non-violent forms of expression for young men;
- › Engaging young men who are fathers or soon-to-be fathers; and
- › Engaging young men as health promoters for reaching other young men.

5. The Video: "Once upon a Boy"

The manual is accompanied by a no-words cartoon video called "Once upon a boy." The video tells the story of an adolescent boy, John, and the challenges he faces in growing up. He comes up against machismo, family violence, homophobia, doubts in relation to his sexuality, his first sexual experience, pregnancy, an STI (sexually transmitted infection) and fatherhood. In a lighthearted and sensitive way, the video introduces the themes dealt with in the manual's activities. We have often found it useful to use the video as an introduction to the activities – both to generate interest among the young men and to assess their initial attitudes in relation to the various topics.

”

We have often found it useful to use video as an introduction...

“

6. Reprinting the manual

We would like for this manual to be widely used. Reproduction of the content is permitted, provided that the source and authorship are cited. We would also like to hear about where and how you use the manual – to share your experiences or to ask any questions, you can write to one of the collaborating organizations listed on the cover page.

Workshops

⚙️ Workshop 1: Talking stick – opening session

OBJECTIVE:
To encourage dialogue based on respect and to establish ground rules for the group sessions.

MATERIALS REQUIRED:
A stick (preferably carved wood or other ceremonial stick or staff), flipchart paper, and markers.

RECOMMENDED TIME:
40 minutes

PLANNING NOTES:
This session should be combined with a general overview of the topics to be discussed in future sessions.

The History of the Talking Stick

The purpose of the talking stick is to promote understanding and dialogue...

The idea of the talking stick began with groups of Native Americans who used it in ceremonies when groups of men from the tribe sat down in a circle at the end of the day to discuss any disagreements or for the elders to pass on information and oral traditions to the younger members. The talking stick represented the power of the tribal chief or leader. When he took the stick, it was a sign for the others to remain quiet and listen to his words. When another man wanted to speak, he asked permission to hold the stick, and then he was acknowledged by the others as having the right to speak. Symbolically, passing on the stick signified passing on the power and the right to be heard by the other members of the tribe.

In many cases, the stick can also be used as a weapon. It is a piece of wood or a heavy club which can also be used to defend someone or attack a person or an animal. The person that holds the stick has a potential weapon in his hands. Just as with the stick, we can use our ability to speak and express ourselves to bring people closer or to insult them. The same hand that can caress or embrace others can also be used to hit them. The talking stick can be used by the group as a symbol of cooperation or as a weapon.

The purpose of the talking stick is to promote understanding and dialogue, distributing power among everyone. Each member of the group has the right to ask for the stick, and must respect the person that is holding it, waiting for him to stop talking. Similarly, each person who holds the stick must also be ready to give it up.

This activity was used initially with a group of young men with whom Promundo worked in a low-income area of Rio de Janeiro, Brazil. When we started working with the young men, they were not used to waiting their turn to speak, and showed little respect when someone else was speaking, whether it was an adult or another young man. The conversation or discussion among them sometimes led to threats of force, albeit half-hearted, as well as criticism or insults. With the use of the talking stick, we observed a striking change in attitudes at the group meetings. The young men began to listen to one another and to insist on the use of the stick and compliance with the rules. After some time (over six months) we stopped using the stick because the practice of listening and following turns when speaking had already been incorporated into the group's dynamics.

In many settings, we have used a ceremonial stick used by indigenous groups. If one cannot be found, you can improvise. A piece of cane can be used, a baseball bat, a rolling pin, or a club made of wood or metal. Even a broom stick serves the purpose. While it is preferable to have an authentic talking stick or ceremonial staff, the most important thing is the meaning that the group attaches to the stick. The group can also create its own stick, writing their names or the name of the group on it or painting it.

“Patience was very much part of the culture... And this is why I sometimes find it very difficult to understand the African dictators of today, because in traditional African society people discussed issues. They talked and talked – you know the tradition of palaver, you go under the tree and you talk. If you can’t solve the problem, you meet the next day and you keep talking till you find a solution...” – [Kofi Anan](#)

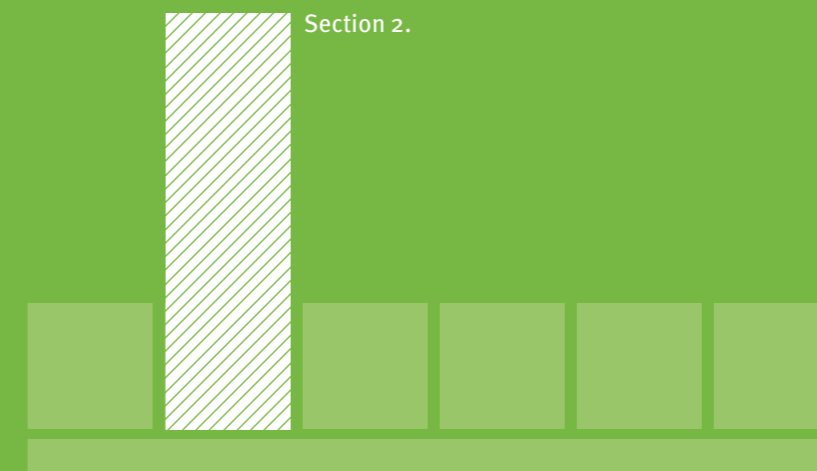
PROCEDURE:

1. Ask the participants to sit in a circle.
2. Holding the stick in front of you, tell the story and rules of the talking stick.
3. Passing the stick around the group, ask each participant to briefly express one hope and one fear about the workshops. They should be encouraged to say “I hope that...” and then “I fear that...” Everyone should have the chance to hold the talking stick in his hands.
4. When the stick returns to you, ask the participants to think of other rules for the peaceful coexistence or functioning of the group. Participants who wish to speak should address you to ask for the stick, and then the next participant should address whoever has the stick at that moment to ask him for it and so on. As the facilitator of the group, the stick should not return to you each time. It should be passed directly between the members of the group, allowing them to control the discussion themselves. When you, as the facilitator, want to speak, you should request the stick from whoever is holding it.
5. Write the rules that the participants suggest on flipchart paper and ask the group if everyone is clear about them and agrees with them all.
6. Encourage the participants to try to follow these rules and to regularly remind one another about them during the workshops.
7. Ask the participants if they liked using the talking stick and if they would like to continue using it. In some groups, the talking stick activity might seem too rigid and might only be used for one session. In other groups, it might be used throughout the other activities or returned to every now and then.

PROCEDURE

Section 2:

Reasons and Emotions – What and Why



— WORKSHOPS —

- 1. What is this thing called gender?
- 2. Act like a man, Act like a woman
- 3. Expressing My Emotions
- 4. Labeling
- 5. Power and Relationships
- 6. Scenes of Dating
- 7. Aggressive, Passive or Assertive

- 8. Negotiating Skills
- 9. What are drugs
- 10. Drugs in our lives and communities
- 11. Pleasures and Risks
- 12. Decision-Making and Substance Use
- 13. Talking About Alcohol and Alcoholism
- 14. Learning not to Drink too Much

Section 2:

Reasons and Emotions – What and Why

Overview

It is rare to find discussions about young men's emotional and mental health from a socio-cultural perspective. In fact, emotional and mental health in general is often still approached primarily from a biological point of view, focusing on a narrow range of problems, rather than taking a comprehensive or holistic approach. In this section, we discuss ways in which the socialization of boys and men influences their overall emotional and mental health and take a detailed look at the issues of substance abuse and suicide.

BOX 1: What is Emotional and Mental Health?

According to the WHO, mental health is “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.”³ In its essence, this definition encompasses also emotional well-being – indeed expressing one's emotions is seen not only as a positive manifestation of mental health, but is also highly recommended to promote mental health.

BOX
1.

Emotions, gender, and young men

As with other aspects of their lives and health, gender norms influence young men's emotional and mental health. For example, social expectations which espouse that "real men" must be "tough" and "brave" can lead young men to hide their fear, sadness, even kindness, and not to seek out help when they need it. The denial or repression of tensions and problems, as well as having difficulty in talking about the associated emotions, may in turn lead to the use of substances, including alcohol, as a coping mechanism. In addition to its role in confronting stressful situations, substance use can also be perceived as a mean to proving one's manhood or fitting in with the peer group.⁴ Research has shown that the ability to process and express emotional stress in non-violent ways is a protective factor against various health and developmental problems. Thus, young men are made vulnerable when they feel constrained to express emotions associated with adverse circumstances and stressful life events.⁵

³ – <http://www.who.int/mediacentre/factsheets/fs220/en/>

⁴ – WHO – What about the boys

⁵ – Cohler, 1987 and Barker, 1998 in WHO 2000 What about the boys

Globally, young men are more likely than young women to smoke, drink and use other substances. In terms of alcohol use in particular, men are ranked higher than women in episodic and binge drinking and are also more likely to die from alcohol use disorders.⁶ Moreover, substance use, particularly alcohol use, is frequently part of a constellation of male risk-taking behaviors, and is linked to various other problems that are also more commonly associated with young men, from involvement in traffic accidents to use of violence.⁷

In recent years, substance use prevention programs have gradually changed from being aggressive and fear-based to more holistic educational models that work with young people to build self-esteem and develop the skills necessary to overcome emotional, family and social conflicts and find ways to enjoy life that do not include substance use, recognizing that these needs are at the core of successful prevention.

”
...young men are more likely than young women to smoke, drink...
“

BOX 2: Alcohol use among youth in the Western Balkans

Bosnia and Herzegovina: A study with 600 adolescents found that approximately 16% of the respondents had abused alcohol.⁸ Moreover, those adolescents who had abused alcohol also reported other risk behaviors, including: truancy 44.1%; low success at school 14.0%; suicidal thoughts 36.6%; unprotected sex 17.7%; drunken driving 10.0%; non use of seat belts 24.7%; delinquency (stealing) 22.2%; destructive behavior 18.9%. The study also found that drug abuse is more common among adolescents in urban areas and adolescents aged 15-17.

Croatia: A study with 2815 15 to 16 year olds found that 70% had drunk an alcoholic beverage in the last 12 months, and 33 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 82 per cent (85 per cent for boys and 79 per cent for girls).⁹

Montenegro: A study with 15-16 year old students found that 74% had ever drunk alcohol, while 50% had drunk alcohol more than three times. Twenty-six percents of the students had drunk alcohol 10 or more times, among them 70% were boys and 30% were girls.¹⁰

BOX 2.

6 — WHO Global Status Report on Alcohol, 2004
7 — Sendoritz 1995 in WHO 200 What about the boys
8 — Alcohol abuse and risk behavior among adolescents in larger cities in Bosnia and Herzegovina, Psychiatric clinic, Clinical Centre University of Sarajevo, PMID: 15997674 [PubMed - indexed for MEDLINE].
9 — The ESPAD Report Alcohol and Other Drug Use Among Students in 35 European Countries – 2003.
10 — European School Survey Project on Tobacco, Alcohol and Drugs, National Report Montenegro, 2008.

FIGURE 1. Selected variables on tobacco, alcohol and drug consumption among boys in four European countries, including Croatia.¹¹

SUMMARY TABLE. SELECTED VARIABLES ON TOBACCO, ALCOHOL AND DRUG CONSUMPTION. BOYS

COUNTRY	CIGARETTE SMOKING		ALCOHOL CONSUMPTION LAST 30 DAYS				DRUNKENNESS		BINGE drinking	LIFETIME USE OF OTHER ILLICIT DRUGS			Lifetime use of inhalants (sedativesb)		
	Lifetime use 40 times or more	Smoked during the last 30 days	Any alcohol 10 times or more	Beer 3 times or more	Wine 3 times or more	Spirits 3 times or more	Lifetime use 20 times or more	Last 30 days 3 times or more	Last 30 days 3 times or more	Amphetamines	LSD	Exstasy			
Austria	41	48	27	50	20	36	37	22	-	23	4	2	3	1	14
Belgium	28	32	28	49	21	33	11	12	28	37	3	4	5	9	9
Bulgaria	32	42	13	55	16	27	15	17	26	23	2	2	3	2	4
Croatia	32	36	15	42	23	20	14	12	19	24	2	2	5	4	14

Box 3: Youth and Tobacco Abuse

On a global scale, tobacco continues to be the substance that causes the most health problems. In most countries, it is predominantly at the age of 15 – 16 years when young people start using cigarettes. In all likelihood, individuals who begin regular smoking during their teenage years will maintain the habit later during their adult life, thus increasing the likelihood for the development of smoking-related chronic diseases.

Smoking is often regarded as socially desirable behavior among adolescents and youth; namely, it is often accepted as a symbol of adulthood, of fitting in with a certain group and being accepted by it.¹² A study with youth in Croatia found that 70% had smoked at least once and 36% had smoked in the last 30 days.¹³ A study in Montenegro found that 44% of students had smoked at least once, with a slight predominance of boys over girls (51% boys and 49% girls).¹⁴

BOX
3.

What about Suicide?

Worldwide, suicide is a leading cause of death worldwide, and one of the three leading causes of death for young people under 25.¹⁵ European countries experience some of the highest rates of suicide, which is increasing among young men.¹⁶ Among the many factors underlying these suicide rates are mental health problems like depression or alcohol use disorders, which play a major role in European countries.¹⁷ When we breakdown suicide data by sex, we see that girls and women are more likely to attempt suicide but men are more likely due to die by suicide, generally because their methods are more lethal, such as firearms.¹⁸ Another belief is that men's greater propensity for aggression and risktaking (closely linked to gender norms, as previously discussed) lead them to also be more "effective" in terms of their suicide methods.¹⁹

The causes and risk factors associated with suicide are of course complex, but some risk factors or issues are frequently found to be associated with suicide in adolescents and young adults, including: abuse or dependence on alcohol and other psycho-active substances; dysfunction and/or violence in the family; difficulties in defining and accepting homosexual feelings; and depression or loneliness.

”
...suicide, one of the
three leading causes
of death for young
people...
“

11 – The ESPAD Report Alcohol and Other Drug Use Among Students in 35 European Countries – 2003.
12 – European School Survey Project on Tobacco, Alcohol and Drugs, National Report Montenegro, 2008.
13 – The ESPAD Report Alcohol and Other Drug Use Among Students in 35 European Countries – 2003.
14 – European School Survey Project on Tobacco, Alcohol and Drugs, National Report Montenegro, 2008.
15 – <http://www.voanews.com/english/news/a-13-2009-09-10-voa31-68662367.html>
16 – Google to find source
17 – <http://www.voanews.com/english/news/a-13-2009-09-10-voa31-68662367.html>
18 – Google to find source WHO violence report
19 – WHO what about boys

When we talk about suicide, we must keep in mind that suicide is the final event in a chain of events and factors. Therefore, general mental health promotion - for example, enhancing social networks, promoting self-care and enhancing self-care and communication care - are all in themselves ways to reduce suicide.

Box 4: Myths and Facts about Suicide

Discussing suicide can be intimidating for many groups of young people and for many youth workers or educators. To start the discussion, we recommend that the youth worker review some common myths and facts about suicide:

Myth: People that threaten to commit suicide never do it.

Fact: Out of every 10 people who commit suicide, 8 give clear signs of their intentions.

Myth: A person who tries to commit suicide really wants to die.

Fact: Most suicidal people are in doubt about wanting to live or die and are open and/or want to talk to others about this decision.

Myth: Speaking openly about suicide and suicidal ideas can be dangerous.

Fact: Asking questions and allowing free expression of these ideas is the best way of outlining strategies of intervention and support for persons at risk.

BOX
4.*Box 5: Summary Points*

› As with other aspects of their lives and health, gender norms influence young men's emotional and mental health. For example, social expectations which espouse that "real men" must be "tough" and "brave" can lead young men to hide their fear, sadness, even kindness, and to not seek out help when they need it. The denial or repression of tensions and problems, as well as having difficulty in talking about the associated emotions, may in turn lead to the use of substances, including alcohol, as a coping mechanism.

› Globally, young men are more likely than young women to smoke, drink and use other substances. These behaviors generally form part of a constellation of male risk-taking behaviors, and are linked to various other problems that are also more commonly associated with young men, from involvement in traffic accidents to use of violence.

› Worldwide, suicide is a leading cause of death worldwide, and one of the three leading causes of death for young people under 25. When we breakdown suicide data by sex, we see that girls and women are more likely to attempt suicide but men are more likely due to die by suicide, generally because their methods are more lethal, such as firearms.

BOX
5.

Workshops

⚙️ Workshop 1: What is this thing called gender?

📍 OBJECTIVE:

To understand the differences between sex and gender and reflect on the ways that men and women are expected to act.

📋 MATERIALS REQUIRED:

Flipchart paper and markers.

🕒 RECOMMENDED TIME:

1 hour

📄 PLANNING NOTES:

When discussing the concepts and definitions of “man” and “woman” it is important to start with the words that are used by the participants themselves. If the group is shy, you should offer suggestions. Be sure to also address the use of words that might be derogatory or offensive.

PROCEDURE:

1. Draw two columns on flipchart paper. In the first column write “man.” In the second column write “woman.”
2. Ask the participants to make a list of things associated with the idea of being a man. Write these in the first column while they are being said. The responses can be positive or negative. Help the participants mention both social and biological characteristics.
3. Repeat the same process for the column labeled “woman.”
4. Briefly review some of the characteristics that were listed in each column.
5. Exchange the titles of the columns putting “woman” in the place of “man” and vice versa. Ask the participants if the characteristics mentioned for men could also be attributed to women and vice versa.
6. Use the questions below to facilitate a discussion about which characteristics the participants do not think can be attributed to both men and women, and why. Explain that those characteristics that are biological and that cannot be attributed to both men and women are considered sex characteristics and those that are social and can be attributed to both men and women are gender characteristics.

PROCEDURE

OPTIONAL STEP: To help reinforce the differences between sex and gender you might want to collect and present images of men and women that reflect examples of biological (sex) and social (gender) roles.

These might include: a woman washing dishes (gender); a woman breastfeeding (sex); and a man fixing a car or hunting (gender). Ask participants to identify whether gender or sex is represented in the photo and to explain their answers.

...images of men and women that reflect examples of biological (sex) and social (gender) roles...

DISCUSSION QUESTIONS:

1. What does it mean to be a man?
2. What does it mean to be a woman?
3. Do you think that men and women are raised in the same way?
4. What is a man’s role in an intimate relationship? What is a woman’s role?
5. How does a man express his emotions? Is this different from how a woman expresses her emotions? Why do you think that it is different?
6. How does a man express his sexuality? Is this different from how a woman deals with hers? Why do you think that it is different?
7. What is the role of the man in reproduction? Is it different from the woman’s role? In what way(s)?
8. Are our perceptions about the roles of men and women affected by what your family and friends think? How?
9. Do the media have an effect on gender norms? If so, in what way(s)? How do the media portray women? How do the media portray men?
10. How do these differences and inequalities in being a woman or a man affect our daily lives?
11. How do these differences affect our relationships with family and partners?
12. How can you, in your own lives, challenge some of the non-equitable ways men are expected to act? How can you challenge some of the non-equitable ways that women are expected to act?

QUESTIONS

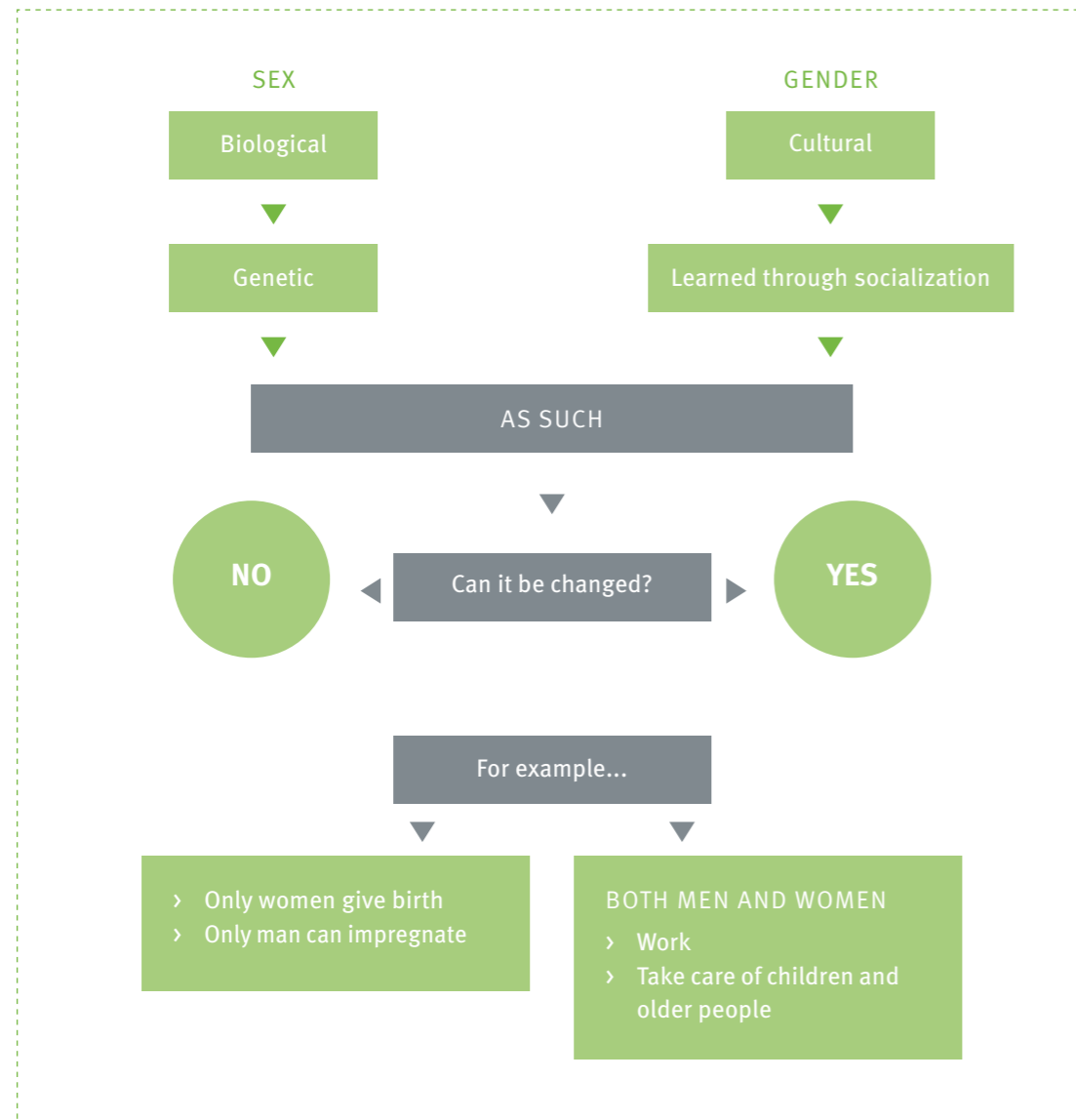
CLOSING:

Throughout our lives, we receive messages from family, media, and society about how we should act as men and how we should relate to women and to other men. It is important to understand that although there are differences between men and women, many of these differences are constructed by society, and are not part of our nature or biological make-up. Even so, these differences can have fundamental impacts on men’s and women’s daily lives and relationships. For example, a man is often expected to always be strong and dominant in his relationships with

others, including with his intimate partners. At the same time, a woman is often expected to be submissive to a man’s authority. Many of these rigid gender stereotypes have consequences for both men and women, as you will be discussing throughout these sessions. As you become more aware of how some gender stereotypes can negatively impact both men and women, you can think constructively about how to challenge them and promote more positive gender roles and relations in your lives and communities.

- > **SEX** – refers to the biological attributes and characteristics that identify a person as male or female
- > **SEXUALITY** – refers to the expression of our feelings, thoughts and behaviors as men or women. It includes our feelings of attractiveness, being in love and our behaviors in intimate relationships.
- > **GENDER** – refers to the socially constructed differences and inequalities between men and women (for example, how they should dress and behave). These ideas and expectations are learned through families, friends, religious and cultural institutions, schools, workplaces and the media.

The **DIAGRAM** below presents examples of sex and gender characteristics for men and women:



OBJECTIVE:
To understand how gender norms affect the lives of men and women.

RECOMMENDED TIME:
1 hour

MATERIALS REQUIRED:
Flipchart paper and markers.

PLANNING NOTES:
None.

PROCEDURE:

1. Ask the participants if they have ever been told to “act like a man.” Ask them to share an experience when someone said this or something similar to them. After a participant shares his experience, ask: Why do you think the person said this? How did it make you feel? Tell the participants that we are going to look more closely at these two phrases. By looking at them, we can begin to see how society can make it very difficult to be either male or female.
2. In large letters, print on a piece of flipchart paper the phrase “Act Like a Man.” Ask the participants to share their ideas about what this means. These are society’s expectations of who men should be, how men should act, and what men should feel and say. Draw a box on the paper, and write the meanings of “act like a man” inside this box. Some example responses are “be tough” or “don’t cry.”
3. Now in large letters, print on a piece of flipchart paper the phrase “Act Like a Woman.” Ask the participants to share their ideas about what this means. These are society’s expectations of who women should be, how women should act, and what women should feel and say. Draw a box on the piece of paper, and write the meanings of “act like a woman” inside this box. Some responses may include “be a good homemaker” or “don’t be too aggressive.”
4. Once you have finished brainstorming the two lists, initiate the discussion by using the questions below.

PROCEDURE

²⁰ – Adapted from “Men as Partners: A Program for Supplementing the Training of Life Skills Educators” developed by Engender Health and The Planned Parenthood Association of South Africa. For more information visit the Engender Health website: www.engenderhealth.org/ia/wm/wwmo.html

1. Which of these messages can be potentially harmful? Why? (Note: Facilitator should place a star next to each message and discuss each message one by one).
2. How does living in the box impact men's health? How does living in the box impact women's health?
3. How does living in the box limit men's lives and relationships? How does living in the box limit women's lives and relationships?
4. What happens to men who do not follow the gender rules (e.g. try to "live outside the box")? What happens to women who do not follow the gender rules? What do people say about them? How are they treated?
5. What is necessary to make it easier for men and women to live outside the boxes? How can we contribute?

OPTIONAL STEP: Divide the participants into small groups and ask them to develop a short skit (one or two minutes) that portrays someone telling another person to "act like a man" or "act like a woman/lady."

CLOSING

The purpose of this activity is to help us begin to see how society creates very different rules for how men and how women are supposed to behave. These rules are sometimes called "gender norms" because they say what is 'normal' for men to think, feel and act and what is 'normal' for women. However, these norms, as we will be discussing in other activities, can often restrict men and women by trying to keep them in their "Act like a man" or "Act like a woman/lady" boxes, with consequences for their decision-making, health and relationships.

...society creates different rules for how men and how women are supposed to behave...

QUESTIONS

Workshop 3: Expressing My Emotions

OBJECTIVE:
To recognize the difficulties young men face in expressing certain emotions and the consequences for themselves and their relationships.

MATERIALS REQUIRED:
Flipchart paper, markers, small pieces of paper, and Resource Sheet.

RECOMMENDED TIME:
1 hour

PLANNING NOTES:
Prior to the session, it is recommended that the facilitator go through this activity individually and reflect about his or her own ways of expressing emotions. It is also important to identify local counseling centers or professionals to whom young men can be referred if necessary.

PROCEDURE:

1. Draw five columns on flipchart paper and write the following emotions as headings: Fear, Affection, Sadness, Happiness, and Anger (see the Resource Sheet for an example of how to arrange the words and ranking described below).
2. Explain to the participants that these are the emotions²¹ which they will be discussing in this activity and that they will be thinking about how easy or difficult it is for young men to express these different emotions.
3. Give each participant a small piece of paper and ask them to write down the five emotions that are being discussed, in the order that you have written them on the flipchart paper. Next, read the following directions: *Think about which of these emotions you express with greatest ease. Put a number one (1) next to the emotion which is the easiest for you to show. Now think about the emotion you express easily but not as much as the first. Put a number two (2) next to that emotion. Put a number three (3) next to the emotion that falls in between; that is, it is neither too hard nor too easy to express. Put a number four (4) next to the one you have some difficulty expressing. Finally, put a number five (5) next to the emotion which you have the greatest difficulty expressing.*
4. After the participants have finished ranking their emotions, collect the pieces of paper and write down the rankings in the columns on the flipchart (see example).
5. With the entire group, reflect on the similarities and differences found among the participants. Explain that:
 - The emotions that we numbered as 1 and 2 are the ones we have often learned to express in an exaggerated way;
 - Numbers 4 and 5 are those that we have learned to express less, or maybe even to repress or keep hidden;
 - Number 3 may represent the emotion that we do not exaggerate nor repress but probably deal with more naturally.
6. Use the questions below to facilitate a discussion.

PROCEDURE

1. Have you discovered anything new about yourself from this activity?
2. Why do people exaggerate or repress certain emotions? How do they learn to do this? What are the consequences of exaggerating or repressing emotions?
3. Are there similarities in how men express certain emotions?
4. Are there differences between how men and women express emotions? What are the differences?
5. Do you think women express certain emotions more easily than men? Why do you think this is?
6. Why do men and women have different ways of expressing emotions? How do peers, family, community, media, etc. influence how men and women express emotions?
7. How does the way we express our emotions influence our relationships with other people (partners, family, friends, etc.)?
8. Is it easier or harder to express certain emotions with peers? With family? Intimate partners?
9. Why are emotions important? Give examples if necessary: Fear helps us in a dangerous situations; anger helps us to defend ourselves. Ask the participants for examples, also.
10. How do you think expressing your feelings more openly can affect your well-being and your relationships with other people (romantic partners, family, friends, etc.)?
11. What can you do to express your emotions more openly? How can you be more flexible in expressing what you feel? NOTE: It might be interesting to brainstorm as a large group different strategies for dealing with emotions and then encourage each of the participants to make a note of his personal reflections and, if he so desires, share his reflections with the others in small groups.

QUESTIONS

CLOSING

Emotions can be seen as a form of energy that allows you to perceive what is oppressing you or bothering you. Different emotions are simply the reflection of different needs, and it is best to learn how to deal with all of your emotions as they appear in your lives. Being able to express your emotions without causing harm to others helps to make you stronger individuals and helps you to relate better with the world around you. How each person expresses his or her emotions varies. However, it is important to note a number

of tendencies that emerge, particularly related to how boys are brought up. For example, it is often common for young men to hide their fear, sadness, and even their kindness. But it is also often common for them to express their anger via violence. Although you are not responsible for feeling certain emotions, you are responsible for what you do with what you feel. It is critical to distinguish between “feelings” and “acting” in order to find forms of expression that do not bring harm to yourself or to others.

Being able to express your emotions without causing harm to others

21 — Other proposals of feelings might emerge from the group which, generally speaking, fit in with or are related to one of those already mentioned. For example, hate relates to anger. Once a young man proposed indifference as an emotion, but in working through it, he discovered that the real feelings behind his indifference were fear and sadness. Also shame, guilt, or violence might come up as feelings. Explore with the participants what is behind these feelings and encourage them to reflect on the costs and consequences of such feelings.

It may be useful to connect this activity to “From Violence to Peaceful Coexistence” in which the men can use drama to practice non-violent alternatives to dealing with anger and conflicts in relationships.

Resource sheet

BELOW is an example of how to organize the columns of emotions and participant responses. During the discussion, the facilitator should help the participants identify similarities and differences in rankings. For example, the table below shows that there is almost an even split in the number of participants who find it easy to express anger and those who find it difficult. This could lead to a discussion of why these differences exist and, whether or not young men, in general, find it easy or hard to express anger. Another interesting pattern in the sample below is that most of the participants find it difficult to express fear. Often, men are indeed expected to be brave and fearless and this example would be interesting to use as a basis for discussion about socialization and gender norms.

	FEAR	AFFECTION	SADNESS	HAPPINESS	ANGER
Participant #1	5	4	3	2	1
Participant #2	2	3	4	1	5
Participant #3	4	1	3	2	5
Participant #4	4	3	5	2	1
Participant #5	5	1	3	2	4

FINALLY, it is important to remember that the collection and listing of rankings in the table should be anonymous. That is, each line of the table above should represent a different participant’s ranking but should not include his name. As in the example above, the facilitator can instead write a number to which the participants can easily refer during the discussion.

Workshop 4: Labeling

OBJECTIVE:
To recognize how labeling people can limit individual potential and affect relationships.

MATERIALS REQUIRED:
Pieces of paper, tape, and pens/pencils.

RECOMMENDED TIME:
1 hour and 30 minutes

PLANNING NOTES:
It is important to make sure that none of the participants become aggressive or offended by any of the labels used.

PROCEDURE:

1. Brainstorm positive and negative labels or stereotypes that are commonly used in the community in which the young men live. These might include labels such as: smart, lazy, shy, violent, etc. Try to think of at least as many different labels as there are participants in the group.
2. Write these labels on pieces of paper and tape a piece of paper on the back of each participant. Note: In order for this activity to be effective, it is very important that the participants should not be able to see the labels on their own backs; they should only be able to see other people's labels.
3. At random, ask two or three participants to carry out a short role play in which they relate to each other according to the labels they have been given.
4. Ask each of the participants in the role play to try to guess what their label is based on the way they were treated and then think about the following questions:
 - › How did it feel having someone treat you according to a label?
 - › How did it feel treating someone else according to a label?
 - › After the volunteers have answered these questions, ask the larger group for reactions to the role play.
5. Ask for other volunteers to carry out other role plays, allowing time after each role play for the volunteers to try to guess their labels and to reflect on how they felt.
6. Open up the discussion to the larger group.

PROCEDURE

DISCUSSION QUESTIONS:

1. How do you react when you are treated according to a label?
2. How do you react when you, or someone else, treat another person according to a label?
3. Are these labels commonly used in your community? What other examples of labels do people use?
4. Why do people label others?
5. What are the effects of labeling individuals? What are the effects on relationships?
6. Thinking about the previous activity about power and relationships, what do you think is the link between labeling and power?
7. What have you learned here that you can apply in your own lives and take back to your communities?
8. How can you avoid labeling others?
9. How can you encourage other young people to not label others?

CLOSING:

Labels and stereotypes affect people as individuals as well as their relationships with others. It is important to think critically about how you treat people and the way that people treat you and how you can “unlearn” some of the ways that you interact with others. For example, how to not:

1. Be judgmental of someone before you get to know them;
2. Use labels or negative nicknames;
3. Discriminate based on sex, religion, ethnicity, or socioeconomic class;
4. Make someone in the family and/or community a scapegoat;
5. Be inflexible or stubborn in your attitudes;
6. Show indifference, silence, or spite.

The feeling of belonging to a group and being accepted for who we are, are fundamental for learning and for developing our individual and collective potential. As you move forward with these sessions and with your daily lives, you should actively try to move beyond labels and be more open-minded in how you relate to others.

QUESTIONS

...feeling of belonging to a group and being accepted for who we are fundamental...

Workshop 5: Power and Relationships

OBJECTIVE:

To increase awareness about the existence of power in relationships and reflect on how we communicate about and demonstrate power in relationships.

RECOMMENDED TIME:

1 hour and 30 minutes

PLANNING NOTES:

None.

MATERIALS REQUIRED:

None.

PROCEDURE:

Part 1 – The Mirror Activity

1. Ask the participants to stand up and get into pairs. Each pair should then decide which one of them will be the “person” and which will be the “mirror”. Explain that, within each pair, the “mirror” must imitate every movement done by the “person”. Give them 2-3 minutes to do this.
2. Ask each pair to swap roles and to repeat the process.
3. Use the questions below to facilitate a discussion about what happened:
 - How did you feel when you were the “person”?
 - How did you feel when you were the “mirror”?
 - In your lives, are there times when you feel like you did as a “person”? When?
 - In your lives, are there times when you feel like you did as a “mirror”? When?

Part 2 – Power in Relationships

1. Assign pairs of participants to develop and present short skits which depict the power dynamics involved in the relationships below. The facilitator should add any other types of relationships that are relevant to the local contexts and experiences. Ask each pair to swap roles and to repeat the process.
 - Teacher and Student
 - Parent and Child
 - Husband and wife
 - Boss and employee
2. After the skits, use the questions below to facilitate a discussion.

PROCEDURE

QUESTIONS

DISCUSSION QUESTIONS:

1. Are these skits realistic?
2. In your daily life, do others use their power in negative ways? Who? Why?
3. In your daily life, do you use your power in negative ways? Who? Why?
4. Why do people treat each other like this?
5. What are the consequences of a relationship where one person might treat another person like an “object”?
6. How does society/culture perpetuate or support these kinds of relationships where some people have more power over other people?
7. How can this activity help you think about and perhaps make changes in your own relationships?

CLOSING:

There are many different types of relationships in which one person might have more power over another person. As you will discuss throughout many of the activities in this manual, the unequal power balances between men and women in intimate relationships can have serious repercussions for the risk of STIs, HIV/AIDS, and unplanned pregnancy. For example, a woman often does not have the power to say if, when, and how sex takes place, including whether a condom is used, because of longstanding beliefs that men should be active in sexual matters and women should be passive (or that women “owe” sex to men). In other cases, a woman who is dependent on a male partner for financial support might feel that she does not have the power to say no to sex. In cases of cross-generational sex, the age and class differences between men and women can

further create unequal power relations that can in turn lead to risk situations.

There are also other examples of power relationships in your lives and communities. Think of relationships between youth and adults, students and teachers, employees and bosses. Sometimes the power imbalances in these relationships can lead one person to treat another person like an object. As you discuss gender and relationships between men and women, it is important to remember the connection between how you might feel oppressed in some of your relationships and how you, in turn, might treat others, including women, like “objects.” Thinking about these connections can help motivate you to construct more equitable relationships with other men and with women in your homes and communities.

Workshop 6: Scenes of Dating²²

OBJECTIVE:

To identify the characteristics of a healthy relationship.

RECOMMENDED TIME:

1 hour

MATERIALS REQUIRED:

Flipchart paper, markers, scissors, paste, and copies of Resource Sheet.

PLANNING NOTES:

There might be different opinions about what qualifies as a healthy or unhealthy relationship. Prior to starting the activity, the facilitator should work with the group to come to a consensus.

PROCEDURE:

1. Draw two columns on a piece of flipchart. Label one column “healthy relationships” and the other “unhealthy relationships.”
2. Divide the participants into three or four small groups and give each group a copy of the Resource Sheet - Dating Situations.
3. Ask each group to cut, sort and tape the dating situations under either the “healthy” or “unhealthy” column. Allow the groups 15 minutes to do this. Tell the groups that if time permits, they can use the blank squares at the bottom of Resource Sheet to come up with their own scenarios and classify them as either healthy or unhealthy.
4. Review the Dating Situations and ask each group to explain why they classified them as “healthy” or “unhealthy.”
5. Use the questions below to wrap-up the discussion.

PROCEDURE

DISCUSSION QUESTIONS:

1. Are these situations realistic?
2. Have you ever been in any of these situations? How did you feel?
3. How does the community respond to these situations?
4. What are the most common characteristics of healthy relationships?
5. What are the most common characteristics of unhealthy relationships?
6. Do you think young people in your community usually have healthy or unhealthy relationships? Explain.
7. What are the greatest challenges to building a healthy relationship? How can these challenges be faced?
8. What should you do if you think you are in an unhealthy relationship?
9. What could you do if a friend is in an unhealthy relationship?

QUESTIONS

CLOSING:

A healthy relationship is one that is based on mutual respect and free of physical or emotional manipulation, control or abuse. It is important to know what you value in romantic relationships and to know how to be assertive (as opposed to aggressive or

dominant) as well as how to listen. Everything that happens in a relationship, whether it is a choice of what to do on a date or what sort of physical relations to engage in or not, should be a matter of mutual discussion, mutual respect, and consent.

Resource sheet

DATING SITUATIONS			
You've made plans with your partner and s/he cancels the plans at the last minute because s/he doesn't think what you've planned would be much fun.	He calls her a stupid — during an argument.	You take turns picking the band or television show you'll watch.	Your partner is critical of your friends.
He grabs her arm during an argument.	He drives fast and she says it makes her uncomfortable. He slows down and apologizes for making her feel that way.	He tells his friends that he “scored” with her last night when all they did was talk.	He is pressuring her to have sex.
He grabs her arm during an argument.	Even if you have different beliefs and points of view, you can respect each other's views.	He thinks she wants to have sex if she is dressed in a low-cut top and short skirt.	When one of you has some good news, you celebrate together.
She doesn't want him to go out with his friends. She says she can't trust him farther than she can throw him.	You both share the cost of the dinner and movie.	When they go out together he's always looking at other women's bodies. Sometimes he comments on how “hot” they are.	You get angry at something but always talk it out together, listening to each other's point of view.
Whenever she has trouble reading the map, he rolls his eyes and says, “Oh I guess it's genetic that girls don't have any spatial sense.”	He calls her the next day after an important date to say what a great night he had and he hopes she slept well.	She decides to cheat on him to try to make him jealous.	She cheats on him. He gives her a black eye.
They go on a camping trip and before they go, they make a list of what they need and do the shopping and prep together.	She tells him that he could use a bit of help with picking out his clothes. She also tells him that he could kiss better.	When she hears that he cheated on her, he says he was drunk and it wasn't his fault.	He's pressuring her to let him take naked photos of her. He plans to post them on the Internet, saying, “Oh baby, you just look so hot and I want the world to see you.”
The night before a big essay is due, he demands that she write his essay for him because he hasn't had time.	They tell each other when they are going through a difficult time at home or school.	He feels he always has to be strong in her presence.	When she's angry at him, he listens carefully to what she's saying.

22 — Adapted from: White Ribbon Campaign Education and Action Kit. White Ribbon Campaign, Toronto, Canada. For more information, visit http://www.whiteribbon.ca/educational_materials/

Workshop 7: Aggressive, Passive or Assertive²³

OBJECTIVE:
To learn the difference between assertive, aggressive and passive communication.

MATERIALS REQUIRED:
Flipchart paper, markers and copies of Resource Sheets B and C.

RECOMMENDED TIME:
1 hour and 30 minutes

PLANNING NOTES:
Prior to the session, it is recommended that the facilitator go through this activity individually and reflect about his or her own ways of expressing emotions.

PROCEDURE:

1. Review the examples of the different types of communication presented in Resource Sheet A. Be sure to review the definitions of aggressive, passive and assertive and the concepts of communicator, receiver and bystander.
2. Divide the participants into three groups and distribute copies of Resource Sheet B.
3. Tell the groups that they should complete Resource Sheet B either by using direct examples from their own lives, or by coming up with fictional scenarios. Allow the groups 15 minutes to complete the Resource Sheet.
4. Ask the groups to pick one of their examples to present as a skit to the other groups. In each group, one student will take the role of Communicator, one will be the Receiver and the others will be the Bystanders. Allow the groups 10 minutes to rehearse their skits.
5. After the presentation of the skits, facilitate a discussion using the questions below.

DISCUSSION QUESTIONS:

1. What types of communication were presented in the skits?
2. Were these skits realistic?
3. What are the benefits of assertive communication?
4. Over time, what happens to people who communicate passively?
5. What types of communication do young men most use with each other? Why?
6. What types of communication do young men most use in their intimate relationships with women? Why?
7. How is aggressive behavior related to violence?
8. What types of communication are linked to healthy relationships?
9. What types of communication are linked to unhealthy relationships?
10. What happens when aggressive behavior is not confronted?
11. Are young men ever bystanders in your community? When? Why?
12. What have you learned from this exercise? How can you apply this in your own lives and relationships?

PROCEDURE

QUESTIONS

CLOSING:

Assertiveness is the skill of clearly representing your thoughts and feelings in a respectful way that does not employ guilt, infringe on others' rights or use emotional blackmail. On the other hand, aggressive behavior can silence people. It is important to know how to identify and handle situations when dating and interpersonal relationship behavior is unhealthy.

LINK:

The activity “[What do I do when I am angry?](#)” can help participants think about how to identify when they are angry and how it might affect the way they communicate. This activity can be linked to “[Scenes of Dating](#)” and a discussion of what types of communication contribute to healthy or unhealthy relationships.

Resource sheet A

COMMUNICATION TYPE	SCENARIO	HOW IS THE COMMUNICATOR ACTING?	HOW DOES THE RECEIVER ACT?	WHAT CAN THE BYSTANDER DO/ SAY?
ASSERTIVE Assertive: tending toward bold or confident declaration of opinions and feelings	The principal (communicator) was speaking to me (receiver) in the hall about the good job I did on my science project.	Treating me with respect. Acknowledging my hard work. Paid attention to what I was saying and now what was going on in the hallway.	Happy. Wanted to share with the principal how much I liked my science class and how I want to study science all the time.	Listen Not interrupt Offer words of encouragement to Receiver
AGGRESSIVE Aggressive: tending toward or exhibiting hostile, forceful or destructive behavior	Jeb and Renee have been dating for about three months. Jeb gets angry when Renee has to go to class without him and he thinks other guys want to get with Renee. One day when Renee walks back to their locker with Rizwan, Jeb (with his arms folded and in an angry voice) says “What exactly do you two think you are doing?”	He is acting superior and controlling. He thinks he owns Renee. He does not trust or respect Renee.	Scared, unsure. Silenced. Angry. Caught off guard. Unsure what to say but wants him to stop making a scene.	Assess the safety of confronting Jeb Confront Jeb using “I” statements such as “I feel you are treating Renee poorly.” Either during the incident or after it tell Renee and Rizwan that you feel they were treated aggressively by Jeb.
PASSIVE Passive: receiving or enduring something without being active, open or direct	Fatima (communicator) sits on the yearbook committee. She is always working on the project after school and over every lunch hour. Angela offers to help here because she knows she is supposed to be working on the project with Fatima. However, Fatima seems aloof and just shrugs here shoulders when Angela talks to her about it.	Vague, unsure of herself, seems a bit shy. Makes Angela feel she has to guess what Fatima’s needs are.	Not sure what Fatima wants. Angela asks for clarification but Fatima is reluctant. Makes Angela frustrated and Angela wants to cut the conversation short. Angela feels Fatima is incompetent.	Listens. Tries to guess what the problems might be. Tells Fatima that she shouldn’t have to do this all alone.

COMMUNICATION TYPE	SCENARIO	HOW IS THE COMMUNICATOR ACTING?	HOW DOES THE RECEIVER ACT?	WHAT CAN THE BY-STANDER DO/SAY?
ASSERTIVE				
AGGRESSIVE				
PASSIVE				

⚙️ Workshop 8: Negotiating Skills²⁴

📍 OBJECTIVE:
To discuss and practice skills for conflict resolution and negotiation.

🕒 RECOMMENDED TIME:
2 hours

📄 MATERIALS REQUIRED:
Flip-chart, paper, pens, tape, and a sufficient number of copies of the Resource Sheet for each participant.

📝 PLANNING NOTES:
None.

PROCEDURE:

PART 01.

1. Prior to the session prepare two pieces of flipchart with the information from the Resource Sheet.
2. Carry out a brainstorm with the participants of common conflict scenarios which they face in their relationships and community. Encourage the participants to think of different kinds of relationships e.g. girlfriend and boyfriend, parent and child, boss and employee, neighbors.
3. Divide the participants into small groups and assign each one of the conflict scenarios.
4. Review the flipchart with “Ways of Resolving Conflicts” and explain that each group should develop a short skit to illustrate how the conflict could be resolved using one of the methods from the flipchart.
5. Invite the groups to present the skits and ask the participants to identify the different methods of resolving conflict.
6. Facilitate a short discussion of the benefits and disadvantages of the different methods.

PART 02.

1. Review the flipchart with “Four Steps of Successful Win/Win Negotiation”
2. Ask the participants to return to their groups and discuss an example of a win/win negotiation and develop a role-play to demonstrate it.
3. Invite the groups to present the role-plays.
4. Use the questions below to wrap-up the session.

PROCEDURE

²⁴ — Adapted from: CEDPA “Choose a Future! Issues and Options for Adolescent Boys” 1998 Centre for Development and Population Activities: Washington, D.C.

1. Why is it sometimes difficult to negotiate a solution to a conflict?
2. What makes it easier to negotiate? What makes it harder?
3. What are examples of situations in which you would be unwilling to compromise?
4. What have you learned from this activity? How can you apply this in your lives and relationships?

CLOSING:

Negotiating is a fact of life but it is not always easy. Learning and practicing negotiating skills can help you to resolve conflicts in different spheres of your lives and build healthier and more equitable relationships.

LINK:

The activity “[What do I do when I am angry?](#)” can help participants think about how to identify when they are angry and how it might affect the way they communicate. This activity can be linked to “[Scenes of Dating](#)” and a discussion of the importance of negotiation in building healthy relationships.

Resource sheet

Ways of Resolving Conflict (Part 1)

- › **Avoid conflict:** Simply withdraw from any conflict
- › **Smooth it over:** Pretend there is no conflict and everything is OK
- › **Win at all costs:** Get what you want; the other person loses
- › **Compromise:** Give up something you want to get something else that you want
- › **Win/win negotiation:** Use creative problem solving to give both people what they want or need.

Four Steps of Successful Win/Win Negotiation (Part 2)

1. **State your position.** Use “I” statements, say what you want or need.
2. **Listen to the other person’s position.** Find out what the other person needs or wants. Restate the other person’s position to be sure that you understand.
3. **Brainstorm win/win solutions.** Take into account both partners’ needs and wants. Be creative.
4. **Agree on a solution.** Try it out. If it does not work, start the process over again.

⚙️ Workshop 9: What are drugs?

📍 OBJECTIVE:
To discuss the different types of drugs that exist and how they are viewed and used by society, particularly young people.

🕒 RECOMMENDED TIME:
2 hours

📦 MATERIALS REQUIRED:
Four pieces of flip chart paper, tape and markers.

📖 PLANNING NOTES:
As facilitator, it is important to discuss this theme in an open-minded way. The young men themselves will no doubt have criticisms on the hypocritical attitudes of some adults and many policies and laws related to substance use.

PROCEDURE:

1. Prior to the session, write each of the following questions on a separate piece of flip chart paper:
 - › a) What comes to mind when you hear the word “drugs”?
 - › b) Who uses drugs?
 - › c) What are some examples of drugs and where are they available?
 - › d) What are the risks associated with using drugs?
2. Put up the four pieces of paper in different areas of the room.
3. At the beginning of the session, divide the participants into four groups.
4. Assign each group to one of the four questions. Explain that each group has 10 minutes to discuss the question and write out their responses on the flip chart paper. For low literacy groups, read aloud the questions and ask them to discuss amongst themselves.
5. After 10 minutes, tell all of the groups to rotate clockwise. Give them another 10 minutes to discuss the new question and write out their responses.
6. Repeat steps 4 and 5 until all of the groups have had an opportunity to discuss and respond to the each of the four questions.
7. Read aloud and summarize the responses provided on the flip chart papers. If the groups did not write out their responses, ask them to share with the larger group what they discussed.
8. Use the questions below to facilitate a discussion about different types of drugs and the different types of uses among young people.

PROCEDURE

1. Did all of the groups have the same ideas about what drugs are, who uses them and the risks related to their use? (review the content of Resource Sheet with the group)
2. Do people in your community have easy access to alcohol and cigarettes? (Is it prohibited for minors under the age of 18? Are these laws enforced?)
3. Do people have easy access to other types of drugs?
4. What do you think determines whether the use of a drug is legal (licit) or prohibited (illicit)?
5. Are advertisements for cigarettes and alcohol allowed in newspapers, magazines, or television? How do these advertisements try to promote the use of these substances? What do you think of this?
6. How do these media advertisements portray the women who use their products? How do these media advertisements portray the men who use their products? Do you think that these portrayals are accurate? How do these media advertisements influence women's and men's attitudes about cigarettes and alcohol?
7. Are there campaigns where you live that try to reduce the use of drugs? What do you think of these campaigns?
8. What actions can you ensure that people in your community have accurate information about the consequences of using drugs?

CLOSING:

Drugs touch the lives of most women and men. There exist many different types of drugs, some legal, some illegal, some more commonly used by men, some more commonly used by women, etc. It is important to think about the different personal and social pressures that might lead young women and young men to use different types of drugs and to be aware of the consequences that drug use can have on individual lives, relationships and communities. In the next activity, we will be discussing some of these consequences more in-depth.

Resource sheet

What are drugs?²⁵

A drug can be defined as any substance that is capable of producing changes in the functioning of a living organism, be it physiological or behavioral. There is a special category of drugs, called psychoactive or psychotropic, that alter the mood, perceptions, sensations and behaviors of the user in accordance to the type and the quantity

of drug consumed, the physical and psychological characteristics of the user, the moment and context of usage, and the expectations the person has in relation to the drug. These psychoactive or psychotropic drugs can be classified in three groups according to their effect on brain activity:

QUESTIONS

Resource sheet

- › **Depressants:** depress brain activity, causing sluggishness and disinterest. Examples include alcohol, sleeping medicines and inhalants.
- › **Stimulants:** increase brain activity, causing wakefulness and alertness. Examples include appetite control medicines, cocaine and caffeine.
- › **Hallucinogens:** modify brain activity by altering how reality, time, spaces and visual and auditory stimulants are perceived. Examples include ecstasy and LSD.

DEPRESSANTS	SENSATION THEY PROVOKE	EFFECTS THEY CAN CAUSE
TRANQUILIZERS	Relive tension and anxiety, relaxes the muscles and induces sleep.	In high doses they cause a drop in blood pressure; combined with alcohol, they can lead to a state of coma; in pregnancy, they increase the risk of fetal malformation. They generate tolerance, requiring increase in dosage.
SOLVENTS OR INHALANTS (GLUE, VANISH, BENZENE, LIQUID PAPER)	Euphoria, hallucinations and excitation.	Nausea, drop in blood pressure; repeated use can destroy neurons and cause lesion in the spleen, kidneys, liver and peripheral nerves.
COUGH SYRUPS AND DROPS WITH CODEINE OR ZIPEPROL	Pain relief, feeling of well being, sleepiness, floating sensation.	Drop in blood pressure and temperature; risk of coma; convulsion, generates tolerance, requiring increase in dosage; when withdrawn, dependent users experience cramps and insomnia.
SEDATIVES	Relive tension, calm and relaxing sensation.	In association with alcohol, cause a drop in blood pressure and breathing rate, which can lead to death. Generates tolerance, requiring increase in dosage and dependence.
OPIUM, MORPHINE, HEROINE	Somnolence, pain relief, state of torpor, isolation from reality, sensation of wakeful dreaming, hallucination.	Cause dependence; reduce the rhythm of heart-beat and breathing and can lead to death; collective use of syringes spreads AIDS; difficult withdrawal.
ALCOHOL	Euphoria, frees speech, feeling of anesthesia.	Slight tremors and nausea, vomiting, sweating, headaches, dizziness and cramps, aggressiveness and suicidal tendencies.

25 — Adapted from: White Ribbon Campaign Education and Action Kit. White Ribbon Campaign, Toronto, Canada. For more information, visit http://www.whiteribbon.ca/educational_materials/

STIMULANTS	SENSATION THEY PROVOKE	EFFECTS THEY CAN CAUSE
AMPHETAMINES	Resistance to sleep and tiredness, tachycardia, sensation of being "turn on", full of energy.	Tachycardia and increase in blood pressure; dilatation of the pupil, danger for drivers, high dosage can cause persecution deliria and paranoia.
COCAINE	Sensation of power, of seeing the world more brilliant, euphoria, loss of appetite, sleep and tiredness.	In high dosage, causes an increase in temperature, convulsion and severe tachycardia, which can result in cardiac arrest.
CRACK	Sensation of power, of seeing the world more brilliant, euphoria, loss of appetite, sleep and tiredness.	In high dosage, causes an increase in temperature, convulsion and severe tachycardia, which can result in cardiac arrest. Causes a strong physical dependence and high mortality.
TOBACCO (CIGARETTE)	Relive tension, calm and relaxing sensation.	Reduces appetite, can lead to chronic states of anemia, Aggravates diseases such as bronchitis, and can perturb sexual performance. In pregnant women increases the risk of miscarriage. Is associated with 30% of all types of cancer.
CAFFEINE	Resistance to sleep and tiredness.	Excessive dosage can cause stomach problems and insomnia.

HALLUCINOGENS	SENSATION THEY PROVOKE	EFFECTS THEY CAN CAUSE
MARIJUANA	Calmness, relaxation, desire to laugh.	Immediate loss of memory; some people can have hallucinations; continuous use can affect the lungs and the production (temporary) of spermatozoa.
LSD	Hallucinations, perceptive distortions fusion of feelings (sound seems to acquire forms.	Sates of anxiety and panic; delirium, convulsions; risk of dependence.
ANTICHOLLINERGICS (PLANTS SUCH AS LILY AND SOME MEDICINES)	Hallucinations.	Drop in blood pressure and temperature; risk of coma; convulsion, generates tolerance, requiring increase in dosage; when withdrawn, dependent users experience cramps and insomnia.
SEDATIVES	Relive tension, calm and relaxing sensation.	Bad trips; tachycardia, dilation of the pupils, intestinal constipation and increase in temperature can lead to convulsions.
ECSTASY (MDMA)	Somnolence, pain relief, state of torpor, isolation from reality, sensation of wakeful dreaming, hallucination.	Bad trips; with states of anxiety and panic, convulsions, risk of dependency.

⚙️ Workshop 10: Drugs in our lives and communities

📍 OBJECTIVE:
To discuss various situations in which men and women might use drugs and the consequences of this use in their lives and relationships.

🕒 RECOMMENDED TIME:
2 hours

📄 MATERIALS REQUIRED:
Copies of case studies from Resource Sheet A

📖 PLANNING NOTES:
Review the cases studies from Resource Sheet A and make any necessary adaptations or changes for the local context. If these case studies are not applicable, you should create new ones more relevant to the reality and experiences of the participants. If possible, invite a professional, or someone else knowledgeable in drugs, to participate in this session.

PROCEDURE:

1. Divide the participants into four small groups. Give each group a copy of one of the case studies from Resource Sheet A. Explain that each group should discuss and analyze the case study and come up with a possible ending. For low literacy groups, you can read the situations aloud.
2. Allow the groups 10 minutes to discuss the case studies.
3. Ask the groups to present the case studies and endings they developed. These presentations can be done in the form of a narrative or a skit. The groups should address the following questions in their presentation:
 - › Is the situation realistic? Why or why not?
 - › What factors influenced the character's decision to use drugs?
 - › What are some possible consequences that the character might face? (see Resource Sheet B)
 - › What other options did they have? (Other than using drugs?)
4. After the presentation of the case studies, use the questions below to facilitate a discussion about the different contexts in which young people use drugs and the consequences of this use.

PROCEDURE

1. What are the most common reasons men use drugs? Are these different from the most common reasons why women use drugs? In what ways?
2. Are there different degrees, or levels, to which an individual can use a drug? What are these different degrees? (see Resource Sheet C)
3. What are the cultural norms around alcohol use in your community/country?
4. What effects do alcohol and other substances have on sexual decision-making and behavior? (see Resource Sheet C)
5. How can drinking alcohol or using other substances make someone more vulnerable to unplanned pregnancies and STIs, including HIV/AIDS?
6. How does the use of drugs affect relationships? Families? Communities?
7. What actions can you take if a friend is abusing alcohol or other substances? (Carry out a brainstorm with participants then use Resource Sheet D to add to/complement their ideas.)
8. How can we create other forms of fun and social activity where alcohol and other substances are not the most important things?

QUESTIONS

CLOSING:

It is difficult to generalize the motives that lead a person to use drugs. Each person has his or her own motives and sometimes these motives are not even clear to the individual. In the majority of cases it might be a variety of factors, not just one, which leads an individual to use drugs, for example: curiosity, a desire to forget problems, an attempt to overcome shyness or insecurity, dissatisfaction with one's physical appearance, etc. Young men often use alcohol at higher rates than young women, because they may believe that

using alcohol helps prove their manhood or helps them fit in with their male peer group. It is necessary to question the norms around alcohol use and to think about how you and others can create forms of leisure and entertainment which do not include alcohol at the center. It is important that family, friends, and peers offer support, without blame or judgment, to help the individual reflect on the harms of drug use and identify healthy alternatives, and, when necessary, how to seek competent professional help.

Resource sheet A

CASE STUDIES ON DRUG USE

Case Study # 1

Tomislav is a quiet boy who likes to hang out with friends and play football. On Saturday, some friends invited him to go to a bar to drink and hang out. When he got there he felt very shy and insecure and gave in to his friends urging and teasing for him to drink. He ended up drinking four bottles of beer in a very short time.

Case Study # 2

Ivan loves soccer and was invited to participate in an inter-school championship. He has been training very hard. Hoping to improve his game, he decided to take some steroids that a friend of his bought at a gym.

Case Study # 3

Sara and Filip have been dating for several months. On Filip's birthday, Sara organized a surprise party for him. She invited all of their friends and even got her older brother to buy some beer for the party. Filip was indeed very surprised and both he and Sara drank and danced a lot at the party. That night they had sex without a condom.

Case Study # 4

It's New Years Eve. Everybody is partying and drinking a bit. Someone has brought some ecstasy. Marijana, like most of her friends at the party, thinks: "Why not to bust some atmosphere here with one ecstasy? One can't be harmful, right?"

Case Study # 5

Kruno had a bad day at school; he got bad marks in physics and literature. He decides to relax in the park with friends. One of his friends has some pot, marijuana. Kruno decides to try some pot and see for himself if it really helps you to relax like everyone is saying.

Case Study # 6

Friday night a group of friends go to a disco to meet some girls they like. The party is groovy, the music is great, and the girls are there. Darko sees some of them taking pills and he realizes that it is ecstasy. One of the girls, Matija, comes over and offers him some. Darko refuses, but Matija pushes him "Try some, it will help you relax and enjoy!". Darko grabs a pill and swallows it.

EFFECTS OF DIFFERENT SUBSTANCES

ALCOHOL

In small doses, alcohol can create a sensation of relaxation, calming, well-being, and sometimes even a mild euphoria. When ingested in large quantities, it can cause a lack of motor coordination, mental confusion, sleepiness, and slower reflexes. These effects can lead an individual to engage in various high-risk behaviors, including unprotected sex, driving under the influence, and/or violence. When alcohol is consumed with high frequency, there is an increased risk of cirrhosis, brain problems, and other chronic problems.

Having one drink can be pleasant at a meeting, party, or get together with friends. One drink²⁶ is considered the following: **1 can of beer** (± 300ml) or **1 glass of wine** (120ml) or **1 shot of liquor** (36ml). Two drinks per day for men and one drink per day for women and older people are generally considered to be non-detrimental. However, for some people, even low quantities of alcohol can be extremely harmful. In general, women tend to have a lower tolerance for alcohol than men, in part because they typically have a higher proportion of fat and a lower proportion of water in their bodies than men: therefore, a woman will have higher blood alcohol content than a man who is of the same weight and who drinks the same amount. Additionally, women have lower levels of an enzyme which breaks down alcohol in the stomach, so they absorb a higher concentration of alcohol than a man who drinks the same amount.

A woman who drinks alcohol during pregnancy risks the health of her unborn child. Alcohol

passes freely through the placenta, creating a level in the fetus almost identical to that in the mother. Babies whose mothers drank frequently or heavily during pregnancy may be born with serious birth defects, including low birth weight, physical deformities, heart defects, joint and limb deformities, heart defects, joint and limb malformations and mental retardation.

PRESCRIPTION MEDICINES

The purpose of medicine is to cure disease, relieve pain or suffering, and promote well-being. However, if used by people who do not need it or if used in high or inadequate doses, medicine can damage one's health.

For example, amphetamines are often misused, and this can lead to heart problems, paranoia, or convulsions, among other things. Because amphetamines are stimulants, and therefore increase one's stamina and physical energy, they are sometimes used by students to pull all-nighters. Additionally, varying perceptions of beauty often lead women to endanger their health by taking amphetamines to lose weight in pursuit of the "perfect" body.

Tranquilizers, also known as "calmers," cause the brain (the central nervous system) to act more slowly. They are often used to treat anxiety and some sleep disorders. As the body becomes accustomed to tranquilizers, the initial symptoms can disappear and the user can develop a tolerance to and dependency on the substance. When combined with others drugs—such as alcohol—

tranquilizers can have more intense side effects, which in turn can increase some health risks, such as respiratory depression or cardiac arrest.

MARIJUANA

Marijuana is one of the most frequently used illegal drugs today. Its most common effects are the sensation of well-being and relaxation. Sometimes users can become very chatty, anxious, or see hallucinations. While a young person experimenting with this drug may not become addicted, even innocent experimentation can have detrimental health effects such as problems with memory, thinking clearly, coordination, and an increased heart rate, or it may result in problems with the law, since it is an illegal substance. Long-term users who smoke marijuana have an increased likelihood of respiratory illnesses, such as a persistent cough or lung cancer. Users may also suffer from personality disorders, such as depression or anxiety. The drug most often causes the greatest risk during the intoxication period itself, because the user can lose the capacity to carry out actions such as driving a motorcycle or car.

COCAINE

Surveys indicate that cocaine use is much less common than the use of other drugs such as alcohol and tobacco. Cocaine use can lead to dependency and can affect both mental and physical functions. Mental effects include euphoria, hyperactivity, visual and tactile hallucinations, and the sensation of being pursued. Some physical effects are an abnormally high heart rate, convulsions, and chills. Cocaine is particularly harmful when used with alcohol. Cocaine is also an appetite suppressant, which has led some women to use it to lose or keep off weight.

Cocaine can cause damage to the body at the time of use as well as afterwards. Some users report heightened sexual stimulation at the beginning of their use. However, regular use can decrease sexual desire and cause impotence.

Cocaine can be snorted or injected. When injected, there is the additional risk of transmitting diseases such as HIV/AIDS and Hepatitis B and C.

Marijuana is one of the most frequently used illegal drug...

26 — Adapted from nº 06 da Série Diálogo. Álcool: o que você precisa saber. 4ª ed., Brasília: Presidência da República, Gabinete de Segurança Institucional. SENAD, 2003.

STEROIDS

Steroids are most often used to accelerate the building of muscle. They are typically taken orally in pill form or injected. Steroids are artificial versions of 'testosterone,' a naturally produced hormone in the body. In some cases, people use steroids not intended for human use. For example, there are reports of young people ingesting steroids intended for veterinary use, again in order to rapidly increase their muscle mass.

Steroids have a variety of physical effects. They can decrease the function of the immune system, which is the body's defense system against germs. They can also damage the liver, cause cancer, and change normal hormonal function, i.e. interrupting menstruation in women and affecting the hypothalamus and reproductive organs. They can even cause death. Steroids can also have emotional affects, such as causing depression or irritability.

Steroids can also have sex-specific effects. For women, these include: alteration of the menstrual cycle, deepening of the voice, decrease in the size of the breasts, excessive hair growth, and changes in disposition, including aggressiveness and anger. Common effects for men include: breast development, reduced sexual function and infertility, and testicular atrophy.

As with any injected drug, sharing needles for injecting steroids can lead to the transmission of HIV/AIDS and Hepatitis B and C.

TOBACCO²⁷

Tobacco products are products made entirely or partly of leaf tobacco as raw material, which are intended to be smoked, sucked, chewed or snuffed. All contain the highly addictive psychoactive ingredient, nicotine. Tobacco use is one of the main risk factors for a number of chronic diseases, including cancer, lung diseases, and cardiovascular diseases. It is currently responsible for the death of one in ten adults worldwide (about 5 million deaths each year). Despite this, it is common throughout the world although a number of countries have legislation restricting tobacco advertising, and regulating who can buy and use tobacco products, and where people can smoke.

...main risk factors for a number of chronic diseases, including cancer, lung diseases...

27 — Source: World Health Organization website www.who.int

TYPES OF SUBSTANCE USERS

The United Nations distinguishes four types of substance users:

THE EXPERIMENTER – Limits himself/herself to experimenting one or several substances, for various reasons, e.g., curiosity, desire for new experiences, peer pressure, publicity, etc. In most cases, contact with the substance does not go beyond the initial experiences.

THE OCCASIONAL USER – Uses one or several substances occasionally if the environments are favorable and the substance is available. There is no dependency or rupture of affective, professional, and social relations.

THE HABITUAL USER – Makes frequent use of substances. In his/her relationships, one can already observe signs of breaking away. Even so, he/she still functions socially, though in a precarious way, and running risks of dependence.

THE DEPENDENT OR “DYSFUNCTIONAL” USER – Lives through substance use and for substance use, almost exclusively. As a consequence, all social ties are broken, which causes isolation and marginalization. ing who can buy and use tobacco products, and where people can smoke.

SUBSTANCE USE AND SEXUAL BEHAVIOR

Many people believe that certain substances can improve sexual performance. In reality, the effect of substance use varies from person to person and according to many factors including: biological (the metabolism of the human body), frequency of use, environment and culture, and psychological aspects. Very often, the positive effects produced by substance use during sexual relations have more to do with what people believe will happen than with their pharmacological properties. For example, contrary to what many people believe, alcohol can initially make people feel less intimidated, but as the playwright William Shakespeare once said: “Alcohol provokes the desires, but puts an end to the performance.” That is to say, it can hinder an erection. In the same way, marijuana reduces the production of the male hormone testosterone and can temporarily lead to a reduction in the production of sperm.

Cocaine reduces desire and excitement since users are more interested in using the substance than in having sex. Moreover, when people are using drugs, it is more difficult to establish communication and negotiation at the time of sexual relations, as the person is often more concerned about their own immediate sensations than with their partner's sensations or with possible risks of unplanned pregnancy, STIs or HIV/AIDS. According to various surveys, a person under the effects of any substance is very unlikely to be able to use a condom because his or her capacity of judgment and reflexes are reduced. It is also important to remember that even the rare or occasional use of alcohol or substances can still put individuals at risk, as it takes only one incident of drinking too much alcohol and having unprotected sex for an unplanned pregnancy and/or STI/HIV/AIDS infection to happen.

Resource sheet D

HOW TO HELP A FRIEND WITH AN ALCOHOL OR SUBSTANCE ABUSE PROBLEM

1. Stick by them. Do not turn your back on them.
2. Listen to them.
3. Do not criticize them to their face or other people.
4. Suggest what they might do, but do not be pushy. They will have to make their own decisions.
5. If they want, offer to go with them to seek help from a drug agency, doctor, or counselor.
6. Encourage them to be positive about themselves.
7. Encourage them to feel they can do something about their problems.
8. Encourage them to seek treatment for their problem. Offer to help investigate clinics or centers that could help them.

There are trusted adults with whom a person can speak to get help and support if they have an alcohol or drug problem. Below are some examples:

1. Doctor, nurse, or counselor
2. Religious leader
3. Local youth leader
4. School teacher or school nurse/counselor
5. Parent, aunt, uncle, or grandparent

Workshop 11: Pleasures and Risks²⁸

OBJECTIVE:
To reflect on the risks associated with some of the things that give us pleasure, and to discuss strategies for reducing these risks.

MATERIALS REQUIRED:
Magazines and newspapers; scissors; glue; flip chart paper

RECOMMENDED TIME:
2 hours

PLANNING NOTES:
The discussion for this activity, as written here, is focused on risks related to using drugs. However, the questions can be easily adapted for the discussion of risks and protective factors associated with other things, including sex.

PROCEDURE:

1. Divide the participants into two to three smaller groups.
2. Give each group a piece of flip chart paper and explain that they should create a collage of things that give them pleasure. Tell them that they can create by writing, drawing and/or pasting images cut out from magazines and newspapers.
3. Allow the groups 15 minutes to create these collages.
4. Give each group another piece of paper and ask them to divide it into three columns. Tell them to write the following words as headings to the columns: Risks/Harms; Pleasures; Protection Factors. In the middle column, the groups should write up to five things that give them pleasure. In the left column, the groups should describe risks/harms associated with the pleasure. In the right column, the groups should write protection factors, that is, things they can do to ensure that the thing that gives them pleasure does not cause them harm or minimizes harm. See Resource Sheet A for an example of how to organize and complete the table. For low literacy groups, the participants can use drawing/collages to identify the risks/harms and protection factors associated with the pleasure they identified.
5. Allow the groups 20 minutes to fill out the table.
6. Ask each group to present their collages and tables to the other groups.
7. Use the questions below to facilitate a discussion about pleasure and risk and harm reduction.

PROCEDURE

²⁸ — Adapted from the *Andando se faz um caminho manual*, by Ana Sudária de Lemos Serra in *ECOS: Adolescência e Drogas*, São Paulo, 1999.

1. Why is it important to think about the risks/harms associated with those things that give us pleasure?
2. Why is it important to think about the protective factors associated with those things that give us pleasure?
3. What is the relationship between drugs and pleasure?
4. What is the relationship between drugs and risks/harms?
5. What is the relationship between drugs and protection factors?
6. When do people think about the risks or protection factors associated with a given pleasure? When SHOULD they think about them?
7. Do some people do things because of the risks involved? (Link to prior discussions about how risk is a quality often associated with masculinity and how young men might do some things perceived as risky in order to prove they are “real” men.)
8. Have you heard of harm reduction? What have you heard? (Explain that harm reduction involves adopting strategies to reduce the harm associated with a particular behavior. For more information see Resource Sheet B)
9. What information and supports do you think that young people need in order to practice risk reduction in their own lives?
10. How can you engage other young people in your community in reflections about risk reduction?

QUESTIONS

CLOSING:

Many of the decisions in your lives come with pleasures and with risks. In terms of drugs, you can make the decision to drink alcohol or not to. The decision to drink or smoke might bring some immediate pleasures, but it can also involve risks. For example, alcohol can reduce your reasoning and power, increasing your risk of accidents and injuries and your vulnerability to violence and HIV/STI infection, while long-term or sustained use can lead to serious health problems. While it may not be realistic to think that young men and others will stop using drugs altogether – it is important that you be aware of the risks associated with drug use and feel capable of minimizing the harm it might have on your lives and relationships.

...it is important that you be aware of the risks associated with drug use and feel capable of minimizing the harm...

Resource sheet A

Example Table with Pleasures and Associated Risks and Harms and Protective Factors

Below is an example of how the groups should organize their tables. It also includes a description of the risks and protective factors associated with some common pleasures. If it is helpful, the facilitator can share these with the participants before they create their own tables.

RISKS/HARMS	PLEASURES	PROTECTIVE FACTORS
Excess weight and health problems due to sweets or junk food Illness from not washing food that is dirty or eating food past the expiration date	Eating	Wash food well Eat a balanced diet Conserve food well Verify the expiration date
Driving while intoxicated Becoming injured in an accident Speeding. Being part of a collision	Driving a car	Don't drink alcohol before driving Use a seatbelt Obey the traffic laws
Smoking too many cigarettes Bad breath Smelly clothes Lung problems	Smoking	Smoke few cigarettes per day/week Stop smoking

WHAT IS HARM REDUCTION?²⁹

Harm reduction is public health philosophy/movement that arose in response to the need for more pragmatic and adaptive strategies to reduce the risk of HIV transmission among injection drug users. In its essence, harm reduction is intended to be a progressive alternative to the prohibition of certain potentially dangerous lifestyle choices. The central idea of harm reduction is the recognition that some people always have and always will engage in behaviors which carry risks, such as casual sex, prostitution, and drug use. The main objective of harm reduction therefore is to mitigate the potential dangers and health risks associated with the risky behaviors themselves. It seeks to meet individuals, such as drug user, “where they’re at” in order to help them reduce risks to themselves and others. Moreover, instead of using pejorative terms to label people who engage high-risk sexual or drug-taking behavior, harm reduction shifts the focus to the individuals’ behavior and its consequences. For instance, the shift is from speaking of “drug abuse” to speaking of the “harmful use of drugs”, or labeling someone a “drug abuser” to calling him/her a “consumer”.

Another objective of harm reduction is to reduce harm associated with, or caused by, the legal circumstances under which the behaviors are carried out (for example, prohibition of certain acts or substances can help create a black market where illicit trade flourishes).

Harm reduction initiatives range from widely accepted ideas, such as designated driver campaigns, to more controversial initiatives, like the provision of condoms in public schools, needle exchange programs or safer injection sites for intravenous drug users, drug legalization, and heroin maintenance programs.

*Some specific examples include:***Syringe exchange and related programs**

The use of heroin and certain other illicit drugs can involve hypodermic syringes (mainly because of high prices, limited quality and thus limited availability as a saving measure. In some areas (notably in many parts of the US), these are available solely by prescription. Where availability is limited, users of heroin and other drugs frequently share the syringes and use them more than once. As a result, one user's infection (such as HIV or Hepatitis C) can spread to other users through the reuse of syringes contaminated with infected blood, and the repeated use of a non-sterilized syringe by a single user also bears a significant infection risk.

The principles of harm reduction propose that syringes should be easily available (i.e. without a prescription). Where syringes are provided in sufficient quantities, rates of HIV are much lower than in places where supply is restricted. Harm reductionists also argue that users should be supplied free of charge at clinics set up for this purpose: so-called needle exchange programs.

Drunk driving and alcohol-related programs

There is a high amount of media coverage informing users of the dangers of driving drunk. Most alcohol users are now aware of these dangers and safe ride techniques like 'designated drivers' and free taxicab programs are reducing the number of drunk-driving accidents. Many cities have free-ride-home programs during holidays involving high alcohol abuse, and some bars and clubs will provide a visibly drunk patron with a free cab ride.

Safer injection sites

"Safe injection rooms" are legally sanctioned, supervised facilities designed to reduce the health and public order problems associated with illegal injection drug use.

Safe injection rooms provide sterile injection equipment, information about drugs and health care, treatment referrals, and access to medical staff. Some offer counseling, hygienic and other services of use to itinerant and impoverished individuals. Most programs prohibit the sale or purchase of illegal drugs. Many require identification cards. Some restrict access to local residents and apply other admission criteria.

Evaluations of safe injection rooms generally find them successful in reducing injection-related risks and harms, including vein damage, overdose and transmission of disease. They also appear to be successful in reducing public order problems associated with illicit drug use, including improper syringe disposal and publicly visible illegal drug use.

Safer sex programs

Many schools now provide safer sex education to teen and pre-teen students, some of whom engage in sexual activity. Given the premise that some, if not most, adolescents are going to have sex, a harm-reductionist approach supports a sexual education which emphasizes the use of protective devices like condoms and dental dams to protect against unwanted pregnancy and the transmission of STDs. This runs contrary to the ideology of abstinence-only sex education, which holds that telling kids about sex can encourage them to engage in it.

Supporters of this approach cite statistics which they claim demonstrate that this approach is significantly more effective at preventing teenage pregnancy and STDs than abstinence-only programs; social conservatives disagree with these claims -- see the sex education article for more details on this controversy.

HARM REDUCTION:

- › is an alternative to moral/criminal and disease models of drug use and addiction;
- › recognizes abstinence as an ideal outcome but accepts alternatives that reduce harm;
- › has emerged primarily as a “bottom-up” approach based on addict advocacy, rather than a “top-down” policy promoted by drug policy makers;
- › promotes low-threshold access to services as an alternative to traditional, high-threshold approaches; and
- › is based on the tenets of compassionate pragmatism versus moralistic idealism.

29 — Text taken from “Harm reduction: Pragmatic strategies for managing high-risk behaviors” edited by G.Alan Marlatt, 1998.

Workshop 12: Decision-Making and Substance Use

OBJECTIVE:

To reflect on peer pressure and decision-making related to substance use and to understand the concept of dependency.

RECOMMENDED TIME:

1 hour

PLANNING NOTES:

None.

MATERIALS REQUIRED:

Sufficient numbers of copies of the Resource Sheet for each participant, flip-chart and markers.

PROCEDURE:

PART 1

1. Give each participant a copy of the Resource Sheet and ask them to complete it in five minutes. For low-literacy groups, read the questions aloud and have them discuss in pairs.
2. Invite the participants to share their responses with each other. If the group is large, the participants can be divided into smaller groups to share their responses.
3. After the participants have shared their responses, use the questions below to facilitate a discussion.
 - › Is peer pressure a big factor in why men use substances?
 - › Do women also experience peer pressure to use substances?
 - › In what ways is this peer pressure similar? In what ways is it different?
 - › How does alcohol influence sex and decisions about sex? Does it help/hurt?
 - › What other decisions or behaviors can alcohol or other drugs influence (e.g. driving, work, relationships, violence)?
 - › How can you challenge some of the peer pressure men may face to use substances? How can you challenge some of the peer pressure women may face to use substances?

PART 2

1. Carry out a brainstorm with participants on the meaning of dependency and addiction. Explain that dependency and addiction do not only pertain to substance use, but also to other types of behaviors, such as eating certain types of food (e.g. fast food, chocolate), watching television, playing videogames) spending all your time watching television. Carry out a brainstorm with the participants on things, substances and activities to which people can become dependent or addicted.
2. Ask the participants to identify which of the mentioned things, substances and activities young men most commonly become dependent on or addicted to.

PROCEDURE

3. Divide the participants into groups of three or four. Ask them to choose one of the things mentioned to which young men may become dependent or addicted and to discuss the reasons why this might happen.
4. Ask each group to present the main points of their discussion and invite other groups to add their comments.
5. Use the questions below to wrap-up a discussion about dependency and addiction.

DISCUSSION QUESTIONS:

1. What are the most common reasons for young men to become dependent on or addicted to something?
2. How does dependency or addiction affect an individual? How does it affect his or her relationships?
3. What is the link between substance availability and risk of abuse or addiction?
4. What are the possible advantages of a dependency or addiction?
5. What have you learned from this exercise? How can you apply this in your own lives and relationships?

CLOSING:

In many settings, it is common for men and women to use substances (e.g. alcohol) as part of their social interactions and gatherings. It is important for individuals to know how to establish limits regarding substance use and respect the limits of others. For example, some strategies for drinking responsibly include drinking a small amount and not mixing drinks with other substances. It is also necessary to create other forms of having fun without alcohol or other substances being at the center and to not put pressure on those who do not want to consume substances. Being aware of anxieties and tensions in daily life helps

you to develop various forms of channeling them positively and to avoid behavior that can lead to dependency or addiction. Dependency or addiction sometimes results from not finding a way out and/or a solution to a problem; however, having an addiction only helps to postpone finding the solution. Frequently, having an addiction is related to emotional problems which begin to create a void in our lives, leading to a growing lack of interest, motivation and/or meaning to life itself. It is important that you learn that even when you might feel really down, there is always something that can be done, and it is never too late to reach out for help.

INDIVIDUAL QUESTIONNAIRE: DECISION-MAKING	YES	NO
<p>1 – Would you feel out of place at a party or gathering with your friends if they offered you a drink (with alcohol) and you decided not to have one?</p> <p>Explain briefly.</p>		
<p>2 – Imagine that you are at a party or social gathering where they are serving alcohol and you are drinking, but one of your friends doesn't want to drink. Would you view your friend as an oddball, a drag, or a nerd?</p> <p>Explain briefly.</p>		
<p>3 – Would you defend your friend's decision not to drink to the other friends? Supposing that you decided to defend him/her, how do you think the other friends would judge you?</p> <p>Explain briefly.</p>		
<p>4 – Do you believe that to be accepted in a group you have to do what the other persons in the group want?</p> <p>Explain briefly.</p>		
<p>5 –Do you think that it is possible for a person to lead an enjoyable social life without consuming alcoholic drinks?</p> <p>Explain briefly.</p>		
<p>6 –Can a person feel good about himself even without drinking?</p> <p>Explain briefly.</p>		
<p>7 – Can a man feel accepted without drinking?</p> <p>Explain briefly.</p>		

OBJECTIVE:
To question various myths related to alcohol use and alcoholism.

RECOMMENDED TIME:
1 hour

MATERIALS REQUIRED:
Ball, chalkboard and chalk or flipchart and felt-tip pens, pieces of cardboard with phrases written on them.

PLANNING NOTES:
Prepare beforehand the phrases on the cardboard written in large legible letters.

PROCEDURE:

- Ask the group to sit in a circle. In the center, place the cardboard sheets in the form of a circle, so that each person can take one when it is his turn.
- Explain that each participant will read out a phrase and answer if they agree or not with the statement and explain why. The other participants will be able to give their opinions in the course of discussing the statements.
- Throw the ball to one person in the group and ask them to start the activity by choosing one of the cardboard sheets. Note their opinions on the flipchart, ask if the other participants agree or not and why, and then read the text elaborated on the basis of scientific information (Responding to Common Myths about Alcohol Use). Ask if there are any other comments.
- After the discussion, the person that has read the first statement throws the ball to another person in the group and so on, until all the statements have been discussed.
- Phrases to be written on the cardboard sheets:
 - › a) Alcohol is not a drug...
 - › b) Having high alcohol tolerance means that the person will not become an alcoholic...
 - › c) Mixing drinks makes you drunk...
 - › d) Beer does not make you drunk...
 - › e) Alcohol is sexually stimulating...
 - › f) Alcoholism is an illness that affects older adults...
 - › g) Alcoholics are those that drink daily ...
 - › h) Having a coffee or washing your face with cold water reduces the effects of alcohol...
 - › i) Alcohol is good for making friends...
 - › j) Parties are not parties without alcohol ...

PROCEDURE

1. Alcohol is not a drug... Alcohol is a drug in the sense that it alters the functioning of the organism, particularly the central nervous system on which thoughts, emotions and behavior depend. It can also cause dependence.
2. Having high alcohol tolerance means that the person will not become an alcoholic... The truth is exactly the opposite; high tolerance means that the brain is becoming accustomed to the drug.
3. Mixing drinks makes you drunk... What really gets one drunk is the quantity of alcohol and the speed that one drinks.
4. Beer does not make you drunk... In the case of beer, the absorption of alcohol through the stomach is a little slower, but depending on the quantity consumed, it does cause drunkenness.
5. Alcohol is sexually stimulating... Initially alcohol can reduce inhibitions and help people to become more outgoing, but since alcohol has a depressant effect on the nervous system it ends up reducing these sensations and can hamper sexual relations. Alcohol use is one of the most frequent causes of erectile dysfunction (impotence).
6. Alcoholism is an illness that affects older adults... The majority of alcohol dependent persons are young men of working age.
7. Alcoholics are those that drink daily... The majority of alcohol-dependent persons, in the initial and intermediate stage of the process, drink mainly on the weekend, and continue with their normal school and work activities, but with increasing difficulty.
8. Having a coffee or washing your face with cold water reduces the effects of alcohol... The only thing that really reduces drunkenness is the gradual elimination of the alcohol from the organism, which means forcing the liver to work, which takes time.
9. Alcohol is good for making friends... In reality, alcohol creates complicity around drinking, but true friendship includes much more than that.
10. Parties are not parties without alcohol... The media often tries to convince us that parties need alcohol, and that alcohol must be at the center of every social gathering. But is this really true? What makes a social gathering or a party – the alcohol or the people?

⚙️ Workshop 14: Learning not to Drink too Much³⁰

📍 OBJECTIVE:
To discuss various attitudes and values that can potentially protect a young person from addiction.

📁 MATERIALS REQUIRED:
Cardboard, felt-tip pens, notebooks.

🕒 RECOMMENDED TIME:
1 hour

📄 PLANNING NOTES:
If a group drinks a lot at parties, one idea that can be suggested is to plan a party where there are no alcoholic drinks and the aim is to have fun in a natural way. This activity, in an adapted form, can also be used in relation to other substances.

PROCEDURE:

1. Introduce the purpose of the activity by referring to the fact that, these days, it is common to use substances (alcohol, marijuana, among others) in our social life, and that many young people use these substances regardless of whether they have a solid family life and an adequate school environment.
2. Explain to the group that this trend means that no one is immune from the risk of getting involved with the drug culture and for this reason it is important to know how to establish limits and protect ourselves.
3. In small groups, ask the participants to discuss practices or strategies for controlling or minimizing the possibility of a risk situation developing in relation to substance use, commencing with the question: "What protective skills do we know or can develop?"
4. After the discussion, ask the participants to present their conclusions and supplement their findings with a number of protective skills that were not mentioned, for example:
 - › Don't get in a car that is driven by a person who is drunk or has used some other substance.
 - › Don't drink or use another substance when you don't feel like it.
 - › Learn protective ways to use substances. For example:
 - drink a small amount
 - don't drink more than one glass an hour;
 - only take small amounts of hard liquor;
 - don't mix drinks with other substances;
 - engage in another activity when drinking instead of only drinking or only using another substance: chat, dance or eat something.
5. Ask each participant to write down in their notebook the protective messages that emerged, with a brief reflection that begins with "One reason for not over drinking is ..."

PROCEDURE

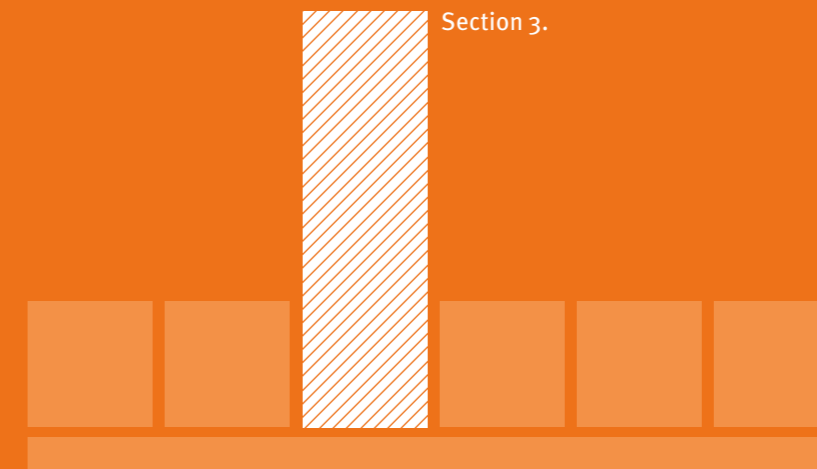
CLOSING:

We can learn to have fun and live our lives without the need for alcohol, which implies creativity, imagination and genuine socializing. Another question concerns the decision to drink responsibly, which means not getting drunk. This principle is linked to the metabolism of alcohol in the liver. This organ has the capacity to process in one hour one measure or unit of hard liquor (whiskey, tequila, rum, vodka, etc.) or one standard glass of beer. For this reason drinking less than one glass per hour is the best way of not getting drunk. Other factors that are recommended to avoid drunkenness from alcohol are: to eat while you drink and to alternate water or

soft drinks with alcoholic drinks. It is important to stress that there are no really moderate drinks, just moderate drinkers. The majority of people are able to follow this pattern of behavior efficiently. However, clarify that there are also factors of personal and psychosocial susceptibilities. There are also authors who talk about genetic factors that make some individuals more susceptible to becoming alcohol dependent (for example, by being alcohol tolerant). Both high alcohol tolerance and loss of control when consuming alcohol should be considered as pre-alcoholism signs or alcoholism.

Section 3:

Fatherhood and Caregiving – What and Why



— WORKSHOPS —

1. What Comes Into Your Head?
2. Caring for Oneself: Men, Gender and Health
3. Men as Caregivers
4. You Have a Message: You're Going to be a Father!

Section 3:

Fatherhood and Caregiving – What and Why

Throughout the world, women are often perceived as natural care-givers. This widely held association is rooted more in social constructions regarding male and female roles than innate capabilities. Moreover, while fatherhood is a central experience in the lives of many men, too many fathers still only play a limited role in caring for their children. In this section, we explore the links between men’s socialization and their participation in care-giving and reinforce the benefits of care-giving roles for men, families and communities.

Gender socialization, care-giving, and fatherhood

In most societies, caring (for children, sick people, the elderly etc.) is viewed as a "woman's business". Indeed, studies from diverse settings have shown that fathers only contribute one-third to one-fourth as much time directly caring for their children as women do.³¹ This unequal participation in care-giving is rooted in the ways girls and boys are raised. For example, in many societies, girls will spend most of their time in the home helping with household chores and taking care of younger children. Even when girls play, they are often provided with toys that emphasize care-giving and domestic chores (e.g. dolls or cooking sets). On the other hand, boys tend to be encouraged to play outdoors and are discouraged from playing with dolls or engaging in other “feminine” games. As they get older, boys are pushed more and more towards what are widely considered to be “masculine” games, such as sports or playing with cars or guns, or into “masculine” household activities, such as helping their fathers fix things around the home. Boys are rarely encouraged to care for smaller children in the same ways that girls are or to take part in domestic chores. If and when men do become fathers, their most important contribution is often seen as being a provider, financially speaking, than a care-giver. Often, in fact, men may be seen as incapable of performing child care and, to some extent, socially authorized not to participate in it. In short, the woman provides care, the man provides. Even when a man wants to play an active role in terms of child care, social institutions - ranging from the family, school, work, health facilities, NGOs and military to society in general - deny him this possibility.

”

...fathers only contribute one-third to one-fourth as much time directly caring for their children...

“

³¹ — Population Council, “The Unfinished Transition: Gender Equity: Sharing the responsibilities of Parenthood.” A Population Council Issues Paper, 2001.

A lack of men's involvement in care-giving tasks often means that women carry a double burden, particularly those who are trying to find a place in the labor market and who at times cannot accept a certain job because they have to take care of the children or other relatives and friends. Many women face what is often called a "double work shift," so as not to be labelled as "negligent mothers." They also are encouraged to be super-moms, often having been told that after their child is born they are expected to achieve, in a flash, an instant bonding with the infant, and develop a receptive ear for the child's crying and a nose that is not bothered in the least by the odour of feces, etc.³²

The father, on the other hand, after his role in conception, finds a gaping hole in his role in the process, recovering some space only when the child reaches pre-school age. In nursery schools

and kindergartens the situation is even more complicated, with the presence of a man often generating concern and anxiety, out of fear that he might sexually abuse the children or might have sexual problems or be a sexual deviant. Thus, the figure of the "caring man" is often associated with the image of an "effeminate" person or an "abuser." Those men who want to share these tasks often find little space to do so or inevitably have to put up with comments like "at times like this, men only get in the way."³³

Finally, from a broader viewpoint, we also see that this assumed "incapacity" for caring for children extends to (or has its origins in) other areas of daily life, as men often are seen (including by themselves) as being incapable of caring for a sick person, things around them, a child, the home and themselves and their own bodies.

BOX 1: Are Children Raised Without a Father at Greater Risk?

Although it is commonly assumed that not having a father present is a risk for children, for example, leading to greater aggressive behavior, or school difficulties, or problems with gender identity, the issue of father absence is complex. So far, existing research has not adequately helped us assess all the reasons for success or failure in child-rearing.

There are some experts who seek to understand the possible implications of father or mother absence but none have gone so far as to state categorically that children raised without one or the other parent are inherently more "problematic" than others. There are more exceptions than rules, as not every child brought up without the father (or mother for that matter) has the predicted problems. Furthermore, a family structure considered "stable" does not necessarily lead to a child having a perfect emotional balance.³⁴

BOX

1.

32 — Elizabeth Badinter, *Um amor conquistado-o mito do amor materno* (Rio de Janeiro: Nova Fronteira, 1985); Ceneveve Parceval, *A Parte do pai* (Porto Alegre: L&PM, 1986)

33 — Eliana C.L. Saporol, "Educador infantil: uma ocupação de gênero feminino" (Dissertação mestrado: São Paulo: PUC/SP, Medrado, 1997); Benedito Medrado, "Homens na arrendado cuidado infantil: imagens veiculadas pela mídia" In: M. Arilha, S. Unbehau, & B. Medrado, *Homens e Masculinidades: outras palavras* (São Paulo: ECOS/ Ed. 34, 1998) 145-161.

34 — Michael E. Lamb (ed.), *The Father's role: applied perspectives* (New York: John Wiley, 1986).

Do Men Care for Themselves?

Men have occupied historically the unenviable first place in various different leagues of statistics: number one in homicides, suicides, accidental deaths (particularly involving vehicles), use of alcoholic drinks and other substances, involvement in thefts and assaults and, as a result, the highest rate of incarceration, in addition to being the major perpetrators of physical aggression in domestic or public spheres. These statistics are also reflected in another constant pattern: the lower life expectancy of men in relation to women and higher mortality rates. Moreover, analyzing the mortality differential according to sex and age, one can clearly see a higher rate of mortality for males, due to external causes, in all the age groups, particularly among adolescents and youth.

Moreover, men are often reluctant to recognize a health problem and seek assistance. Such reluctance has created, for example, complex problems in terms of the spread of HIV/AIDS. Studies from Africa and Asia, as well as in other parts of the world, show that HIV-infected men, in general, draw less support from each other and ask for help from family and friends less frequently than women.³⁵ Men are also less likely to provide care for other HIV-infected individuals, whether in inti-

mate or family relationships. As previously noted, studies carried out in the Dominican Republic and Mexico have highlighted the fact that women who are HIV-positive sometimes go back to their parents' home because there is little likelihood that their husbands will give them adequate attention.³⁶

The ways in which boys are raised underlies many of these statistics and situations. Wherever the setting, the story is often the same: boys are encouraged to defend themselves and fight back, to pick themselves up at once when they fall off a bicycle (preferably without crying!), to climb back up a tree after they have fallen and to be brave and bold. Generally speaking, men are socialized from an early age to respond to social expectations in a pro-active way, where risk is not something to be avoided and prevented, but to be confronted and overcome, on a daily basis. The idea of self-care is displaced by harmful or self-destructive lifestyles, where risk is valued over security. However, in the same way that men learn not to care for themselves or for others, they can also learn caring. For this to happen, it is key that we - as teachers, health educators, youth workers and parents - provide opportunities to reflect on and practice the experience of caring.

35 — UNAIDS, "Men and AIDS: a gendered approach." (Geneva: Joint United Nations HIV/AIDS Programme, 2000).

36 — K.Rivers & P. Aggelton, "Adolescent sexuality, gender and the HIV epidemic." (New York: UNDP HIV and Development Program, 2002) www.undp.org/hiv/publication/gender/adolesce.html

In general, adolescent pregnancy is often confused with adolescent motherhood; that is when we talk about early childbearing, we are nearly always talking about adolescent mothers. Very often, the young father is generally seen as absent and irresponsible: "it's no good looking for him, he doesn't want to know about it!" Indeed, it is very common for us to assume that all adolescent or young men who become fathers were "careless." Their own parents, the parents of the child's mother, the mother herself, and service providers may often discriminate against them and assume the worst.

While many young men do not want to be involved, there are adolescent and young fathers who are just as involved and committed to the children as they are to the mothers of these children. In some cases, however, adolescent or young fathers may want to be involved with their children but are prevented from doing so by the child's mother or her family. In other cases, the adolescent or young fathers may feel that, since they are unemployed and cannot provide financial support for the child, they do not have the right to interact with him or her. For example, research has found that adolescents and young men may initially deny responsibility and paternity when faced with a possible pregnancy because of the financial burden of childcare.³⁷

Overall, however, the fact is that each adolescent parent has his or her own story and realities. Understanding the specific reality or case of each adolescent parent does not mean encouraging adolescent pregnancy - rather it means creating conditions so that this adolescent parenthood is not an impediment to the development and well-being of the adolescent parent or parents, or to their children.

Caring for a child is not an easy task, particularly if we consider the economic implications of raising a child. And of course, some young men (perhaps the majority!) are not adequately prepared to care

for a child. Becoming a parent for the majority of adolescents is probably not the best choice for their lives. However, pregnancy and fatherhood can provide some adolescent parents with substantial emotional benefits.

First, we must acknowledge that some adolescent couples have fared well at school, in family life and in caring for the child. Surveys in the human and social sciences carried out in different countries, highlight that pregnancy is seen by some adolescents exactly as a transition to adulthood, conferring on them status. For some young people, becoming parents allows them to restructure their lives, and sometimes even abandon substance use or involvement in delinquency.³⁸

To be sure, around the world, pregnancy rates are higher among young persons with lower educational attainment, or those with less hope of escaping from poverty, and consequently can contribute to poverty. Furthermore, many young parents leave school early, due to a lack of economic conditions on the part of their families to keep them at school. However, research shows that adolescent pregnancy per se is not the main cause of dropping out of school. When pregnancy occurs, the majority of the adolescents from the underprivileged classes has already dropped out of school, or has never been enrolled. Furthermore, when we review the literature, we see that having a child while still an adolescent is not the cause of health risks to the mother or child; the main risk is the lack of prenatal care and adequate social support.³⁹

In sum, analyzing the causes and effects of early childbearing must be thoughtful, and requires questioning our alarmist tones and stereotypes. We do not advocate for young people to start childbearing in adolescence. We advocate that families, communities and caring professionals take a more balanced view of the issues - taking into account the specific realities and needs of young people themselves.

BOX

2.

BOX 2: Men and Pregnancy

In general, when we talk about pregnancy, we seldom mention the father. Men, particularly young men, whether in hospitals or prenatal clinics are often seen as outsiders or intruders, or maybe only as visitors – they are rarely seen as partners and participants in their own right. We must remember that fathers have the following rights:

- › To participate in prenatal care;
- › To find responses to his doubts about the pregnancy, including doubts he may have about his relationship with his partner and about caring for the baby. As the father, he is not only his partner's companion, but also the father of the child that is going to be born;
- › To be informed about how the pregnancy is progressing and any problem that might appear and;
- › To be recognized, at the time of the birth, as the FATHER and not just as a "visitor" to the clinic or hospital.

It is important for a father to be able to participate in caring for the infant during the first moments and days after birth. Some things, of course, he is not able to do. Others, the woman will also not be able to do, due to her own recovery period. However, both can learn to support each other - assuming their relationship permits such cooperation. If they are separated, they must also negotiate the division of these responsibilities and activities.⁴⁰

Box 3: Summary Points

Throughout the world, women are often perceived as natural care-givers. However, this association is rooted more in social constructions about male and female roles, rather than any innate capabilities. For example, from an early age, girls spend most of their time in the home helping with household chores and taking care of younger children. On the other hand, boys are encouraged to play outdoors and are discouraged from playing with dolls or engaging in other "feminine" or "domestic" games, thus they often have limited opportunities to learn and build confidence in their caring skills.

Men's lack of self-care, reflected in statistics such as their higher rates of homicides, suicides, use of alcoholic drinks and other substances, and involvement in violence, as perpetrators and victims, is linked to the ways in which they are raised. Often, boys and men are encouraged to engage in risk behaviors to provide themselves as "real men" and may view seeking help or services as "unmanly" or a sign of weakness. In this way, the idea of self-care is often displaced by harmful or self-destructive lifestyles.

BOX

3.

37 — Jose Olavarria, "Hombres: Identidades, relaciones de genero y conflictos entre trabajo y familia." Em: J. Olavarria & C. Cespedes, Trabajo y Familia: Conciliacion? Perspectivas de género (Santiago: FLASCO-Chile, SERNAM y Centro de Estudios de La Mujer CEM, 2002).

38 — Gary Barker, "Peace boys in war zone: Identity and coping among adolescent men in a favela in Rio de Janeiro, Brazil" (Unpublished doctoral dissertation, Erikson Institute, Loyola University, Chicago, 2001)

39 — Donald G. Unger & Lois Dall Wandersman, "Social Support and Adolescent Mothers: Actions Research Contributions to theory and practice." Journal of Social Issues 41 (1985) 29-41.

40 — Text adapted from the publication Gravidez saudavel e parto seguro sao direitos da mulher, produzido pela Rede Nacional Feminista de Saude e Direitos Reprodutivos (E-mail: redesaude@uol.com.br)

Workshops

Workshop 1: What Comes Into Your Head? The Meaning of Care-giving

OBJECTIVE:
To explore how young men define care-giving and how they deal with it in their daily life.

MATERIALS REQUIRED:
White sheets of paper, Paper strips, Blackboard (cardboard or flip chart)

RECOMMENDED TIME:
1 hour

PLANNING NOTES:
In the case of persons that have difficulty in reading and writing, the facilitator can ask them simply to talk, without using paper or the blackboard. Nonetheless, it is important to maintain the sequence: first, the brainstorming, and then the stories from their childhood.

PROCEDURE:

1. Hand out a sheet of paper and a pen to each participant. Ask each of them to write on their paper the word CARING.
2. Then ask them to write all the words and phrases that come into their heads when they hear the word CARING.
3. After about 5 minutes, ask each person to read what they have put down and compile a list of all the words and phrases that appear, in order to identify the most frequent associations.
4. Following this, hand out three strips of paper to each participant and place the rest in the center of the circle formed by the participants. Ask them to think about their lives from the time they were children, and then try to remember situations in which they witnessed a scene of care-giving.
5. After 20 minutes, ask one of the participants to volunteer to read his account. Ask if there are other similar stories and open up the discussion.

QUESTIONS:

1. Is it possible to define caring or care-giving based on a single idea?
2. Is it good to be cared for? Why?
3. Is it good to care for someone? Why?

CLOSING:

Comment that, as we can observe from the variety of words that the group produced, it is obvious that there is not a single or correct definition of caring and care-giving, but that these terms have multiple meanings.

PROCEDURE

Workshop 2: Caring for Oneself: Men, Gender and Health⁴¹

OBJECTIVE:
To promote greater awareness of the links between how young men are raised and the health risks they face.

MATERIALS REQUIRED:
Small pieces of paper or cards, flipchart paper, markers, Resource Sheets 4A and 4B.

RECOMMENDED TIME:
1 hour and 30 minutes

PLANNING NOTES:
Resource Sheet B includes examples of statistics on men and various health outcomes. It can be useful for the facilitator to complement these statistics with local and/or national ones which can help the participants better understand some of the health risks young and adult men in their own communities face.

PROCEDURE:

1. Prior to the session, write each of the questions from Resource Sheet A on a small piece of paper or card. For groups with reading difficulty, the facilitator can read the questions out loud rather than distribute them.
2. Divide the participants into two to three small groups and distribute the questions among the groups.
3. Explain to each group that there are three possible answers to each question: men, women or both. Ask them to discuss each of the questions they have received and to try to come up with the answer as a group.
4. Allow 20 minutes for the groups to discuss the questions and their answers.
5. Write the questions on flipchart paper and then read each question out loud; ask how the groups replied and mark the answers on the flipchart.
6. Explore the responses of the group, asking them to explain their answers.
7. After the groups have presented all of their responses, explain that the correct answer for each question is “Men.” Review each question individually, presenting some of the statistics that are included in Resource Sheet B and use the following questions to facilitate discussion:

PROCEDURE

⁴¹ — Adapted from: *Fatherhood Development: A Curriculum for Young Fathers*, by Pamela Wilson and Jeffery Johnson – Public Private Ventures, 1995.

- › Did you know that men are more at risk of this health problem?
- › Why do you think this is true?
- › Is it possible for men to avoid this health problem? How?
- › (Note: Facilitator should encourage the participants to reflect on the behaviors and lifestyles associated with the health problem and how they might be prevented or changed.)

PROCEDURE NOTE: Although the answers to the questions are most often men, in some settings, the answer to some of the questions might be women or both. If this is the case, the facilitator should focus the discussion on the fact that the majority of the questions had a response of men.

8. After discussing each of the individual questions, use the questions below to wrap-up the session.

DISCUSSION QUESTIONS:

1. Do you see these patterns of risk among men in your community?
2. What other health problems do you think that men are more at risk of than women?
3. At what age range are men most at risk for some of these problems?
4. Why do men face these health risks? What is the relationship with these risks and the way that young men are socialized?
5. How do you see yourself in relation to these risks? What can you do to reduce these risks in your own lives? What about in the lives of other men?

CLOSING:

The majority of the causes of death for men are associated with the self-destructive lifestyle that many men follow. Around the world, men are pressured to act in certain ways. For example, men often take more risks, have more partners, are more aggressive or violent in their interactions with others – all of these put them and their partners at risk. As young men, it is important to be critical about your lifestyles and the ways that you put yourselves at risk. You might have been raised to be self-reliant, not to worry about your

health, and/or not to seek help when you feel stress. But being able to talk about one's problems and seeking support are important ways to protect you against various negative health outcomes – such as substance use, unsafe sexual behaviors, and involvement in violence. Through critical reflections of these norms, you can learn to appreciate how health is not merely a matter for women, but also a concern for men, and learn how to take better care of yourselves.

Resource sheet A

GENDER AND HEALTH – QUESTIONS

Respond to each of the following questions with: “Men,” “Women,” or “Both.”

1. Who has a shorter lifespan?
2. Who is more likely to die from homicide?
3. Who is more likely to die in road accidents?
4. Who is more likely to die from suicide?
5. Who is more likely to consume alcohol and get drunk more?
6. Who is more likely to die from an overdose (excessive substance use)?
7. Who is more likely to have sexually transmitted infections (STIs)?
8. Who is more likely to have more sexual partners and more unprotected sex?
9. Who is less likely to seek health services?

Resource sheet B

GENDER AND HEALTH – ANSWER SHEET

Who has a shorter lifespan?

Globally, the life expectancy for men is 65 years and for women it is 69 years.⁴²

In Bosnia, life expectancy for men is 66 years and for women 72 years.⁴³

In Croatia, life expectancy for men is 72.9 years and for women it is 79.6 years.⁴⁴

In Serbia, life expectancy for men is 72 years and for women it is 77 years.⁴⁵

In Montenegro, life expectancy for men is 73 years, and women 77 years.⁴⁶

42 – World Population Datasheet. Population Reference Bureau, 2006

43 – Agency for Statistics of Bosnia and Herzegovina

44 – Central Bureau for Statistic of Republic of Croatia 2011

45 – <http://unstats.un.org>- UN Statistics division

46 – <http://unstats.un.org>- UN Statistics division

Who dies more from homicide?

Globally, approximately 8 out of every 100 deaths among men of all ages are due to homicide. Among women, 2 out of every 100 deaths are due to homicide.⁴⁷

In Croatia in 2006, rate per 100,000 population on intentional homicide was 1.66⁴⁸

In Montenegro 18 men and 6 women were killed in 2005.⁴⁹

In Bosnia there were 67 homicides in 2005.⁵⁰

New data in 2010 show that there were 49 homicides.⁵¹

Who dies more from road accidents?

Globally, 28 in every 100,000 men and 11 in every 100,000 women die from road accidents. In other words, almost three times as many men as women die from road traffic injuries.⁵²

In Croatia men are 50% more likely than women to get injured in car accidents.⁵³

Who dies more from suicide?

Globally males commit suicide nearly 4 times more than women.⁵⁴

In Croatia, men commit suicide 3 times more than women.⁵⁵

In Montenegro in 2005 there were 156 cases of suicide, and ¾ were men.⁵⁶

In Bosnia, 467 persons committed suicide in 2005; out of which 332 man and 135 woman.⁵⁷

Who consumes more alcohol and gets drunk more?

Globally, men are ranked higher than women in percentages of episodic and binge drinking.⁵⁸

In Croatia according to the 1999 ESPAD survey (total sample size n = 3602, males n = 1961 and females n = 1641; age group 15 to 16 years), the rate of binge drinking was 12% (total), 15% (males)

47 — WHO World Report on Violence and Health, 2002

48 — <http://data.un.org>, 2006

49 — Central Bureau for Statistic of Republic of Montenegro 2005

50 — <http://goo.gl/JDpjL>

51 — <http://goo.gl/WUJRM>

52 — WHO World Report on Violence and Health, 2002

53 — Central Bureau for Statistic of Republic of Croatia 2011

54 — Bertolote JM and Fleischmann A. 2002. "A Global Perspective in the Epidemiology of Suicide". *Suicidologi*. Arg. 7, no 2

55 — Central Bureau for Statistic of Republic of Croatia 2011

56 — Department of Criminal Investigations, Republic of Monte Negro

57 — Agency for Statistics of Bosnia and Herzegovina

58 — WHO Global Status Report on Alcohol, 2004

and 7% (females). Binge drinking was defined as consuming five or more drinks in a row three times or more in the last 30 days.⁵⁹

In Serbia 45% of youth from 13 to 17 drink alcohol.⁶⁰

Research that was done on the sample of 3964 among youth shows that 77.6 % of students who had experimented with drugs were from secondary school, with the highest percentage in the second grade (30.6 %).⁶¹

Who dies more from overdoses (excessive substance abuse)?

Globally, among young men aged 15-29, males are more likely than females to die from alcohol use disorders.⁶²

In Croatia, a survey with youth found that 21% of boys and 18% of girls had used alcohol in the past 30 days.⁶³

Who has more STIs?

Globally, men represent a higher number of cases of gonorrhea and syphilis and women represent a higher number of cases of Trichomoniasis and Chlamydia.⁶⁴

In Croatia, there are higher number of cases of gonorrhea among men and a higher number of cases of Chlamydia and HPV among women.⁶⁵

Who has more sexual partners and more unprotected sex?

Globally, men report more multiple partnerships than women, except in some industrialized nations.⁶⁶

Who is less likely to seek health services?

Globally, men are less likely than women to seek health services less often than women.⁶⁷

59 — Hibell B et al. The 1999 ESPAD Report. The European School Survey on Alcohol and Other Drugs: Alcohol and Other Drug Use Among Students in 30 European Countries. Stockholm, Council of Europe, 2000.

60 — Institute for Mental Health, Republic of Serbia

61 — Public Health Institute of Montenegro

62 — WHO Global Status Report on Alcohol, 2004

63 — www.hzjz.hr

64 — WHO Global Prevalence and Incidence of Selected Curable Sexually Transmitted Infections, 2001

65 — www.plivazdrvlje.hr

66 — Wellings, K. et al. 2006. "Sexual Behaviour in Context: A Global Perspective. The Lancet, Volume 368, Issue 9548, Pages 1706-1728

67 — Addis, M and Mahalik, J. 2003. "Men, Masculinity, and the Contexts of Help Seeking." *American Psychologist*, January 2003

⚙️ Workshop 3: Men as Caregivers

📍 OBJECTIVE:

To increase awareness about traditional gender divisions in care giving and promote young men's increased participation in care giving in their homes, relationships, and communities.

📦 MATERIALS REQUIRED:

None.

🕒 RECOMMENDED TIME:

1 hour and 30 minutes

📖 PLANNING NOTES:

If there are young fathers in the group, encourage them to reflect on their participation in childcare and how they could be more actively involved. For those who are not fathers, ask how they envision their participation will be in the future.

PROCEDURE:

1. Ask the participants to spread out and walk around the room.
2. Tell them that when they hear a time of day followed by the word "STATUE," they should freeze in a position that represents the activity they would be engaged in at that particular time. For example, after you speak the words: "Noon, STATUE!" the participants should make themselves into statues that represents what they would typically be doing at noon each day.
3. Say another time of day followed by the order "STATUE!" Proceed like this for the following times:
 - > 3:00 AM
 - > 10:00 AM
 - > Noon
 - > 3:00 PM
 - > 10:00 PM
4. Ask the participants to imagine what they would be doing at these times if they had a child to care for and repeat the same process from Step 3. Note: For younger participants, who have not had direct experience with childcare, encourage them to think of father-child relationships modeled in their family, community and the media.
5. Now have the participants repeat the exercise imagining what they would be doing if they were women with children.
6. Use the discussion questions below to explore the differences between the two occasions – before and after the child – in a young man's life and the differences between a young father and a young mother's routine, identifying what time of day the presence of the child meant a greater (or lesser) change to the young men's routine.

PROCEDURE

ALTERNATIVE PROCEDURE: Rather than acting out the different times of day, ask the participants to brainstorm the different activities which a young man who is a father and a young woman who is a mother would be doing at different times of the day. List these different activities on a flipchart paper with two columns (one for young men and one for young women) and ask the participants to identify some of the similarities and contrasts between the lists of activities.

DISCUSSION QUESTIONS:

1. Does daily life change when a young man has a child to care for? In what way? Why?
2. Does daily life change when a young woman has a child to care for? In what way? Why?
3. What kinds of care giving do women and men do?
4. Who is better at care giving, men or women? Why? Is this due to culture or biology?
5. What factors contribute to men not participating in childcare?
6. How do you think your society views men's participation in childcare?
7. What are the challenges of being a father? How can these challenges be addressed?
8. What is the positive side of being a father? What are the benefits of being a father?
9. What are the benefits for a child who has an active father in their life?
10. What are the benefits of a young man having a good relationship with the mother of their child?
11. Are there positive role models of fathers in your community? What can be learned from them?
12. What have you learned during this activity? How can it help you make changes in your own life and relationships?

QUESTIONS

CLOSING:

If and how a father is involved in childcare depends on how men and women are raised and whether they are raised to believe that men can also take care of children. For example, girls are encouraged from an early age to play with dolls, practicing what supposedly lies ahead for them: domestic life and caring for family members. On the other hand, boys are generally discouraged from playing with dolls or helping out with domestic chores. Although girls and women are frequently brought up from an early age to care for children, men can also learn to care for a child

– and learn to do it well. When fathers are not involved in care giving, mothers end up carrying a heavy burden and the fathers miss out on many of the pleasures involved in caring for children. As you think about promoting equity between men and women in your communities, it is important for you to start in your own home and think about how you as young men can start to participate more in care giving tasks in your family, as well as how you can encourage other young men to do likewise in their homes.

Workshop 4: You have a message: You are going to be a father

OBJECTIVE:
To explore a young man's decision to assume paternity.

MATERIALS REQUIRED:
Paper, pen, scissors and a small box.

RECOMMENDED TIME:
1 hour and 30 minutes

PLANNING NOTES:
It is vital for facilitators to write the messages in their own handwriting to make the activity more

PLANNING NOTES:

“realistic.” Bearing in mind the possibility of cultural differences, the messages can be adapted, providing that the same line of reasoning or storyline is maintained in each of them: (1) persons with a long-lasting relationship in which the pregnancy is unplanned; (2) persons in a one-night-stand situation who have friends in common and in which the pregnancy was not expected; and (3) a couple who wants to have a child and finds out they are going to have a child. Should the group have difficulty in reading, the facilitator can read out the messages to each group.

PROCEDURE:

1. Before starting the activity, write, in your own handwriting, three messages (according to the model on the Resource Sheet).
2. Cut out the three messages, fold them and place them in a small box.
3. Divide the participants in three groups.
4. Hand out a message to each group.
5. Instruct the groups to stage a short role play which covers at least three items: (a) the place where the message was delivered; (b) who delivered it? and (c) the reaction of the person that received it.
6. Each small group should present its role play to the rest of the group.
7. Open up the discussion, exploring the similarities and differences between the scenes.

PROCEDURE

1. If the young man assumes paternity, what will he have to do?
2. If the young man does not assume paternity, what can the girl do?
3. What does it mean to assume paternity?
4. Should they get married?
5. What does a young man feel when he gets the news that his partner is pregnant?
6. How do young men view a woman who has sexual relations with a man on their first date?
7. What is the age of each of the couples?
8. Is there any difference between pregnancy that occurs in a long-lasting relationship and one that occurs in occasional sex?
9. In a situation like this, would you think of having an abortion? In which of the three situations? Why?
10. If the woman wanted to have an abortion and you wanted to have the child, what would you do?
11. And if you wanted her to have an abortion and the woman wanted to have the child, what would you do?
12. How do you imagine your family would react?
13. Would you ask for a DNA test? In which of the three situations? Why?
14. To be a father, do you need to be a husband?
15. What if the woman wants financial support (child support)?
16. Should the father contribute financially? Is contributing only financially enough to be a father?

CLOSING:

The educator should point out the various feelings, expectations and experiences in relation to the news of pregnancy for young men, helping to dispel two common misconceptions (1) pregnancy in adolescence is always and only a problem and (2) young men never assume the paternity of the child.

LINK:

See the discussion on abortion in the section “Sexuality and Reproductive Health”.

QUESTIONS

MESSAGES

Hi, how are you? It's Bette. Remember me? We met three months ago at a club party. It was an unforgettable night, even if I don't remember very well what happened. The only thing I know is that I, or rather we, have a little problem and I would like to talk with you about it. My father always told me that drinking too much is for fools. I didn't believe him, but now see what happened! Well, I shouldn't have had sex on those days. I was ovulating. It was great to meet you. Our bodies spoke the same language from the word go. I even began to think that “love at first sight” really exists. I don't mean to say that I love you, but it was great meeting you and getting on together so well in bed! But we really should have used some contraception, don't you think? We were stupid!! And now I'm pregnant. I did the tests and there is no doubt. I hope you don't think I'm putting pressure on you, but I took the liberty of sending this note through Paula. I would like to meet you on Monday to talk about it personally. What do you think we should do?

Love
Bette

Hi love,
Hope you're enjoying the trip. Have some great news. I went to the doctor. We did it! Now we're no longer two. There are three of us. Have to fly. See you tonight!

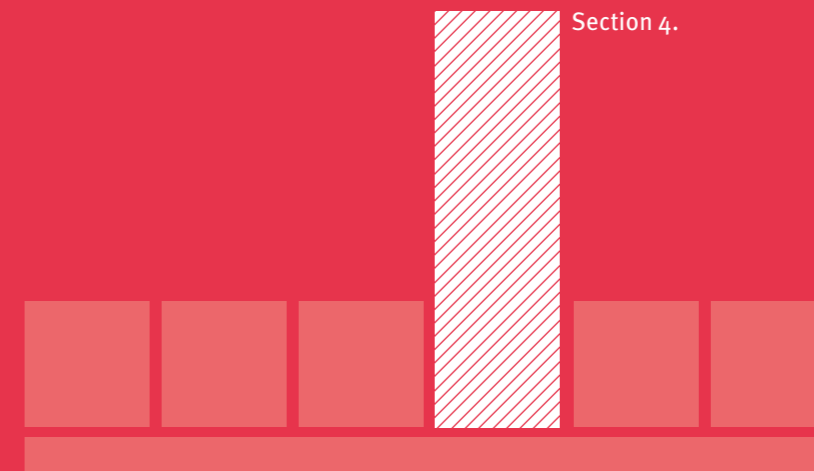
Love
Rita

Hi, baby!
Couldn't face talking to you in person, so I decided to write this note. Last week I started to feel a bit strange, a little bit sick and with a feeling that something was happening. When you took me home after our party to celebrate our two years together, I almost called you, thinking that an accident or something like that had happened. I was really feeling paranoid. I don't know! I was feeling a bit crazy, anyway. Well, now I know the reason for all this. At least I'm feeling more relieved. I don't want to frighten you but I'll get straight to the point. I did some tests and found that I'm pregnant. Since my period sometimes is not on time, at first I thought it might be a false alarm, so I didn't even say anything to you. Trying withdrawal was bound to lead to this. I'm not trying to put the blame on you, but I'm really confused. I don't know what to do now. I'm all mixed up. You're the first person I've talked to about this, and through a note! I know it's not the best way, but I didn't know how to say it to your face. What do you think we should do? I love you so much!

Marcia

Section 4:

Sexual and Reproductive Health – What and Why



— WORKSHOPS —

1. What Comes Into Your Head?
2. Caring for Oneself: Men, Gender and Health
3. Men as Caregivers
4. You Have a Message: You're Going to be a Father!
5. Men and Contraception
6. What about Condoms?

Section 4:

Sexual and Reproductive Health – What and Why

Overview

While our sex is determined by our biological make-up, our attitudes and behaviors in terms of sexuality and reproductive health (SRH) are largely influenced by a complex set of non-biological factors, including culture, gender norms, and socio-economic conditions, among others. For example, in most settings around the world, men are socialized to associate “manliness” with being knowledgeable and experienced in sexual matters. As a result, many men may believe they cannot express doubts about their bodies, sexuality, or reproductive health.

When we look closer, however, we find that, contrary to the prevailing myths, many men, of all ages, often lack a basic understanding of their bodies, sexuality and reproductive matters. Furthermore, in most of the world, there are few sexual education and reproductive health programs directed at men, and even fewer that address young men’s specific concerns and needs.

In this section, we explore some of the main issues related to young men, sexuality and reproductive health.

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...many men, of all ages, often lack a basic understanding of their bodies, sexuality and reproductive matters...

“

What is sexuality and what does it have to do with gender?

Sexuality is an expression of who we are as human beings – it includes all the feelings, thoughts, and behaviors of being male or female, feeling attractive, being in love, as well as being in relationships that include intimacy and physical sexual activity. Moreover, sexuality is a fundamental component in structuring the gender identity of men (and women), and is directly related to what a given society conceives as "erotic" and acceptable. All cultures prescribe what are sometimes called "gender scripts" for both men and women. These scripts are commonly accepted ways in which men's and women's sexual activity is expected to take place. Of course, individuals may adhere to or transgress from these scripts, but we see some common patterns in these scripts across societies and the ways in which they influence actual behaviors.

In most cultures, the sexual scripts for men and women suggest that male sexuality is or should be impulsive and uncontrollable and that, biologically, men have a stronger sex drive than women. Research from diverse settings, for example, has found that men's age of sexual initiation tends to be earlier than women's, and that they have more sexual partners, both outside and within marriage.⁶⁸ Many sexual scripts also dictate that men should share their sexual conquests with the male peer group while hiding from their peers any sexual inadequacies. In nearly all cultures, to be seen as a "real man" means having to maintain heterosexual relations (often seen as a rite of passage to becoming a man) and proving one's fertility by having children.

Many men, and women, are raised to believe that these sexual scripts are unquestionable truths that are part of our nature or biological make-up. However, these models and patterns of

male behavior and sexuality –rather than being biologically programmed—are largely a result of how boys and men are socialized. Researchers have shown how a certain model of masculinity, dominant in Western societies requires men to distance themselves from everything that is seen as feminine and to constantly prove their "manliness" in the company of other men.⁶⁹ Indeed, showing one's virility, or the capacity to conquer and maintain sexual relations with numerous women (in which only penetrative sex counts), are central aspects of the socialization of young men in many settings.

However, these prevailing sexual scripts are a source of doubt and anxiety for many young men who are constantly worried about the normalcy of their bodies and their sexual performance. For example, young men are often taught that the size of their penis is important, and penis size therefore is a source of preoccupation for many boys and men. And because for most boys and young men sex is seen as being a matter of size and performance, masturbation and ejaculation (sometimes in groups) are often more socially accepted than for girls and young women.

Boys generally go through puberty during the ages of 10-13, when hormonal changes drive physical changes, including the production of sperm. Most boys have their first nocturnal emissions or "wet dreams" during this period. These changes and sexual energies are a natural part of life, but also bring confusions and doubts. Boys are generally not encouraged to talk about pubertal changes.⁷⁰ In some cases boys may be given more information about women's bodies than about their own. When we discourage boys from talking about their bodies and sexual health at early ages, we may be starting lifelong difficulties for men in talking about sex.

Throughout the world, virginity and the loss of virginity continue to often have different meanings for young men and young women. While in many cultures, young women must still be concerned about possibly negative peer and social perceptions regarding their first sexual experience, for many if not most young men, sexual debut is seen as a source of prestige and influence in their peer group.

For many young men, talking about sex with family members, teachers, health professionals and peers - when and if it happens - is usually related to discussions about sexual conquests or the peer pressure to prove their sexual prowess. Seeking information or showing doubts or anxieties, in general, are not dealt with publicly. After all, according to popular norms, "real men" do not have doubts about sex nor do they talk about sex, except to talk about their conquests.

Concern about virility and about demonstrating one's capacity for sexual conquest often leads many young men to seek quantity over quality in sexual relationships. To be a "stud" or a "ladies' man" or "to get laid" whenever you can - or at least to make your peers believe that you do these things - is the way that many young men attain status with their peers. It is still common for many young men to talk about an intimate relationship as an opportunity "to get laid" versus an opportunity for an emotional connection. Furthermore, young men may feel pressured to "make the moves" - to take the initiative with women and then to boast of (or invent stories about) these conquests.

Why should we talk with young men about sexuality?

Since most young men do not have spaces to talk about their doubts and questions about sexuality, we need to provide opportunities for young men to discuss and reflect on the topic. Despite the countless discussions about sex education in recent years, the ideas that male sexuality is uncontrollable and that the male sex drive is stronger than women's are still to be found, including among some educators and health professionals. In short, the physical and emotional costs of certain rigid norms and expectations regarding male sexuality and behaviors are not always clear and there are few places and opportunities for young men to express their doubts and frustrations or even less to denounce situations of physical and

symbolic violence to which they are subjected. This includes the insults and jeering that some young men suffer if they seem different, particularly if they are gay or same-sex attracted.

In addition, most young men have never reflected about how gender and gender socialization affect their lives. Certain male behaviors, considered legitimate and even socially expected, can be harmful and make young men vulnerable. For example, excessive drinking - supposedly a way for young men to have the courage to approach a potential sexual partner — makes many young people vulnerable to violence or coercion or puts their health at risk.

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...leads many young men to seek quantity over quality in sexual relationships...
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68 — Gary Barker, "What about Boys?: A literature review on the health and development of adolescent boys." World Health Organization, 2000.

69 — V. J. SEIDLER, (ed.) Men, Sex & Relationships. (Routledge: London and New York, 1992).

70 — Lundgren, R. "Research protocols to study sexual and reproductive health of male adolescents and young adults in Latin America." (Washington, D.C.: Division of Health Promotion and Protection, Family Health and Population Program, Pan American Health Organization, 1999).

What about sexual orientation?

There is no doubt that the AIDS epidemic - which has directly affected men who have sex with men, as well as men who define themselves as heterosexual - has led to increased visibility to the question of homoeroticism and the importance of considering it in the work with young men. Indeed, research from the AIDS field has shown the difficulty of rigidly defining and classifying persons into sexual orientation categories, (homosexuals, bisexuals, transsexuals and heterosexuals). Many men have sex with men and behave in ways considered to be homosexual while at the same time maintaining heterosexual relations, i.e. without considering themselves to be "gay" they have sex with other men. These examples help us see that sexuality and sexual identity are fluid and dynamic, and that our assumptions need to be questioned constantly. Accepting diversity and being open-minded about human sexuality are basic requirements for someone who works with youth.

In some, but clearly not all countries, sexual diversity has increasingly lost its clandestine status and become a right. In many settings homoerotic male and female relationships are being recognized within a context of social and cultural change. This has resulted from the vocal advocacy of social movements (feminist, gay and lesbian), which have generated public debates about individual freedom, sexual and reproductive rights and human rights⁷¹. Various countries, including Denmark, Sweden, Norway, France, Holland and United States, have enacted laws and policies that guarantee homosexual partners important rights such as inheritance, social security benefits, joint

income tax returns and joint health insurance coverage, among others.

Of course, changing social and cultural norms is a slow process. The fact is that homoerotic and bisexual practices among young men are still far less socially accepted than reproductive heterosexual relations. In many settings, intolerance toward same-sex attraction is such that young men who have had same-sex sexual experiences or self-identify as gay or bisexual young men are subjected to discrimination, exclusion and sometimes violence. Homophobic beliefs and slurs are often used as a way to keep heterosexual young men "in line". Calling a young man "gay" or "queer" in much of the world, for example, is seen as a way to criticize his behavior and reduce his social status.

The rigidity of gender socialization and the intolerance of sexual diversity means that it is necessary to demonstrate to young men that they are sexual subjects - which means that they have inherent rights and are "capable of developing a conscious and negotiated relationship...instead of accepting it as something ordained; to develop a conscious and negotiated relationship with family values and those of peer groups and friends; to explore (or not) one's sexuality, independently of the initiative of the partner; to be able and have the right to say no and have it respected; to be able to negotiate sexual practices and pleasure provided they are consensual and acceptable to the partner; to be able to negotiate safer and protected sex and to know and have access to the material conditions for making reproductive and sexual choices."⁷²

71 — C.F. Caceres, "La reconfiguración del universo sexual- Cultura sexual y salud sexual entre los jóvenes de Lima a vuelta de milenio." (Universidad Peruana Cavetano, Heredita/REDRESS, Lima, 2000) ; see also Parker, Richard. *Corpos, prazeres e paixoes*. Sao Paulo, Best Seller, 1991.

72 — Vera, Paiva. *Fazendo arte com a camisinha*. (Sao Paulo: Summus, 2000)

How is male sexuality related to fertility and reproduction?

In the socialization of boys and young men, reproduction is not considered as important as sexuality. A good example is the importance attached to menarche—the initiation of menstruation—versus semenarche, the first male ejaculation. Generally speaking, there is lack of communication between mothers and daughters about the transformation of girls' bodies and their fertility. The silence, however, is even greater between fathers and their sons when it comes to semenarche. The experience of semenarche can generate very different reactions among young men, including surprise, confusion, curiosity and pleasure. Some boys are unaware of what seminal liquid is and think it is urine. It is important then that boys receive guidance during puberty, so that they can feel

more secure in dealing with body changes, and understand their bodies as being reproductive.

Even after semenarche, most young men deal with their sexuality as if fertility did not exist. This means that educators must work with young men to understand that fertility and reproduction are issues that affect and involve both men and women. For example, young men need to be aware that most young men are fertile with each penile-vaginal sexual act and some, before even semenarche occurs. To teach young men about their bodies and to question myths helps them to better understand their own desires as well as their own responsibilities in terms of reproduction.

How can we talk to men about contraception?

In the socialization of boys and young men, reproduction is not considered as important as sexuality. A good example is the importance attached to menarche—the initiation of menstruation—versus semenarche, the first male ejaculation. Generally speaking, there is lack of communication between mothers and daughters about the transformation of girls' bodies and their fertility. The silence, however, is even greater between fathers and their sons when it comes to semenarche. The experience of semenarche can generate very different reactions among young men, including surprise, confusion, curiosity and pleasure. Some boys are unaware of what seminal liquid is and think it is urine. It is important then that boys receive guidance during puberty, so that

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What about HIV and AIDS?

In the Western Balkans, as in many other settings, youth are one of the most vulnerable groups to HIV infection.⁷³ For young men, rigid gender norms about sexuality and intimate relationships, as well as substance use and other health-related behaviors, can create situations of vulnerability both for them and their partners. Socio-cultural norms about masculine strength and self-reliance, for example, may lead young men to feel inhibited from seeking information or admitting their lack of knowledge about sexual matters and consequently engage in unsafe behaviors that put both them and their partners at risk.

Poverty, substance use, family stress or disintegration because of migration, isolation in closed institutions such as prisons or the military also all put young men in situations of even greater vulnerability. Working with young men means thinking about their needs and at the same time recognizing their tremendous potential as agents of change. Convincing young men to question idealized or stereotypical notions of manhood can lead to changes in attitude and behavior – even in cases where young men have already accepted these ideas – provided we work with young men to show them the benefits to themselves and their partners of changing their behaviors. We will discuss these issues at greater length in the section on HIV/AIDS.

What is reproductive health?

The definition of reproductive health is derived from the WHO's definition of health as a state of total well-being, physical, mental and social, and not the mere absence of infirmity or disease. "Reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, 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 are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."⁷⁴

73 — Joana Godinho et al. "HIV/AIDS in the Western Balkans: Priorities for early prevention in a high-risk environment" World Bank Working Paper No. 68. (Washington D.C.:The International Bank for Reconstruction and Development/ The World Bank, 2005)

74 — http://www.who.int/topics/reproductive_health/en. Last accessed on 9/02/2011.

”

...rigid gender norms about sexuality and intimate relationships...

“

What about the issue of adolescent pregnancy?

Adolescent pregnancy has been widely discussed in recent years and the increasing percentage of births to young women in some countries has been a cause for alarm. While some researchers have stressed the biological risks of early childbearing (lower birthweights, higher rates of maternal complications, etc.), the underlying concern is generally social.⁷⁵ The idea of risk associated with adolescent pregnancy reflects a widespread discomfort with the sexuality of young people, and consequently adolescent fatherhood and motherhood.

Furthermore, while early childbearing and pregnancy are often seen as "failures" or problems, listening to the voices of young people themselves sometimes suggests otherwise. Qualitative research with young people in many countries has found that many adolescent mothers, and fathers, see parenthood as a way of attaining status (by becoming parents, they are recognized as adults). For some young people, having a child is a way to organize their lives and identities and to commit themselves to something (or someone) beyond themselves.⁷⁶ Of course, if some young people do not see pregnancy as a burden, many low-income families of adolescent parents are faced with the responsibility of caring for additional children. And in many low-income settings, adolescent fathers are often ignored or discouraged by their own parents or the parents of the mother from maintaining ties with children they have fathered, or because they lack the financial means to support the child, may not be involved in any way with child care.

In sum, for most young people, having a child while still in their adolescence is generally not optimal, given the challenges doing so while also finishing their educations and acquiring employment. Nonetheless, research suggests the importance of taking a more thoughtful view of the issue. These issues have already been discussed in the section on fatherhood and care-giving. In sum, we affirm that health educators should seek to treat adolescent childbearing in a thoughtful and sympathetic way, seeking to avoid the discriminatory attitudes and simplistic views that often surround the issue and seeking to promote the positive involvement of young fathers in child care.

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...having a child is a way to organize their lives and identities and to commit themselves to something ...

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75 — Arline T. Geronimus, "Teenage Childbearing and Social and Reproductive Disadvantage: The Evolution of Complex Questions and the Demise of Simple Answers" *Family Relations* 40, (Oct, 1991) 463-471

76 — Margaret Arilha-Silva. "Masculinidades e gênero: discursos sobre responsabilidade na reprodução" (Master's dissertation, Pontifícia Universidade Católica/PUC, 1999) 117.

BOX 1: INDICATORS OF MORTALITY, INDICATORS OF EDUCATION AND REPRODUCTIVE HEALTH INDICATORS

	Indicators of Mortality			Indicators of education				Reproductive Health Indicators			
	Infant mortality Total per 1,000 live births	Life expectancy M/F	Maternal mortality ratio	Primary Enrollment (gross) M/F	Proportion reaching grade 5 M/F	Secondary Enrollment (gross) M/F	% illiterate (> 15 years) M/F	Births per 1000 women aged 15-19	Contraceptive Prevalence Any method	Contraceptive Prevalence Modern Method	HIV prevalence rate(%) (15-19) M/F
SOUTHERN EUROPE(13)	7	75.5 / 81.9						12	68	46	
ALBANIA	24	71.3 / 77.0	55	105 / 102		81 / 81	1 / 2	16	75	8	
BOSNIA AND HERZEGOVINA	13	71.7 / 77.1	31				2 / 9	23	48	16	
CROATIA	7	71.8 / 78.8	8	97 / 96		89 / 91	1 / 3	15			
GREECE	6	75.8 / 81.1	9	101 / 101	100 / 100	98 / 97	6 / 12	9			0.3 / 0.1
ITALY	5	77.2 / 83.3	5	102 / 101	96 / 97	100 / 99		7	60	39	0.7 / 0.3
MACEDONIA (Former Yugoslav Republic of)	15	71.6 / 76.6	23	96 / 97		86 / 84	2 / 6	24			
PORTUGAL	5	74.2 / 80.8	5	118 / 112		108 / 118		19	66	33	0.7 / 0.2
SERBIA AND MONTENEGRO	12	71.3 / 76.0	11	98 / 98		88 / 89	1 / 6	24	58	33	0.3 / 0.1
SLOVENIA	5	73.0 / 80.3	17	108 / 107		110 / 109	0 / 0	6	74	59	
SPAIN	4	76.2 / 83.5	4	109 / 107		114 / 121		10	81	67	1.0 / 0.3

Is abortion an issue that involves men?

Induced abortion is legal in all of the Balkan countries. For the most part, however, it is still seen as an issue that solely concerns women. Just as the fact that pregnancy occurs in the woman's body allows many men to believe they can evade the responsibility for pregnancy, it also allows many men to believe that they have no role in the decision to have an abortion. However, even in cases where men may want to take part in abortion-related decision-making, are they able to do so? Many men may believe it is in their capacity to convince a partner not to have an abortion and may indeed influence a woman's decision to continue with the pregnancy or seek an abortion. For the most part, however, women generally have the final say in seeking an abortion. Indeed, since women bear the greatest burden and all the physical risk in pregnancy, childbirth and abortion, they should ultimately be the ones to make the decisions about taking these risks. Men, however, share the responsibility for their partner's pregnancies, and it is important that they be involved in supporting women's decisions.

Should We Discuss the Sexual and Reproductive Rights of Men?

Sexual and reproductive rights are universal human rights based on inherent freedom, dignity and equality for all human beings. To have a full sexual life is a fundamental right and for this reason should be considered as a basic human right. However, in most discussions about sexual and reproductive rights, men are rarely mentioned as the subject of these rights. Indeed, there is a need for dialogue and reflection on the importance and relevance of promoting the sexual and reproductive rights of men. Certain questions need to be considered – mainly, is it possible to defend men's sexual and reproductive rights without "naturalizing" or legitimizing the traditionally privileged status of men and "undermining" the rights of women, who have historically been denied their sexual and reproductive rights? For example, how can we reconcile the right of a young woman to not be a mother and the right of a young man to want to be a father, or vice-versa? Dialogues about these issues should include both women and men, and be grounded in an understanding of the relational nature of human rights.

Finally, we should point out that reproductive rights have often focused only on access to contraception or only to fertility, that is, on the number of children that each woman has or wants to have. In this context, reference to the reproductive rights of young men has generally secondary importance, minimizing the importance of sexuality and the underlying power relations in reproduc-

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...Sexual and reproductive rights are universal human rights based on inherent freedom...

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tion. And despite the increasing scope for questioning policies and social practices concerning reproduction, there has not been a clear response on the part of young/adult men to participate more actively in reproductive processes. Furthermore, there is strong resistance from health and education professionals, researchers and activists to associate reproductive rights with men.

To create greater awareness in the field of sexual rights and reproductive rights requires engaging young men themselves, as well as health educators and health professionals. Above all, it requires a conceptual framework for understanding the meaning of reproduction and men's involvement in it, as well as believing that young men have the potential to change toward more positive involvement in reproductive and sexual health.

BOX 2: Sexual and Reproductive Rights

To ensure that every person develops a healthy sexuality, the following sexual and reproductive rights should be recognized, promoted, respected and defended.

THE RIGHT TO SEXUAL FREEDOM – Sexual freedom concerns the possibility of individuals expressing their sexual potential. However, this excludes all forms of coercion, exploitation and abuse at any time or in any situations in life. This includes freedom from all forms of discrimination, irrespective of sex, gender, sexual orientation, age, race, social class, religion or mental and physical disability.

RIGHT TO SEXUAL AUTONOMY, SEXUAL INTEGRITY AND SAFETY OF THE SEXUAL BODY – The right of a person to make autonomous decisions about his or her own sexual life in a context of personal and social ethics. This also includes the control and pleasure of our bodies, freedom from torture, mutilation and violence of any type.

RIGHT TO SEXUAL PRIVACY – The right to individual decision-making and behavior concerning intimacy, provided this does not interfere with the sexual rights of others.

RIGHT TO SEXUAL PLEASURE – Sexual pleasure, including self-eroticism, is a source of physical, psychological and spiritual well-being.

RIGHT TO SEXUAL EXPRESSION – Sexual expression is more than the erotic pleasure or sexual act. Each individual has the right to express sexuality through communication, touching, emotions and love.

RIGHT TO FREE SEXUAL ASSOCIATION – The right to marry or not, the right to divorce and to establish other types of responsible sexual or intimate unions.

RIGHT TO FREE AND RESPONSIBLE REPRODUCTIVE CHOICES – The right to decide whether to have children or not, how many, when and the right of access to contraceptive methods.

Reproductive rights, in turn, “refer to the possibility of men and women making decisions about their sexuality, fertility and their health related to the reproductive cycle and raising their children. In commending the exercise of choice, these rights imply full access to information about reproduction, as well as having access to necessary resources to make the choices efficiently and safely.”⁷⁸

78 – Maria Bethania Ávila, *Direitos Reprodutivos: Uma Invenção Das Mulheres Reconhecendo A Cidadania*. (Recife: SósCorpo, 1993)

BOX 3: ASTRA YOUTH

BOX
3.

ASTRA Youth, a network of youth sexual and reproductive health and rights (SRHR) advocates in the CEE and Balkan regions, addresses the status of youth SRHR in Youth's Voice. Youth's Voice is a research report detailing young people's knowledge of and attitudes towards SRHR in their home countries. Participating countries include Armenia, Bulgaria, Croatia, Cyprus, Georgia, Lithuania, Macedonia, Poland, Serbia, Montenegro, and Slovakia.

What is the role of health services in promoting young men's SRH?⁷⁹

Providing young men-friendly health services is an important piece to promoting young men's access to and use of SRH information, services and support. Unfortunately, throughout the region and the world, there is a lack of youth-friendly health services, particularly those related to sexual and reproductive health. In some settings, where youth sexuality and reproductive health is a taboo topic, laws and policies may restrict young people from accessing sexual and reproductive health services. When these services are made available, they often require the presence or authorization of a parent or guardian, thus prohibiting or limiting opportunities for youth to access confidential services. Even rarer than youth-friendly services are services which include a gender perspective, that is, an understanding of how gender roles and power dynamics shape attitudes and behaviors related to the sexual and reproductive health of young men and women. Both young men and women have specific needs in terms of their health and development because of the ways they are socialized.

As discussed earlier, young men may feel pressured to engage in certain risk behaviors, including substance use or unprotected sex, to prove themselves as “real men.” Moreover, they may view seeking help or services as “un-manly” or a sign of weakness. In many settings, young men may only seek out health services in emergency situations or when they need to obtain condoms.⁸⁰ Many may prefer looking for help and information amongst their peers and at pharmacies rather than formal health services. They may also resist using health services because they view facilities as places for only women and children and/or because they do not expect staff to be sensitive to their needs. Indeed, these perceptions are often reinforced by waiting rooms and services which are mainly targeted at women and staff who are not aware of or trained in SRH issues specific to young men. In this context, promoting young men-friendly health services requires a dual-sided approach: making health services more responsive and attractive to young men AND working with young men to increase their health-seeking behaviors.

79 – Portions of this text were taken Ricardo, C., Barker, G., Nascimento, M., and Segundo, M. (2007) *Engaging young men in HIV prevention: A toolkit for action* New York: UNFPA

80 – S. Pearson, “Men's use of sexual health services” *Journal of Family Planning and Reproductive Health Care* 29 (2003): 190-199.

Box 3: Summary Points

- › We need to show young men that there are different ways of "being a man".
- › We should show young men that there are, indeed, differences between men and women and that many of these differences were constructed by us. It is important that men perceive how these socially constructed differences can have fundamental impacts on our daily life, leading to discrimination and reinforcing gender inequalities.
- › Sexuality needs to be considered in its fullest sense. It is, after all, much more than "having an erection" and "getting laid". As we work with young men, we should explore other dimensions and expressions of human sexuality.
- › We should show young men why it is positive and important to know their own body, that reproductive health is not merely a matter for women, and that sexual rights are not simply a concern for gay or bisexual persons.
- › Finally, when we engage young men in discussions about sexual and reproductive rights, we should relate and connect these specific rights to human rights as a whole.

BOX

4.

Workshops

⚙️ Workshop 1: Young Men's Health

📍 OBJECTIVE:

To discuss how gender norms influence the most common health problems of young men and review basic hygiene practices.

🕒 RECOMMENDED TIME:

1 hour and 30 minutes

📄 PLANNING NOTES:

If possible, it might be interesting to follow-up this activity with a visit to a local health facility where the young men can meet and talk with health professionals.

📁 MATERIALS REQUIRED:

Flipchart paper, small pieces of paper, tape and markers, Resource Sheet.

PROCEDURE:

1. Give each participant two small pieces of paper and ask them (in silence and individually) to write two typical characteristics that are related to being a man (they should write one on each piece of paper). Ask them to hold on to these pieces of paper for a later stage in the exercise.
2. Tape two or three sheets of flipchart paper together and ask for a volunteer to serve as a model to draw the outline of a body.
3. Once they have drawn the outline, ask them to fill-in the sketch with details to make him a young man – give him a face, dress him, and give him a personality. For example, what does he like to do for fun, or what does he do on the weekends? Everyone should take part in the drawing exercise. Ask the participants to give a name to the young man that they have drawn.
4. Next, draw another outline of a body on two or three new sheets of flipchart paper. Ask for a volunteer to sketch the genitals on the body. If the participants are too embarrassed to do this, the facilitator can do so.
5. When the two outlines are finished, give each participant two small pieces of paper and ask them to write two common health problems/needs that men face (they should write one on each piece of paper).
6. When they have finished writing, ask each participant to read out loud the health problems/needs, and stick them on the part of the body where this health problem appears. It does not matter if some problems are repeated.
7. Next, ask the participants to read out loud the characteristics of being a man that they wrote at the beginning of the activity. After reading a characteristic, each participant should stick the piece of paper on the

PROCEDURE

body next to the health problem/need with which the characteristic can be associated. Remind them of the previous activity and the discussion which they had about socialization and the health risks men face. For example, the masculine characteristic of having many sexual partners might be stuck next to the groin area of the body to signify its association with risk for STIs.

8. Probe to see if the participants identify alcoholism, violence, suicide, HIV/AIDS, and substance use as health problems. If they have not mentioned them, ask if these are problems that young men face in their community.
9. Use the questions below to facilitate a discussion.

DISCUSSION QUESTIONS:

1. What health problems/needs do men have?
2. What are the causes of these health problems? What are the consequences of these health problems?
3. Is there a relationship between men's health needs and the characteristics of being a man that we identified?
4. How does a man's role in his family or community affect his health?
5. Do men and women take care of their bodies and health in the same way? How do young men take care of their health?
6. When men are ill or sick, what do they do? Do they usually look for help as soon as they feel ill, or do they wait? When women are ill or sick, what do they do?
7. What is hygiene? What kind of personal hygiene should men practice? What kind of personal hygiene should women practice? (Review Resource Sheet).
8. Where can young men in your community go to ask questions about their health or to seek services for health problems?
9. What can you do in your own lives to take better care of our health? What can we do to encourage other young men to take better care of their health?

CLOSING:

As has been discussed in this and previous sessions, there is a clear relationship between how men are raised and if and how they worry about their health. Many men, as a way of showing their masculinity, do not worry about their health, and may believe that taking care of the body or being overly concerned about health are female attributes. These kinds of attitudes and behav-

iors are learned at early ages and impact men's health throughout their life. For this reason it is important that, as young men, you learn the importance of taking care of yourselves, including basic hygiene practices. Doing so has positive benefits for both you and your partners, as will be discussed further in the upcoming activities.

QUESTIONS

Resource sheet⁸¹

GOOD HYGIENE PRACTICES FOR MEN

Washing the Body

Washing the body helps one to stay clean, avoid infection, and avoid becoming sick. Bathe with water or soap and water once or twice per day. Wash hands before and after meals. Wash hands after using the bathroom to prevent the spread of bacteria and infection. Washing the face at least twice a day with soap and water can help keep acne away or make it less severe.

Smelling Good

Use deodorant, baby powder, or the most common product in your country for smelling good under your arms.

Hair

Shampoo your hair regularly to keep it clean. Every day or every two or three days or once a week is fine. Not all men and women shave. This depends on culture and choice.

Teeth and Mouth

Use what is most common in your country to clean the teeth twice a day, including before bed each night. Cleaning teeth helps avoid cavities or rotted teeth. Using toothpaste with fluoride can also help to strengthen your teeth.

Underwear

Wear clean underwear every day to avoid infection and keep the genital area clean.

Genital Area

It is important to wash and clean the penis every day. Wash the scrotum, between the scrotum and the thighs, in between the buttocks, and the anus with soap and water every day. For uncircumcised men, it is important to pull back the foreskin and gently clean this area. Being uncircumcised is not in and of itself unhygienic but uncircumcised men do need to take extra care in their hygiene. For all men, it is important to wash and clean the penis and the area around the anus every day.

⁸¹ — Taken from E. Knebel (2003) "My Changing Body: Fertility Awareness for Young People" Institute for Reproductive Health and Family Health International.



Workshop 2: Men's and Women's Bodies

OBJECTIVE:

To increase awareness and knowledge of the male and female reproductive systems and genitalia.

MATERIALS REQUIRED:

Small pieces of paper or cards, pens/pencils, one copy of each Resource sheets A and B and a sufficient number of copies of Resource Sheets C, D and E to distribute to all of the participants.

RECOMMENDED TIME:

1 hour and 30 minutes. This activity often generates lots of questions among the participants and it might be useful to set aside two sessions to adequately deal with the topic.

PLANNING NOTES:

It is important that the facilitator is familiar with this topic prior to the session or invites someone who has experience working with youth on this topic. The facilitator will also need to determine the level of detail appropriate for the group. For some of the participants, this session will serve as a quick review. However, much of the information may be new to the young men. Also, many of the participants might have a basic understanding of anatomy and physiology, but they might never have had a chance to ask specific questions. If the information is too basic for some of the participants, encourage them to share facts with the other participants who are less familiar with the material. It is important to keep in mind that some participants might not feel comfortable asking questions about men's and women's bodies and genitalia. If this is the case, it might be helpful to invite them to write down their questions on small pieces of paper which can then be collected and read aloud for discussion. The facilitator should also work to create an open and comfortable atmosphere during the activity and discussion. Resource Sheet G provides a list of websites and resources which provide information or details related to men's and women's reproductive systems and health. It is recommended that the facilitator add any relevant websites or resources and provide copies of the list to the participants.

PROCEDURE:

1. Prior to the session, write out the following words on small pieces of paper or cards: vans deferens, penis, urethra, epididymis, testicle, scrotum, prostate, seminal vesicles, bladder and prostate. On the same pieces of paper write out the description of each of these words as presented in Resource Sheet C – The Male Reproductive System and Genitalia. On another set of small pieces of paper or cards, write out the following words: ovary, fallopian tube, uterus, cervix, vagina, outer lip, inner lip, vaginal opening, clitoris and urinary opening. Write out the description of each of these words on the same pieces of paper as presented in Resource Sheets D and E – The Female Reproductive System and Internal and External Genitalia.

2. At the beginning of the session, divide the participants into two groups. Give one group a copy of Resource Sheet A and the set of pieces of paper with the names and descriptions for the Male Reproductive System. Give the other group a copy of Resource Sheet B and the set of pieces of paper with the names and descriptions for the Female Reproductive System.
3. Explain to each group that they will have to read over the words and descriptions they have received to try to label the different parts on the drawings of the male and female reproductive systems and genitalia.
4. Allow the groups 10 minutes to discuss and label the drawings.
5. Ask the groups to present their pictures and explain their answers. As each group presents its picture, invite the participants to ask questions and make corrections.
6. Distribute copies of Resource Sheets C, D and E to the participants and review the content with them.
7. Review Resource Sheets F – Common questions about men's reproductive system and genitalia. Even if the participants do not bring up these questions themselves, it is important that they have this information.
8. Wrap-up the discussion with the questions below.

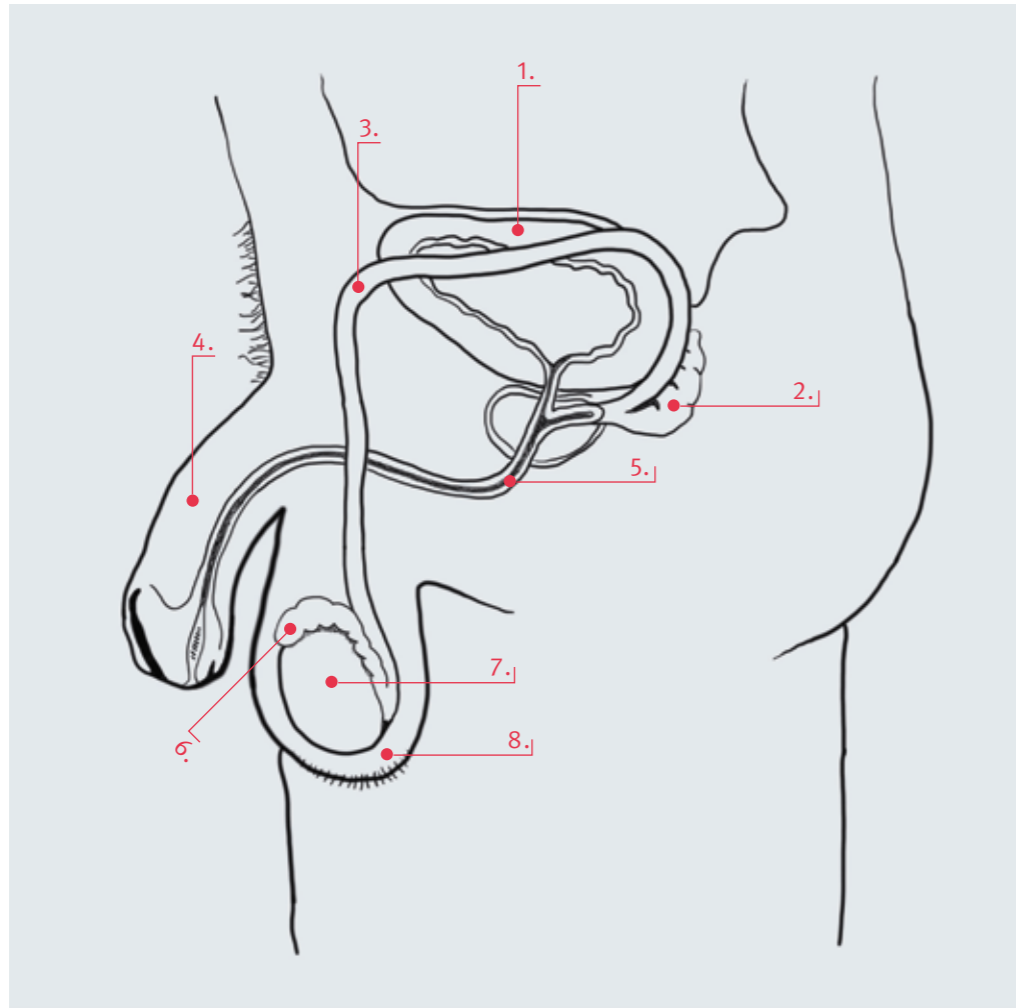
DISCUSSION QUESTIONS:

1. What were the most difficult genital organs to identify? Why?
2. Do you think it is important for young men to know the name and function of the male genital organs? Why?
3. Do you think it is important for young men to know the name and function of the female genital organs? Why?
4. Do young men generally have information about these topics? Why or why not?
5. What can you do to ensure that young people in your community have more accurate information about these topics?

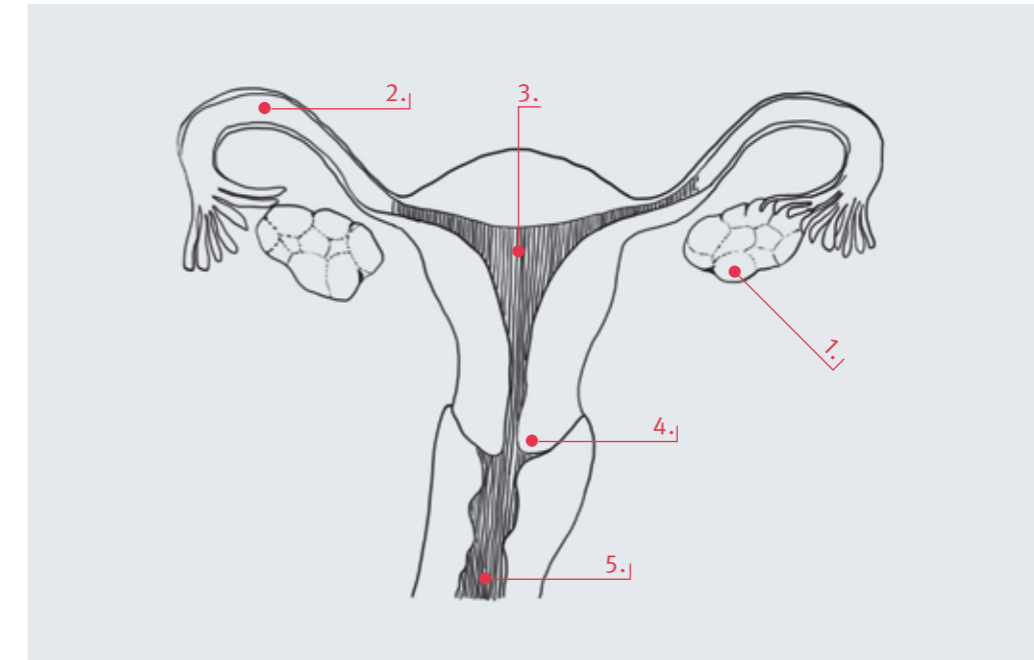
CLOSING:

Many men do not know much about their own bodies, nor believe that it is necessary to devote time to understanding it. As you will continue to discuss in other workshops, this lack of knowledge about one's own body and its functioning

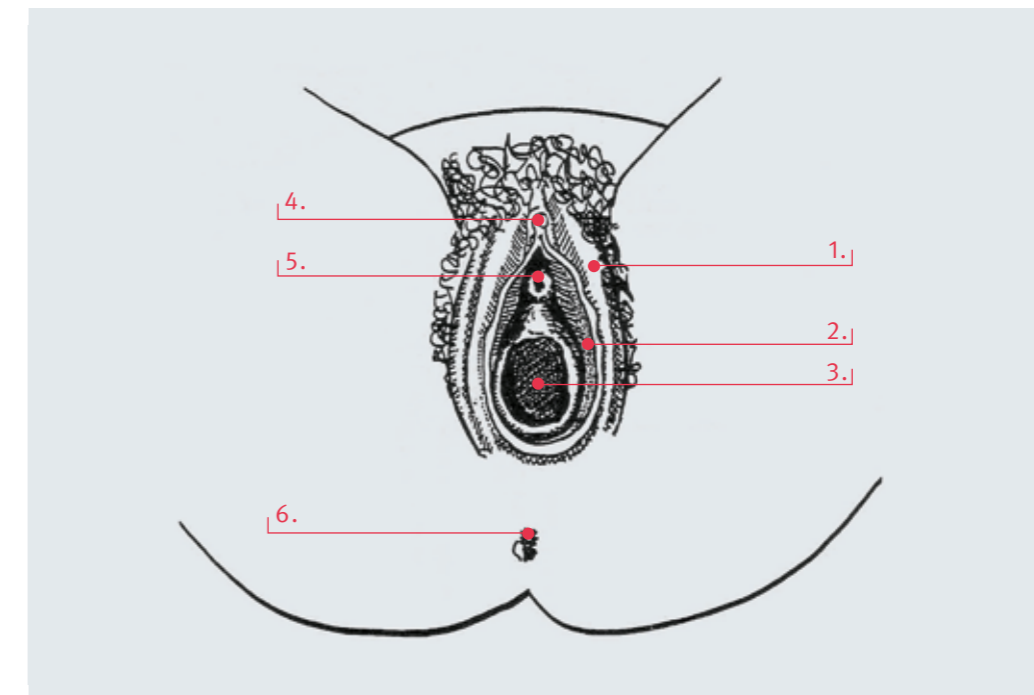
often has adverse effects on hygiene and health. It is also important to have information about women's reproductive systems so that you can be more involved in discussions and decisions about family planning and related matters.



1. Bladder
2. Seminal vesicles
3. Vas deferens
4. Penis
5. Urethra
6. Epididymis
7. Testicle
8. Scrotum

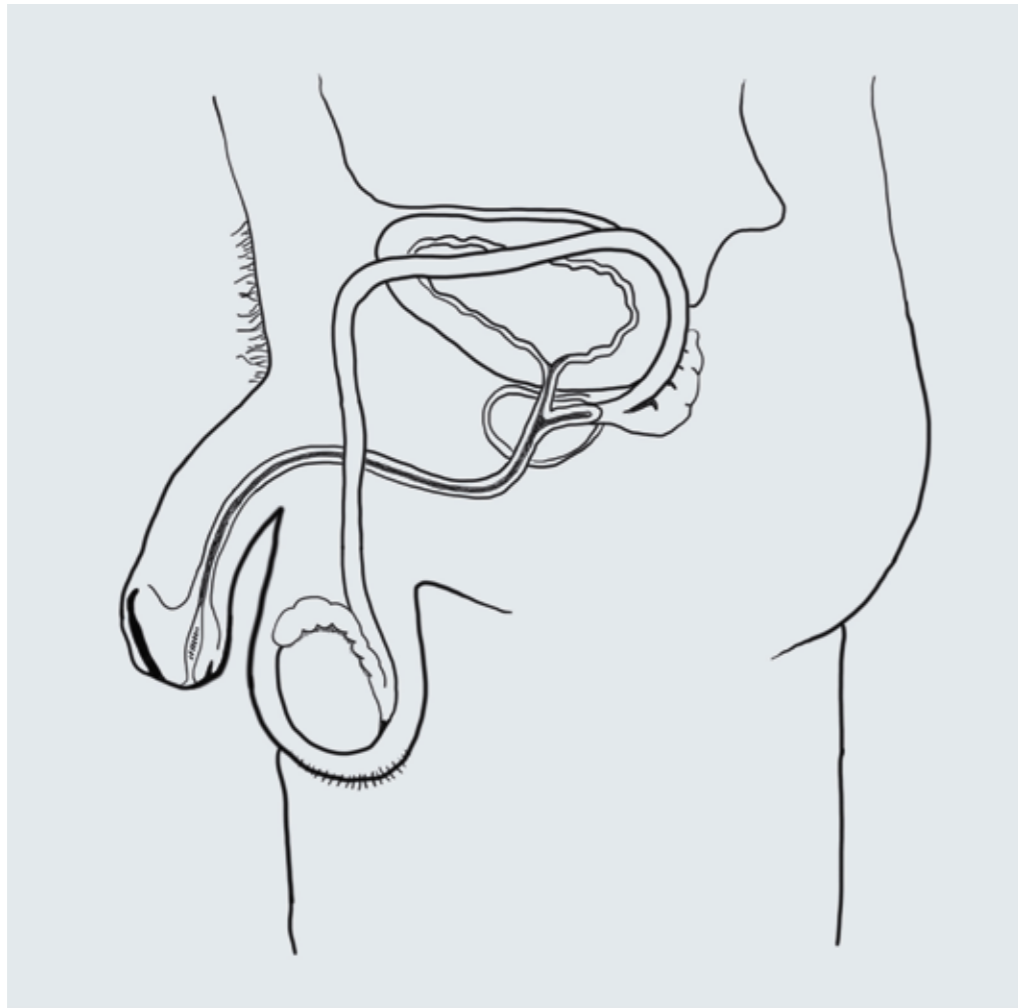


- | | |
|-------------------|-----------|
| 1. Ovary | 4. Cervix |
| 2. Fallopian tube | 5. Vagina |
| 3. Uterus | |



- | | |
|----------------------|--------------------|
| 1. Outer lip | 4. Clitoris |
| 2. Inner lip | 5. Urinary opening |
| 3. Opening of vagina | 6. Anus |

The Male Reproductive System



From puberty on, sperm are continuously produced in the testicles (or testes), which are found inside the scrotum. As the sperm mature, they move into the epididymis, where they remain to mature for about two weeks. The sperm then leave the epididymis and enter the vas deferens. These tubes pass through the seminal vesicles and the

prostate gland, which releases fluids that mix with the sperm to make semen. During ejaculation, the semen travels through the penis and out of the body by way of the urethra, the same tube that carries urine. The urethral or urinary opening is the spot from which a man urinates or ejaculates.

82 — Some text adapted from Institute for Reproductive Health, Family Health International and E. Knebel (2003) "My Changing Body: Fertility Awareness for Young People"

KEY WORDS:

Ejaculation: Forceful release of seminal fluid from the penis.

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

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

Prepuce or foreskin: The skin that covers the head of the penis. When the penis becomes erect, the prepuce is pulled back, leaving the glans (or the "head" of the penis) uncovered.

When this does not occur, the condition is called phimosis, which can cause pain during sexual intercourse and hamper personal hygiene. Phimosis is easily corrected through surgical intervention using a local anesthetic. In some cultures or countries, or in some families, the foreskin of boys is removed in a procedure called circumcision. When the foreskin is present, it is important to clean underneath it daily.

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

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

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

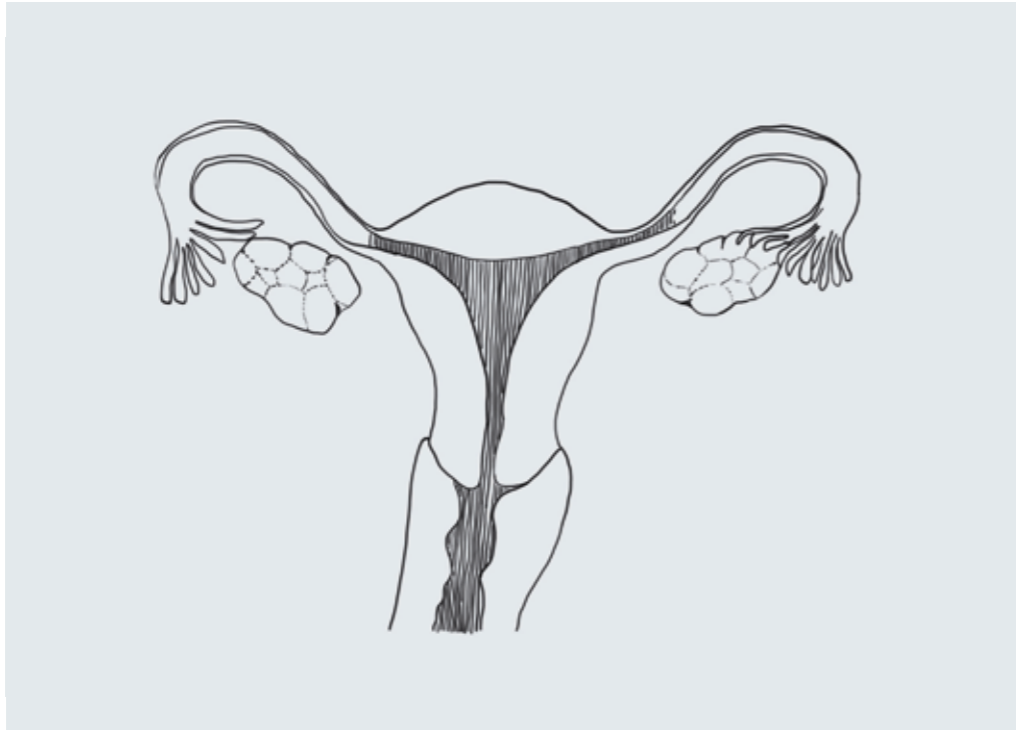
Seminal vesicles: Small glands that produce a thick, sticky fluid that provides energy for sperm.

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

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

Urethral (urinary) opening: Spot from which a man urinates.

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

The Female Reproductive System

Every female is born with thousands of eggs in her ovaries. The eggs are so small that they cannot be seen by the naked eye. Once a girl has reached puberty, a tiny egg matures in one of her ovaries and then travels down a fallopian tube on its way to the uterus. This release of the egg from the ovary is called ovulation. The uterus prepares for the egg's arrival by developing a thick and soft lining like a pillow. If the girl has had sex in the last few days before she ovulates, by the time the egg arrives in the fallopian tube, there might be some sperm waiting to unite with the egg. If

the arriving egg is united with the sperm (called fertilization), the egg travels to the uterus, and attaches to the lining of the uterus and remains there for the next nine months, growing into a baby. If the egg is not fertilized, then the uterus does not need the thick lining it has made to protect the egg. It throws away the lining, along with some blood, body fluids, and the unfertilized egg. All of this flows through the cervix and then out of the vagina. This flow of blood is called the "period" or menstruation.

83 — Some text adapted from Institute for Reproductive Health, Family Health International and E. Knebel (2003) "My Changing Body: Fertility Awareness for Young People"

KEY WORDS:

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

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

Fertilization: Union of the egg with the sperm.

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

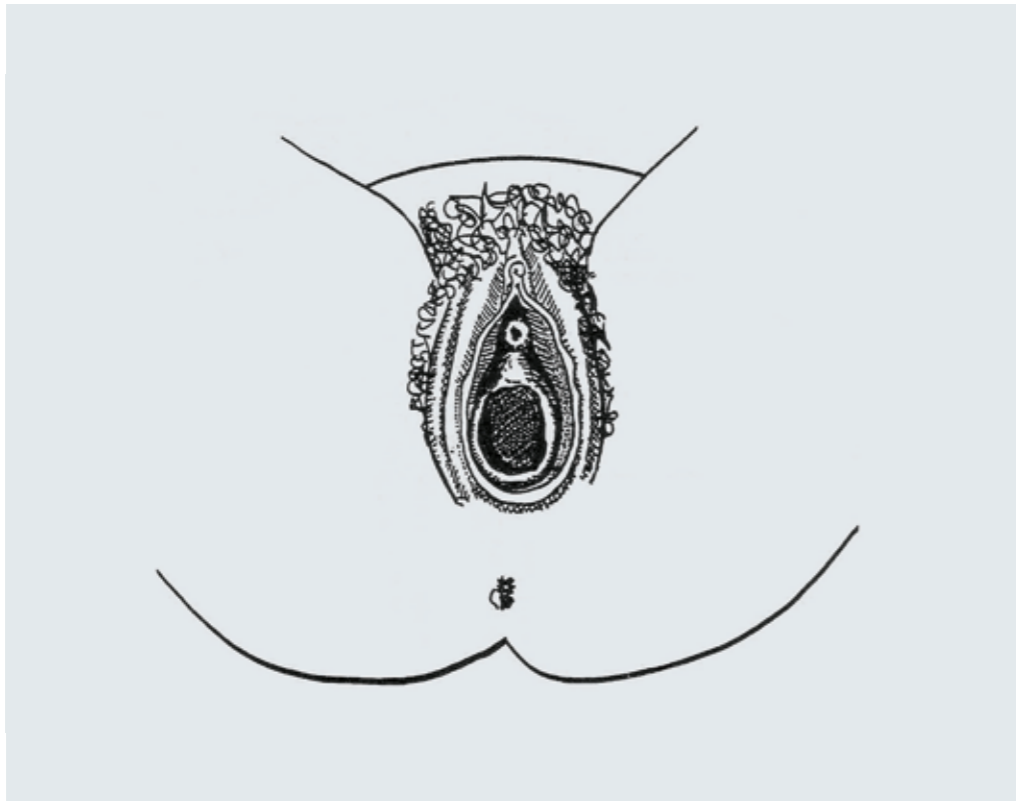
Ovaries: Two glands that contain thousands of immature eggs. The ovaries begin to produce hormones and release an ovum (an egg cell) once a month when a woman reaches puberty.

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

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

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

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

The Female Reproductive System

The external genitalia include two sets of rounded folds of skin: the labia majora (or outer lips) and the labia minora (or inner lips). The labia cover and protect the vaginal opening. The inner and outer lips come together in the pubic area. Near the top of the lips, inside the folds, is a small cylindrical body called the clitoris. The clitoris is made up of the same type of tissue as the head of the male's penis and is very sensitive. The urethra

is a short tube that carries urine from the bladder to the outside of the body. Urine leaves a woman's body through the urethral or urinary opening. The vaginal opening is the place from which a woman menstruates. Both the urethral opening and vaginal opening form the area known as the vestibule. Altogether, the external genital organs of the female are called the vulva.

84 — Some text adapted from Institute for Reproductive Health, Family Health International and E. Knebel (2003) "My Changing Body: Fertility Awareness for Young People"

KEY WORDS:

Clitoris:

Small organ which is sensitive to stimulation and found above the opening to the urethra, where the folds of the labia majora meet and surround it.

Labia majora (outer lips):

Two folds of skin (one on either side of the vaginal opening) that cover and protect the genital structures, including the vestibule.

Labia minora (inner lips):

Two folds of skin between the labia majora that extend from the clitoris on each side of the urethral and vaginal openings.

Urethra:

Short tube that carries urine from the bladder (the place where urine is collected in the body) to the outside of the body.

Urethral (urinary) opening:

Spot from which a woman urinates.

Vaginal opening:

Opening from the vagina where menstrual blood leaves the body.

Vestibule:

Area of the external female genitalia that includes the vaginal and urethral opening.

Vulva:

The external genital organs of the female, including the labia majora, labia minora, clitoris, and vestibule.

Mons Pubis:

This cushion of fat covers the pubic bone. Pubic hair grows on this area.

Common Questions about the Male Reproductive System and Genitalia

Q. What is masturbation?

A. Masturbation is rubbing, stroking or otherwise stimulating one's sexual organs – penis, vagina, and breasts – to get pleasure or express sexual feelings. Both men and women can relieve sexual feelings and experience sexual pleasure through masturbation. There is no scientific evidence that masturbation causes any harm to the body or mind. Masturbation is only a medical problem when it does not allow a person to function properly or when it is done in public. However, there are many religious and cultural barriers to masturbation. The decision about whether or not to do it is a personal one.

Q. Can semen and urine leave the body at the same time?

A. Some boys worry about this because the same passage is used for both urine and semen. A valve at the base of the urethra makes it impossible for urine and semen to travel through this tube at the same time.

Q. What is the right length of a penis?

A. The average penis is between 11 and 18 centimeters long when it is erect. There is no standard penis size, shape, or length. Some are fat and short. Others are long and thin. There is no truth to the idea that a bigger penis is a better penis.

Q. Is it normal to have one testicle hanging lower than the other one?

A. Yes. Most men's testicles hang unevenly.

Q. Is it a problem for the penis to curve a little bit?

A. It is normal for a boy or man to have a curving penis. It straightens out during an erection.

Q. What are those bumps at the head of the penis?

A. The bumps are glands that produce a whitish creamy substance. This substance helps the foreskin slide back smoothly over the glans. However, if it accumulates beneath the foreskin, it can cause a bad smell or infection. It is important to keep the area under the foreskin very clean at all times.

Q. How does one prevent having an erection in public?

A. This is normal. Even though you may think it is embarrassing, try to remember that most people will not even notice the erection unless you draw attention to it.

Q. Will wet dreams or ejaculation make a boy lose all of his sperm?

A. No. The male body makes sperm continuously throughout its life.

...There is no scientific evidence that masturbation causes any harm to the body or mind...

⁸⁵– Taken from Institute for Reproductive Health, Family Health International and E. Knebel (2003) "My Changing Body: Fertility Awareness for Young People"

For more information on this topic, visit the following websites:

1. www.pazisex.net
2. www.sezamweb.net
3. <http://www.who.int>
4. <http://www.zdravlje.nshc.org.rs>
5. www.xy.com.ba
6. www.iwannaknow.org
7. www.teenagehealthfreak.org
8. www.huhiv.hr
9. <http://www.jazas.net>
10. <http://www.juventas.co.me/>
11. www.status-m.hr
12. <http://www.ippf.org>

Workshop 3: The Erotic Body

OBJECTIVE:

To reflect on how men and women experience sexual desire, excitement and orgasm and the different messages they receive from society about sexuality and eroticism.

MATERIALS REQUIRED:

Magazines and newspapers, scissors, paper and glue.

RECOMMENDED TIME:

1 hour

PLANNING NOTES:

It is important that this activity be carried out in the most open and informal way possible. It is OK if the participants laugh or joke about these issues. In fact, joking is one of the ways that men may use to “defend” themselves or express anxiety, particularly when faced with new information.

PROCEDURE:

1. Distribute a sheet of paper to each participant and lay out some magazines, glue and scissors in the middle of the room.
2. Explain that each participant should produce a collage on what makes men feel sexual desire using pictures, words and other images cut out from the magazines and newspapers.
3. Allow the participants 10 minutes to look through the magazines and newspapers and produce their collages.
4. Distribute a second sheet of paper to each participant and ask them to produce collages about what makes women feel sexual desire.
5. Allow the participants 10 minutes to produce the second collage.
6. Invite participants to volunteer to present and discuss their collages.
7. Use the questions below to facilitate a discussion.

NOTE:

If there are both men and women in the group it can be interesting to ask the men to make the collage on what makes women feel sexual desire and the women what makes men feel sexual desire.

PROCEDURE

DISCUSSION QUESTIONS:

1. How was male sexual desire depicted in the collages?
2. How was female sexual desire depicted in the collages?
3. What were the similarities between the collages?
4. What were the differences between the collages? How do you think these differences are linked to the way men and women are raised?
5. What is sexual desire? Do both men and women feel sexual desire? Are there any differences in how they feel sexual desire? Do all men feel sexual desire the same way? Do all women experience sexual desire in the same way?
6. How do we know when a man is excited? And a woman?
7. How do men get excited? What excites a man sexually?
8. How do women get excited? What excites a woman sexually?
9. Do men and women get excited in the same way? What is the difference?
10. What is an orgasm? What happens in a male orgasm? And what about a female orgasm? (Review Resource Sheet).
11. How can sexual desire influence decisions and behaviors related to HIV/AIDS prevention?
12. What have you learned from this exercise? How can you apply this in your own lives and relationships?

CLOSING:

Both men and women have sexual desires and can feel sexual excitement. This excitement depends on biological as well as social and psychological factors. Every part of the human body can produce pleasure when touched but, generally speaking, people have certain areas that are more sensitive to caressing than others. They vary from person to person, thus, only by talking or experimenting will you know what excites your partner most.

QUESTIONS

Human Sexual Desire

There are four stages to human sexual desire: desire, excitation, orgasm and relaxation.

Sexual desire is when one feels like having sex. It occurs through the activation of the brain when confronted with a sexually exciting stimulus. Every part of the human body can produce sexual excitement or pleasure when touched but, generally speaking, people have certain areas that are more sensitive to caressing than others. These are called erogenous zones (breasts, anus, vulva, clitoris, vagina, penis, mouth, ears, neck, etc.).

Moreover, a certain stimulus can be exciting in a certain culture and not in another. For example, a certain standard of beauty can arouse sexual desire in one place and not in another. Also, sexual excitation depends on social and psychological factors that are closely interlinked, which influence each other and which depend on each other. For example, anxiety, depression, the feeling of danger and fear of rejection can affect a person's sexual desire. On the other hand, when a person feels relaxed, secure and has intimacy with his or her partner, this greatly facilitates the desire to have sexual relations.

Sexual excitation is involuntary, that is to say, it occurs independently of a person's will.

What man has not had the embarrassment of having an erection at the wrong moment? We know that a man is excited because his penis becomes hard and his testicles rise or feel tighter. We know a woman is sexually excited when her vagina becomes wet and her clitoris swells and becomes

harder. Physiologically, the excitation results from the increased flow of blood into certain tissues (such as the penis, the vagina, the breasts) and from the muscular tension of the whole body during sexual activity. During this phase, respiratory movements and heartbeat increase. More important than knowing all this, however, is to know that caressing and touching between partners is important in this stage. In the case of most men, all it takes is an erotic image for him to have an erection; for a woman to become excited requires more time, and more caressing and kissing.

Orgasm is the stage of greatest sexual intensity and is difficult to describe objectively because the feeling of pleasure is personal – so much so that descriptions of orgasm are just as varied as people themselves. During orgasm, most individuals feel that the body builds up enormous muscular tension and then suddenly relaxes, accompanied by an intense feeling of pleasure. Furthermore, not all orgasms are the same. As the orgasm depends on sexual excitation; the same person can have orgasms of different intensities at different times. It is during the male orgasm that ejaculation occurs, that is, sperm is ejected through the urethra.

Relaxation is the stage when the man relaxes and needs some time to get excited again. In young men this period is short (around 20 to 30 minutes); in adults, particularly those over 50, it can take longer. Women do not need this interval, which explains why they can have more than one orgasm during sexual intercourse, or multiple orgasms.

⚙️ Workshop 4: Young Men's Health

📍 OBJECTIVE:

To promote greater awareness of the possible consequences, implications, and feelings related to young men becoming fathers while adolescents.

📄 MATERIALS REQUIRED:

Pens/pencils for all participants and Resource Sheet A

🕒 RECOMMENDED TIME:

1 hour and 30 minutes

📅 PLANNING NOTES:

It is common for the issue of abortion to come up as part of the discussion on unplanned pregnancy. This can be a very heated and divisive topic and it is important that the facilitator try to not impose his/her values or take sides but rather, focus on the health and human rights context. The facilitator should also be prepared to deal with questions and misunderstandings that the participants might have about abortion and provide information on local statistics, laws and services.

PROCEDURE:

1. Do not reveal the title of the activity or the topic of discussion.
2. Tell the group that you will read a story out loud in three parts (see Resource Sheet). Explain that after each part, you will ask a few questions relating to each part of the story.
3. After finishing the story, end the session by discussing the questions below.

QUESTIONS:

1. Do young people in your community experience situations similar to that of Nikola and Ana?
2. What can you do to help reduce the number of unplanned pregnancies among young people in your community?

CLOSING:

In many cases young men, either through ignorance or lack of concern, do not participate in the decision concerning a pregnancy. Young women themselves, also through misinformation or difficulty in approaching the subject with the young man (particularly if it is the first time they are having sex), can find themselves pregnant without any previous planning. It is important to think about how traditional gender roles and power relations lead to these situations in which couples do not discuss contraception and an unplanned pregnancy happens. Often, if the discussion does happen it happens in the heat of the moment when contraception might not be easily accessible.

Moreover, some young men may question whether they are the father when a partner becomes pregnant. This attitude may be associated with fear, or with a rejection of the probable change in lifestyle resulting from unplanned paternity. This change is represented as a passage from youth to adulthood and, therefore, associated with the loss of freedom. It also reveals a distrust of women – particularly young women who may have had more than one sexual partner. It is important to remember that although pregnancy might not be the best option for a young man or young women, life does continue and the best course is to always look for support from family, peers and others in the community.

THE STORY OF NIKOLA

Part 1

Nikola is a 17-year-old young man who lives with his family in Banja Luka. He studies hard in school, loves to talk with his friends, and plays football whenever he can. One Saturday, when he was hanging out with some friends in town, Nikola met Ana, who was 16. It was love at first sight. They talked for hours that afternoon. Before leaving each other, they hugged and kissed. They also agreed to meet in the same spot in three days time. Nikola was in love! He had never felt like this before. As he walked home that evening, Nikola could not stop thinking about Ana. For three days straight, he thought about her. Nikola had finally found the love of his life.

- › How do you think this story will end?

Part 2

When Nikola and Ana met again, they were very happy. After that, they saw each other nearly every day and the times they were apart, they talked on the phone. One day Nikola's parents went to visit a sick aunt in Belgrade. Nikola thought that this was a good opportunity to invite Ana over to his house. Who knows what might happen, he thought to himself. Ana arrived at the agreed time, looking more beautiful than ever! Talking soon turned into kissing, which became increasingly more heated.

- › Who should be thinking about contraception in this story? Ana or Nikola?
- › What about STI and HIV prevention?
- › Do you think that either of them took any precautions? Why or why not?
- › How do you think this story will end?

Part 3

Nikola and Ana had sexual intercourse, but they did not use any protection. On her way back home, Ana began to worry about what they had just done. Maybe she should not have allowed it to happen. What would her family and friends think if they knew she was no longer a virgin? Nikola was also worried. He wondered what his parents would think if they knew he had brought Ana to their home. For the next two weeks, Nikola tried to avoid Ana. She called him every day, but he always found an excuse to not talk with her. Then, about a month later, Nikola received a call from Ana who was weeping and very upset. Ana told Nikola that she was pregnant and did not know what to do.

- › Why do you think that they ended up having sex without using a condom or any other type of contraceptive method?
- › What do you think Nikola felt when he found out Ana was pregnant?
- › What passes through the mind of a young man when he discovers that his girlfriend is pregnant?
- › What passes through the mind of a young woman when she discovers that she is pregnant?
- › What choices do Nikola and Ana have?
- › How will having a child change Nikola's life? How will it change Ana's life?
- › How will Nikola's parents react? How will Ana's parents react?
- › Do families, peers and communities react differently to young man who is going to be a father than to a young woman who is going to be a mother? Why or why not?
- › How do you think this story will end?

⚙️ Workshop 5: Men and Contraception

📍 OBJECTIVE:

To provide information on contraceptive methods and discuss male involvement in contraceptive use.

📄 MATERIALS REQUIRED:

Samples of contraceptive methods and/or drawings of methods, paper, pens/pencils, and sufficient number of copies of Resource Sheets A and B to distribute to participants.

🕒 RECOMMENDED TIME:

2 hour

📅 PLANNING NOTES:

If available, you should bring samples of contraceptive methods to the session. In the discussion about each of the methods, discuss advantages and disadvantages, as well as cultural and personal beliefs about each method. It is also important to research beforehand where young men can access different methods and the cost of these methods. If possible, invite a staff person from a local health facility, or someone else knowledgeable in family planning methods, to participate in this session.

PROCEDURE:

Part 1 – Discussing Different Contraceptive Methods (1 hour)

1. Divide the participants into six small groups. Distribute the method samples or the names of the methods on pieces of paper according to the list below:
 - › Group 1: Abstinence
 - › Group 2: Oral Contraceptives and Injectables (Hormonal Methods)
 - › Group 3: Intra-uterine Device
 - › Group 4: Condoms, Diaphragm, and Spermicides
 - › Group 5: Natural Family Planning and Fertility Awareness Methods
 - › Group 6: Male and Female Sterilization (Vasectomy and Tubal Ligation)
2. Ask each group to try to answer the following questions about the methods they have received:
 - › Does this method prevent pregnancy and STIs/HIV?
 - › How is it used?
 - › What are the myths and facts about this method?
 - › What are its advantages?
 - › What are its disadvantages?
 - › What do young men in your community think about this method? Why?
3. When they have finished, go over the information contained in Resource Sheets A and B. Be sure to emphasize the importance of abstinence as the most effective method to protect against pregnancy and disease. Also review the information on withdrawal, emergency contraceptive pills, and dual protection and female and male fertility. Clarify any questions or concerns the participants might have regarding any of the contraceptive methods.

4. Ask the same groups to use their creativity to prepare a presentation to teach other young men about the method they have been assigned. Encourage them to discuss its use with others through a drama, dance, advertisement, or posters.
5. After each group presents their method, follow-up with the discussion questions below.

DISCUSSION QUESTIONS:

1. Who has to think about contraception? The man or the woman? Why?
2. Who is expected to initiate a conversation about it, the man or the woman? Why?
3. Is it difficult to have this conversation?
4. What happens in real life? Do couples talk about contraception? Why or why not?
5. What are the most recommended contraceptive methods for adolescents and youth?
6. Where do young people generally get information about sex and contraceptive methods? Is this information usually adequate? Are there other sources?
7. Do young people have access to these methods? What are the most commonly used methods among youth in your community?
8. How should a couple choose a contraceptive method?
9. Which methods are safest for preventing pregnancy and STIs/HIV?
10. If you forget to use a condom, or the condom breaks, what can you do?
11. What did you learn in this session that you did not know before? What will you do with this information?

CLOSING:

In many places, contraception is considered a woman's responsibility. Indeed, many men, particularly young men, often lack information about fertility and how contraceptive methods work. However, contraception is a shared responsibility. It is essential that, as young men, you have accurate information on contraceptive methods and how to access them to better protect yourselves and your partners from unplanned pregnancies and STIs/HIV. Just as the decision to have sex

should be discussed, shared, and planned, so should the decision about contraception. It is not always easy to have these kinds of discussions with a partner, but it's an essential part of being intimate with someone. Remember to always listen to and respect the concerns of your partner. Finally, in the case of doubts or uncertainties, you should seek out information from health professionals or other knowledgeable persons in the community.

QUESTIONS

LINKS

The activity **"Want...Don't Want, Want...Don't Want"** can be used to discuss and practice the negotiation of contraceptive methods in intimate relationships.

The activity **"Everything You Ever Wanted to Know About Condoms"** provides an opportunity for young men to further explore facts and myths around condoms, practice its proper use, and reflect on difficulties that can come up when discussing its use with partners, peers, and families.

Resource sheet A**Common Questions about Fertility and Contraception****Fertility Awareness –****When are women and men fertile?**

Women: From the time a girl starts having menstrual periods, it means that her reproductive organs have begun working and that she can become pregnant if she has sexual intercourse. Ovulation is the periodic release of a mature egg from the ovary. This usually happens around the middle of a woman's menstrual cycle – about 14 days before her next period begins. Variety of factors, including stress, illness, and nutrition, can affect the length of the menstrual cycle.

Men: Beginning with his first ejaculation, a man is fertile every day and has the ability to father a child for the rest of his life.

Withdrawal – Is it a reliable method?

Withdrawal is a method in which the man removes his penis from a woman's vagina prior to ejaculation. It is not a reliable method to avoid pregnancy, and it does not protect against STIs/HIV. One reason withdrawal is ineffective is that most men do not actually know when they are going to ejaculate, and, in the heat of the moment, they might not withdraw in time. A second reason is

that prior to ejaculating, the penis releases a small amount of fluid which can include sperm and cause a pregnancy or the transmission of STIs/HIV.

Dual Protection – Is it possible to prevent pregnancy and STIs/HIV at the same time?

A couple can use the male or female condom to protect against both pregnancy and STIs/HIV. A couple may also use two contraceptive methods (for example, a condom and an IUD) to protect against both pregnancy and STI/HIV transmission. Lastly, the surest form of protection from unplanned pregnancy and infection can be achieved through abstinence, the avoidance of sexual intercourse altogether.

Emergency Contraceptive Pills (ECPs)**– When to use them?**

Often called the "morning-after pill" or post-coital contraception, ECPs can reduce the risk of pregnancy after unprotected sexual intercourse or in the case of condom breakage. This is no longer correct, as new ones are more modern and do not require high doses of hormones. The sooner ECPs are taken after unprotected intercourse, the greater their effectiveness. ECPs should not be used as a routine contraceptive method, but only in emergency situations.

METHOD	HOW IT WORKS
ABSTINENCE	<p>Abstinence is the total avoidance of sexual intercourse between partners. It is the safest and most effective way to prevent pregnancy and the transmission of STIs/HIV. While many sexual activities, including oral sex, cannot result in pregnancy, they can still result in the transmission of infection.</p> <p>100% effective against pregnancy and STIs.</p>
ORAL CONTRACEPTIVES	<p>Oral contraceptives (sometimes called birth control pills or “the pill”) contain hormones that protect against pregnancy. These pills stop the release of an egg every month – but do not stop periods. They do not protect against STIs/HIV.</p> <p>97% effective against pregnancy if taken correctly</p>
INJECTABLES	<p>Injectables work the same as the pill. However, a woman receives a shot every eight to 12 weeks (depending on the type of injectable used) instead of taking a pill every day. Common names for these contraceptives are DMPA, Depo-Provera, and NET-EN. Injectables protect against pregnancy, but they do not protect against STIs/HIV.</p> <p>Not currently available in Western Balkans</p>
INTRA-UTERINE DEVICE (IUD)	<p>IUDs (sometimes called coils, spirals, or the loop) are small plastic or metal devices of varying shapes and sizes that are placed in the uterus to prevent pregnancy. IUDs do not protect against STIs/HIV. Women who have not had children can safely use the IUD although some doctors may prefer to not prescribe it as these women's uteri tend to be smaller and may be more likely to get irritated by an IUD.</p> <p>99% effective against pregnancy when inserted properly.</p>
MALE CONDOM	<p>The male condom is a thin rubber tube made of latex or plastic. It is closed on one end like the finger of a glove so that when a man puts it over his penis, it acts as a barrier to stop the sperm from entering the woman's vagina. Male condoms protect against both pregnancy and STIs/HIV.</p> <p>Estimated pregnancy rates during perfect use of condoms, that is for those who report using the method exactly as it should be used (correctly) and at every act of intercourse (consistently), is 3 percent at 12 months.</p>
FEMALE CONDOM	<p>The female condom is a rubber sheath that fits inside the vagina and covers the vulva, preventing sperm from entering a woman's vagina. Female condoms protect against both pregnancy and STIs/HIV.</p> <p>79-95% effective against pregnancy and STIs when used consistently and correctly. It is still not widely available in the Western Balkans.</p>

METHOD	HOW IT WORKS
DIAPHRAGM	<p>The diaphragm is a shallow, dome-shaped rubber cap with a flexible rim. It fits in to the vagina and over the cervix (the opening to the uterus), keeping sperm from joining the egg. It is most effective when used with spermicidal cream, jelly, or foam. The diaphragm protects against pregnancy, but it does not protect against STIs/HIV.</p> <p>94% effective against pregnancy when used correctly. Only offers partial protection from SOME STIs.</p>
SPERMICIDES	<p>Spermicides are chemical agents inserted into the vagina that keeps sperm from traveling up into the cervix. They protect against pregnancy, but they do not protect against STIs/HIV.</p> <p>70-80% effective against pregnancy when used correctly.</p>
NATURAL FAMILY PLANNING AND FERTILITY AWARENESS METHODS	<p>These are methods by which couples time sexual intercourse to avoid the woman's days of fertility in her menstrual cycle (the time when she is able to become pregnant). Women with regular menstrual cycles can use the necklace as a family planning method to identify when a woman is fertile. Other women may want to use other ways to know which their fertile days are. They can check each day to see whether or not they have secretions. If they do, they will know that they are fertile on those days and should avoid sexual intercourse. They can also take their temperatures to determine when they are ovulating. During these fertile days, sexual intercourse must be avoided or another contraceptive/barrier method must be used. These methods are not recommended for adolescents, since it is difficult to follow the requirements for correct and consistent use. Natural family planning and fertility awareness methods do not protect against STIs/HIV.</p> <p>Can be effective against unplanned pregnancy when methods are followed correctly, however failure rates are generally very high.</p>
MALE STERILIZATION (VASECTOMY)	<p>This is surgical operation performed on a man. A small portion of each sperm duct is cut. Afterward, the sperm, which are produced in the testicles, can no longer be transported to the seminal vesicles. Therefore, the ejaculate of a man who has been sterilized does not contain sperm. Vasectomy protects against pregnancy, but it does not protect against STIs/HIV.</p> <p>99% effective against pregnancy.</p>
FEMALE STERILIZATION (TUBAL LIGATION)	<p>This is a surgical operation performed on a woman in which the fallopian tubes are tied and cut, thus blocking the egg from traveling to the uterus to meet sperm. Tubal ligation protects against pregnancy, but it does not protect against STIs/HIV.</p> <p>99% effective against pregnancy.</p>

Workshop 6: What about Condoms?

OBJECTIVE:

To discuss myths and truths about condoms and provide basic information about correct condom use.

MATERIALS REQUIRED:

Small pieces of paper, pens/pencils, a box or basket, male and female condoms (if available), and Resource Sheet A

RECOMMENDED TIME:

2 hours

PLANNING NOTES:

If available, try to bring along a couple of male and female condoms to the session, so that the young men can see what they look and feel like. You may also provide the participants with information on where to get condoms in the community.

PROCEDURE:

Part 1 – Myths and Truths about Condoms (1 hour)

1. Give each participant a few pieces of paper and ask him to write one statement (phrase or idea) on each card that comes to his mind when he thinks of condoms. Encourage the participants to think of both positive and negative phrases.
2. Ask each participant to put his paper(s) in the box or basket, which should be placed in front of the group. Then, ask each participant to come forward, take a piece of paper from the box, read its statement out loud, and say if the statement is a myth or truth.
3. As the statements are being read, use Resource Sheet A to complement or correct the information given by each participant. Be sure to talk about the female condom as an alternative for pregnancy and STI/HIV prevention.
4. Give the participants an opportunity to touch the male and female condoms, if available. Reinforce the importance of correct AND consistent condom use during sexual intercourse.
5. Open the discussion to the larger group with the following questions:
 - › Are condoms easily available to young people in the community? Why or why not?
 - › What do you think about the female condom?
 - › What are the reasons that lead young men, including those who know the importance of using condoms, to not use them?
 - › How can you help to dispel some of the myths among your peers and community about condom use?

PROCEDURE

Part 2 – Talking About Condoms (1 hour)

6. Ask for two or more volunteers to carry out a role play that demonstrates the most common difficulties that young men have when it comes to talking about the use of condoms and how they can deal with these difficulties. The role play can take place between two friends, a parent and son, a doctor and client, a teacher and student, etc. For example, the role play could present the reaction of a young man's parents after they see a condom fall out of his pocket. The role play also can be repeated more than once, with different participants.
7. Open up the discussion to the larger group using the following questions:
 - › If a couple decides to have sex, what are the advantages and disadvantages of using a condom?
 - › When should a couple discuss condom use?
 - › How can a young man tell a young woman that he would like to use a condom?
 - › What if a young woman does not want to use a condom?
 - › What if the young woman asks him to use a condom and he does not have one? What should he do?
 - › Who should suggest condom use? What would you think about a young woman who carried a condom with her?
 - › What if the young woman says she will only have sex with a young man if he has a condom? How would he feel?
 - › What are the ways to overcome these possible difficulties in discussing condom use with a partner?

Part 3 – Practicing Condom Use

8. Demonstrate how to properly put on a condom. Allow time for the participants themselves to also practice putting on a condom. If time allows, facilitate some fun activities such as filling up the condoms with fruits or water to show their resistance.

CLOSING:

Simply knowing that condoms can help avoid pregnancy and STIs/HIV is not enough. It is important that you also know how to correctly use them and to understand the importance of consistent use. Moreover, you need to be able to engage your partners in discussions about the pros and

cons of sexual intercourse, including the importance of abstaining before marriage. If you and a partner decide to have sexual intercourse, then you should discuss together how best to protect against unplanned pregnancy or STI/HIV infection, including using a condom.

LINK:

The activity “*Want...Don't Want, Want...Don't Want*” can be adapted to practice the negotiation of condoms in intimate relationships and to build upon the discussions in this activity.

Resource sheet A

MYTHS AND TRUTHS ABOUT CONDOMS

MYTH: Condoms have tiny invisible holes through which both sperm and the HIV can pass through.
TRUTH: Condoms are tested for defects before they are packaged and sold. It is not possible for HIV to pass through a condom in any way. If someone uses a condom but still contracts HIV or a pregnancy results, this is almost exclusively due to human error, such as using oil-based lubricants; using old, expired condoms; leaving the condom in the sun or a hot place (such as your pocket); or tearing them with your fingernails and teeth as you struggle to get them out of the package.

MYTH: If a condom slips off during sexual intercourse, it might get lost inside the women's body (womb).
TRUTH: Because of its size, a condom is too big to get through the cervix (the opening to the womb from the vagina).

MYTH: Condoms take away the pleasure of sex.
TRUTH: Using condoms does not reduce enjoyment or a man's or woman's ability to have an orgasm.

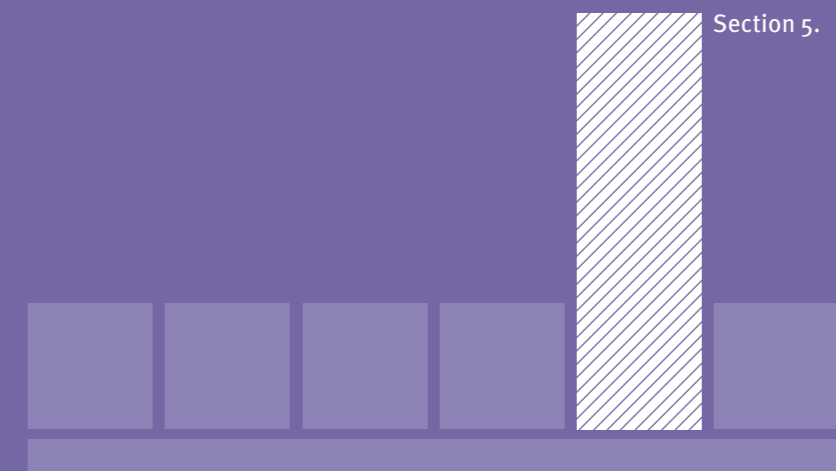
MYTH: Using two condoms at the same time means you are better protected.
TRUTH: Using two condoms can create a lot of friction, which can make the condoms break more easily. People should use only one lubricated latex condom for sexual intercourse.

MYTH: A woman who carries a condom in her purse is "easy" or promiscuous.
TRUTH: A woman who carries a condom with her is acting responsibly and protecting herself against unplanned pregnancy, STIs, and HIV/AIDS.

Section 5:

Preventing and Living with HIV/AIDS

– What and Why



— WORKSHOPS —

1. Want...Don't Want, Want...Don't Want
2. I Am at Risk When...
3. Health, STIs, and HIV/AIDS
4. Transmission of HIV/AIDS: A Signature Hunt
5. Case Study: The Story of Marko
6. Positive Life – Empowering People Living with HIV/AIDS (PLWHA)

Section 5:

Preventing and Living with HIV/AIDS – What and Why⁸⁶

Overview

In most of the world, the attitudes and sexual behaviors of men of all ages are at the core of the HIV/AIDS epidemic. For many young men, sexual experience is often associated with initiation into manhood and multiple partners with sexual prowess. And it is most often men, including young men, who determine when and where sex will take place and whether a condom will be used. Young men also often have lower perceptions of their own risk of contracting HIV and are more likely to use injectable drugs than are young women. In this section, we explore how these and other rigid attitudes and ideals related to masculinity, including those which espouse male dominance over women (physical and sexual), have implications for the vulnerability of both young men and women to HIV and AIDS.

Note: Portions of this text were taken with permission from "Men and AIDS: A Gendered Approach", UNAIDS, to which Gary Barker contributed. Other portions were taken from a text writing by Gary Barker for Population Council and UNFPA, "Engaging Boys in Sexual and Reproductive Health: Lessons, Dilemmas and Recommendations for Action" (2001).

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For many young men, sexual experience is often associated with initiation into manhood...

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⁸⁶— Portions of this text were taken Ricardo, C., Barker, G., Nascimento, M., and Segundo, M. (2007) Engaging young men in HIV prevention: A toolkit for action New York: UNFPA

Why Focus on Young Men and HIV/AIDS?

Worldwide, the behavior of many men — adult and adolescents — puts themselves and their partners at risk of HIV. Since both young and older men on average have more sexual partners than women — and because HIV is more easily transmitted sexually from man to woman and man to man than from woman to man — an HIV-infected man is likely to infect more persons than an HIV-positive woman. Moreover, due to cultural norms of masculine strength and self-reliance, men may also feel inhibited from seeking information or admitting their lack of knowledge about sexual matters and may consequently engage in unsafe behaviors that put both them and their partners at risk. Young men are often more likely to use alcohol and other drugs, including injection drugs.

Sharing used needles is the most efficient way to transmit HIV and both alcohol and drug use increase the likelihood that young men will engage in unsafe sex. Among the other factors that contribute to the vulnerability of young and adult men, as well as their partners, are a lack of information and skills regarding the correct use of condoms; low risk perception; dislike of condoms; and rigid gender norms regarding communication between partners; and about whose responsibility it is to propose condom use and which associate condom use with lack of manliness.

”

HIV is more easily transmitted sexually from man to woman and man to man than from woman to man...

“

BOX 1: HIV and AIDS Globally: Quick Facts⁸⁷

BOX

1.

- › There are approximately 33.3 million people currently living with HIV.
- › Slightly more than half of all people living with HIV are women and girls.
- › Each year, approximately 2.6 million people become infected with HIV.
- › Approximately 40% of new infections are youth aged 15-24.

As has been discussed in other sections, the roots of many of young men's sexual and HIV/AIDS-related behaviors - whether they negotiate with partners about condom use, or whether they take care of family members living with AIDS - are found to a large extent in the ways that boys are raised. It is also important to keep in mind a developmental perspective – that is, to remember that youth is often a period of experimentation and risk, and many factors increase young people's vulnerability to HIV during these years of rapid physical and psychosocial development. These factors include a lack of knowledge about HIV/AIDS, lack of education and life skills, poor access to health services and commodities, early sexual debut, early marriage, sexual coercion and violence, trafficking and growing up without parents or

87 — UNAIDS, “Global Report: UNAIDS report on the global AIDS epidemic” (Geneva: Joint United Nations Programme on HIV/AIDS, 2010)

other forms of protection from exploitation and abuse. Young people are sexual beings and have the right to a happy, healthy sex life. However, we also need to keep in mind that youth are not a homogenous group. Differences in age, sex, experience, marital status, interests and preferences, family background, income and religion can mean that adolescents can be worlds apart in terms of what they need and want.

Finally, thinking about young men and HIV/AIDS also requires discussing men who have sex with men (MSM), an issue that has too often been hidden. Discussion of sexual activity between men is often distorted by simplistic assumptions that only men who have “effeminate” behavior, or men who define themselves as gay or bisexual have sex with other men. However, the reality is that

sexual behavior seldom corresponds neatly to identities of being heterosexual, homosexual, or bisexual. For this reason, UNAIDS and WHO generally use the terms “same-sex sexual behavior” or men who have sex with men (MSM) rather than saying gay or homosexual men.

Since young men are often socialized to believe that being a “real man” means being not only “not a woman” but also “not a homosexual,” young men who diverge from these norms in their mannerisms, attitudes or behaviors are likely to be ridiculed or criticized. For young men who are gay, or who have sex with men, this stigmatization can lead them to practice their sexuality clandestinely and inhibit them from seeking out sexual health information and services, thus creating situations of extreme vulnerability to HIV and AIDS.

BOX 2: HIV and AIDS in the Western Balkans and Southeast Europe

The incidence and prevalence of HIV/AIDS in the Balkans is very low, and it is difficult to identify clear patterns of transmission and possible trends. However, in Serbia there is a concentration of the epidemic among injecting drug users (IDU); and in Montenegro higher incidence has been reported among sailors and tourist workers. Other vulnerable groups include commercial sex workers, men who have sex with men, and youth in general.

At the same time, it is important to keep in mind that existing data may not reflect the true extent of HIV and AIDS in the region. In fact, the number below may represent only 10–20 percent of the real number of cases. Among the various factors underlying the unreliability of the data are: the stigma associated with the disease and associated risk factors such as drug use, commercial sex work, and homosexuality; low level of awareness among highly vulnerable groups, health staff, and the general population about the epidemic and HIV prevention, which reduces voluntary testing and; the low number of testing facilities especially outside capital cities. Moreover, despite the low incidence and prevalence, there is a need for caution to ensure that an epidemic does not emerge. There are several factors that could foster an environment in which individuals are more likely to engage in high-risk behaviours, most notably the fact that the region suffered severe conflicts that displaced thousands of people, brought international peacekeeping forces and international workers to the region, contributed to increased poverty and unemployment, especially among young people, and facilitated trafficking of women and children and commercial sex work.⁸⁸

BOX

2.

88 — Text taken from J. Godinho, “HIV/AIDS in the Western Balkans: Priorities for early prevention in a high-risk environment” World Bank Working Paper No. 68 (Washington D.C.: The International Bank for Reconstruction and Development/ The World Bank, 2005)

Bosnia and Herzegovina⁸⁹: As of 2009, Bosnia and Herzegovina had reported a cumulative total of 163 HIV cases. In 2006, the authorities reported 17 new HIV cases and in 2009, seven new cases. More than 70% of all reported HIV infections are among men. Heterosexual contact is the leading means of HIV transmission (more than 50%), followed by bisexual and homosexual contact and injected drug use. It should be noted that much of the data was lost during the war in Bosnia and Herzegovina. Many people who lived with HIV/AIDS left the country or did not follow-up before treatment became available.

Croatia⁹⁰: Between 1985 and 2009, there were 792 documented cases of HIV infection in Croatia. Four fifths of HIV/AIDS cases are male, who are mostly infected between the ages of 25 – 49. With respect to probable transmission routes, 7.7% of all HIV infections occurred through injecting drug use, while the majority of cases are attributed to sex between men, of which there is 48.5% among all HIV cases. Altogether, 36.1% of HIV infections occurred through heterosexual transmission, 2.2% of infections occurred in persons receiving blood transfusions, and 1.4% occurred from mother to child transmission. Finally, 4.2% of cases were reported as unknown mode of transmission.

Kosovo⁹¹: As of 2009, Kosovo had a total of 83 reported cases of HIV. It had four new cases in 2010, reflecting a slow increase over previous years.

Montenegro⁹²: According to data released by the Institute of Public Health (IPH) the cumulative number of people registered with HIV/AIDS by the end of 2009 was 101. According to the World Health Organisation (WHO), the estimated number of people living with HIV in Montenegro is 388.

Serbia⁹³: As of 2009, 2,472 people were officially registered HIV-positive.

Each year, there are just over 100 new HIV cases, almost half of whom are aged between 15 and 29. The epidemic in Serbia is driven by injecting drug use, first noted in the mid-1980s. IDUs now represent 47% of all HIV/AIDS cases reported in the Republic of Serbia. In recent years, however, the majority of newly diagnosed HIV cases have been reported as sexually transmitted (59% MSM, 31% heterosexual in 2006). Among all reported HIV cases, 74% are male. The decline observed in both new AIDS cases and AIDS deaths was primarily due to the increased use of HAART (anti-retroviral medications), which was introduced by the public health insurance system in 1997.

BOX
2.

89 — <http://www.balkaninsight.com/en/article/world-aids-day-poses-challenge-for-balkans>. Last accessed on 10/02/2011

90 — UNGASS Country Progress Report. Croatia. Reporting Period: January 2006 – December 2007. UNAIDS: Geneva

91 — <http://www.balkaninsight.com/en/article/world-aids-day-poses-challenge-for-balkans>. Last accessed on 10/02/2011

92 — NGASS Country Progress Report. Montenegro. Reporting Period: January 2008- December 2009. UNAIDS: Geneva

93 — <http://www.balkaninsight.com/en/article/world-aids-day-poses-challenge-for-balkans>. Last accessed on 10/02/2011

Box 3: HIV/AIDS Knowledge among Youth in the Western Balkans

Despite generally high levels of HIV/AIDS awareness among youth in the Western Balkans, there are still some misconceptions. For example, in a study in Montenegro, more than 60% of youth aged 18-24 believed that it was possible to be infected by HIV by mosquito bites, using a public bathroom, and sharing meals with an HIV positive person.⁹⁴ A nationally representative study with youth aged 18-24 in Croatia found that one in five respondents lacked basic knowledge about HIV transmission.⁹⁵

BOX
3.

Young Men and Condom Use

Condoms are effective in preventing HIV and AIDS when used correctly and consistently. While condom use among youth has increased in many countries over the last 10 years, it is still inconsistent, and may vary according to the reported nature of the partner or relationship (e.g., occasional, regular, sex worker). A study among urban high school students in Bosnia and Herzegovina, Macedonia, Montenegro and Serbia found that 73.7% of the young men and 69% of the girls had used a condom at first sex.⁹⁶ However, the study also found declining condom use after sexual initiation: only 64.3% of the young men and 48.5% of the young women reported that condoms were consistently used during sexual intercourse with a current or last partner.

A nationally representative study with youth aged 18 – 24 years in Croatia found that 60% of respondents had used a condom at their first sexual intercourse, while only 53% had used a condom on their most recent sexual intercourse. Only about 21% reported regular condom use.⁹⁷ Other research suggests that young men's condom use and support of their partners' contraceptive use may be higher when there is more communication or negotiation between partners, suggesting the importance of promoting communication about condom use.⁹⁸

94 — Institute of Public Health, "HIV/AIDS related knowledge, attitudes and sexual behaviour in young adults, aged 18-24 years" (Montenegro: Institute of Public Health, 2007)

95 — Nemeth Blažić, "HIV/AIDS epidemiology in Croatia" (Croatia: Croatian Institute of Public Health, 2010) <http://www.hzjz.hr/epidemiologija/hiv.htm>

96 — W. Delva, "Sexual Behaviour and Contraceptive use among Youth in the Balkans" (Ghent, Belgium: International Centre for Reproductive Health, 2007)

97 — Institute of Public Health, "HIV/AIDS related knowledge, attitudes and sexual behaviour in young adults, aged 18-24 years" (Montenegro: Institute of Public Health, 2007)

98 — See, for example: R.L. Rickman, et al., "Sexual communication is associated with condom use by sexually active incarcerated adolescents" *Journal of Adolescent Health* 15 (1994) 383-388; D.J. Whitaker et. al., "Teenage partners' communication about sexual risk and condom use: the importance of parent-teenage discussions" *Family Planning Perspectives* (1999) 31(3): 117-121

Studies on condom use among youth confirm that knowing about condoms and HIV/AIDS is not enough. Barriers to young men's greater use of condoms include cost, the sporadic nature of their sexual activity, lack of information on correct use, reported discomfort, social norms that inhibit communication between partners and rigid sexual scripts or norms about whose responsibility it is to propose condom use. For example, the "sexual script" for young men in many settings is that since reproductive health is a "female" concern, women must suggest condom use or other contraceptive methods. At the same time, the prevailing sexual script frequently also holds that it is the male's responsibility to acquire condoms, since for a young woman to carry condoms would suggest that she "planned" to have sex which is often seen as "promiscuous". Many young men may also not use condom because they believe it reduces sexual pleasure or because they believe they cannot turn down any opportunity to have sex, even if they do not have a condom with them. For some men, having unsafe sex may be appealing precisely because it is risky and spontaneous. In sum, working with young men to promote condom use is much more than just offering information. It requires discussing deeply-rooted ideas and values about men and women and how sexual relations take place, and encouraging young men to pay attention to their sexual behavior and hygiene — issues we promote in various activities in this manual.

Finally, promoting condom use among young men is important in the short term, but is also important for their future condom use. Research from the U.S. found that teens who use condoms at first intercourse were 20 times more likely to use condoms in subsequent sexual encounters⁹⁹. Furthermore, learning about condoms even before starting sexual activity was found to be important, suggesting the need to work with boys even earlier on these issues.

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Many young men may also not use condom because they believe it reduces sexual pleasure...

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BOX

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Box 4: Should we talk to young men about the female condom?

When discussing the relationship between condom use and negotiation and gender-equity, it is relevant to reflect on the female condom as a prevention method. The female condom, like the male condom, is a barrier device used for birth control and protection against HIV and AIDS and other STIs. It is not readily available in all countries, and even where it is, most young men might not be familiar with it. Nevertheless, it should be noted as a prevention method, and used to explore young men's ideas about women's sexuality, negotiation about condom use, and the role of female-initiated methods.

Initial studies with the female condom find that the men involved in the trial studies generally accept it and in some cases even prefer it over the male condom. Some men and women found inserting the female condom to be erotic.

For some couples, discussions about the female condom led to increased negotiation about sex. These initial studies with the female condom suggest that many men are open to their use, and hence the importance of increasing distribution and reducing the price¹⁰⁰. Some researchers have suggested that the female condom may be a tool to promote women's sexual confidence and autonomy that may in a small way open up the possibility of greater equality in sexual relations. To date, however, there have not been studies on young men's attitudes about the female condom, nor has it been widely promoted among young people in general.

What is the link between STIs and HIV?

Because of their role in increasing the risk of HIV infection, STIs deserve special attention.¹⁰¹ Worldwide, there are approximately 340 million new cases of STIs (other than HIV) among youth and adults aged 15-49).¹⁰² Young and older women suffer the most complications from STIs, including infertility, cervical cancer, pelvic inflammatory disease and ectopic pregnancies. As with the spread of HIV, men play a major role in the transmission of STIs to women.

Young men often lack basic information about the range of STIs and their link to increased HIV risk. In fact, the field-testing of this manual found that young men are particularly interested in learning more about STIs and it can often serve as an entry-point for discussing sexuality and reproductive health more generally, as well as HIV vulnerability.

Since many STIs do not show symptoms among men it is particularly important that young men also understand the importance of seeking out professional health services if they have had unprotected sex, both for their own health and well-being as well as that of their partners. Moreover, it is important to call attention to young men's responsibilities and roles in informing their partners when they have a suspected or diagnosed STI. Reducing men's and women's risk of HIV infection, requires providing adequate testing and treatment of STIs, promoting greater sexual hygiene and convincing young men to seek testing and treatment for STIs even when they have no symptoms.

99 — K.S. Miller, M.L. Levin, D.J. Whitaker, and X. Xu "Patterns of condom use among adolescents: the impact of mother-adolescent communication. American Journal of Public Health, October 1998; 88:1542-154495 — Nemeth Blažič, "HIV/AIDS epidemiology in Croatia" (Croatia: Croatian Institute of Public Health, 2010) <http://www.hjz.hr/epidemiologija/hiv.htm>

100 — E.Ankrah & S.Attika, "Adopting the female condom in Kenya and Brazil: Perspectives of Men and Women" (Arlington, VA, USA: Family Health International, 1997)

101 —The presence of an untreated ulcerative or non-ulcerative (those STIs which cause ulcers or those which do not) infection increases the risk of both acquisition and transmission of HIV by a factor of up to 10. Thus, prompt treatment for STIs is important to reduce the risk of HIV infection. Controlling STIs is important for preventing HIV in people at high risk, as well as in the general population. Taken from <http://www.who.int/mediacentre/factsheets/fs110/en/index.html>

102 — <http://www.who.int/mediacentre/factsheets/fs110/en/index.html>. Last accessed on 10/02/2011.

Box 5: What does male circumcision have to do with HIV risk?

In recent years, there has been increasing discussion about the role of male circumcision in helping to reduce the HIV epidemic.¹⁰³ In 2005 and 2006, three randomised trials undertaken in South Africa, Kenya and Uganda found that circumcision reduced the risk of HIV infection among men by up to 60 percent¹⁰⁴. Based on this evidence, male circumcision is now recognized as an additional intervention to reduce the risk of heterosexually acquired HIV infection in men, specifically in countries with high HIV prevalence and low prevalence of circumcision. Some researchers have concluded that the foreskin of the penis has a high density of Langerhans cells, which present a possible source of initial cell contact for HIV infection. In addition, the foreskin may provide an environment for survival of bacterial and viral matter and may be susceptible to tears, scratches and abrasions which can heighten the chances for a man to become infected with HIV and/or other STIs.

It is important to note that the preventive effect for women has yet to be proven. Moreover, male circumcision should not be seen as an "immunization-type" intervention or a one-time or stand-alone HIV intervention. Rather, MC should be offered in a culturally-appropriate and human rights-based way and as part of a comprehensive package that includes HIV testing and counselling services, STI treatment, safe sex education, the provision of male and female condoms and the promotion of their correct and consistent use.

Young Men who Have Sex with Other Men (MSM)

The needs and realities of men, younger or older, who have sex with men (MSM) have often been ignored because of deep-seated taboos about homosexual behavior. Moreover, men's sexual activity with other men is often clouded by simplistic assumptions that only men who identify themselves as or "act" gay or bisexual have sex with other men. However, the reality of MSM is far more complicated.

Some young and older men prefer other men sexually, some men have both male and female sexual partners, while many men have only female sexual partners. In almost every known society - past and present - some men have sex with other men. For some young and adult men, regardless of whether

they identify themselves as heterosexual, homosexual or bisexual, homosexual activity is a part of their sexual experimentation or their current sexual activity.

In some settings, homoerotic play between boys is common and tolerated during adolescence, while adult homosexual behavior is socially condemned. In societies where boys and girls are segregated during adolescence, sexual experimentation between boys may be even more commonplace. In many developing countries - particularly in Asia and Africa - men's sexual activity with other men has been widely denied; in some countries, it is illegal. By repressing and outlawing such behavior, HIV prevention becomes even

103 — Male circumcision is the surgical removal of all or part of the foreskin of the penis and is practiced in some countries and cultures.
104 — B. Auvert et al., "Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial" *PLoS Medicine* (2005); R.C. Bailey et al., "Male Circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized control trial" *The Lancet* 369 (2007) 643-656; R.Gray et al., "Male Circumcision for HIV prevention in men in Rakai, Uganda: a randomized trial" *The Lancet* (2007) 657-666.

more difficult. Some MSM may identify themselves as gay or homosexual and have long-term or casual relationships with other men; others may be married or have long-term relationships with women but occasionally have sex with men; other men may have sex with men because it is the only sex available, as in the case of men in prison or in single-sex institutions. In some places, a man who takes the penetrative or "active" role in anal and oral sex may not be considered gay, while the man who receives penetration is. In other settings, men may be "allowed" to have homosexual relationships if they fulfill their traditional "male" obligations by marrying and having children (Rivers & Aggleton, 1998).

The sexual practices of MSM are varied, but anal sex is often a component, practiced by 30%-80% of MSM (PANOS, 1998). Anal sex represents the highest risk of sexual transmission of HIV. The social denial of men's sexual activity with other men means that in some cases we do not know how much HIV transmission may be related to MSM, and this hinders HIV prevention efforts.

The social stigma attached to homosexual activity often creates anxiety for young men who identify themselves as gay. A study in Australia found that 28.1% of youth who identified themselves as gay had attempted suicide compared to 7.4% of heterosexual youth (Nicholas & Howard, 1998). Research in the U.S. found that 30% of gay and bisexual adolescent boys interviewed report having attempted suicide (American Academy of Pediatrics, 1993). Gay-identified youth may feel isolated from or excluded by peers. While heterosexual boys share their "conquests" with pride with the peer group, gay-identified young men often hide their sexual experiences. Because of prejudices, gay young men sometimes have their first sexual experiences in secretive or anonymous situations and may feel unsure if this is "normal."

Engaging men in HIV prevention and adequately responding to the challenge of HIV requires confronting widespread examples of homophobia, or prejudice toward MSM. Homophobia serves both to keep homosexual behavior and young men of homosexual or bisexual orientation hidden, hindering prevention, but also serves as a way to reinforce rigid views about manhood for heterosexual men. In many settings, boys who act in non-traditional ways - for example participating in domestic chores or having close friendships with girls - may be teased by calling them "gay." Using homophobia as a way to "educate" boys both reinforces rigid views of what men believe they can do and promotes prejudice toward MSM.

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The social stigma attached to homosexual activity often creates anxiety for young men who identify themselves as gay...

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Around the world some young men live in settings or face disadvantages that put them at higher risk of HIV/AIDS. For example, young men who migrate for work and live away from their wives and families may engage in sex with sex workers and use substances, including alcohol, as a way to cope with the stress of living away from home. For young men living or working in all-male settings, including the military, the male peer group may create a "macho" culture that reinforces risk-taking behaviors. Some men working in mines in South Africa said that sex with sex workers and drinking were the only "fun" available. The men also believed that the risk of HIV was small compared to the risk of death in the mines.

The mobility of young men who work away from home, including those in the military, and their travel across borders, means that they sometimes play an important role in introducing HIV into an area. Young men away from home may have a limited choice of sexual partners, including sex workers. Frequent and unprotected sexual contact with a limited number of partners increases the chance that one HIV-infected partner can infect a whole group. Millions of men, many of them young, are in prison and jail - at rates far higher than women. Prison conditions in much of the world include sex between prisoners and between prisoners and guards – both forced and consensual – as well as unprotected sex, or sex in degrading conditions with the men's female partners or sex workers. A few studies on HIV prevalence among men in prisons have confirmed high rates of HIV among prison populations.

Young women's exploitation in sex work has received increased attention in recent years, but there has been less attention to young men involved in survival sex. It is difficult to estimate how many young men are involved in sex work or sexual exploitation because such activity is hidden.¹⁰⁵ Young men involved in survival sex – like young women – often lack power in their sexual encounters with clients to negotiate safer sex.

Among youth and children living on the streets around the world - the majority of whom are boys - unprotected sex, both forced and consensual, is a common fact of life. Studies with street youth in some countries have confirmed high rates of STIs and forced sex.¹⁰⁶ It is important to keep in mind that HIV prevention efforts with young men living on the streets or other young men living in high-risk settings and situations, need to address the men's general living conditions and human rights, in addition to promoting safer sex.

105 — Young people under the age of 18 who engage in sex for money or favors are considered to be sexually exploited. Over the age of 18, engaging in sex for money is legal in some countries and illegal in others and is generally referred to as sex work.

106 — Childhope, "Gender, sexuality, and attitudes related to AIDS among low income youth and street youth in Rio de Janeiro, Brazil" Childhope working paper #6. (New York: Childhope, 1997)

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Prison conditions in much of the world include sex between prisoners and between prisoners and guards...

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As has been discussed elsewhere in this manual, men and boys generally use alcohol and substances at higher rates than women and girls. For many young men, for example, using alcohol or another substance can help prove their manhood or help them fit in with a male peer group. Among the various negative health and social outcomes associated with substance use is an increased vulnerability to HIV infection. For example, injecting drugs use accounts for approximately one-third of all new HIV infections outside of sub-Saharan Africa, and is one of the major drivers of the epidemic in Eastern Europe¹⁰⁷. Men account for approximately four-fifths of injecting drug users, and studies have shown that male users are also more likely to share needles and not use condoms.¹⁰⁸ Additionally, the use of substances such as alcohol is also associated with higher rates of unsafe sexual activity. It is therefore essential that HIV/AIDS education with young men address the link between substance use and HIV and AIDS vulnerability.

Young Men, Voluntary Testing and Counseling and Use of Health Services

Numerous studies have confirmed that young men are less likely than women to seek health services¹⁰⁹. Research from numerous settings has also found that boys and men often see themselves as being invulnerable to illness or risk, and may just "tough it out" when they are sick, or seek health services only as a last resort. In other cases, men may believe that clinics or hospitals are "female" places. A nationwide survey of boys aged 11-18 in the U.S. found that by high school, more than one in five boys said there had been at least one occasion when they did not seek needed health care.¹¹⁰ A national study in the UK found that men aged 16-44 visited a doctor or health care provider less than twice a year on average, while women visited a doctor more than four times per year.¹¹¹

107 — <http://www.irinnews.org/pdf/pn/Plusnews-Media-Fact-file-HIV-transmission.pdf>. Last accessed on 10/02/2011

108 — UNAIDS, "Men and AIDS- a gendered approach" (Geneva: Joint United Nations Programme on HIV/AIDS, 2000)

109 — P.M. Galdas et al., "Men and health seeking behavior: literature review" *Journal of Advanced Nursing* 49 (2005)

110 — K. Shoen et al., "The Health of adolescent boys: Findings from a Commonwealth Fund survey"

111 — A.Wilson, "Getting Help" in T.Dowd & D. Jewell Eds. *Men's Health*. (Oxford: Oxford University Press, 1997)

Voluntary counseling and testing (VCT) has been a key strategy in HIV/AIDS prevention and treatment, with the rationale that offering such services would lead to increased help- and health-seeking behaviors among all or segments of the population. Unfortunately, while routine gynecological and family planning care – including prenatal services – provide a common entrypoint for VCT services for women, there are generally no comparable entrypoints for men except perhaps couple testing. It is therefore important that services seek to identify and make the most of what opportunities there are for engaging young men in VCT services – from routine physical exams to condom distribution schemes.

How can young men be encouraged to use health services and to seek help and support when they need it, including seeking voluntary testing and counseling for HIV? When asked what they want in health centers, young men often want the same things that women ask for: a high quality service at an accessible price; privacy; staff who are sensitive to their needs; confidentiality; and clinic

hours that are compatible with their schedules. Many young men also prefer male doctors and nurses. The fact that there are no specific health professionals trained to deal with young men's needs - the way that gynecologists or some nurse practitioners specialize in women's health - may also be a barrier to attracting men to health facilities. In terms of seeking help when they face stress, including living with AIDS, discussion groups in which young men interact with other men who have similar needs have been effective.

Finally, many young men who do test positive for HIV may be reluctant to accept the positive result and to seek treatment. While some women also hide their HIV status because of the stigma, men may deny their HIV status because they believe that "real men don't get sick" or that seeking help means admitting weakness or failure. As such, part of working with young men should help them explore the gender norms which contribute to these fears – especially those which imply that men shouldn't be concerned with their health and that to do so, or to assume a health problem, is a sign of manliness.

Young Men's Roles in Families in the Face of HIV/AIDS

Worldwide, women and girls shoulder a disproportionate share of care-giving, including care-giving for individuals living with HIV/AIDS. Why don't men take a greater role in caring for children, and in caring for family members with AIDS? Young men clearly are capable of taking care of children and family members living with AIDS, however, they are often socialized to believe that care-giving is a female characteristic and responsibility¹¹².

Looking specifically at HIV/AIDS, men's roles in children being orphaned by AIDS, and children infected by AIDS from their mothers, have seldom been considered. Both in the case of children who are orphaned because one or both parents died from AIDS, and in the case of children infected by mother-to-child transmission, men as fathers are indirectly involved. In the vast majority of these cases, men became infected with HIV in their outside sexual relationships and passed HIV to women who subsequently died from AIDS, or passed HIV to their children during childbirth. How might men as

112 – For more information on young men and care-giving, see the chapter on Fatherhood and Care-giving.

fathers, including young fathers, be engaged to consider the potential impact of their sexual behavior on their current or future children? Do young men consider the consequences of their sexual behavior for their children? Greater involvement of fathers in their children's lives may reduce their likelihood of practicing unsafe sex.

What about HIV-positive men who are not fathers, but want to become fathers, even knowing of their HIV status? Fatherhood is an important and rewarding role for men and a form of status in many societies, regardless of HIV. Should men who are HIV-positive seek to become fathers? What factors go into this decision-making? A few programs are beginning to offer counseling about parenting to couples in which one or both are HIV-positive.

Young Men Living with HIV/AIDS

As previously mentioned, young men aged 15-29 represent one of the populations most affected by HIV/AIDS. Furthermore, as discussed, with advances in treatment for HIV/AIDS and greater understanding of the virus, the quality and in some cases the life expectancy of persons living with HIV/AIDS has increased substantially in the last years. The AIDS "cocktail" (called antiretrovirals, or ARVs) is currently available in most settings, in some cases, for free. In spite of this increased understanding of the HIV virus and advances in treatment, there are still many myths and misconceptions about being seropositive. Many persons continue to believe that HIV can be transmitted by hugging, kissing, or via casual contact in public spaces (public bathrooms, swimming pools, etc.). Stigma and prejudice toward persons living with HIV/AIDS are still common in many parts of the world - a fact which motivated UNAIDS to dedicate its current World AIDS Campaign to the issue of stigma.

Although the issue is often given secondary attention, HIV prevention for persons living with HIV/AIDS is an important topic; indeed practicing safer sex for a young man who is HIV-positive is as important as for a young man who is not HIV-positive. In the case of young men living with HIV/AIDS, using condoms in all sexual relations protects partners and also protects the seropositive young man himself from increasing his viral load or exposure to other STIs that can be even more debilitating in the case of a weakened immune system. Every seropositive person has a particular viral load, that is the quantity of the virus in his/her system. Additional contact with another seropositive person can increase the viral load. These issues make it important for individuals living with HIV/AIDS to communicate and negotiate with their partners - whether seropositive or not.

Given the spread of HIV/AIDS, and the advances in treatment, there are more and more couples and relationships that are serodiscordant (that is when one person is HIV-positive and other is not), both homosexual and heterosexual. In some cases, HIV-positive men have also sought to become fathers. Stud-

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...young men living with HIV/AIDS need special attention and access to services and support networks.

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ies are going on in some countries on the possibility of treating sperm (that is removing the virus via in vitro fertilization), but so far results are limited.

Finally, as AIDS has become a chronic disease rather than an immediately fatal disease, persons living with HIV/AIDS increasingly require various kinds of long-term support (medical, psychological, social, legal, etc). Due to these changes, there are now young men who have reached adolescence and adulthood having been born HIV-positive, and who know no other reality than being seropositive. These young men living with HIV/AIDS continue to have their dreams, to live their lives and to have relationships – like any other young men. For this reason, young men living with HIV/AIDS need special attention and access to services and support networks.

Box 6: Summary Points

- › Young men's behavior puts women at risk. On average, men have more sexual partners than women. HIV is more easily transmitted sexually from man to woman than from woman to man. An HIV-infected man is likely to infect more persons than an HIV positive woman. Engaging men more extensively in HIV prevention has a tremendous potential to reduce women's risk of HIV.
- › Young men's behavior puts themselves at risk. While HIV among women is growing faster, men continue to represent the majority of HIV infection. Young men are less likely to seek health care than young women. In stressful situations – such as living with AIDS - young men often cope less well than young women. In most of the world, young men are more likely than women to use alcohol and other substances - behaviors that increase their risk of HIV infection.
- › The issue of young men who have sex with men (MSM) has been largely hidden. Surveys from various parts of the world find that between 1%-16% of all men regardless of whether they identify themselves as gay, bisexual or heterosexual - report having had sex with another man. Hostility and misconceptions toward MSM have led to inadequate HIV/AIDS prevention measures.
- › From a developmental perspective, there is evidence that styles of interaction in intimate relationships are "rehearsed" during adolescence. Viewing women as sexual objects, delegating reproductive health concerns to women, use of coercion to obtain sex and viewing sex as performance generally begin in adolescence (and even before) and may continue into adulthood. While ways of interacting with intimate partners change over time, context and relationship, there is strong reason to believe that reaching boys is a way to change how men interact with women.
- › Men need to take a greater role in caring for family members with AIDS, and to consider the impact of their sexual behavior on their children. The number of men affected by AIDS means that millions of women and children are left without their financial support. Caring for HIV-infected persons is mostly carried out by women. Both young and adult men need to be encouraged to take a greater role in this caregiving. Young men who are fathers must consider the potential of their sexual behavior to leave their children HIV-infected or orphaned due to AIDS.

BOX
6.

Workshops

⚙️ Workshop 1: Want...Don't Want, Want...Don't Want

📍 OBJECTIVE:

To discuss the challenges in negotiating abstinence or sex in intimate relationships.

📄 MATERIALS REQUIRED:

Flipchart paper, markers, and Resource Sheet 8A.

🕒 RECOMMENDED TIME:

2 hours

📖 PLANNING NOTES:

During this activity, some young men might be asked to play the part of a woman. This is not always easy for young men, and it should be presented as optional (an alternative procedure can be to involve the young men in a debate, rather than role play, based on the scenarios presented). In the case of the role play, it is likely that some young men will laugh during the exercise. It is important to understand how some of this laughter could be due to the awkwardness, or even discomfort, that the young men may feel playing the role of women or seeing other young men play the role of women. You should be flexible to these kinds of responses, and if the moment is appropriate, you should remind the young men of the discussions from the activity "What's This Thing Called Gender" and encourage them to reflect on why they might respond in certain ways when they see men taking on traditional female roles or characteristics. If time allows, this activity can also be used to have the group role play the negotiation of condom use in an intimate relationship, or other possible issues such as deciding upon the number of children to have or how to spend household income.

PROCEDURE:

1. Divide the participants into four groups and assign each group a topic of discussion from the table below. Two groups will represent men (M1 and M2), and two groups will represent women (W1 and W2).

GROUP	TOPICS OF DISCUSSION
M1	Reasons why men want to have sex in an intimate relationship?
M2	Reasons why men do not want to have sex in an intimate relationship
W1	Reasons why women want to have sex in an intimate relationship
W2	Reasons why women do not want to have sex in an intimate relationship

2. Explain that the groups (or volunteers from each group) will be paired together to negotiate abstinence and sex. Allow the groups five to 10 minutes to discuss and prepare for the negotiations.
3. The first negotiation:
 - › Group M1 (men who want to have sex) negotiates with Group W2 (women who do not want to have sex). Ask the individuals or groups to negotiate, imagining that the context is an intimate relationship where the man wants to have sex but the woman does not.
4. The second negotiation:
 - › Group M2 (men who do not want to have sex) negotiates with Group W1 (women who want to have sex). The role play should be conducted in the same way as above. After negotiating, ask them how they felt and what they learned from the exercise.
5. In both cases, the facilitators should write on flip chart paper the most important arguments, both in favor and against.
6. Open up the discussion to the larger group.

PROCEDURE

DISCUSSION QUESTIONS:

1. In which way are these negotiations similar to what happens in real life?
2. What makes it easier to negotiate abstinence with an intimate partner? What makes it harder?
3. What happens if the negotiation happens in the heat of the moment, rather than before? Does it become easier or more difficult?
4. What are the reasons why a young woman would want to have sex? To not have sex? (see Resource Sheet)
5. What are the reasons why a young man would want to have sex? To not have sex? (see Resource Sheet)
6. How does a young man react if a woman takes the initiative in asking for sex?
7. Can men ever say no to sex? Why or why not?
8. Can women ever say no to sex? Why or why not?
9. Is it fair to pressure someone to have sex? Why or why not?
10. How can young men and women deal with pressure from peers and partners to have sex?
11. What have you learned from this exercise? How can you apply this in your own relationships?

QUESTIONS

CLOSING:

Many factors go into making the decision to abstain or to have sex. In the case of women, the fear of losing their partner or low self-esteem might lead them to accept sex. Among men, the decision to have sex might come from peer or social pressure to prove their manhood. Furthermore, communication styles, emotions, self-esteem, and unequal power relations all play a role in if

and how partners negotiate abstinence or sex. It is important to be conscientious of how these different factors influence your own and your partners' desires and decisions. It is also important to remember that negotiation does not mean winning at all costs, but seeking the best situation for both parties.

LINK:

The discussion of negotiation in sexual relationships can be linked to the activity "[Power and Relationships](#)" and the unequal power relationships that often exist in male female relationships and the activity "[Aggressive, Passive or Assertive](#)" about different types of communication that young men use in their relationships.

REASONS WHY YOUNG MEN AND YOUNG WOMEN HAVE SEX

1. To stop the pressure from their friends/partners
2. To communicate loving feelings in a relationship
3. To avoid loneliness
4. To prove his/her manhood/womanhood
5. To get affection or to feel loved
6. To receive and get pleasure
7. Believes everyone is doing it
8. To show independence from parents and other adults
9. To hold onto a partner
10. Do not know how to say “no”
11. To prove one is an adult
12. To become pregnant or to become a parent
13. To satisfy curiosity
14. Nothing better to do
15. To get money or gifts
16. Media messages make it seem glamorous
17. Thinks that it will cure them of HIV/AIDS

REASONS WHY YOUNG MEN AND YOUNG WOMEN DO NOT HAVE SEX

1. To follow religious beliefs or personal/family values
2. To avoid an unplanned pregnancy
3. To avoid STIs and HIV infection
4. To avoid hurting his/her reputation
5. To avoid feeling guilty
6. Afraid that it will hurt
7. To wait for the right partner
8. Not ready
9. To wait for marriage
10. To not disappoint their parents

113 — Adapted from: CEDPA “Choose a Future! Issues and Options for Adolescent Boys” 1998 Centre for Development and Population Activities: Washington, D.C.

 **OBJECTIVE:**

To discuss situations in the life of young men that put them at risk of STIs, HIV/AIDS, and/or unplanned pregnancy and to identify sources of support to reduce these risks.

 **MATERIALS REQUIRED:**

Selection of phrases from the Resource Sheet written on small pieces of paper

 **RECOMMENDED TIME:**

1 hour and 30 minutes

 **PLANNING NOTES:**

It is important to listen to young men and to understand their needs. Many young men put themselves in situations of risk because they feel pressure to be “real men.” They feel that to be “manly” they cannot express their true emotions and feelings.

It is also important to keep in mind that also underlying many of the vulnerabilities of young men – of youth in general - is country’s political commitment to its people’s health and education. To obtain information and incorporate it in one’s life does not depend only on individuals, but also on factors such as access to education and health services. It also depends on whether people have the power to influence political decisions and the possibility to challenge cultural barriers. For young men to make positive changes in their lives, it is critical that programs provide opportunities for young people to learn and practice the skills necessary to protect themselves. The more a country is committed to providing quality resources and programs to prevent HIV, the greater the possibility of empowering young men to make healthier decisions and lead more responsible lives.

PROCEDURE:

1. Begin the activity by asking the young men to think about situations which may put them at risk of STIs or HIV. For example, if a person does not know that having sexual relations without a condom increases their risk for HIV, they are more vulnerable to contracting the disease than someone who has this information.
2. Ask the participants to divide into small groups. Give each group a piece of paper with a phrase written on it from the Resource Sheet. Each group should have a different phrase. Each pair can be given more than one phrase.
3. Ask each pair to read their phrase, discuss what it means, and then decide if they agree or disagree with the statement and why.
4. When they have finished, each group should read its phrase(s) out loud and share their responses with the larger group.
5. Discuss the following questions with the young men.

PROCEDURE

1. Do you think that young men are particularly vulnerable to unplanned pregnancy, STIs and HIV? Why or why not?
2. In a relationship, what makes a person vulnerable to contracting an STI or HIV?
3. What cultural beliefs put young men at risk for STIs and HIV? What cultural beliefs put young women at risk for STIs and HIV?
4. How are gender norms linked to risk? (Remind participants of the discussion from “Act like a man” and how trying to fit into social expectations of what it means to be men and women (the boxes) can have negative consequences on decision-making and actions.)
5. What could help a young man to feel and act less at risk? What could help a young woman to feel and act less at risk?
6. What are alternatives to some of the most common risk behaviors of young men?
7. What support do young men and young women need to protect themselves from STIs and HIV? Is this kind of support available in the community?

CLOSING:

The roots of many young men’s risky sexual behaviors are found to a large extent in the way that boys are raised and socialized. These behaviors often put both young men and young women at risk. As young men, it is important for you to be aware of how gender norms influence your decisions and behaviors and to think critically about the impact of those decisions and behaviors.

LINK:

The video “[Once upon a Boy](#)” can be a useful tool to help participants identify the links between how young men are raised and the various risks they may face in their lives and relationships.


 QUESTIONS

Resource sheet¹¹⁴

I am at Risk When...

1. I am at risk when I think that nothing is going to happen to me.
2. I am at risk when I want to prove I am macho.
3. I am at risk when I have no one that I can count on to help me in times of need.
4. I am at risk when I do something to make someone like me.
5. I am at risk when I will do anything to have sex.
6. I am at risk when I am afraid to show how I feel.
7. I am at risk when I do not think for myself.
8. I am at risk when I do not take care of an STI symptom.
9. I am at risk when I do not take responsibility for my own sexual behavior.
10. I am at risk when I am under the influence of alcohol or drugs.
11. I am at risk when I have multiple sexual partners.
12. I am at risk when I do not talk to my partner about how to prevent an unplanned pregnancy.
13. I am at risk when I have sex with someone who has not been tested for HIV/AIDS.
14. I am at risk when I do not use a condom consistently and correctly.

¹¹⁴ — Phrases adapted from *Álbum Seriado Adolescência e Vulnerabilidade*. Projeto Trance esta Rede. São Paulo: GTPOS, 1998.

Workshop 3: Health, STIs, and HIV/AIDS

OBJECTIVE:

To increase knowledge about STIs and HIV/AIDS and the importance of diagnosis and treatment.

MATERIALS REQUIRED:

Flipchart paper, markers, small pieces of paper and sufficient number of copies of Resource Sheets A and B to distribute to participants.

RECOMMENDED TIME:

2 hours

PLANNING NOTES:

Prior to the session, research the most recent information about STIs, HIV transmission, local and/or national statistical data about HIV/AIDS (number of persons infected, most common modes of transmission, age groups affected, life expectancy, etc.), the difference between being HIV-positive and having full-blown AIDS, and current access to treatment. These are topics that commonly come up during this activity. It is also highly recommended to invite a staff person from a local health facility or NGO who is knowledgeable in these topics to help respond to participant questions and concerns.

PROCEDURE:

1. Prior to the session, make copies of Resource Sheet A WITHOUT the names of the STIs in the first column and write out the names of the STIs on a piece of flip chart paper.
2. Divide the participants into smaller groups and give each group a copy of the Resource Sheet without the names of the STIs in the first column.
3. Tell the participants that they should read and discuss the information on symptoms/consequences and treatment and try to identify the correct STIs from those you have listed on the flip chart.
4. When they have finished, review the correct answers with them.
5. Ask the participants what they know about HIV/AIDS. Make notes on the flipchart paper. Emphasize the link between STIs and HIV (see box below). Explain that HIV/AIDS does not always have noticeable symptoms and that the only way of knowing if one is infected with HIV is through a blood test. Review the content of Resource Sheet B.
6. Divide the participants into two or three small groups. Ask the groups to do a role play that explains what the symptoms of STIs and/or HIV/AIDS are. Suggest that the role play can take place between two friends, a parent and son, a doctor and client, a pastor and young church member, a teacher and student, etc.
7. After about 20 minutes, ask the groups to perform their role plays for all of the other participants.
8. Use the questions below to wrap-up the discussion.

PROCEDURE

DISCUSSION QUESTIONS:

1. What should a young man do when he thinks that he may have an STI? Who should he talk to?
2. How would a young man tell his girlfriend that he has an STI and that he might have given it to her?
3. How would a young man tell a casual acquaintance that he has an STI and that he might have given it to her?
4. Why is it so difficult to talk about STIs?
5. Why is it so difficult to talk about HIV/AIDS? Has knowing about HIV/AIDS changed the sexual practices of young men? Why or why not?
6. What factors make it difficult for a young man to avoid getting HIV/AIDS? What factors make it difficult for a young woman to avoid getting HIV/AIDS?
7. How can you deal with these factors in your own lives and relationships?

QUESTIONS

NOTE:

If time permits, review and discuss some of the common myths about STIs that are presented in Resource Sheet C.

CLOSING:

Because of their role in increasing the risk of HIV infection, STIs deserve special attention. In various parts of the world, young men have increasing rates of STIs and frequently ignore such infections or rely on home remedies or self-treatment. Moreover, many STIs do not show symptoms in men. For this reason, it is essential to think about, discuss, and plan how to best protect yourself and your partners from STIs, be it through abstinence, faithfulness, partner reduction, and/or correct and consistent use of condoms. If you notice any STI symptom(s), you should consult a health professional immediately. It is important to remember the ethical questions involved in dealing with STIs and HIV/AIDS and your responsibility to communicate to your sexual partner(s) if you have an STI or HIV/AIDS.

STI SYMPTOMS, CONSEQUENCES, AND TREATMENTS¹¹⁵

GROUP	SYMPTOMS AND CONSEQUENCES	TREATMENTS
CHLAMYDIA	Caused by a bacterium. Known as a “silent” disease because three quarters of infected women and half of infected men have no symptoms. The infection is frequently not diagnosed or treated until complications develop. Usually found in the cervix and urethra in women. Men may have a discharge from the penis, a burning sensation when urinating, burning and itching around the penis, and pain and swelling in the testicles.	Can be treated and cured easily with antibiotics.
GENITAL HPV INFECTION (HPV IS HUMAN PAPILLOMA VIRUS) – ALSO CALLED GENITAL WARTS	<p>Name of a group of viruses that includes over 100 different types. More than 30 of these viruses are sexually transmitted and they can infect the genital area of men and women. Most people who become infected will not have any symptoms and will clear the infection on their own.</p> <p>Some of these viruses are called “high-risk” types, and may lead to cancer of the cervix, vulva, vagina, anus, or penis. Others are called “low-risk” types and may cause mild Pap test abnormalities or genital warts. Genital warts are single or multiple growths that appear in the genital area and look like a small hard bump or cluster of bumps. They start off as small painless spots but warmth and moisture can make them grow larger. Some cannot be seen by the naked eye.</p> <p>The available test is designed to find certain types of the virus on a woman’s cervix that can cause cervical cancer. There is currently no approved test for men. Scientists are still studying how best to screen for penile and anal cancers in men who may be at highest risk for those diseases.</p>	<p>There is no treatment or cure for the viruses. Diagnosis of genital warts is usually made by a direct visual exam. There is a magnification procedure for locating warts on the cervix. Genital warts can be treated with medicine, removed (surgery), or frozen off. Treating genital warts may not necessarily lower a person’s chances of passing HPV on to a sex partner. If they are not treated, genital warts may go away on their own, stay the same, or grow (in size or number). They will not turn into cancer or threaten your health.</p> <p>Penile and anal cancers can be treated with new forms of surgery, radiation therapy, and chemotherapy.</p>
GONORRHEA	Caused by a bacterium. Symptoms appear from two days to four weeks after exposure. They include painful urination, pus-like discharge, bumps on the cervix, anal irritation, and painful bowel movement. As the disease progresses, pain in the lower abdomen, vomiting, fever, and irregular menstrual periods occur. In women, it can lead to pelvic inflammatory disease (PID), a secondary infection that can cause sterility. Found in the cervix, uterus, and fallopian tubes in women, and in the urethra in women and men. The bacterium is also found in the mouth, throat, and anus.	
HEPATITIS A	<p>Caused by a virus which is present in a person’s blood, semen, and body fluid. Can be passed from an infected person to another during sexual contact.</p> <p>Can cause swelling of the liver, but does not normally cause permanent liver damage.</p>	Hepatitis A usually gets better on its own.

115 — Adapted from: CEDPA “Choose a Future! Issues and Options for Adolescent Boys” 1998 Centre for Development and Population Activities: Washington, D.C.

HEPATITIS B	<p>Caused by a virus which is present in a person’s blood, semen, and body fluid. Can be passed from an infected person to another during sexual contact.</p> <p>Causes the liver to swell, and liver damage can occur. Most people will get rid of the virus after a few months. Some people are not able to get rid of the virus, which makes the infection chronic, or life-long. This may lead to a scarring of the liver, called cirrhosis, liver failure, and can also lead to liver cancer.</p>	The acute form usually gets better on its own. Most people develop immunity to the virus and, after recovery, cannot give it to others. Someone with chronic (long-term) form still carries the virus and can pass it to others.
HEPATITIS C	<p>Caused by a virus which is present in a person’s blood, semen, and body fluid. Can be passed from an infected person through sharing dirty needles, syringes and other drug using equipment. Sexual transmission is rare but you may be at risk if you are a sexual partner of someone who has Hepatitis C or has used drugs by injection.</p> <p>It may be years before someone shows any signs of illness. Causes swelling of the liver and liver damage. Most people who are infected develop a chronic infection. This might lead to scarring of the liver, called cirrhosis, liver failure, and can also lead to liver cancer.</p>	There is no cure, but treatment is available to help control the virus.
GENITAL HERPES	<p>Caused by the herpes simplex viruses type 1 (HSV-1) and type 2 (HSV-2). Most individuals have no or only minimal signs or symptoms from HSV-1 or HSV-2 infection. When signs do occur, they typically appear as one or more blisters on or around the genitals or rectum. The blisters break, leaving tender ulcers (sores) that may take two to four weeks to heal the first time they occur. Typically, another outbreak can appear weeks or months after the first, but it is almost always less severe and shorter than the first episode. Although the infection can stay in the body indefinitely, the number of outbreaks tends to go down over a period of years.</p>	There is no treatment that can cure herpes, but antiviral medications can shorten and prevent outbreaks during the period of time the person takes the medication.
SYPHILIS	<p>Caused by a bacterium that is passed from person to person through direct contact with sores which occur mainly on the external genitals, vagina, anus, or in the rectum. Sores can also occur on the lips and mouth. wPregnant women with the disease can pass it to the babies they are carrying.</p> <p>Time between infection and the start of the first symptom - usually a single sore (called a chancre) - can range from 10 to 90 days, but there may be multiple sores. The chancre is usually firm, round, small, and painless and appears at the spot where the bacterium entered the body. These chancres also make it easier to transmit and acquire HIV infection sexually. The chancre lasts 3 to 6 weeks, and it heals without treatment. However, if adequate treatment is not administered, the infection progresses to the secondary stage which is characterized by skin rash and mucous membrane lesions. Other secondary stage symptoms may include fever, swollen lymph glands, sore throat, patchy hair loss, headaches, weight loss, muscle aches, and fatigue. These signs and symptoms will resolve with or without treatment, but without treatment, the infection will progress to the latent and late stages of disease during which the disease may subsequently damage the internal organs, including the brain, nerves, eyes, heart, blood vessels, liver, bones, and joints. This internal damage may show up many years later. This damage may be serious enough to cause death.</p>	Easy to cure in its early stages with an antibiotic. For people who are allergic to penicillin, other antibiotics are available. Treatment will kill the bacterium and prevent further damage, but it will not repair damage already done.

LEARNING ABOUT HIV AND AIDS

What is HIV?

H = Human (only found in humans)

I = Immunodeficiency (weakens the immune system)

V = Virus (a type of germ)

What is AIDS?

A = Acquired (to get something that you are not born with)

I = Immune (the body's defense system which provides protection from disease)

D = Deficiency (a defect or weakness, lack of or not enough of something)

S = Syndrome (a collection of diseases, getting sick)

Many people do not know the difference between HIV and AIDS. HIV and AIDS are not the same. HIV is the virus; AIDS can occur as a result of becoming infected with HIV. AIDS is a collection of diseases/sicknesses that results from a weakened immune system. A person can have HIV for a long time before he/she develops AIDS.

HIV lives in four types of body fluids:

- › Blood
- › Semen – Fluid that a man ejaculates when sexually excited
- › Vaginal fluids – Fluid that a woman releases when sexually excited
- › Breast milk

These kinds of body fluids make it possible to spread the virus from person to person. All of these fluids have white blood cells, which are the types of cells which HIV attacks or infects. For a person to be infected with HIV, the virus must enter the body. If any of these four fluids come in contact with the body, a person is at risk of HIV infection. Below are some examples of where the virus can enter the body.

- › Lining of the vagina
- › Thin skin on the penis
- › Lining of the rectum (anus)
- › Veins
- › Cuts, wounds, or open sores on the skin
- › Mouth (through sores or cuts)
- › Lining of the esophagus (e.g., in a newborn baby who is breast feeding)

The kinds of behaviors that might allow the four fluids to enter the body and, therefore, put a person at risk for HIV include the following:

Unprotected sexual intercourse

- › Vaginal, anal, or oral intercourse

Blood-to-blood contact

- › Blood transfusions (in places where blood is not tested and infected blood can be donated)
- › Traditional scarring (through sharing of non-sterilized razors and other instruments)
- › Circumcision (through sharing of non-sterilized razors and other instruments)
- › Intravenous drug use (through sharing of contaminated needles)

Mother-to-child transmission (also called vertical transmission)

- › While mother is pregnant with the child
- › When the baby is born, i.e., during childbirth
- › While breastfeeding

THE LINK BETWEEN STIS AND HIV INFECTION

There is increasing evidence that the presence of an STI increases susceptibility to HIV. Specifically, ulcerative STIs, such as genital herpes and syphilis, increase one's susceptibility to HIV, because the ulcers disrupt the skin barrier. However, presence of other STIs has also been linked with increased risk for HIV transmission. Furthermore, the presence of STIs in an HIV-positive person can increase the viral copies in the genital fluid making it easier to transmit the virus. For these reasons, STI control has the potential to play an important role in HIV prevention. Some programs focusing on STI control and treatment have seen a decrease in the prevalence of HIV. It is also important to note that the presence of HIV changes the clinical manifestations of STIs, often making them more severe and more difficult to treat.

Is there a cure for HIV/AIDS?

Unfortunately, there is no cure for HIV/AIDS. What has been discovered so far are medicines capable of prolonging and improving the quality of life of persons that have contracted the virus. Antiretroviral therapy (ART) is the treatment of the HIV virus with drugs – it is not a cure. Antiretrovirals (ARVs) attack HIV directly, therefore decreasing the amount of virus in the blood. Below are some important things to know about ART:

- › ART helps the body strengthen its immune system and fight off other infections.
- › ARVs are taken in combination – usually three different ARVs are taken every day. It is absolutely essential that a person takes every dose of every pill every day exactly as prescribed by their doctor. This is not like other medicine where, if you miss once or twice, it is not so bad. If a person does not take all of the right medicines every day at the right times, the therapy will not work. When a person takes all of the medicines every day at the right times, we say that there is compliance or adherence.
- › ARVs should not be started until a person has AIDS (this needs to be determined by a competent medical professional).
- › Once started, ARVs must be taken for the rest of a person's life.
- › ARVs can cause unpleasant side effects, e.g., nausea, anemia, rashes, headaches.
- › ART can prevent HIV transmission from mother to child.

MYTH	FACT
WITH ADVANCES IN MEDICINE, THERE IS NO NEED TO WORRY ABOUT SEXUALLY TRANSMITTED INFECTIONS (STIS). IT ONLY TAKES A COURSE OF ANTIBIOTICS AND YOU ARE FINE, ANYWAY!	It is quite true that most sexually transmitted infections (STIs) can be completely cured if they are caught at an early stage, and that the treatment may be as simple as a course of antibiotics. In fact, this is one of the reasons why you should be tested regularly, and why you should immediately approach a healthcare professional if you have any concerns about an STI. However, if left untreated, STIs can pose a long-term risk to your health and fertility. The infections Chlamydia and gonorrhoea can both lead to pelvic inflammatory disease (PID) if they are not treated. This can, in turn lead to long-term pelvic pain, blocked Fallopian tubes, infertility and ectopic pregnancy in women, and pain and inflammation of the testicles and the prostate gland in men. Genital warts and genital herpes are two common viral infections, so antibiotics will not treat them. They can be treated with antiviral medications, but both conditions can recur.
CONDOMS PROTECT AGAINST ALL STI'S.	Using a condom correctly for oral, anal and vaginal sex is a good protection against infections such as Chlamydia and gonorrhoea. Condoms are also important in preventing the transmission of HIV. However, according to the Family Planning Association, there is little evidence to suggest that condoms protect against the transmission of genital warts.
YOU CAN TELL THE SORT OF PERSON WHO IS LIKELY TO HAVE AN STI BY WHAT THEY LOOK LIKE - YOU JUST HAVE TO BE A GOOD JUDGE OF CHARACTER.	STIs are common enough to affect anyone who is sexually active. You don't have to have a large number of sexual partners to contract an STI. 'Gut instinct' is not a reliable way of judging the likelihood of infection from a partner. Safer sex and medical tests are the only sensible solution.
MY IUD/PILL WILL PROTECT ME AGAINST STIS TO SOME DEGREE	Non-barrier contraceptives only offer protection against pregnancy. They do not offer any protection whatsoever against sexually transmitted infections (STIs). Using a condom to protect yourself against STIs is usually the best option. However, you may choose to combine condoms with the Pill or another contraceptive method for increased protection against unwanted pregnancy.

MYTH	FACT
YOU ARE NOT AT RISK OF AN STI IF YOU ARE IN A MONOGAMOUS RELATIONSHIP	<p>On average, individuals have more lifetime sexual partners these days than before, are more likely to have a sexual relationship with more than one person at once, and are more likely to pay for sex than before.</p> <p>Many of us believe that having only one partner exempts us from sexually transmitted infections, but with increasing opportunities for transmission, it is very easy to 'be unlucky'. There are only a few scenarios where you can be sure enough of protection against STIs to stop using a condom. These are:</p> <ul style="list-style-type: none"> – When neither you or your partner have had a sexual relationship before – OR when you and your partner have been tested for all STIs since the beginning of your monogamous relationship – AND when you are certain that your partner is telling the truth, and is not having sex outside of your relationship.
ANYONE INFECTED WITH AN STI WILL HAVE OBVIOUS SYMPTOMS SUCH AS A RASH OR DISCHARGE	<p>There are many potential signs of a sexually transmitted infection (STI). These include:</p> <ul style="list-style-type: none"> – Itching around the genitals or anus – Burning or pain when you urinate – Bleeding and pain during or after sex – Rashes, blisters or bumps around the genitals or anus – Unusual discharge from the penis or vagina. <p>However, even if someone does not have any of these symptoms, they can still be infected and able to pass on the infection to someone else.</p>
PEOPLE WHO USE SEXUAL HEALTH CLINICS TO GET TESTED ARE ALL PROMISCUOUS. AND PEOPLE WILL FIND OUT THAT I'VE BEEN THERE!	<p>People who use sexual health clinics are people with the sense to get tested. If you have engaged in any sexual behavior that could have put you at risk of a sexually transmitted infection (STI) you'd be wise to join them. Sexual health clinics are completely confidential, and will not even tell your GP (general physician) about your visit without your permission. People of any age and sexual orientation can visit these clinics. All tests and treatments are free.</p>



Workshop 4:

Transmission of HIV/AIDS: A Signature Hunt¹¹⁶

OBJECTIVE:
To discuss the sexual transmission of STIs and HIV/AIDS.

RECOMMENDED TIME:
1 hour and 30 minutes

MATERIALS REQUIRED:
Pens/pencils for all participants and small pieces of paper marked as described in the procedures below

PLANNING NOTES:
None.

PROCEDURE:

- Before the session, organize a number of small pieces of paper equal to the number of participants in the group and mark them in the following way:
 - › Write an “H” and “Follow all of my instructions” on one card.
 - › Write a “C” and “Follow all of my instructions” on three cards.
 - › Write “Do not participate in the activity and do not follow my instructions until we sit down again” on three cards.
 - › On the remaining cards, simply write “Follow all of my instructions.”
- At the beginning of the activity, do not tell the participants the topic to be discussed. Distribute the cards randomly to the young men. Ask them to read the instructions on the card they have received and to not share those instructions with other participants. Tell them that they should follow the instructions written on their cards.
- Ask the participants to stand up and choose three people to sign the back of their cards (preferably not someone right next to them).
- When everyone has collected their three signatures, ask them to sit down.
- Ask the person that has the card marked with an “H” to stand.
- Ask everyone who has their cards signed by this person, or has signed that person’s card, to stand up.
- Ask everyone who has the signature of these persons to stand up. Continue like this until everyone is standing up, except those who were requested not to participate in the activity.
- Tell the young men that giving or receiving a signature represented having sexual intercourse with that person. Ask them to imagine that the person who has the card marked with an “H” is infected with HIV or some other

PROCEDURE

STI and that he had sexual intercourse without protection with the three persons who signed his card. Remind them that they are pretending and that the participants are not, in fact, infected.

- Ask the group to imagine that the persons who did not take part in the activity, those that received the “Do not participate” card, are persons that abstained from sex, that is, they did not have sexual intercourse with anyone.
- Finish the activity by explaining to the participants that those who have the cards marked with a “C” used a condom and, for this reason, run less risk. These young men can also sit down.
- Use the following questions to facilitate a discussion about the exercise.

DISCUSSION QUESTIONS:

- How did person “H” feel? What was his reaction when he found out he was “infected”?
- How would you feel if you were infected with HIV/AIDS?
- How did the other participants feel toward person “H”?
- How did those who did not participate in the activity, i.e., those who abstained, feel at the start of the exercise? Did this feeling change during the course of the activity? What did the rest of the group feel toward those who did not participate?
- Is it easy or difficult to not participate in an activity where everybody takes part? Why?
- How did those who “used a condom” feel?
- How else could a sexually active individual protect himself and his partner from an STI or HIV? Explore the meaning of “being faithful” with the young men.
- What were the feelings of those that discovered that they might have been infected with HIV/AIDS? How did they feel about having signed the card of someone “infected” by an STI or HIV?
- What are other ways that HIV/AIDS is transmitted? What do you think are the most common ways that HIV/AIDS is transmitted in your community?
- What was the most important thing that you learned today? How will this help you protect yourself and your partners from STIs and HIV/AIDS in the future?

QUESTIONS

CLOSING:

Each decision you make related to your sexuality is important and can lead to long-lasting consequences. In thinking about STI/HIV prevention, there should be open communication between partners about when, how, and why they will have a sexual relationship. For some couples, this might lead to a decision to abstain from sex. For others, this might lead to a decision to have sexual relations in which case it is fundamental

that the couple discuss previous risk for HIV infection, testing and counseling, as well as the precautions they will take to protect each other from HIV infection, including committing to a faithful relationship and/or using condoms. As young men, it is important that you be open to and respectful of your partners’ beliefs and values regarding these issues.

¹¹⁶ — Adapted from the activity “In Search of Signatures” contained in the manual *Adolescência: Administrando o futuro* produced by Advocates for Youth and SEBRAE, 1992.



Workshop 5: Case Study: The Story of Marko

OBJECTIVE:
To discuss the stigma that people living with HIV/AIDS face.

MATERIALS REQUIRED:
Resource Sheets A and B

RECOMMENDED TIME:
2 hours

PLANNING NOTES:
This activity involves young men playing the roles of female characters. If this creates too much difficulty, the characters can be switched to be all male.

PROCEDURE:

1. Before the activity begins, ask for seven volunteers to take part in a role play.
2. When the volunteers are gathered, inform them that they are going to prepare a short role play called “The Story of Marko” (see Resource Sheet A) which is to be presented to the other members of the group. Remind the volunteers that one of them will have to read the part of the narrator.
3. After presenting the role play, explain that it will be presented repeatedly until the group, as a whole, finds a satisfactory ending. Tell them that to come up with this ending, they will have to change the dialogue of some of the characters. Invite other participants to take the places of the participants who did the role play the first time and think about how they would have reacted. For example: if someone thinks that one of Marko’s friends reacted inappropriately, he should stand up and take that person’s place and demonstrate how the friend could have reacted differently. The role play should be repeated until the group is satisfied with the ending of the story.
4. After finishing the role play, end the session by using the discussion questions below.

DISCUSSION QUESTIONS:

1. What did you feel when the role play was presented for the first time?
2. What did you think of the changes that were made?
3. What happens in the community when someone is suspected of having HIV/AIDS?
4. Do people in your community usually respect persons who are HIV-positive? Do they respect the families of persons who are HIV-positive?
5. What is stigma? (see Resource Sheet B)
6. What are the consequences of stigma on an individual? On relationships? On communities?
7. How can you and other young people show more support for people who are HIV-positive?

PROCEDURE

QUESTIONS

CLOSING:

Although HIV/AIDS is constantly being discussed in the media, prejudice towards people living with HIV/AIDS (PLWHA) is still strong, and there are still many myths and misconceptions about being HIV-positive. For example, many people continue to believe that HIV can be transmitted by hugging, kissing, or via casual contact in public places. It

is important to have accurate information about HIV/AIDS and to ensure that others in your community also have this information. Moreover, we should think critically about the “labels” and social discrimination that HIV-positive people face and how to work with others in our community to foster greater solidarity with PLWHAs.

ADDITIONAL RESOURCE:

You can use also “Nikolina’s life story” as a case study. Discussion questions from “The story of Marko” can be useful, but you can add some more including:

1. Should Nikolina have told Vanja she was HIV positive before they had sex? Why or why not?
2. What do you think will happen now to Nikolina and Vanja?

LINK:

The Activity “[HIV/AIDS Counseling and Testing](#)” can be linked to this activity through a discussion on the experience of seeking HIV/AIDS testing and speaking to friends about the results.

THE STORY OF MARKO

Narrator: Marko is 18 years old and works in a hardware store in Kraljevica. He meets a girl who comes into the store, and they really like each other. After a few weeks of seeing each other, they end up having unprotected sex. Afterward, Marko worries that he might be HIV-positive.

He worries about it for months before he finally tells his best friend, Ivan. Ivan tells Marko he should go to the clinic in Zagreb and get tested. When Marko finally goes to the clinic, he finds out from the nurse that he is HIV-positive. Marko is devastated. He wanders through the streets aimlessly. He could hardly hold back his tears when he bumps into Ivan.

Ivan: Marko, you look terrible. Are you okay??

Marko: I went to the clinic to get tested for HIV. They told me I was positive.

Ivan: I'm so sorry, Marko. Let's go to a bar and have a beer and we can talk about it. That's what friends are for.

[In the bar]

Ivan: So what are you going to do, man?

Marko: I don't know. I was walking wondering why this happened to me. I don't do drugs. I don't sleep with lots of girls. I usually use a condom. It was just this one time...

[Some of Marko's and Ivan's friends walk into the bar]

Friend: Hey Ivan. Hello Marko. How are you? What is going on?

Ivan: Good. We're good.

Marko: Excuse me. I have to go to the bathroom.

Sonja: Ivan, is everything okay with Marko? He doesn't look so good.

Ivan: Not really. Marko just told me he has HIV.

Mary: What? I never knew he did drugs...

Hrvoje: Wouldn't surprise me if he slept with a prostitute.

Sonja: (with eyes wide open, is about to cry): I was with him at Maja's party.

Katarina: Did you kiss?

Sonja: Yes. Oh my God! Do you think I'm infected?

Hrvoje: You should probably go to the clinic. But how could anyone go with a guy like that? I always thought he was a bit strange...

Ivan: Be quiet! Here he comes.

[Marko comes back and sits down]

Katarina: I have to go help my mom.

Hrvoje: Wait for me. I'm going too.

Ivan: I have to go as well.

Sonja: (staring at Marko): How could you do this to me? I bet you already knew and even so you went with me...

[She goes away, leaving Marko alone.]

Resource sheet A

THE STORY OF NIKOLA

Narrator: Nikolina is a 16 years old young woman. She has been HIV positive since she was a kid. When she was in primary school, someone has found out that she was HIV+ and spread the word amongst the parents. The parents then refused to allow their children to play with her. Back then, she didn't really understand what was going on. She didn't even know what HIV was. She does remember that she was really sad when the other children ignored her, and that her parents were also upset about it. Eventually, they moved to another town. At first, she had a hard time making new friends, but eventually things got better.

Now she is in high school and in love with Vanja, a schoolmate. They are dating and she is the happiest she has ever been.

Vanja: Nikolina, do you want to come over tonight? My parents are out of home for two day and we can make popcorn and watch a movie. What do you say?

Nkolina: Super! That is great! I'll bring some soda and a film, OK?

Vanja: OK! See you at 8!

Narrator: That night Nikolina and Vanja had sex with a condom. Nikolina is very responsible and always has condoms with her.

[A few weeks later Vanja is talking with his friend Toni about his sexual experience with Nikolina.]

Vanja: I'm so in love! I'm flying! She is amazing. And now, we are also having sex. Everything is perfect!

Toni: I'm glad for you!

[A few weeks later, Vanja and Nikolina and their friends are at a party at Toni's house. Nearby a few people are speaking with Toni in low voices.]

Resource sheet A

Maja: I know that girl over there, Nikolina. She is from the same small town Ivanići where my grandmom lives. She is HIV positive! What is Vanja doing with her?

Lidija: Look, they just kissed!

Toni: Nooo! Really? I have to warn Vanja! He might be infected too!

[Toni comes to Vanja]

Toni: Sorry Vanja, but I have to say to you something! I just heard that Nikolina is HIV positive! Did you know that?

Vanja: What??? You are wrong! She would tell me herself, if it were true.

[Vanja goes over to Nikolina]

Vanja: Nikolina, is it true that you have HIV?

Nkolina: Mmmm, well, yes. But I didn't tell you, because I was scared that you would leave me. And we used a condom each time we had sex so you don't have to worry about being infected.

Stigma and Discrimination against People living with HIV/AIDS¹¹⁷

Stigma is the use of stereotypes or labels when defining someone or a group of people. Because of its association with behaviors that may be considered socially unacceptable by many people, HIV infection is widely stigmatized.

People living with the virus are frequently subject to discrimination and human rights abuses: many have been thrown out of jobs and homes, rejected by family and friends, and some have even been killed.

Together, stigma and discrimination constitute one of the greatest barriers to dealing effectively with the epidemic. They discourage governments from acknowledging or taking timely action against AIDS. They deter individuals from finding out about their HIV status.

And they inhibit those who know they are infected from sharing their diagnosis and taking action to protect others and from seeking treatment and care for themselves. Experience teaches that a strong movement of people living with HIV that affords mutual support and a voice at local and national levels is particularly effective in tackling stigma. Moreover, the presence of treatment makes this task easier too: where there is hope, people are less afraid of AIDS; they are more willing to be tested for HIV, to disclose their status, and to seek care if necessary.

Understanding the difference between stigma and discrimination:

Stigma refers to unfavorable attitudes and beliefs directed toward someone or something

Discrimination is the treatment of an individual or group with partiality or prejudice

Stigmatization reflects an attitude

Discrimination is an act or behavior

⚙️ Workshop 6: Positive Life – Empowering People Living with HIV/AIDS (PLWHA)

📍 OBJECTIVE:

To promote a greater understanding of the lives and experiences of people living with HIV/AIDS (PLWHA), including the stigma and discrimination they face.

📄 MATERIALS REQUIRED:

Pens/pencils and a sufficient number of copies of the Resource Sheet to distribute to the participants.

Note: If it is not possible to make copies of the Resource Sheet, you can read the questions out loud. Along the same lines, if the participants have difficulties writing, you can ask the participants to draw pictures instead.

🕒 RECOMMENDED TIME:

2 hours

📅 PLANNING NOTES:

Prior to the session, research local and/or national laws and policies concerning PLWHA rights, existing support networks, and the most up-to-date information about sexual partnerships between HIV-discordant persons (when one person is HIV-positive and the other is not) and the question of PLWHA that want to have children (how this is possible for men and women and what implications and risks are involved).

It can be interesting to invite someone living with HIV/AIDS to come to the session and share his/her experiences with the participants. If someone is able to come, it will be important to help mediate the discussion between the guest and the participants, making them feel as comfortable as possible to ask questions. Another possible idea is to show and discuss a film that touches on experiences of PLWHA.

PROCEDURE:

1. Ask each participant to describe through writing or drawing a typical week in his life. The facilitator can and should adapt the questions in the Resource Sheet, according to the setting in which he is working. Explain to the participants that it is not necessary to answer ALL of the questions, but rather to use them to think about the different aspects of a typical week.
2. Allow 15-20 minutes for the participants to answer these questions.
3. Ask each participant to now write (or describe to a neighbor) what a typical week in their life would be like if they had HIV.
4. Use the following questions to facilitate a discussion about what they have written (or said).

PROCEDURE

1. What do you think would change in your life if you were HIV-positive?
2. Can a young HIV-positive person live a life like any other young person? Why or why not?
3. What difficulties might a young HIV-positive young man face? Can he date, have sex, get married, and have children?
4. What difficulties might a young HIV-positive woman face? Can she date, have sex, get married and have children?
5. How might a HIV-positive young man's or young woman's relationship with his/her family change?
6. Who generally cares for people living with HIV/AIDS? Women or men? Why?
7. Who can a young man or young woman who is HIV-positive ask for help? Is there any support network for PLWHAs in your community or region?
8. If a young man or young woman suffers some type of discrimination, who can he/she turn to?
9. How can we be more accepting of people in the community who are living with HIV/AIDS?

CLOSING:

Nowadays, with advances in medicine and a greater understanding of HIV/AIDS itself, the quality of life of people with HIV/AIDS has increased considerably. This means that PLWHAs can lead normal lives. For example, they can continue to date people; marry; have an active sexual life; have children; and work. However, PLWHAs still often suffer prejudice and discrimination in society and require special care concerning health treatments and the use of medicine. But, above all they require and want respect and dignity in their lives. There are many examples of individuals who have been infected for a long time and who continue to lead active and productive lives (try to find in your community, country, or region examples of this). It is fundamental that you and other young people do your part to help build a community that is just and supportive of all people, including those living with HIV/AIDS.


 QUESTIONS

Resource sheet

Describe in a couple of sentences a typical week in your life, covering the following:

At home:

1. How many people live together in your home?
2. Do you do any housework?
3. What is the atmosphere like in your home?
4. How do you relate to the people that live in your home?

At school:

1. Do you go to school?
2. Where do you study?
3. What time?
4. How many hours a day?
5. What do you like most at school?
6. What do you like least at school?

Dating:

1. Do you have a girlfriend (wife)?
2. How long have you been going out together?
3. Do you generally see each other every day?
4. Where do you go?
5. What do you do together?
6. What do you like most about her?
7. What do you like the least about your relationship?

At work:

1. Do you work?
2. What do you do?
3. How many hours a day? What are your working hours?
4. How do you get along with your colleagues?
5. What do you expect from your job?

With friends:

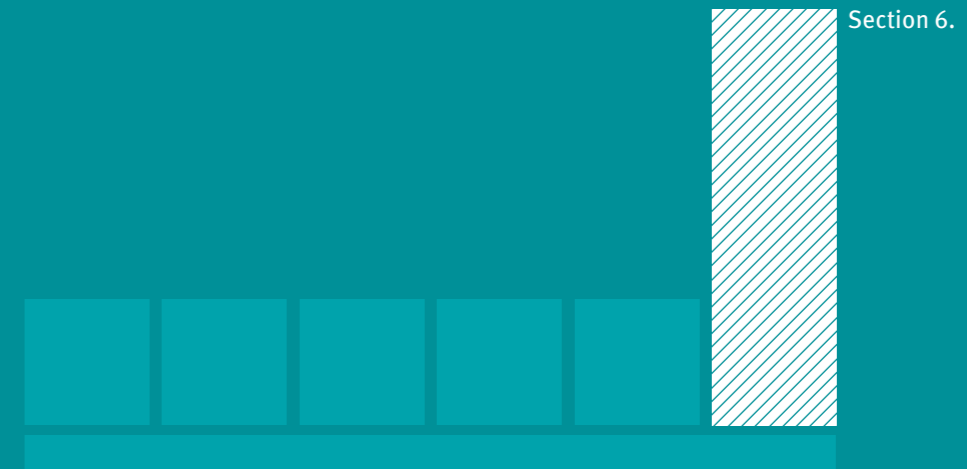
1. When do you meet your friends (morning, afternoon, night)?
2. What do you do together?
3. Do you have a favorite place to go to (beach, bar, club, street, someone's house)?
4. Do you play any sport together?
5. What do you do to have fun?

Leisure:

1. What leisure activities do you have?
2. Do you spend any time alone? How long? What do you generally do during this time?
3. Do you do any activities by yourself? What? How often? Toni's house. Nearby a few people are speaking with Toni in low voices.]

Section 6:

From Violence to Peaceful Co-existence – What and Why



— WORKSHOPS —

1. What is Violence?
2. Understanding the Cycle of Violence
3. What is Sexual Violence?
4. A Live Fool or a Dead Hero: Male Honor
5. What Do I do when I am Angry?
6. From Violence to Respect in Intimate Relationships
7. Men and Violence: Moving toward Change
8. Can a man like another man?
9. Leaded fantasy: understanding homosexuality
10. Homophobia in the Youth Environment
11. Making changes in our lives and in our communities

Section 6:

From Violence to Peaceful Co-existence – What and Why

Overview

Worldwide, men are disproportionately the perpetrators and victims of violence, with the exception of sexual violence.¹¹⁸ In the public sphere, the majority of interpersonal violence occurs between men – in the private sphere, the majority of interpersonal violence is perpetrated by men against women. Why is it that men are disproportionately the perpetrators and victims of violence? And what can we do to engage young men in the prevention of violence?

In this section, we explore the factors of young men's attitudes towards and use of violence, calling particular attention to the gendered aspects of violence.

What is violence?

The World Health Organization defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group of community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation".¹¹⁹ This inclusion of the word "power" in the definition expands the conventional understanding of violence to include such act as threat, intimidation, and oppression that result from a power relationship between individuals, between individuals and groups, or between groups. For the purposes of this manual, we are going to focus on interpersonal violence, or violence inflicted against one individual by another, or by a small group of individuals.

¹¹⁸ — WHO, "What About Boys? A Literature Review on the Health and Development of Adolescent Boys" (Geneva: World Health Organisation and Pan American Health Organisation, 2000).

¹¹⁹ — WHO, "Global Consultation on Violence and Health. Violence: a public health priority." (Geneva: World Health Organization, 1996)

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...in the private sphere, the majority of interpersonal violence is perpetrated by men against women.

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It is also important to start with the affirmation that violence is not a random act. It happens in specific circumstances and settings. Violence happens more frequently in some settings than others, and around the world it is more likely to be carried out by and against men – usually young men. In the public sphere, young men are most likely to be the perpetrators of this violence and most likely to be victims. In the private sphere – the home and other private spaces – men are more likely the aggressors and women the victims. Research on the causes of violence fills volumes of books and has been the topic of thousands of studies. But what is too often left out of these discussions is the gendered nature of violence - the fact that men, and particularly young men, are more likely to use violence than any other group. When we talk about violence, we must also talk about peace and peaceful coexistence. Too often, we hear about "stamping out violence" or a new program to "combat violence," or even a "war against violence." The language we often use for talking about violence and preventing violence is itself violence-laden. We want to combat it and to punish, often violently, those who use violence. At the level of schools and communities, we often hear residents talking about wanting to punish those young men who are violent, to repress them while significantly less attention goes to thinking about what would actually prevent violence.

We often punish violence with violence and then ask ourselves where violence comes from. In a particularly insightful overview of violence in the U.S., James Gilligan of Harvard University argues that rather than deterring violence, the use of the death penalty and other harsh methods for repressing crime in the U.S. actually contributes to a culture of violence.¹²⁰

In engaging young men in violence prevention, we must be able to visualize, imagine and create with them the conditions that promote peaceful coexistence and not just "combat violence." Talking about peace, negotiation and peaceful coexistence is sometimes given a bad rap and is even ridiculed. But as the British singer Elvis Costello asked: "What's so funny about peace, love and understanding?" When we get past the bravado, we find that most young men, when allowed to express it, are fearful of the potential for violence within themselves and of the violence inflicted on them or threatened by other young men. Many young men have experienced or witnessed violence at some point in their lives (or various points in their lives) and are eager to talk about peaceful coexistence. In the activities included here, we want to promote conditions for young men to talk not only about competition, power, fighting and violence - but also about peaceful coexistence.

BOX 1: Violence on a Global Scale

BOX
1.

- › Each year, over 1.6 million of people lose their lives to violence.¹²¹
- › Violence is the leading cause of death for people aged 15-44 years, accounting for 14% of deaths among males and 7% of deaths among females.¹²²
- › Between 15 -70% of women have experienced physical or sexual violence by an intimate partner.¹²³
- › About 815,000 people each year kill themselves.¹²⁴

120 — Gilligan, Violence: Our deadly epidemic and its causes. (New York, New York: Putnam Publishing Group, 1996)

121 — http://www.who.int/violence_injury_prevention/violence/en/. Last date accessed 10/02/2011.

122 — Ibid.

123 — Garcia-Moreno et al. "Multi-country study on women's health and domestic violence" (Geneva: World Health Organization, 2005)

124 — http://www.who.int/violence_injury_prevention/violence/en/. Last date accessed 10/02/2011.

Men's Violence is NOT Natural: Finding the Roots of Young Men's Violence in Their Socialization

Research has confirmed that violence is mainly a learned behavior.¹²⁵ Boys and young men learn to be violent by watching their fathers and brothers use violence. By being encouraged to play with guns and being rewarded when they fight. By being told that the only way to "be a real man" is to fight with anyone who insults them. By being treated in violent ways or subjected to violence by their peers or families. By being taught that expressing anger and aggression is okay, but that expressing sadness or remorse is not.

Biology may also be involved in the fact that men perpetrate violence more than women, but to a very limited extent. For example, some research finds that there are some biological differences between boys and girls in terms of temperament, with boys having higher rates of lack of impulse control, ADHD and other traits such as sensation-seeking, reactivity and irritability - traits that may be precursors to aggression.¹²⁶

Research has found that as early as four months of age, temperamental differences can be detected between boys and girls, with boys showing higher levels of irritability and manageability, factors that are associated with later hyperactivity and aggression.¹²⁷ However, some studies also find that boys may be more irritable because researchers expect boys to be more irritable, or because parents, showing gender stereotypes, stimulate boys in different ways or are less likely to soothe or calm boy babies to the extent that they calm girl babies. Researchers of violence are nearly unanimous in stating that while there may be

some limited male biological basis for aggressive and risk-taking behaviour, the majority of boys' violent behavior is explained by social and environmental factors during childhood and adolescence. In sum, young men are not born violent. They are taught to be violent.

Families and parents have a major role in encouraging – or discouraging – violent behavior by boys and young men. In low income settings where families are stressed, they may have less ability to watch over their children, particularly sons, and have less control over where they go and who they hang out with. Stressed parents are more likely to use coercive and physical discipline against boys, which may lead some boys to rebel against this treatment. On the other hand, families who have open styles of communication, who interact with respect with their sons (and daughters), and who have the ability to both monitor their sons' activities, to know who they hang out with and to offer them opportunities, are less likely to have violent sons. Young men who are more attached to families, participate more in joint family activities and are more closely monitored by their families are less likely to be violent or delinquent.

Young men who are labelled as "delinquent" or "violent" or "troublemakers" are more likely to be violent. Boys in many settings have more behavior "problems" than girls - they may be more disruptive in the classroom, they sit still less than girls or they show hyperactive behavior. Parents and teachers often label these behaviors as troublesome, and react in authoritarian ways that create

125 — A. Bandura, "Influence of models' reinforcement contingencies on the acquisition of imitative responses". *Journal of Personality and Social Psychology*, 1,(1965) 589-595. ; Cunningham et al., – "Theory-derived explanations of male violence against female partners: literature update and related implications for treatment and evaluation" (London: London Family Court Clinic, 1998)

126 — M. Miedzian, . Boys will be boys: Breaking the link between masculinity and violence. (New York: Anchor Books, 1991); F Earls, "A developmental approach to understanding and controlling violence". In H. Fitzgerald, et al, Eds., *Theory and Research in Behavioral Pediatrics*, Vol. 5 (New York: Plenum Press, 1991)

127 — Stormont-Spurgin, & S. Zentall, "Contributing factors in the manifestation of aggression in preschoolers with Hyperactivity" *J. Child Psychol Psychiat* 36 (1995) 491-509.

a chain of expectations. Parents and teachers believe some boys will be violent or delinquent and these same boys often become delinquent. Why? Because when teachers and parents label boys as "aggressive" or "troublemakers" they often exclude these boys from activities such as sports. Rather than listening to "troublesome" young men, teachers and parents often stigmatize and exclude them, ultimately encouraging violent behavior rather than preventing it.

Some research has also shown that boys who witness violence or are victims of violence are also more likely to be violent.¹²⁸ Witnessing violence around them is stressful for both boys and girls, but this stress may show itself in different ways for girls and boys. For boys, trauma related to witnessing violence is more likely to be externalized as violence than it is for girls.¹²⁹ Many young men are socialized to believe that it is inappropriate for them to express fear or sadness but that it is appropriate for them to express anger and aggression. Young men who experience and witness violence in the home and outside the home may come to see violence as a "normal" way - and particularly a male way - to resolve conflicts.

Easy access to weapons can also contribute to violence. Having access to weapons, of course, does not cause violence but it does increase the likelihood that violence will be more lethal. A fight over an insult or a girl is more likely to lead to a homicide when one of the actors has a gun or a knife. In some settings, learning how to use and play with weapons - particularly knives and guns - may even be part of how boys are socialized.

Where young men live can also be a major factor related to their use of violence. For example, boys who are raised in neighborhoods where armed gangs exist, or where sectarian violence involves men and boys, are more likely to use violence and to be victims of violence. Gangs and similar groups often emerge when other social institutions that may support and protect young men - the government, family, community organizations, schools - are weak. Higher rates of violence in some areas may also have to do with local culture. In some settings, young men may believe they are supported by their peers or local norms when they use violence as a response to insult or injury.

Another major factor that can contribute to violent behavior is a young man's peer group. Studies in the U.S. find that hanging out with delinquent or violent peers is one of the strongest factors associated with young men' violent behavior.¹³⁰ However, it would be simplistic to conclude that violent peers "cause" other young men to be violent. Young people tend to look for

128 — Bell & E.J. Jenkins, "Traumatic stress and children" *Journal of Health Care for the Poor and Underserved* 2 (1991) 175-185.; E.R. Parsons, "Inner city children of trauma: Urban violence traumatic stress syndrome (U-VTS) and therapists' responses" In J.Wilson & J.Lindy Eds. *Center transference in the treatment of post-traumatic stress disorder* (New York: Guilford Press, 1994); R.S. Pynoos, "Traumatic stress and developmental psychopathology in children and adolescents" In J.M. Oldham, M.B. Riba, & A.Tasman Eds. *American Psychiatric Press Review of Psychiatry* Vol. 12 (Washington D.C.: American Psychiatric Press, 1993)

129 — U.S. Department of Justice "The Prevalence and Consequences of Child Victimization.: NIJ Reserch Preveiw". (Washington, DC: National Institutes of Justice., 1997)

130 — Michael B. Green "Implications of Research Showing Harmful Effects of Group Activities with Anti-Social Adolescents," Paper presented at Persistently Safe Schools: The National Conference of the Hamilton Fish Institute on School and Community Violence, available at <http://goo.gl/UBhFU>

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Some research has also shown that boys who witness violence or are victims of violence are also more likely to be violent...

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other young people like themselves for their peers. Violent young men may be more likely to hang out with other violent young men. But clearly, who young men hang out with and who they listen to is a factor to be considered. Some researchers suggest that because young men generally spend more time outside the home – often in street-based peer groups who promote competition, fighting and delinquency – they are more likely to be violent than girls, who are more likely to be socialized in the home or around family members.

Studies in the U.S. have found that young men who are violent are more likely than their less violent peers to perceive hostile intentions in others, or to misinterpret the behaviour of others as hostile.¹³¹ Young men who use violence seem to have difficulty with "emotional intelligence" - i.e. the ability to "read", understand and express emotions in appropriate ways. In other words, they are more likely than less violent young men to "misread" the intentions of others, believing them to be hostile when they are not. In addition, young men who are violent often justify their violence by blaming it on others, and often use dehumanizing labels for their victims. Similarly, young men who have an exaggerated sense of honor are also more likely to use violence. Some cases of man-to-man homicide start over relatively minor altercations, generally about an insult, often in bars or other public spaces, and escalate to lethal levels.

For some young men, being violent is a way to define who you are. Adolescence is the time of life when we generally define who we are. For some young men, this might be defining yourself as a good student, or as religious, or an athlete, or a hard worker, as artistic, or as a computer geek. Or it might be defining yourself as a bully, or thug. For some young men, participation in organized peer groups such as gangs can provide them with a sense of identity and belonging that they do not find elsewhere. For some young men, being part of a violent peer group may be a way to survive or a mean of self-protection. For young men in some low-income urban settings in the region, many of whom have little else which gives them meaning and clear roles in society, violence can be a way of achieving a name for themselves. On the other hand, when young men find an identity in something else - as students, hard workers, fathers, husbands or in music, sports, politics (depending of course on which politics), religion (again depending on which religion) or some combination of those - they generally stay out of gangs or violent peer groups. A study with young men whose peers were involved in gangs in Chicago and Rio de Janeiro found that those young men who weighed the cost of violence, were fearful of violence, and found alternative identities and alternative peer groups, were more likely to stay out of gangs.¹³²

Young men who are doing poorly in school, are less connected to the school setting, or are marginalized or excluded within the school setting are more

131 — M.R. Fondacaro and K Heller "Attributional style in aggressive adolescent boys" *Journal of Abnormal Child Psychology* (1990) 18(1):75-89; C Hudley and J Friday, "Attributional bias and reactive aggression" *American Journal of Preventive Medicine* (1996) 12 (5 Suppl):75-81

132 — Gary Barker, "Peace boys in a war zone: Identity and coping among adolescent men in a favela in Rio de Janeiro." (Unpublished doctoral dissertation, Erikson Institute, Loyola University: Chicago 2001).

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For some young men, being part of a violent peer group may be a way to survive...

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likely to be violent or delinquent. Numerous studies have found that poor school performance, school drop out and the lack of a sense of belonging in school are associated with higher rates of delinquency and other violent behavior. In some settings, young men are dropping out of school at higher rates than girls. However, being enrolled in school is not enough. For some young men, school can be the place where they meet and interact with violent peers. Other studies suggest that young men who are marginalized or excluded or treated as "misfits" while in school are more likely to be violent. In sum, the school – as the most important social institution where young people hang out – is an important site for encouraging or preventing violence.

Does the media have anything to do with young men's violence? Some studies have found that viewing violent media images may be associated with carrying out violence, but the causal connection is unclear.¹³³ Watching violence on TV or in movies probably does not "cause" young men's

violence but it no doubt contributes to some young men's belief – and our general belief as a society – that men's violence is normal, even cool.

Finally, it is also important to keep in mind that violence is not merely associated with low-income young men. Much research on violence has focused on low-income young men; in some settings, poverty is associated with higher rates of some kinds of violence. Poverty is itself a form of social violence, but poverty should not be considered the cause of interpersonal violence. Middle class young men in many settings are also involved in violence, and also socialized to use violence to express emotions and resolve conflicts, just as most young men in low-income settings are not perpetrators of violence. In studying and responding to violence, it is imperative that we not stigmatize or label low-income young men, or young men in general, as inherently violent, and that we recognize that the majority of young men are not perpetrators of violence.

What is gender-based violence?

Gender-based violence (GBV) is widely recognized as an international public health problem and human rights concern. GBV can have devastating effects on women's physical and emotional health, as well as the well-being of families and communities, and larger society. The concept of GBV seeks to distinguish violence that is based on gendered expectations and/or on the sex or gender identity of another person from other types of violence. While GBV can apply to women and men, girls and boys the focus of most GBV efforts is on ending the violence against women and girls, since it is they who are overwhelmingly affected.¹³⁴ Over the past decade, the international community has begun to use the term "gender-based violence" instead of "violence against women" to shift the focus from women as victims and to emphasize the role of gender norms, inequity and power relationships in the increase of women's vulnerability to violence. Within this discourse, increasing recognition is also being given to understanding masculinities and the role that male socialization plays in condoning men's use of violence. Some men and boys are raised to believe they have the "right" to expect certain things from women, and the right to use physical or verbal

133 — A. McAlister, "La violencia juvenil en las Americas: Estudios innovadores de investigación, diagnóstico y prevención." (Washington, D.C.: Organización Panamericana de la Salud, 1998)

134 — UNFPA, "Strategy and Framework for Action to Addressing Gender-based violence 2008-2011" Gender, Human Rights, and Culture Branch. (New York: UNFPA, 2008).

abuse as a form of "punishment" if a woman does not provide these things (responding to sexual demands, for example). Sexual violence in particular is also rooted in non-equitable gender norms – especially those that define male sexuality as uncontrollable and aggressive and female sexuality as passive. Successful interventions working with men to deconstruct hegemonic masculine identities and to support community and institutional change have shown the positive contribution that men make as allies and anti-violence activists.^{135 136}

BOX 2: GBV in the Western Balkans

- › In Serbia, a survey with a representative sample of women found that 30.6% had suffered physical violence, 46.1% had suffered psychological violence and 8.7% had suffered sexual abuse in their lifetime. Another survey carried out in 2003 confirmed these findings.¹³⁷
- › In Montenegro, a survey with a representative sample of women found that 25% had been beaten by a partner, 25% had also been forced to have sex by a partner, and 14% had been threatened with the kidnapping of their children.¹³⁸
- › In Croatia, a survey with a representative sample of women found that 21% of the women had experienced physical violence at the hands of a current or former male partner and 34% reported having experienced forced sex.¹³⁹
- › In Bosnia and Herzegovina, a survey found that 23% of the women had been beaten by their partners, while 29% knew a woman who had been beaten.¹⁴⁰

Violence between Men¹⁴¹

The violence that occurs between men is often linked to rigid gender norms and power dynamics. Boys and men are often taught that aggression or violence toward others is an acceptable mean of demonstrating strength and control or that to avoid being victims they must perpetrate violence towards others.

135 — Gary Barker, "Engaging boys and men to empower girls: Reflections from practice and evidence of impact", United Nations Expert Group Meeting on the Elimination of all forms of discrimination and violence against the girl child, Florence, Italy, 25-28 September 2006

136 — D. Peacock, & A. Levack. "The Men as Partners Program in South Africa: Reaching Men to End Gender-Based Violence and Promote Sexual and Reproductive Health", *International Journal of Men's Health* 3 (2004) 173-188.

137 — AŽC, 2005

138 — Radulović, 2003

139 — Otročak, 2005

140 — H. Peele & D. Andric-Ruzici Eds. "To Live With (out) Violence: A second look 2- Experts." *Final Report Violence Against Women.* (Zenica: Bosnia Herezgovina & Medica Zenica, 1999) 54-55.

141 — G. Barker, C. Ricardo, and M. Nascimento, "Engaging men and boys in changing gender inequity in health: Evidence from programme interventions." (Geneva: World Health Organization, 2007)

The use of violence against other men can be, among other things, a way to achieve a socially recognized status as a man when other forms of recognition of affirmation are unattainable or perceived to be unattainable. In this way, violence may serve as a mechanism by which some men and boys are placed or kept in a position subordinate to other men.

Male-to-male violence can also be linked to gender norms that underlie violence against women and girls. Violence can act as a means of censorship and form of control over male behavior. It can be used against men who do not adhere to rigid gender scripts and norms, the most extreme example being homophobic violence against men who have sex with men (MSM) or who self-identify themselves as non-heterosexual. Men who deviate from norms regarding male behavior, dress, interests, etc. can also find themselves victims of violence or harassment.

Gangs

Throughout the world, there are example of young men who organize themselves along race, class, national or other lines, for mutual protection or profit, often engaging in violent and/or illegal activities. These groups vary from place to place, and it is important to understand the context in which they exist. Also, it is worth mentioning that it is not just poverty or unemployment that may lead a young man to participate in a gang, but various factors – individuals, family, and local context – can lead young men to join these groups. It is also important to emphasize that even in communities where gangs have a powerful presence, not all young men participate. Generally, only a minority become involved.

There have been and still are, various attempts to repress these groups of young men, primarily via police repression. Diverse experiences suggest that police repression has not been an adequate response. More promising work with gang intervention shows the importance of offering alternatives to young men who participate or who have the potential to participate: cultural activities, job access, opportunities for community participation, and spaces for bringing young men together - with a shift away from repression.

It is clear that for some young men, violence is a way to form an identity. For many, adolescence is the time of life to think about the question: who am I? A young man can define himself as a good student, a religious, an athlete, a hard worker, an artist, a computer wiz, or various other things. But he can also define himself as a bandido (bandit). Research with young men who participate in these violent groups in the US and in Brazil concludes that

”
It is clear that for some young men, violence is a way to form an identity...

“

they feel a sense of belonging and identity that they don't find elsewhere.¹⁴² For many low-income, socially excluded young men living in urban areas, belonging to a violent group is a way for them to survive, to feel important, and to gain a sense of belonging in their lives. On the other hand, when young men discover their identity in a different outlet, as students, fathers, partners or husbands, in music, at work, in sports, politics (depending on what type of political group), in religion (again, depending on which religion), or even in a combination of these - they generally stay away from gangs or violent groups.

Resilience, young men, and violence prevention

How can we explain how some youth from certain backgrounds become involved in violent activities like gangs, and others, from the same context, do not? Recent research has identified individual and family characteristics of youth from low-income areas and in high-risk situations who become successful in school and at work, and who do not become involved in gangs and other violent groups.¹⁴³

These studies frequently refer to the concept of resilience, which addresses "successful adaptation, despite risk and adversity." Resilience is a concept that helps us understand the subjective realities and the individual differences that youth exhibit, and offers insights in how to stimulate positive ways to overcome adversity in particularly difficult contexts. In other words, resilience means that some young men, even in difficult circumstances, find positive alternatives for overcoming the risks that surround them. In a comparative study between young male juvenile delinquents in Rio de Janeiro and their cousins and brothers who were not, the author identified a series of protective factors that favor non-delinquency on the part of young men. In this study, the youth who were not delinquent, or resilient 1) showed greater optimism in relation to their life realities, 2) had a greater ability to express them-

selves verbally, 3) were the oldest or the youngest child in the family, 4) had a calm temperament, and 5) exhibited a strong, affectionate connection with their parents or teachers (Assis, 1999). Similarly, other research in Brazil, with young men from an area where the "comandos" had a strong presence, identified the importance of alternative models, the ability to reflect and construct positive meanings in the face of adversity and non-violent peer groups in keeping low-income youth away from violent groups.¹⁴⁴

Youth represent a key opportunity to construct alternative definitions of masculinities and reduce gender-based violence. Although strong forces influence young men to adopt traditional masculinities during gender socialization, it is possible to change this path. Youth is a key developmental stage when gender identities are constructed and can be reshaped. During this period of their lives, behaviors toward women or partners are rehearsed and carried into adulthood, and reaching young men is a way of changing the way men interact with women. In the context of youth development efforts, working to support gender equitable constructions among youth also can strengthen their own leadership development, including their ability to engage as actors to advocate for gender equity more broadly.

142 – Gary Barker “ Dying to be Men: youth, masculinity, and social exclusion.” (Routledge: Global Public Health, 2007)

143 – Gary Barker “ Dying to be Men: youth, masculinity, and social exclusion.” (Routledge: Global Public Health, 2007)

144 – Gary Barker “ Dying to be Men: youth, masculinity, and social exclusion.” (Routledge: Global Public Health, 2007)

BOX 3: Summary Points

- › Violence happens more frequently in some settings than others, and around the world it is more likely to be carried out by and against men - usually young men. In the public sphere, young men are most likely to be the perpetrators of this violence and most likely to be victims. In the private sphere - the home and other private spaces - men are more likely the aggressors and women the victims.
- › Violence is a learned behavior. Boys and young men learn to be violent by watching their fathers and brothers use violence. By being encouraged to play with guns and being rewarded when they fight. By being told that the only way to "be a real man" is to fight with anyone who insults them. By being treated in violent ways or subjected to violence by their peers or families. By being taught that expressing anger and aggression is okay, but that expressing sadness or remorse is not.
- › The concept of gender-based violence (GBV) seeks to distinguish violence that is based on gendered expectations and/or on the sex or gender identity of another person from other types of violence. Over the past decade, the international community has begun to use the term "gender-based violence" instead of "violence against women" to shift the focus from women as victims and to emphasize the role of gender norms, inequity and power relationships in the increase of women's vulnerability to violence.
- › The violence that occurs between men is also often linked to rigid gender norms and power dynamics. The use of violence against other men can be, among other things, a way to achieve a socially recognized status as a man when other forms of recognition or affirmation are unattainable or perceived to be unattainable. In this way, violence may serve as a mechanism by which some men and boys are placed or kept in a position subordinate to other men.
- › Youth represent a key opportunity to construct alternative definitions of masculinities and reduce gender-based violence. Working with young men to reduce gender-based violence is critical because young men are more apt than older men to learn to use alternatives to violence in communicating respectfully with their partners. Furthermore, youth is a key developmental stage when gender identities are constructed and can be reshaped.

BOX
3.

Workshops

⚙️ Workshop 1: What is Violence?

📍 OBJECTIVE:

To identify different types of violence that may occur in intimate relationships, families and communities.

📋 MATERIALS REQUIRED:

Flipchart paper and markers, the talking stick, copies of case studies from Resource Sheet A and Resource Sheet B.

🕒 RECOMMENDED TIME:

1 hour and 30 minutes

📖 PLANNING NOTES:

Prior to the sessions on violence, it is important to research locally relevant information concerning violence, including existing laws and social supports for those who use and/or suffer from violence. It is also important to be prepared to refer a participant to the appropriate services if he reveals that he is suffering violence or abuse (also see Planning Notes for the following activity- Understanding the Cycle of Violence).

The case studies included in Resource Sheet A depict diverse examples of violence, including men's use of physical, sexual and emotional violence against women in intimate relationships, men's use of physical violence against women outside the context of an intimate relationship, physical violence between men, and community-level, or institutional violence against individuals and groups of people. If necessary, you can make adaptations to these case studies or create new ones to address other types of violence that also occur in intimate relationships, families and/or communities. The use of the talking stick is suggested for this activity. However, the facilitator should think about if it is necessary or appropriate. The flipchart paper with the meanings of violence discussed in Part 1 below will also be useful for the next activity, "Understanding the Cycle of Violence."

Part 1 – What Does Violence Mean to Us? (30 minutes)

1. Ask the group to sit in a circle and to think silently for a few moments about what violence means to them.
2. Using the talking stick, invite each participant to share with the group what violence means to them. Write the responses on flipchart paper. Alternative Step: Invite the participants to write or draw what violence means to them.
3. Discuss with the participants some of the common points in their responses, as well as some of the unique points. Review the definitions of violence below and tell the participants that there is often not a clear or simple definition of violence and that in the second part of the exercise you are going to read a series of case studies to help them think about the different meanings and types of violence.
 - › **Physical violence:** using physical force such as hitting, slapping, or pushing.
 - › **Emotional/Psychological violence:** often the most difficult form of violence to identify. It may include humiliating, threatening, insulting, pressuring, and expressions jealousy or possessiveness such as the controlling of decisions and activities.
 - › **Sexual violence:** pressuring or forcing someone to perform sexual acts (from kissing to sex) against their will or making sexual comments that make someone feel humiliated or uncomfortable. It does not matter if there has been prior consenting sexual behavior.

Violence is often also categorized according to the victim-perpetrator relationship:¹⁴⁵

- › Self-directed violence refers to violence in which the perpetrator and the victim are the same individual and is subdivided into self-abuse and suicide.
- › Interpersonal violence refers to violence between individuals.
- › Collective violence refers to violence committed by larger groups of individuals and can be subdivided into social, political and economic violence.

Part 2 – Discussion of Different Types of Violence (1 hour)

4. Read each case study on violence and use the talking stick to facilitate a discussion with the questions following each case study.
5. After having read all of the cases, discuss the following questions.

¹⁴⁵ — Text taken from <http://www.who.int/violenceprevention/approach/definition/en/index.html>. Last accessed on 11/02/2011.

PROCEDURE

QUESTIONS

1. What kinds of violence most often occur in intimate relationships between men and women? What causes this violence? (Examples may include physical, emotional and/or sexual violence that men use against girlfriends or wives, as well as violence that women may use against their boyfriends or husbands.)
2. What kinds of violence most often occur in families? What causes this violence? (Examples may include parents' use of physical, emotional or sexual violence against children or other types of violence between family members.)
3. What kinds of violence most often occur outside relationships and families? What causes this violence? (Examples may include physical violence between men, gang or war-related violence, stranger rape and emotional violence or, stigma against certain individuals or groups in the community.)
4. Are there types of violence that are related to a person's sex? What is the most common type of violence practiced against women? (See section of Resource Sheet B – What is Gender-based violence?) Against men?
5. Are only men violent, or are women also violent? What is the most common type of violence that men use against others? What is the most common type of violence that women use against others?
6. Does a person – man or woman – ever “deserve” to be hit or suffer some type of violence?
7. What are the consequences of violence on individuals? On relationships? On communities?
8. What can you and other young men do to stop violence in your community?

CLOSING:

At its most basic level, violence can be defined as the use of force (or the threat of force) by one individual against another. Violence is often used as a way to control another person, to have power over them. It happens all around the world and often stems from the way that individuals, especially men, are raised to deal with anger and conflict. It is commonly assumed that violence is a “natural” or “normal” part of being a man. However, violence is a learned behavior and in that sense, it can be unlearned and prevented. As has been discussed in other sessions, men are often socialized to repress their emotions, and anger is sometimes one of the few socially acceptable

ways for men to express their feelings. Moreover, men are sometimes raised to believe that they have the “right” to expect certain things from women (domestic tasks or sex, for example), and the right to use physical or verbal abuse if women do not provide these things. It is important to think about how these rigid gender roles regarding how men should express their emotions and how they should interact with women are harmful to both to individual men and to our relationships. In your daily lives, it is fundamental that you, as young men, think about what you can do to speak out against other men's use of violence.

LINKS:

This activity can also be linked to the earlier one on “[Expressing my Emotions](#)” and a discussion about how to handle anger.

CASE STUDIES ON VIOLENCE

Case Study # 1

Mirko and Lidija are a young married couple. Mirko's family is coming over to their home for dinner. He is very anxious that they should have a good time, and he wants to show them how great of a cook his wife is. But when he gets home that night, nothing is prepared. Lidija has not been feeling well, and she has not started making the dinner yet. Mirko is very upset. He does not want his family to think that he cannot control his wife. They begin to argue and yell at each other. The fight quickly escalates, and Mirko hits her.

- › How should Lidija react?
- › Could Mirko have reacted differently in this situation?

Case Study # 2

You are dancing with a group of friends at the disco. When you are about to leave, you see a couple (a boy and a girl, apparently boyfriend/girlfriend) arguing at the entrance. He calls her a bitch and asks her why she was flirting with another guy. She says: "I was not looking at him... and even if I was, aren't I with you?" He shouts at her again. Finally, she says: "You don't have the right to treat me like that." He calls her worthless and tells her to get out of his face – he can't stand to look at her. He then hits her, and she falls down. She screams at him, saying that he has no right to do that.

- › What would you do? Would you leave? Would you say anything? Why or why not?
- › Would it be different if it was a guy hitting another guy?
- › What can you do in situations like this one? What are your options?
- › What is our responsibility to prevent others from using violence?

Case Study # 3

Mihael is an older boy who comes from a wealthy family. He meets Petra one day on her way home from school and they chat a little. The next day, he meets up with her again and this continues until one day he invites her to dinner. At dinner he tells Petra how much he likes her and then invites her to come over to his house. At his house, they start to kiss and Mihael starts touching Petra under her blouse. But, then Petra stops and says that she doesn't want to go anything further. Mihael is furious. He tells her that he has spent lots of time with her and says: "What are my friends going to say?" He pressures her to get her to change her mind. First he tries to be seductive, then he begins yelling at her in frustration. Then he begins pulling at her forcefully, pushing her down. He then forces her to sex, even though she keeps saying, "No, stop!"

- › Is this a kind of violence? Why or why not?
- › What do you think Mihael should have done?
- › What do you think Petra should have done?

Case Study # 4

Oliver has had a hard day at school. His mother is giving him a hard time because of his grades and tells him that he cannot go out that night. In class, he is unable to answer a question that the teacher asks him. In the playground, after the class, Renata, a girl in Oliver's class, laughs at him because he could not answer such an easy question. "It was so easy. Are you really that stupid?" Oliver tells her to shut up and pushes her against the wall. Renata is furious and says: "If you touch me again, you just wait and see..." Oliver replies: "No, you just wait and see..." He slaps her across the face, turns around, and walks away.

- › Do you think that Oliver was right to hit Renata?
- › How else could he have reacted?

Case Study # 5

A group of friends go dancing. One of them, Borna, sees that some guy is staring at his girlfriend. Borna walks up to the guy and shoves him and a fight begins.

- › Why did Borna react this way? Do you think that he was right to shove the other guy?
- › How else could he have reacted?
- › What should his friends have done?

Case Study # 6

In many communities, people who are living with HIV/AIDS are shunned. They are insulted. Sometimes their children are not allowed to go to school.

- › Is this a type of violence?
- › Do you think that this type of discrimination hurts people living with HIV/AIDS?
- › What can be done to stop these types of things from happening?

Case Study # 7

Monika is a 19 year old university student who just moved in with a roommate to a one-room flat near campus. Monika has been HIV positive since she was 17. She takes medications for HIV which need to constantly be refrigerated. One day, her roommate asks her what the medications are for. Monika decides to be honest and tells her roommate that she is HIV positive. Her roommate is shocked and furious. She tells Monika that she needs to move out of the flat immediately, before she passes her infection to her.

- › What do you think about the way that the roommate reacted?

Resource sheet A

- › Do you think there is risk for the roommate to be infected by living with Monika?
- › Is this a type of violence?
- › What can be done to stop these types of things from happening?

Case Study # 8

Valentino and Anita are a young couple who just had their second baby. Before they started to have children, they agreed that Anita would be the one to stay at home to take care of the children, and Valentino would work to earn the money. However, more recently Valentino has started to pass less and less money to Anita. At first, she had to cancel her German language classes, then she didn't have enough to buy any clothes for herself or even meet her friends for a coffee. When she brings up the issue with Valentino, he just says "We don't have enough money. You ask for too much anyway and you don't even make anything." When Anita points out that he goes out almost every other night with friends and maybe one night she could go out with friends instead of him, he says "Yes, I go out a lot, but I have to relax from work. You spend the entire day at home, doing nothing."

- › Is this a type of violence? Why or why not?
- › What you think Anita should do?
- › Could Valentino have reacted differently?
- › What would you do in this situation?

Case Study # 9

A group of friends are hanging out in the park. Jasna is a quiet and introverted girl and Ivica is teasing her about it. She doesn't respond, but Goran, who likes her, decided to stick up for her. He tells Ivica to cut it out and the two get into an argument. Goran hits Ivica and they start to fight.

- › What do you think about the way Ivica was treating Jasna? Is this a type of violence? Why or why not?
- › What do you think about the way Goran reacted? Is this a type of violence? Why or why not?
- › What would you do in situation like this?

Case Study # 10

Krešo is a young gay man who has recently come out to his family and friends. At first, it was hard with his family but they have finally come around. At school, however, some kids have started to call him "fag" and other derogatory names. They also push him around a lot, and sometimes even beat him up.

- › Is this a type of violence? Why or why not?
- › What can Krešo do?
- › What can his friends do?
- › What would you do in a situation like this?

Resource sheet B

WHAT IS GENDER-BASED VIOLENCE?

In many settings, most laws and policies use "family violence" or "domestic violence" to indicate acts of violence against women and children by an intimate partner, usually a man. However, there has been an increasing shift toward the use of "gender-based violence" or "violence against women" to encompass the broad range of acts of violence that women suffer from intimate partners, family members, and other individuals outside the family.

These terms also draw focus to the fact that gender dynamics and norms are intricately tied to the use of violence against women (Velseboer, 2003). In its essence, the concept of GBV seeks to distinguish violence that is based on gendered expectations and/or on the sex or gender identity of another person from other types of violence. While GBV can apply to women and men, girls and boys the focus of most GBV efforts is on ending the violence against women and girls, since it is they who are overwhelmingly affected.

Below is a definition of gender-based violence and violence against women based on the United Nations General Assembly Declaration on the Elimination of Violence Against Women in 1994:

...any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women because of being women and men because of being men, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

...shall be understood to encompass, but not be limited to the following:

- › a. Physical, sexual and psychological violence occurring in the family, including battering, sexual exploitation, sexual abuse of children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation
- › b. Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution
- › c. Physical, sexual and psychological violence perpetrated or condoned by the State and institutions, wherever it occurs.



Workshop 2: Understanding the Cycle of Violence

OBJECTIVE:

To discuss the relationship between the violence that young men suffer and the violence that they use against others.

MATERIALS REQUIRED:

Flipchart paper, markers, pens/pencils, and five small pieces of paper for each participant

RECOMMENDED TIME:

2 hours

PLANNING NOTES:

During this activity, you might notice that it is easier for participants to talk about the violence they have suffered outside their homes than the violence they have suffered inside their homes or the violence they have used against others. The young men might not want to go into details about these experiences and it is important that you do not insist that they do. Being a victim of interpersonal violence is associated with committing acts of violence later in life. Moreover, in talking about violence which they have committed, the participants might seek to justify themselves, blaming the other person for being the aggressor. Helping

young men to recognize the cycle of violence and to reflect on the pain that violence has caused them is a potential way of interrupting the victim-to-aggressor cycle of violence. If necessary, this activity can be extended for two sessions. Prior to the session, consult local and national laws regarding mandatory reporting procedures in the case that a minor (or individual under a certain age) reveals that he is suffering violence or abuse. It is also important to clarify with your organization any ethical and legal aspects related to dealing with situations that might come up during the discussions on violence.

PROCEDURE:

- Before the session, tape five pieces of flipchart paper to a wall. On each paper write one of the five categories below:
 - › Violence used against me
 - › Violence that I have used against others
 - › Violence that I have witnessed
 - › How I feel when I use violence
 - › How I feel when violence is used against me
- At the beginning of the session, explain to the participants that the purpose of this activity is to talk about the violence in our lives and our communities. Review the flipchart from the previous activity with the meanings of violence.
- Give each participant the five small pieces of paper
- Ask the participants to think for a while about the five categories from above and then write a short reply for each on the pieces of paper that they have received. They should put one response on each paper, and they should not put their names on the paper.
- Allow about 10 minutes for this task. Explain to the participants that they should not write much, just a few words or a phrase, and then tape it to the corresponding flipchart paper.

PROCEDURE

- After taping their papers to the flipchart, read out loud some responses from each category.
- Open up the discussion with the questions below. Use the talking stick, if appropriate.
- After the discussion, ask the group what it was like for them to talk about the violence they have experienced. If anyone in the group shows a need for special attention due to an act of violence they have suffered, you should consider referring the individual to the appropriate services and discuss the issue with other staff at your organization.

DISCUSSION QUESTIONS:

- What is the most common type of violence used against us?
- How do we feel about being a victim of this type of violence?
- What is the most common type of violence we use against others?
- How do we know if we are really using violence against someone?
- How do we feel when we use violence against others?
- Is there any connection between the violence we use and the violence that is used against us?
- Where do we learn violence?
- Is any kind of violence worse than another?
- Is there a link between violence and power? Explain.
- In general, when we are violent or when we suffer violence, do we talk about it? Do we report it? Do we talk about how we feel? If we do not, why not?
- How does the media (music, radio, movies, etc.) portray violence? (see box below)
- What is the link between violence in our families and relationships and other violence that we see in our communities?
- Some researchers say that violence is like a cycle, that is to say, someone who is a victim of violence is more likely to commit acts of violence later. If this is true, how can we interrupt the cycle of violence?

QUESTIONS

CLOSING:

When people talk about violence, they think mainly of physical aggression. It is important, however, to remember that there are other forms of violence, including emotional and institutional. It is also important to think about the acts of violence that you as young men might perpetrate, because

very often you might think that it is only other people who are violent but never yourselves. The purpose of this session was to help you recognize the cycles of violence in your lives and communities and think about how you can help stop it.

NOTE:

Some studies have found that viewing violent media images may be associated with carrying out violence, but the causal connection is not entirely clear.¹⁴⁶ Watching violence on TV or in movies

probably does not “cause” boys’ violence, but it can contribute to some boys’ beliefs – and our general belief as a society – that men’s violence is normal, or even cool.

146 – McAlister, A. (1998) La violencia juvenil en las Americas: Estudios innovadores de investigacion, diagnostico y prevencion (Innovative Research, Diagnostic and Prevention Studies). Washington, D.C:PAHO

Workshop 3: What is Sexual Violence?

OBJECTIVE:

To discuss sexual violence and the different situations in which it can occur.

Materials required: Two – three copies of the Resource Sheet

MATERIALS REQUIRED:

Two – three copies of the Resource Sheet

RECOMMENDED TIME:

2 hours

PLANNING NOTES:

In the same way that talking about other forms of violence might cause discomfort because of possible connections with participants' own lives, it is important to be sensitive to the possibility that some of the participants might have suffered some type of sexual violence in childhood or adolescence and might need help. They may have suffered sexual violence (from men or women), but never spoken with anybody about the matter out of shame since perhaps they were convinced that nobody would believe that a man could be the victim of sexual violence (particularly when the perpetrator was a woman). Others might know of female relatives or friends who have been victims of sexual violence. It is important to be prepared for these possibilities and know to where and to whom you can refer participants who might need professional support.

PROCEDURE:

1. Explain that the purpose of the activity is to talk about sexual violence.
2. Carry out a brainstorm with the group on the meaning of sexual violence and the different situations in which it can occur. Review the definition of sexual violence included in the introductory activity to violence - What is violence?
3. Depending on the number of participants, divide them into two or three smaller groups, handing out a copy of Andrej's story to each group. Alternatively, you can read the story out loud to the participants.
4. After reading the story, have an open discussion and discuss the following points, encouraging the young men to reflect on the story and what other paths Andrej could have taken:
 - › Is this story realistic?
 - › What do you think about Andrej's behavior?
 - › Can it be considered violence? Why or why not?
 - › Why do you think he acted this way?
 - › What could be the consequences of Andrej's behavior for himself? And for the young woman?

PROCEDURE

5. If Andrej had not given in to the pressure, how do you think his friends would have treated him?
 - › And what about Andrej, how do you think he would have felt?
 - › Remind participants of the discussions they had about Case study #3 from the activity – What is Violence? If necessary or if the case study was not discussed previously, read the case study out loud. Ask the participants the following questions:
 - › Is this story realistic?
 - › How is it different from Andrej's story? How is it similar?
 - › Can it also be considered violence? Why or why not?
 - › Can sexual violence also happen in relationships in which the couple has had sex previously? Why or why not?
 - › What is consent to have sexual relations? (Note: Consent is when two people knowingly and willingly agree to have sexual relations. It is required for every sexual contact. That is, the fact that a couple might have had previous sexual relations is NOT sufficient consent for future relations. If force, threats of force or any sort of emotional coercion is used to get someone to have sexual relations it is NOT considered consent.)
 - › What is the relationship between consent and power in relationships?
 - › Can sexual violence happen in a married relationship? Why or why not?

6. After the discussion of the two stories, wrap-up the discussion using the following questions.

DISCUSSION QUESTIONS:

1. What are the consequences of sexual violence?
2. Can sexual violence also be committed against men? What type? And how do men generally react?
3. What can you do to help prevent situations of sexual violence in your own relationships? In your community?

CLOSING:

For many young men, peer pressure, or the feeling of having to have sexual relations in order to prove their manhood, might make them view women as sexual objects. These kinds of views can lead to situations in which young men may disregard women's wishes and employ emotional and/or physical coercion to get sex. In this way, sexual violence, as with other types of violence, can be understood as the result of one person having

power over another. As young men, it is important that you reflect on how to promote healthier and more enjoyable consensual sexual relations in your own lives, as well as how to increase awareness among other young men about what is sexual violence. Above all, it is fundamental that all young men understand that when a young woman says "no," she means just that.

PROCEDURE

ANDREJ'S STORY

Andrej is 18 years old and likes to hang out with a large group of friends from school. He is very popular among his peers, and they all love to go out and have fun. The group is always having great parties at Josip's house, with lots of music and beer. Last weekend, there was another party. There were a lot of people there that Andrej knew. He was already a bit late and had hardly arrived when Josip came up to him:

Josip: Hi my craze! Give me five. Adrijana, that gorgeous chick is here... She's totally high. You're the only that's still hasn't-

Andrej: Stop it man...

Josip: No, I mean it ... This is your chance. Don't be scared. Be a man! What are you afraid of? Make the most of it, while she's still drunk. Just go for it!

Andrej could see that the girl was slumped in an armchair. She must have drunk too much, he thought. And with his friends pressuring him, Andrej went over to where Adrijana was sitting.

Andrej: Hi babe... It's me Andrej. Let's go somewhere quiet.

Andrej helped her up – the girl was so drunk that she was half-asleep, almost passed out. Even so, his friends urged him on as he took her upstairs to Josip's bedroom.

 Workshop 4:

A Live Fool or a Dead Hero: Male Honor

**OBJECTIVE:**

To discuss how “male honor” is associated with violence and think of alternatives to violence that young men can use when they feel insulted.

**RECOMMENDED TIME:**

2 hours

**PLANNING NOTES:**

None.

**MATERIALS REQUIRED:**

Copies of Resource Sheet A.

PROCEDURE:

1. Divide the participants into small groups and distribute a case study from Resource Sheet A to each group.
2. Explain that each group should create and present a short skit (3-5 minutes) based on the case study. Tell them that they are welcome to add more details to the case study if they would like.
3. Give the groups about 20 minutes to discuss the case study and develop the skit.
4. Invite the groups to perform their skits. After each skit, allow time for comments and discussion based on the following questions:
 - a. Are these situations realistic?
 - b. Why do we sometimes react this way?
 - c. When you are confronted with a similar situation, in which you have been insulted, how do you normally react?
 - d. How can you reduce the tension or aggression in a situation like this?
 - e. Can a real man walk away from a fight?
5. Read aloud and discuss the Resource B “Where does ‘Male Honor’ come from?” and then use the questions below to wrap-up the session.

DISCUSSION QUESTIONS:

1. What does “male honor” mean to us?
2. Does “male honor” still exist?
3. What can we do to change this “honor” culture?
4. Knowing where this comes from, does this help us to change it?
5. What have you learned from this exercise? How can you apply this in your own lives and relationships?

The idea of “male honor” is still strong in many settings. For many young men, to be perceived as tough – as someone who doesn’t walk away from a fight – is often seen as a way to secure respect and to not be hassled by others. As we have discussed in this activity, however, this idea

of “honor” often brings many risks and consequences with it. While it is very probable that you will feel insulted on more than one occasion in your life, it is important to learn how to deal with these situations and with your feelings in ways that do not put you or others in harm’s way.

Resource sheet A

CASE STUDIES ON VIOLENCE

Case Study #1

Milan and Fabijan are arguing at break-time because of school work. One accuses the other of having cheated off of him. Milan says that he will wait for him outside to settle the matter. When the class is over...

Case Study #2

A group of friends are at a football game. They are fans of the same team. A fight begins when a fan of the opposing team arrives and ...

Case Study #3

A group of friends are in a bar. A fight begins between one of the young men and a stranger (another young man) ...

Case Study #4

A group of friends go dancing. One of them, Leon, sees that some guy is staring at his girlfriend. A fight begins when Leon...

Case Study #5

Emanuel is stopped in his car in traffic. When he starts to turn right, another car on his left cuts him off, forcing him to brake sharply. Emanuel decides to...

Case Study #6

A group of young men are sitting in a park. A young Roma boy passes by and a fight starts when...

Case Study #7

Luka and Emil are engaged in a heated debate. Emil is raising his tone of voice and...

Case Study #8

A group of young men from a small town are exploring the capital city. They can be picked up by the dialect they speak and end up getting in trouble with some boys from the city when...

Resource sheet B

In many cultures, a man’s name, honor and pride are important factors, sometimes taken to extremes. Some researchers suggest that the “honor culture” in some parts of the Americas comes from the nature of colonizing these frontier regions. In rural Mexico, in parts of South America and the Southern parts of the USA, men often herded livestock on land in regions where boundaries and borders were not clearly defined. There was no judicial or law enforcement system nearby (it is common in cowboy films to have disputes over land where the sheriff arrives a couple of days after the conflict started). To survive, the men believed that they themselves had to defend their property. In such a context, it was necessary for the men to be seen by others as someone “not to be messed with.” To be seen as an aggressive man or even dangerous meant that no one would bother you.

Machismo is associated with the image of the tough guy who has many sexual partners (in addition to his wife), who struggles to defend his family’s integrity who protects his ‘honor’ and seeks out danger, often in the form of disputes or duels. From the machismo viewpoint, men are “sexual predators” and women are “pure and innocent”. According to the macho culture, a women’s place is in the home, while the man demonstrates his virility by having a large number of sexual conquests and a large number of children. Thus, for the macho, a “real man” is someone who protects the honor of the women in his family – his wife, sisters and mother. They should be “pure” and their sexual life and honor should never be brought into question. A man in a bar, who wants to fight another, has only to direct his gaze at the other’s girlfriend and the age-old traditional scene is played out. The same would occur if he said something about the other’s mother or sister.

These and other forms of “male honor” are deeply rooted in our culture. How many times have we seen groups of men trading insults? How many of these insults have something to do with sexual conquests? Think of how many expressions we have to “tarnish” the reputation of someone else’s mother. This is the worst insult that a “real man”, in the macho world, can be faced with – someone doubting the honor and purity of his mother, and hence doubting his very honor.



Workshop 5: What Do I do when I am Angry?

OBJECTIVE:

To help the participants to think about how to identify when they are angry and how to express their anger in constructive, non-violent, ways.



RECOMMENDED TIME:

1 hour



PLANNING NOTES:

None.



MATERIALS REQUIRED:

Flip-chart, paper, pens, tape, sufficient number of copies of the Resource Sheet for each participant.

PROCEDURE:

1. Begin the activity with a short introduction to the theme, for example:
 - › Many adolescents and men confuse anger and violence, thinking they are the same things. It should be stressed that anger is an emotion, a natural and normal emotion that every human being feels at some point in life. Violence is a way of expressing anger, that is to say, it is a form of behavior that can express anger. But there are many other ways of expressing anger – better and more positive ways – than violence. If we learn to express our anger when we feel it, it can be better than allowing it to bottle up inside us, as many times when we allow our anger to build up, we tend to explode.
2. Explain to the group that the purpose of the activity is to discuss how individuals express anger.
3. Hand out copies of the Resource Sheet. Read out each question and ask the participants to answer the questions individually, allowing two or three minutes for each question. For low-literacy groups, read the questions aloud and have the participants discuss in pairs or design a picture.
4. After filling in the sheet, divide the group into small groups of 4 or 5 participants at the most. Ask them to share their responses with each other. Allow 20 minutes for this group work.
5. With the participants still in the small groups, distribute a piece of flip-chart paper to each group and ask them to make a list of:
 - A.) Negative ways of reacting when we are angry
 - B.) Positive ways of reacting when we are angry
6. Allow the groups 15 minutes to write out their lists and then ask each group to present their answers to the whole group.
7. It is very likely that for “Positive Ways” the participants will suggest: (1) take a breath of fresh air, or count to 10; and (2) use words to express

PROCEDURE

what we feel without offending. It is important to stress that to “take a breath of fresh air” does not mean going out and jumping into the car (if that is the case) and driving around at high speed exposing oneself to risk or going to a bar and tanking up on alcohol. If these two tactics proposed here are not on any of the lists presented, explain them to the group.

In short: To take a breath of fresh air simply means to step away from a situation of conflict and anger, to get away from the person toward whom one is feeling angry. One can count to 10, breathe deeply, walk around a bit or do some other kind of physical activity, trying to cool down and keep calm. Generally, it is important for the person who is angry to explain to the other that he is going to take a breath of fresh air because he is feeling angry, something like: “I’m really fed up with you and I need to take a breath of fresh air. I need to do something like go for a walk so as not to feel violent or start shouting. When I’ve cooled down and I’m calmer, we can talk things over.”

The other example of a tactic for dealing with anger is to try to express oneself without offending others. This entails explaining why you are upset and how you hope to resolve the situation, without offending or insulting the other. Give an example to the group: If your girlfriend arrives late for a date, you could react by shouting: “You’re a bitch, it’s always the same, me standing here waiting for you.”

OR, you could express that you are upset without being offensive by saying, for example: Look, I’m angry with you because you’re late. Next time, if you don’t think you are going to be on time, just let me know – call me on my cell – rather than make me wait.

8. Discuss the following questions.

Optional step:

If time allows, invite the participants to develop some role plays or think of other examples of situations or phrases that exemplify the differences between shouting /using offensive words and using words that do not offend.

1. Generally speaking, is it difficult for men to express their anger, without using violence? Why?
2. Who are generally our role models for learning how to express our emotions, including anger?
3. Very often we know how to avoid a conflict or a fight, without using violence, but we don't do so. Why?
4. Is it possible "to take a breath of fresh air" to reduce conflicts? Do you have experience trying this strategy? How did it work out?
5. Is it possible "to use words without offending?"
6. What have you learned from this activity? How can you apply this in your lives and relationships?

QUESTIONS

CLOSING:

Anger is a normal emotion that every human being feels at some point in his or her life. The problem, however, is that some people may confuse anger and violence, thinking they are the same things and may think that violence is an acceptable way of expressing anger. However, there are many

other ways of expressing anger – more productive and positive ways – than violence. If we learn to express our anger when we feel it, it can be better than allowing it to bottle up inside us, as many times when we allow our anger to build up, we tend to explode.

Resource sheet

What do I do when I am angry: Reflection Sheet

1- Think of a recent situation when you were angry. What happened? Briefly describe the situation (one or two sentences):

2- Now, thinking about this incident, try to remember what you were thinking and feeling. Try to list here one or two feelings that you felt:

3- Very often, when we feel angry, we react with violence. This can even happen before we realize that we are angry. Some people react immediately, shouting, throwing something on the floor, hitting something or someone. Sometimes, we can even become depressed, silent and introspective. Thinking about the incident when you felt angry, how did you demonstrate this anger? How did you behave? (Write a sentence or a few words about how you reacted, what you did or how you behaved).

Workshop 6:

From Violence to Respect in Intimate Relationships

OBJECTIVE:

To discuss the use of violence in intimate relationships and how to construct intimate relationships based on respect.

MATERIALS REQUIRED:

Flipchart paper, markers, and tape.

RECOMMENDED TIME:

2 hours

PLANNING NOTES:

It is important to understand that young men might feel a type of helplessness in responding to the violence that they see other men perpetrating. Many might believe that they should not interfere with the affairs of other men. Throughout this activity, it is important to explore the helplessness many men might feel when they witness another man using domestic violence. This activity uses role plays with female characters. If you are working with a male-only group, some of them may be reluctant to act as a female character. Encourage the group to be flexible. If none of the young men want to act as a female character, you can ask them to describe the scenes using pictures or narrative, for example.

PROCEDURE:

1. Explain to the participants that the objective of this activity is to discuss and analyze the various types of violence that we sometimes use in our intimate relationships and discuss ways of demonstrating and experiencing intimate relationships based on respect.
2. Divide the participants into small groups and ask them to invent a short role play or skit.
3. Ask two groups to present an intimate relationship – boyfriend/girlfriend or husband/wife – which shows scenes of violence. Remind participants of the discussions from the Activity "What is Violence" and emphasize that the violence portrayed in the skits can be physical but does not necessarily have to be. Ask them to try to be realistic, using examples of persons and incidents that they have witnessed or they have heard about in their communities.
4. Ask the other groups to also present an intimate relationship but based on mutual respect. There may be conflicts or differences of opinion, but the presentation should show what respect looks like in a relationship and should not include violence.
5. Allow 15 to 20 minutes for the groups to develop their stories and skits. Tell the groups that the skits should be no longer than five minutes each.
6. Invite the groups to present their skits. After each skit, invite the other participants to ask questions about what they saw.
7. When all of the groups have had their turn, facilitate a discussion using the following questions.

PROCEDURE

1. Were the examples of violence in the skits realistic? Do you see similar situations in your community?
2. What are the characteristics of a violent relationship?
3. What do you think are the causes of violence in intimate relationships?
4. In the skits depicting violence, how could the characters have acted differently?
5. Do only men use violence against women, or do women also use violence against men? How are they violent? How should men react to this violence?
6. When you see couples using violence, what do you normally do? What could you do? Where can you go to seek help?
7. What role do alcohol and other drugs play in violence in relationships?
8. What are consequences of violence in an intimate relationship?
9. What is the social/community response to violence in relationships?
10. What does a healthy intimate relationship look like? Do we see examples of respectful relationships in our families and communities?
11. What can we do individually to construct healthy intimate relationships?
12. What can we do as a community?

CLOSING:

Conflict happens in all relationships. It is the way that you handle these conflicts that make all the difference. Learning how to take the time to think about your feelings and express yourselves in a calm and peaceful way is an important part of building healthy and respectful relationships.

LINKS:

The activity “[Expressing My Emotions](#)” provides an opportunity for young men to examine how easy or difficult it is for them to express anger and other emotions and reflect on how this impacts them and their relationships.

In the activity “[Want...Don't Want, Want...Don't Want](#)” the young men can practice how to resolve disagreements in intimate relationships. The activity is written in terms of negotiating abstinence or sex but can be adapted to other which explores how to handle other differences of opinion or desire that might arise in the context of a relationship.

“[Power and Relationships](#)” encourages young men to think about unequal power relations between men and women and the implications for relationships and communication. This activity can also be linked with “[Scenes of Dating](#)” and the discussion of what characterizes healthy or unhealthy relationships.

QUESTIONS

⚙️ Workshop 7: Men and Violence: Moving toward Change¹⁴⁷

📍 OBJECTIVE:
To review what participants have learned about gender, masculinities and violence and to discuss visions and possibilities for change.

🕒 RECOMMENDED TIME:
2 hours

📄 PLANNING NOTES:
None.

📁 MATERIALS REQUIRED:
Flipchart, markers, stickers, double-sided tape.

PROCEDURE:**Part 1.**

1. Explain the objective of the activity and facilitate a discussion with the participants using the following questions:
 - › What have you learned about masculinity and violence over last few weeks?
 - › Which aspects of society's ideas about masculinity would you like to keep or strengthen? Why? Which aspects would you like to change? Why?
 - › Make notes of the participants' responses on a flipchart.

Part 2.

2. Divide the participants into small groups and tell them that each group is to draw two cartoons or pictures. The first should depict how families, schools and other social institutions currently support (or do not support) young men in addressing issues around rigid masculinities and violence. The second should depict how they hope that families, schools and other social institutions will be supporting young men around these issue five years from now.
3. Invite each group to briefly present their cartoons to the larger group and explain their current and future visions of support for young men around masculinity and violence.
4. On a flipchart paper, make two columns: title one “enabling factors” and the other “potential obstacles”.

PROCEDURE

¹⁴⁷ — Activity taken from the PLA – Exploring dimensions of Masculinity and Violence, Care International -2007

5. Ask the participants to brainstorm a list of enabling factors that will promote the necessary changes, and write them in appropriate column. Be sure that they give an adequate explanation of each factor.
6. Ask the participants to brainstorm potential obstacles and list these in the appropriate column. Be sure that they give an adequate explanation of each potential obstacle.

Part 3

7. Divide the participants into groups again and ask them to come up with strategies and solutions that they themselves can put into motion in order to achieve the visions they developed for five years from now. Allow the groups 15 minutes to do this, providing them with the following questions to help guide their discussions:
 - › What are three specific things that young men can do to contribute to this change?
 - › How can youth organizations support young men in achieving and sustaining this change?
 - › Besides youth organizations, which individuals and organizations in your community will be most important to achieving and sustaining this change?
8. Invite the groups to present their responses.
9. Wrap-up the activity by identifying and discussing similarities and differences in the groups' response.

PROCEDURE

⚙️ Workshop 8: Can a man like another man?

📍 OBJECTIVE:

To review what participants have learned about gender, masculinities and violence and to discuss visions and possibilities for change.

📋 MATERIALS REQUIRED:

Flip-chart, markers, and tape.

🕒 RECOMMENDED TIME:

2 hours

📄 PLANNING NOTES:

Prior to this activity, the facilitator should examine his/her opinions and attitudes toward sexual diversity and sexual orientation. It is a taboo topic in many settings and participants may express strong opinions and attitudes. During the discussion, the facilitator should seek to maintain a position of advocating respect toward people of every sexual orientation without, however, censoring the participants. It is important to listen to the different comments – even when homophobic – and question them, but without judging them. Prior to the session, the facilitator should identify common myths and misunderstandings about sexual orientation that can be integrated and addressed in the discussion. It can also be helpful to research information regarding local laws and movements that promote the rights of gay individual and couples and resources such as local organizations or websites on sexual orientation and rights that can be shared with participants.

PROCEDURE:

1. Carry out a brainstorm with the participants on how they would define homophobia. (The Merriam Webster dictionary defines homophobia as an irrational fear of, aversion to, or discrimination against homosexuality or homosexuals).
2. Divide the participants into smaller groups and give each group one of the story beginnings included in the Resource Sheet (or other story beginnings that the facilitator might create).
3. Explain to the groups that they will have 15 minutes to read and continue the stories.
4. Invite the groups to present their stories (the beginning and details they added) by reading it aloud, through dramatization or other method of their choosing.
5. After the presentation of the stories, use the questions below to facilitate a discussion.

PROCEDURE

1. Why is it difficult for many people to accept homosexuality or homosexual behavior?
2. What is the difference between lesbian, gay and bisexual?
3. Can a person have sexual relations with someone of the same sex and be heterosexual?
4. What type of prejudice and/or violence against gays or lesbians have you seen or heard about? What are the consequences of this prejudice and/or violence?
5. What names are commonly used to refer to gays? Do any of these names have negative meanings?
6. Have you ever been called gay by some of your friends for not doing something, such as fighting? What do you think about this? Why do you think that men are called gay when they do not act according to the dominant norms of masculinity?
7. What have you learned from this exercise? How can you apply this in your own lives and relationships?

QUESTIONS

CLOSING:

Everyone has a sexual orientation – that is, you are romantically and sexually attracted to men, women, or both. Although we do not know precisely what determines a person's sexual orientation, we do know that is formed early in life, is not chosen by the person, and cannot be changed, although because of social taboos and homophobia, it might be hidden. Such social taboos

and homophobia can put gays and lesbians at particular risk for violence, discrimination, depression, and self-destructive behaviors like drug and alcohol abuse or suicide. It is important to work to dispel myths and promote respect for the right of women and men to express their sexual orientation free from discrimination.

Resource sheet

Story #1

When he was 18, Toma had his first sexual experience with another man, and from then on he knew he was gay. He had many partners before he met Jova. They were together for a long time and finally decided to tell their families and move in together...

Story #2

One night, Braca went out with a group of friends, all from the same class at school. One of them, Robert, said: "Let's go and beat up some fags. I saw some transvestites in the square. Come on!"...

Story #3

One night, when he was down at the beach camping with a group of friends, Luka found himself in the same tent with his friend, Goran. They had had a few beers before going to the tent. Luka always considered himself to be heterosexual. He was thinking about sex with his girlfriend and became excited when he went to the tent. When Goran saw that Luka was excited, he began...

Story #4

At 17, Armin thought he was bisexual. He liked sex with girls and with boys. One night his father saw him embracing another boy and when Armin got home his father started shouting at him...

Workshop 9: Leaded fantasy: understanding homosexuality

OBJECTIVE:

To make participants identify with a person who is a homosexual, and to make them more sensitive and to influence on their attitudes related to homophobia.

RECOMMENDED TIME:

1 hour

PLANNING NOTES:

None.

MATERIALS REQUIRED:

None.

PROCEDURE:

1. Ask participants to close their eyes and try to fit in the role from the story.
2. Read the story from the resource sheet.
3. After reading a story, lead the discussion based on the questions, or add some of your additional ones depending on the discussion flow.

DISCUSSION QUESTIONS:

1. Can this be a realistic situation?
2. How did you feel?
3. What do you think; do homosexuals feel like you did in the story?
4. Why is it difficult for homosexuals to live in environment such as ours?
5. Is it really important what your sexual orientation is?
6. What can we do to stop discrimination and homophobia?

CLOSING:

LGBT population cannot always choose their surroundings and are forced to move in it, where discrimination exists, and exists in a significant degree. It primarily concerns the work environment. Every day they are experiencing discrimination at work, in school, in the gym... which is result of different sexual orientation. Much of homophobia and heterosexism is based on perceptions of what it is to be "masculine" or "feminine" in our soci-

ety. These gender-role standards and the pressure to adopt gendered patterns of behavior converge on children from a range of sources: from family, peers, schools, popular culture, authority figures, and the media. Young people who do not adopt gender-stereotyped patterns of behavior are often the targets of homophobic and heterosexist bullying, harassment, and discrimination.

Resource sheet

Story: Heterosexual in the homosexual world

I will bring you on a journey into your imagination. Assume a comfortable position and close your eyes.

Take a deep breath. Now I will start my story.

Imagine you are 13 and grow as a heterosexual person in gay world where all are homosexuals. Your teacher is gay, your instructor of tennis, your uncle, your brother...

You're going to the school library and trying to find information about what is normal. You find a book, but do not dare to take it, because you are afraid what is written in it.

Every year, there is a party organized in the school. What will you do?

You're leaving because you do not want people think you're weird or different. On the party, girls are dancing with girls, boys with boys. You wonder what will you do if your partner and you are too close? What happens if you kiss? What if everyone found out about your sexual orientation? Some people say that it is a sin to be heterosexual. How do you feel when people speak in the church where you are going?

Now you are 18. At a nearby newsstand you see a magazine with heterosexual news in the headline. You ignored your fear and shame, and you bought the magazine. You are hiding the magazine and carrying it home. You read about a new club in town for young heterosexuals and decide to go there. Finally you go to the club and you meet people who are like you. Young men and women dance together, talk to each other.

After a few months, you decide to live together with your partner, but you should be careful, in the evening you have to put curtains on your window, because the owner of the apartment can accidentally see you, who is also a homosexual.

Unfortunately one day your partner is hit by a car. You run to the hospital, but you cannot go into the room, and you stay and look through the glass to your love one, who is full of bruises and fractures. A sign on the door says that the entrance is allowed only to partners and family. How can you see your partner? Do you need to tell all these people that this person is your partner? Will it affect their care for your partner? What will you do?

Now, slowly open your eyes.



Workshop 10: Homophobia in the Youth Environment

OBJECTIVE:

The objective of this workshop is to develop a critical dialogue that examines young man in their environment such as school.

Schools, classrooms and communities should be models of diversity in which every student is given the potential to be, become and belong as a full contributing member who can feel valued, welcome and safe regardless of sexual orientation. To help students to address this topic within their schools and to influence on the school staff.

MATERIALS REQUIRED:

Papers and pencils

RECOMMENDED TIME:

1 hour

PLANNING NOTES:

Give participants one or two minutes to reflect and write down their thoughts on the following question: “Is homophobia an issue in your school environment/classroom for teachers, administrators, school staff and/or students?” Next, give participants one or two minutes to share their thoughts with the person beside them.

PROCEDURE:

1. Have participants number themselves aloud and form groups based on their numbers.
2. Post large sheets around the room entitled “Discussing Homophobia in the Schools: Factors That Hinder and Factors That Help.” Give each group five minutes to list ideas and to designate a speaker to report back to the larger group.
3. Ask each group speaker to share the group’s key thoughts with the entire audience (5–10 min.)
4. Personal Reflection/Issues for Inquiry. From what the participants have heard or from personal experience, ask them to take five minutes to write down the most important issues for teachers addressing homophobia in schools/classrooms.
5. After the discussion, point out next facts why Do Schools Need to Address This Issue?

An issue of safety.

- › Schools must be safe places for all students and must provide environments that positively contribute to students’ physical and emotional development. This responsibility extends to all students regardless of sexual orientation.

Ensuring the emotional well-being of students.

- › Negative experiences in school settings can have a profound impact on the emotional and physical well-being of lesbian, gay, bisexual and transgendered (LGBT) students.

PROCEDURE

Suicide is the leading cause of death among LGBT youth.
Human Rights Issues

- › Students are protected against discrimination by the Canadian Charter of Rights and Freedoms and provincial human rights legislation. All students have the right not to be discriminated against in school settings. For LGBT youth, this right is often violated. The most common forms of discrimination are verbal and physical harassment. But even in schools that attempt to minimize verbal and physical harassment, LGBT youth still experience the oppression of silence. The silence may come in the form of avoidance of discussions of homosexuality or in the absence of positive information or images of LGBT youth.
- › Teachers and administrators have a mandated responsibility to ensure that LGBT youth are treated with respect and integrity within their classrooms and school communities.

CLOSING:

Ask each participant to write down the answer on this question: What do you see as the most important issues in addressing homophobia in your school and /or classroom? Are there areas of particular resistance in your school? If yes, what do you think they are? After that use this to conclude the workshop:

This workshop highlights some of the ways how to address homophobia. However, it is important that entire school knows that many lesbian, gay, bisexual and transgender young people lead fulfilled lives where they are proud to celebrate their identity. However, other LGBT young people experience serious levels of prejudice and discrimination. Homophobia is prejudice or discrimination against lesbian, gay, bisexual or transgender (LGBT) people, or people believed to be LGBT. Homophobia can happen in a range of ways, for example, through bullying, or through a failure to address the needs of LGBT young people, or a failure to address the risks to young people’s safety from bullying. A common type of homophobia

that many people do not notice is the use of the word “gay” in negative way, such as when young people say a mobile phone is “so gay”.

It is very important that schools are aware why is it so important to address homophobia which means that having an equal and inclusive environment, in which LGBT people are truly valued, makes a significant contribution to the prevention of homophobic bullying. In order to address the prevention of homophobic bullying, as well as intervention in bullying incidents, the schools needs a pro-active ethos which:

- › Fully integrates and welcomes on an equal basis, LGBT young people and workers;
- › Addresses the needs of LGBT people;
- › Addresses the particular safety needs of those who may be targets of homophobic bullying;

The support and commitment of management is crucial to this process. To be able to successfully address homophobia, it is essential for them to have strong support from their management and from school staff.



Workshop 11:

Making changes in our lives and in our communities

OBJECTIVE:

To provide the opportunity for participants to reflect on what they have learned throughout the workshops and how it can help them to make changes in their lives and in their communities.

MATERIALS REQUIRED:

Paper and pens; flip-chart and markers.

RECOMMENDED TIME:

2 hours to commence with – the group will decide how long the campaigns or projects will run.

PLANNING NOTES:

Part 2 of this activity involves the participants developing a community project to create awareness about an important social issue in their communities. It is up to the facilitator to decide if the group is really in a position to take on an activity of this kind, particularly in terms of time and resources. It might also require other people to collaborate on carrying it out. Some organizations and facilitators are in a position to implement a community project, others are not. While it is important to engage the participants in this kind of exercise, it is also necessary to be realistic. A good starting point might be to collect examples of young people who have mobilized themselves to promote awareness and changes in their communities and discuss with participants the possibilities of doing something similar in their community.

In order to ensure that the project efforts are sustained over some period of time, it might be worth doing this activity at the onset of the group workshops so that the facilitator can provide support and follow-up for at least the initial stages of the project. In that case, the last session can include Part 1 -Personal Reflections - and a discussion on how the project has progressed and how its efforts could be sustained.

PROCEDURE:

Part 1 – Individual reflections (1 hour)

1. Ask participants to reflect individually on what they have learned throughout the workshops and how it will help them to make positive changes in their lives and relationships.
2. Explain that they should create a collage, a short essay, a poem, or a drawing based on the problem they have identified affects men and women differently, and how it affects them, if at all, in their daily lives.

3. Allow 15 minutes for the participants to complete this task.
4. Invite each participant to briefly present their reflections (in about two minutes) and their medium of representation.
5. Open the discussion to the larger group with the following questions:
 - › What will be some obstacles you might face in making these changes?
 - › What will be some benefits?
 - › How can you support each other to make these changes?

Part 2 – Developing a community project (1 hour)

1. Explain to the participants that they are going to now think about the changes they can try to make beyond their own lives and relationships.
2. Ask the participants to think of the most pressing social issues in their community and how they are related to the topics they have discussed in the sessions.
3. As a group, ask them to select one of these issues to be the focus of their project.
4. Divide them into smaller groups and ask them to carry out brainstorm of what they can do as a group with other young men in their community or school about the social issue they have decided to address. Ask them to write down or sketch out their ideas on a flip-chart paper. Tell them that the ideas do not need to be totally finalized, but to simply list a number of first ideas, however “raw” they may be.
5. Allow about 30 minutes for the group work.
6. Invite each group to present its ideas.
7. Ask the participants to help identify the main types of ideas presented, dividing them into categories, for example: (1) political /advocacy action; (2) awareness campaigns in the community; (3) development of educational materials and information; (4) implementation of a local plan in their schools and communities, etc.
8. Use the following questions to help the group focus on and give priority to their ideas by asking them which of the ideas they consider to be the most interesting and easiest to implement. Remember that it is important to leave the final decision to them.
9. Once the idea has been finalized, review the Resource Sheet and work with the group to answer the questions and determine an appropriate time to implement the plan. In other cases the group may wish to meet on their own to finalize the planning. The important thing for the facilitator is to assist the participants in developing a viable plan so that they have a sense of fulfillment and not frustration.

CLOSING:

Changing your attitudes and behaviors is not always easy. It is important to keep this in mind and to think about how you can support each other to make these changes in your lives and relationships. Try to also think about how you can share the information you have learned in these activities with other young men and women in

your community, and engage them in the kinds of questioning and discussions you have had here. Remember, everyone has a role to play in building more equitable and peaceful communities and starting with our own lives and relationships is an important first step.

Resource sheet A

DEVELOPING A PROJECT

1 – Description

(in 2 or 3 phrases, describe your plan)

2 – Collaboration

Who do you need to collaborate with to put this plan into operation? How can you obtain this support and collaboration?

3 – Materials/Resources

What resources do you need to carry out your plan?
Where and how can you obtain such resources?

4 – Time Schedule

How long do you need to execute the plan?
Steps: list in order the steps required to carry out the planning.

5 – Evaluation

How do you know if your plan is working?
What expectations do you have about the result of your activity?

6 – Risks

What things can go wrong?

