SRHR Training Manual for Deaf and Hard of Hearing Young People

THE GLOBAL GOALS
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Y-PEER

Y-PEER Asia Pacific Center

SRHR Training Manual for Deaf and Hard of Hearing Young People

The information contained in this document does not necessarily represent the views or positions of Y Peer. Instead, it serves as guide to train Deaf young and hard of hearing people on SRHR.

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This manual can be nationalized, and will be updated in 2022 via Y-PEER Asia Pacific.

List of Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral Medicine
CRPD	Convention on the Rights of Persons with Disabilities
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HOH	Hard of Hearing
ICF	International Classification of Functioning, Disability and Health
LGBTQIA	Lesbian, Gay, Bisexual, Transgender, Genderqueer/ Queer, Intersexed, Agender/Asexual/Ally community
MSM	Men who Have Sex with Men
PWD	Person with Disability
SOGIESC	Sexual Orientation, Gender Identity, gender Expression and Sexual Characteristics
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

TABLE OF CONTENTS

"The challenges to SRH faced by persons with disabilities are not necessarily part of having a disability, but instead often reflect lack of social attention, legal protection, understanding and support. Persons with disabilities often cannot obtain even the most basic information about SRH. Thus they remain ignorant of basic facts about themselves, their bodies, and their rights to define what they do and do not want."

- WHO/UNFA (2009)

PART 1

Introduction

In 2018, the World Health Organization (WHO) estimated that around 15% of the world's population - that's approximately one billion people - live with disabilities, making them the "world's largest minority" (WHO, 2018).

Disability is diverse, since it is an umbrella term used to refer to different conditions. As defined by the Convention on the Rights of Persons with Disabilities (CRPD), persons with disabilities include "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" ((UN, 2006).

As may be gleaned from the aforementioned definition, disability is both internal and external to the PWD. As noted by the International Classification of Functioning, Disability and Health (ICF), "disability is the interaction between individuals with a health condition (e.g. cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports)" (WHO, 2018).
Persons with disabilities are among those whose health care needs are not served even if they have the same needs as everyone else.

For instance, in a survey of people with serious mental disorders, it was found that between 35% and 50% of people in developed countries, and between 76% and 85% in developing countries, received no treatment in the year prior to the study (WHO, 2018). The WHO similarly noted that health promotion and prevention activities rarely target persons with disabilities, women with disability receive less screening for breast and cervical cancer, and adolescents and adults with disability are more likely to be excluded from sex education programs.

And so, while persons with disabilities make up 15% of the world's population, their full participation in society continues to be challenging.

SRH and People with Disability

An issue that continues not to get the attention it truly deserves is the sexual and reproductive health (SRH) of persons with disabilities even if they have the same SRH needs as other people.

According to WHO/UNFPA (2009):

"The challenges to SRH faced by persons with disabilities are not

necessarily part of having a disability, but instead often reflect lack of social attention, legal protection, understanding and support. Persons with disabilities often cannot obtain even the most basic information about SRH. Thus they remain ignorant of basic facts about themselves, their bodies, and their rights to define what they do and do not want."

Person with disability encounter difficulties when accessing SRH services due to various reasons, including:

1. Physical barriers, such as lack of physical access and lack of information and communication materials;
2. Prohibitive costs, with 32% to 33% of people without disability unable to afford health care compared to 51% to 53% of people with disability (WHO, 2018);
3. Limited or lack of disability-related clinical services, such as the lack of sign language interpreters and materials in Braille; and
4. Stigma and discrimination, including of health care providers who may have negative attitudes towards persons with disabilities.

This is why the ICPD calls for governments "to consider the needs and rights of persons with disabilities and to eliminate discrimination against persons with disabilities with regard to reproductive rights and household and family formation" (WHO/UNFPA, 2009). Specifically, governments "should recognize needs concerning… reproductive health, including family planning and sexual health, HIV/AIDS, information, education and communication. Governments should eliminate specific forms of discrimination that persons with disabilities may face with regard to reproductive rights (and) household and family formation…"

SRH of Deaf People

Among the PWDs whose SRH remain under-served - if they are served at all - are Deaf people.

Based on data from WHO (2020), over 5% of the world's population – or 466 million people – has disabling hearing loss (432 million adults and 34 million children). By 2050, it is estimated that over 900 million people – or one in every 10 people – will have disabling hearing loss. Sadly, majority of people with disabling hearing loss live in low- and middle-income countries; and the prevalence is greatest in South Asia, Asia Pacific and sub-Saharan Africa (WHO, 2020).

Background and objectives

Globally, Y-PEER has been working for Sexual and Reproductive Health and Rights (SRHR) issues of young people, including SRHR issues of young people with disabilities since 1999. In the Asia-Pacific region, Y-PEER has been advocating and building the capacity of young people with disabilities since 2009.

In July 2020, Y-PEER Asia Pacific Center sought to develop the "SRHR Training Manual for Young People with Disabilities".

As a pilot effort, this manual's current iteration will specifically focus on young Deaf and hard of hearing people.

This manual specifically intends to provVlide :

1. Guidelines for Deaf and hard of hearing young people to learn about SRHR issues;
2. Guidelines for other young people and youth advocates to work on SRHR issues particularly of Deaf and hard of hearing young people; and
3. Provide knowledge and skills for both Deaf and hard of hearing young people and youth advocates to advocate for SRHR rights of young people with disabilities.

This effort is considered timely, particularly considering the plight of young Deaf people.

Deaf health literacy

Numerous studies have highlighted the health literacy issues of Deaf people.

For instance, an American study noted that "communication and language barriers isolate Deaf American Sign Language (ASL) users from mass media, health care messages, and health care communication, which, when coupled with social marginalization, places them at a high risk for inadequate health literacy" (McKee et al, 2015). The same study noted that "48% of Deaf participants had inadequate health literacy, and Deaf individuals were 6.9 times more likely than hearing participants to have inadequate health literacy."

Surprisingly, even those who know sign language encounter difficulties in getting SRH information because existing health-related information are not necessarily understandable to them.

Still in the US, Pollard and Barnett, for example, noted in 2009 that even among Deaf people with college degrees, there was a risk for low health literacy because the pattern of words used in existing materials were not necessarily understood.

Because of the big number of Deaf sign language users with inadequate health literacy, interventions are necessary. And this manual aims to help provide needed support to teach SRHR among Deaf young people, and service providers who tap them.

Access to SRH services by Deaf people

Both the WHO and UNFPA were blunt in their observation that "people who are deaf and hard of hearing are unlikely to benefit from policies and programs intended to address SRH problems" (WHO/UNFPA, 2009). This is because of the negative perceptions about deafness and lack of societal understanding of the concerns specific to the Deaf community.

There are specific issues encountered by Deaf and hard of hearing people when they try to access SRH services. These include:
Existing SRH materials are not understandable to the Deaf community (Fedorowicz 2006; Groce, Yousafzai & Maas 2007; Heyederick 2006; Roberts 2006; Wilson & Monaghan 2006)
Services that are not customized to the needs of Deaf and Hard-of-Hearing people (Mprah, 2013)
Communication issues, including:

1. Lack of sign language interpreters in health centers (Mprah, 2013)
2. In the absence of sign language interpreters, there are instances when healthcare providers underestimate the difficulties of speech reading and overestimate Deaf people's ability to understand written notes (Margellos-Anast et al, 2005)
3. Ignorance about deafness
4. Negative attitudes about deafness and the Deaf culture (Mprah, 2013)

These issues have devastating effects on the lives of Deaf people. These were noted to put Deaf people at higher risk to early pregnancy, STIs, forced marriage and sexual violence and exploitation (Mprah, 2013).

Suffice it to say, if it is to succeed, any SRH program for the Deaf community must deal with these issues to ensure that they are truly beneficial to Deaf people.

Learning from the Covid-19 pandemic

That Deaf people continue to encounter difficulties in accessing health-related services may be have also been highlighted by the Covid-19 pandemic. And in both instances - i.e. accessing SRH services and Covid-19 responses - problems revolve around the absence of information and resources that are easily accessible to Deaf people, as well as their exclusion in the decision-making processes.

Some of the issues encountered by Deaf people when accessing Covid-19 services include:
Lack of Covid-19 materials that Deaf people can comprehend; this includes the exclusion of sign language when announcements are made about Covid-19;
Lack of qualified sign language interpreters who can properly discuss medical issue like Covid-19;
Lack of sign language interpreters in healthcare settings for Deaf people who test positive for Covid-19; and
Absence of transparent face masks approved for use in healthcare settings (Grote & Izagaren, 2020).

If anything, Covid-19 highlights that even good intentions could be bad for Deaf people. For instance, those who advocate for the use of masks overlook its impact on the Deaf community. And "in the rare instances that the matter has been tackled, it is dismissed as a short term concession that the community could make for the greater good of society" (Grote & Izagaren, 2020).

This attitude - and approach - further isolates the Deaf community when accessing healthcare services.

Contents of the manual

Since 1999, Y-PEER has been working for Sexual and Reproductive Health and Rights (SRHR) issues of young people, including young people with disabilities.

Specifically to build the capacity of Deaf and hard of hearing young people on SRHR issues, as well as those who provide services to young Deaf and hard of hearing people, this manual was developed.

This manual has two major parts:
Context setting, which briefly discusses the difficulties experienced by young Deaf and hard of hearing people in accessing health services, particularly SRHR; and
Training module that may be used by young Deaf and hard of hearing people, as well as those offering services to them.

For the purpose of this manual, nine SRHR areas are emphasized:

- Family planning
- Infertility services
- Maternal and newborn health services
- Prevention of unsafe abortion and post-abortion care
- HIV and AIDS
- Diagnosis and treatment of STIs, including reproductive tract infections, cervical cancer and other gynecological morbidities

- Sex education
- Prevention and management of gender-based violence
- SOGIESC

To provide a practicable training manual on SRHR specifically for young Deaf and hard or hearing people, the concepts have been simplified and visuals used as recommended by Deaf community members.

Who should use the manual

Anyone interested in SRHR, or involved with the Deaf community in whatever capacity may find this manual useful.

More specifically, however, this is targeted to:

1. Young Deaf and hard or hearing people interested to learn more about SRHR, and train other Deaf community members about SRHR; and
2. Other young people who currently serve or are looking to teach SRHR among young Deaf and hard of hearing people.

While recognizing the availability of different sign languages - e.g. Filipino Sign Language (FSL), Nepalese Sign Language/Nepali Sign Language (NSL) - this manual is written in English, so familiarity with this language is needed by those who will use this.

Nonetheless, even if there are different sign languages, this manual simply presents evidence-based facts that may be translated in various sign languages.

How to use the manual

Those who will use this manual need to be familiar with its content and should be competent in workshop-based training delivery. As such, it may be best for experts or those who are familiar with the topics to do the first training. This is to ensure that no miscommunication happens pertaining the lessons/messages provided here.

While the manual outlines basic principles required for the successful running of group-based training, it can only be used as a general guide for those running the workshop.

- The curriculum in this manual is ideal for use for approximately 25 participants, excluding sign language participants. Changes in the group size will require some modifications particularly in group work/activities.
- This is structured around a two-day training program. A day is typically 7 ½ hours in duration, inclusive of a morning and afternoon break and an hour's lunch.
- Each module in this manual is designed to be delivered in approximately 90 minutes. Most sessions may be divided into:
    a. Exercises/Activities
    b. Lecture
    c. Q&A/Discussions

  However, the time allocation may change depending on the knowledge and experience of the participants. All exercises should nonetheless be completed in the order they are set out and following the time allocation given.
- The training module is structured to allow flexibility of use in line with local learning objectives, participant abilities and needs of the audience. For instance, the exercises/activities mentioned in the modules may be amended to suit various conditions, like the capacity of the location where the training is done, cultural sensitivities of the participants, and so on. There are additional exercises/activities in ANNEX 2.
- The techniques used in this curriculum are accompanied by training notes. These notes provide information to help trainers understand why a topic is important, or how a particular technique will contribute to the objectives of the training.
- There are opportunities to use a range of video resources throughout the module. If videos are used, be sure to allocate additional time.
- Guidelines are provided to help trainers prepare..

Because this manual tackles SRHR, some of the issues here are sensitive in nature - for example, sexual practices. The intention here is not to titillate or to offend, but simply to offer evidence-based information.

Everyone trained on the topics tackled here need continuing support, including further training. This is to inform them of new developments and access new materials, thereby help them develop better their training skills.

PART 2

SRHR training in the Deaf community

While this manual eyes to provide trainers with tools and skills they can use in order to properly hold training/workshops on SRHR, it is still only a guide. Every training should be flexible enough to accommodate the needs of the participants. This is to ensure that different considerations that could affect the learning are considered.

Having said this, all trainings should include the following key components:

RATIONALE OF THE TRAINING

At the start of the training, the rationale or the reason why it is offered should be specified. This is to ensure that the trainers and the trainees understand each other on what the training aims to achieve, and the processes that could help attain these goals.

This will also set the scope and limitations of the training. This way, the trainees understand that every training is not all-encompassing but has limitations or pitfalls.

TRAINER SKILL SET

A. *Self-awareness*

Trainers need to recognize that they also have biases that could affect the delivery of the training. This is not to say that trainers should not have their own ways of thinking. But in case these biases could gravely affect the discussion of a certain topic, it may be best to assign another trainer to handle this topic.

B. *Knowledge of topics*

A trainer should at least have basic knowledge of the topics in the curriculum. This way, if there are questions asked about them, the trainer is able to provide adequate answers.

C. *Communication and facilitation skills*

Facilitating a training requires thorough knowledge of communication techniques, including managing discussion flows, rephrasing statements or questions to make sure that the trainer and the trainee are on the same level of understanding, and ability to summarize discussions for clarity and documentation purposes.

D. *Group work skills*
Because the curriculum contains group activities, the trainer should have basic know-how on handling groups. Skills may include group management, role plays and other theater-based techniques as an approach to developing skills, facilitating group games, etc.

E. *Information about peer education resources*
Trainers should be familiar with resources that can complement their knowledge of SRHR issues, including other training modules. This could help them modify parts of this curriculum to suit the changing group of trainees.

BASIC GUIDELINES FOR TRAINING PLANNING, IMPLEMENTATION, AND M&E

Holding a training does not start and end with the event; instead, it involves planning that requires the participation of the everyone involved in the project (for example, the project manager, trainer/s, and documenter). Everyone involved in the project should understand all the processes, such as needs assessment or monitoring and evaluation.

BEHAVIOR CHANGE INTERVENTIONS

The training does not only intend to share knowledge, but also eye to change the behaviors of the trainees/participants. This is why the delivery of the training should be comprehensive, particularly focusing on skills development to effect behavioral changes and so they can eventually echo what they learned to other Deaf community members.

INFORMATION ABOUT SRHR SERVICES PARTICULARLY FOR THE YOUTH

It is better if the trainer knows of the supportive services in his or her area - for instance, government health facilities, non-government organizations, information sources, pharmacies, etc. This information may be included as part of the training to instruct participants how to access these resources.

Issues to consider for effective training/ workshop delivery

To provide a COMPREHENSIVE learning experience, keep in mind that learning does not start and stop with the training session. A good trainer takes care of all the stages of the learning transfer: before, during, and after the training.

While this is true in all trainings, this is even more important to highlight when the training involves Deaf people. This is because there are special requirements that need to be taken into consideration to make a Deaf training work.

Here are some of the issues that trainers for Deaf people should consider before, during and after any training.

PREPARING FOR THE TRAINING/WORKSHOP

VENUE

The setting can make a make or unmake a training as it could affect the learning there.

Particular to the Deaf community, when selecting a venue, be sure to consider the following:

- Space - There should be enough space for the participants to move because of their need to use sign language. The space should have no visual barriers - for example, a pole in the middle of a room may hinder the view of the participants.
- Allocate space for the sign language interpreter/s, usually in front, beside the trainer/facilitator or the speaker. The sign language interpreter must be visible to all participants.
- Lighting - The venue should have proper lighting to allow the participants see each there, the sign language interpreter/s, and the trainer/s.
- Choose an environment without distraction (for instance, avoid venues with windows that provide views of the outside world, which could distract participants during the training). Accessibility - The chosen location should be readily accessible to participants. The organizer must provide specific instructions relating to travel, parking and public transport to reach the venue.
- Consider to the needs of participants with disabilities or special needs, such as those using wheelchairs.

TRAINING/WORKSHOP LOGISTICS

All facilities must be properly marked - for example, the registration table, toilets

and dining facilities.

Similarly, always check that the equipment to be used is available and working - for example, the projector, TV and video player, computer, and so on.
Lastly, prepare all training materials beforehand.

IDENTIFY MEMBERS OF SECRETARIAT (FOR EXAMPLE, THE FACILITATORS, DOCUMENTERS, ETC)

By identifying the key people who will run the training/workshop, tasks will be assigned to ensure that it will run smoothly. This will also allow the people organizing the training/workshop to identify things that need attention - for example, if supplies of materials used in group activities are running out, and re-stocking may need to be done.

Meet before the training to discuss the sessions; and then meet again after the sessions (for example, at the end of the day for trainings/workshops that run for more than a day) to revisit what worked or what did not work at the sessions. Amend the approaches/strategies to be able to deliver a more engaging session the next time.

In case there are numerous facilitators, confer with each other after each module so that any issues that arise can be dealt with (such as engaging less participative learners).

PARTICIPANTS

Define the size of the group. When there are too many participants, there may not be enough time to process their inputs.

Define the composition of the group, including:
Their SOGIESC
Culture
Age
Existing knowledge and skills
Religious affiliations
Literacy levels
Be sensitive to these differences because some of these could affect their participation in discussions. Choose the right delivery method for the different audience.

Give all participants the training/workshop outline before the start of the sessions. This is to help them familiarize themselves with what will be coming ahead.

Meet the learners. By knowing the participants, the trainers become aware of cues that may not be apparent - for example, one person may be held in high esteem by the group, and this person may dominate in all discussions at the expense of

others. Upon this realization, the trainer can amend the training approach to make sure that other participants are also given the chance to speak during discussions.

HANDOUTS

Be sure to have sufficient copies of the handouts and relevant materials. Have these ready for distribution at the start of training.

CERTIFICATE OF COMPLETION

Prepare a certificate of attendance or completion for the participants. This may be useful for people whose offices require this, or it may be used as evidence of ongoing professional development.

RUNNING THE TRAINING/WORKSHOP

The trainer's job starts even before the start of the actual training/workshop. So arrive early to:

1. Review all preparatory paperwork (for example, this manual, the handouts, etc)
2. Check the venue to make sure it is arranged accordingly
3. Familiarize yourself with locations of facilities (for example, the fire exits, toilets, etc)

Arriving ahead of the participants will make you feel in control of all of the above.

Starting the workshop

Start the day with an activity - for example, an ice-breaker. This helps the participants become comfortable with the trainers and with each other; while also starting the training in a more upbeat manner.
Refer to **ANNEX 3** for sample ice-breakers.

Start on time, particularly when the participants have already arrived.

Open the training/workshop by welcoming the participants, introducing yourself and other members of the organizing group.

Any training/workshop should always start with introductions of everyone at the venue. Let the participants take turn stating their name, their affiliations (for example, where they are from, where they work or where they go to school), and should they wish, something about their background. The latter point should be non-threatening and should allow the participants to offer about themselves to the group.

If needed, particularly when the participants do not know each other, prepare name cards.

Practicalities, housekeeping and group rules

After the introductions, summarize the outline for the day - for example, what will be discussed within the day, how long the sessions will last, and the order of the discussions.

Inform the participants about the facilities - for instance, where the toilet is, fire exits, and where meals will be served.

With the participants, identify "house rules". This is an explicit agreement between the trainer and the participants on what behaviors are acceptable or not. Ask the participants to suggest ways to make the training/workshop flow efficiently. Put these rules up on a flipchart as they are stated, and place that flipchart on the wall so that the participants always see it as reminder of the agreements.

Some of these rules include:

- Arriving on time for the beginning of each module and after each break
- Participants may ask questions freely at any time
- Only one person should speak at a time
- Participants should only speak for themselves, not for a/the group
- Comments should be made to the whole group; there should be no side conversations
- Work towards resolving conflicts rather than taking up inflexible positions
- Discuss ideas or opinions, not the person expressing them
- No smoking, alcohol or drug consumption during the training/workshop
- Switch off mobile phones while in training
- No to violence (verbal/physical); people must feel free to express opinions that may not be popular so that everyone can hear these opinions

Confidentiality

Confidentiality needs to be addressed at the start of every training/workshop. Usually, the participants are expected not to share any sensitive information disclosed during the training with others who are not in the training. The mantra, "Keep the story, share the lesson", hold true here. For example, if a participant shares his/her experience with drug use, in no way must this information be shared outside of the training/workshop.
Although openness is desired for learning to happen, the participants need to be told to be wary about what they share. They should only share what they are comfortable with sharing because confidentiality is bounded and not absolute.

Facilitating the training/workshop

There are several types of facilitation that could be used, and every trainer/facilitator has his/her own style in delivering them.
However, when facilitating, a trainer/facilitator should pay attention to the following:

1. ***Spacing out by dividing the program into modules***

Microlearning is helpful to ensure that no information overload happens.

2. ***Use visual materials***
   Some points may not be properly explained by words alone. Use visuals, including illustrations, photographs and videos.

3. ***Ensure everyone contributes to the discussions***
   There may be participants who will dominate the discussions. But a good trainer is sensitive to those who are less vocal.
   A trainer can engage others by:
   a) Specifically mentioning the names of other participants: "Michael, what do you think about this?"
   b) Asking for an opposing position to what has been given: "Are there people here who do not agree with this statement? Would you care to tell us why?"
   c) Emphasizing that everyone is valid; and that what they have to say also deserves to be heard.

4. ***Keep the discussion on track***
   Discussions are done to attain specific goals. When a discussion strays, it is the trainer/facilitator's job to return it to its focus. He/she may say: "We may be discussing a related - and yet separate - issue here. We can take that up later; but do you think we should answer these concerns first?"
   There may be times when discussions stray for the better; for example, there may be issues that the trainer/facilitator - or even the training/ workshop - did not know exists, but are being raised by the participants. When this happens, negotiate with the group. Remind them of the objectives, and then let them decide if they want to abandon these and follow the new direction. In this case, re-allocating time may be needed.

5. ***Pay attention to the time***
   Be mindful that when you allocate more time on another topic or task, it will take away time from another topic or task. It is usually during Q&A when more time is needed. To wrap up a module/topic even if there are still questions being asked, you may gather the other questions/concerns and provide answers later; allocate a separate Q&A session when all the modules are done; or schedule one-on-one meetings particularly for those whose questions may be sensitive in nature.

6. ***Clarify contributions***
   Explore statements in a non-confrontational way: "That sounds interesting, Julie; can you tell us a bit more about it?"

7. ***Summarize the discussions***
   Summing up allows the trainer/facilitator to end the discussion.
   make sure that the participants agree with the summary. This is to ensure

that everyone is on the same page.

8. ***Draw upon the participant's prior knowledge to create associations***
   People learn best by associations. Using what the participants already know to explain a point can be helpful.

9. ***Use instructional strategies that establish relevance***
   If you can tell the participants how the knowledge they are learning will be relevant to them, then they may learn about this better. Applicability in real life situations could motivate others to learn.

   Incorporate realistic scenarios that simulate the topics discussed. For example, incorporate practical exercises that are similar to what the participants will be expected to perform at the workplace. The practical exercises give the training a semblance of reality.

10. ***Align content with real-life job roles and responsibilities***
    If the participants can see that they can apply what they are learning to their lives, they will be more motivated to learn them. So take every opportunity to establish this relevance.

    Create scenarios or stories that demonstrate positive outcomes, incorporate realistic case studies, show video testimonials, or even introduce testimonies of people.

11. ***Provide action plans***
    Include in the discussions action plans that will guide the participants when they return to work/school/their communities. These action plans should assist them to apply what they have learned during the training/workshop.

FROM THEORY TO PRACTICE IN PEER EDUCATION

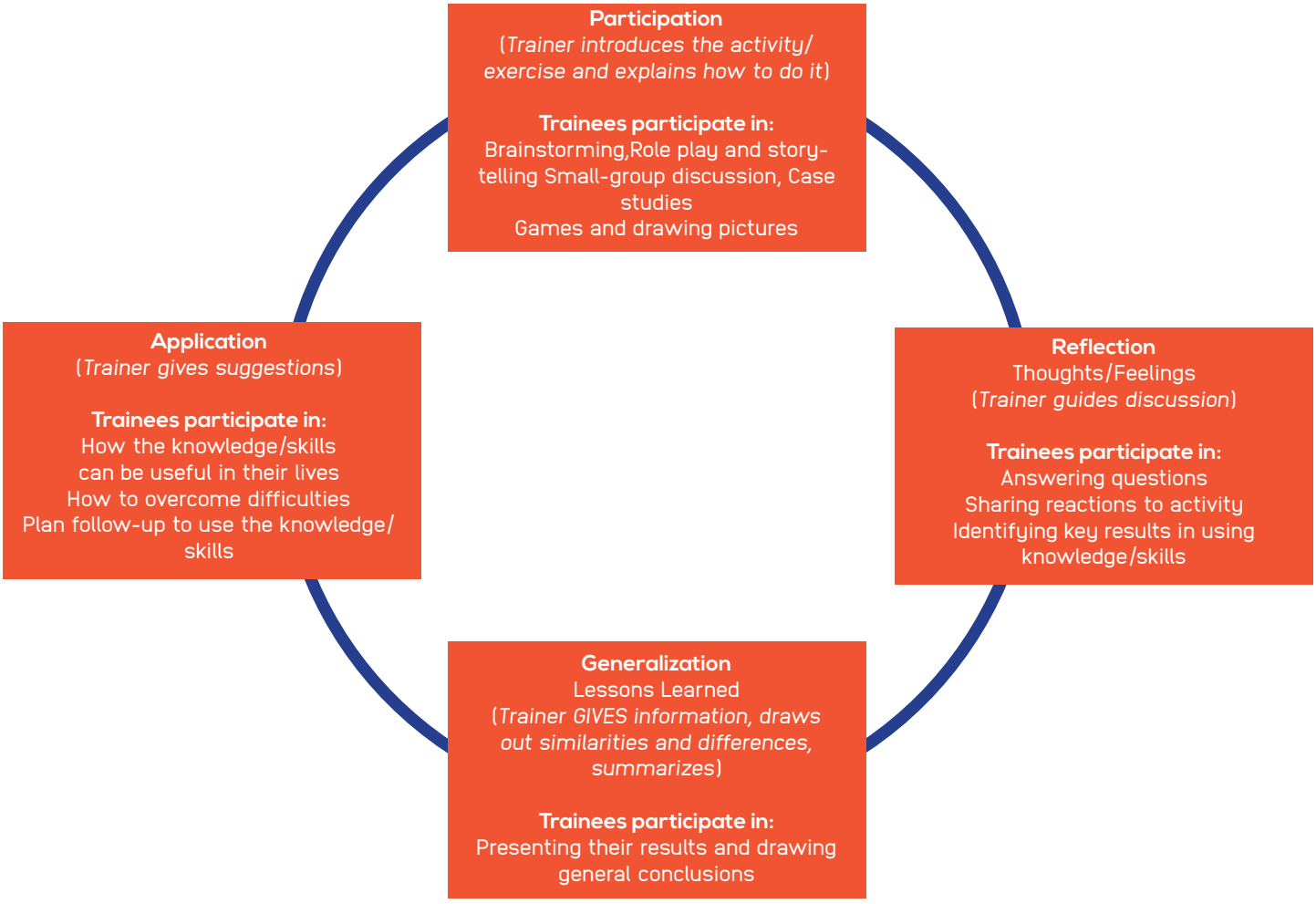
In the context of this manual, peer education is the process whereby well-trained and motivated young people undertake informal or organized educational activities with their peers (those similar to themselves in age, background, or interests). These activities, occurring over an extended period of time, are aimed at developing young people's knowledge, attitudes, beliefs, and skills and at enabling them to be responsible for and to protect their own health.

Examples of youth peer education activities include organized sessions with students in a secondary school, where peer educators might use interactive techniques such as game show quizzes, role plays, or stories, informal conversations with young people at a discotheque, where they might talk about different types of behaviour that could put their health at risk and where they can and more information and practical help. The key personality traits of peer

educators are:

- Respected by peers
- Non-judgemental
- Discreet
- Tolerant
- Role model
- Energetic
- Interested
- Self-confdent

While implementing a training of trainers (TOT) workshop, training of peer educators, or peer education sessions with the target population, there are some basic methodological considerations for translating the theory into prac- tice. Most important are experiential learning (learning based on experience and observation) and use of interactive methodologies, including drama. The TOT approach proposed in this manual is based upon an experiential learn- ing model with highly interactive techniques. The model includes four elements: participation, reflction on the experience, generalization (lessons learned), and application of lessons learned. It can be summarized in a diagram as follows:



AFTER THE TRAINING/WORKSHOP

Perhaps the biggest challenge lies in what happens after the training/workshop. This is because learning on it own is not enough; instead, how the learning is put into practice should also be considered.

Here are some strategies trainers/facilitators can use to cement what was learned:

1. ***Create opportunities for practice***
   Participants should be given opportunities to put what they learned into practice. For example, they may be tasked to give future trainings/ workshops themselves. They may also be linked with other NGOs that can use what they learned.

2. ***Provide refresher courses***
   For the participants to retain the key learning points after the training, gather them again for refresher courses. These need not be as elaborate than the initial training/workshops, but should be simple and provide coherent summary of the key learning concepts.

3. ***Conduct post-training follow-up sessions***
   The trainers/facilitators, and even the organizers, may want to follow-up with the participants to know how they are using what they have learned, and if there is support that they can give to make the participants effective in their work.

   In case actual meetings are not possible, even follow-up emails are enough to:

   a) Reinforce key learning points
   b) Provide supplementary lessons
   c) Discuss their experiences as they try to apply their new knowledge
   The answers provided by the participants will also give insights to trainers/facilitators/organizers about how successful the training/ workshop was, and if there may be changes they can do to make this even more effective.

4. ***Evaluate the training***
   Assess the participants' reactions including on:

   a) Curriculum
   b) People involved (like the trainers/facilitators/secretariat)
   c) Logistics
   d) Recommendations
   e) Other issues that the participants deem to be important
   An evaluation sheet prepared beforehand may be given to the participants; or interviews may be conducted for the participants to

elaborate on their evaluations.

Prepare a summary report based on the results of the evaluation to help other trainers offering similar trainings/workshops in the future.

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Rebecca Grossman & Eduardo Salas (2011)

PART 3

Lessons from the Philippines and Nepal

Signs of times

Dealing with HIV in the Deaf community in the Philippines

In 2018, three public service announcements (PSAs) on HIV were released by Bahaghari Center for SOGIE Research, Education and Advocacy, Inc. (Bahaghari Center) and Y PEER in the Philippines.

PSAs on HIV are actually regularly released in the country, but these three were different. They used Filipino Sign Language (FSL), and were produced with and for the Deaf community. Both organizations worked with Deaf organizations, including Pinoy Deaf Rainbow Inc., TransDeaf Philippines, and Davao Deaf Club. With the approach, these were the first PSAs that dealt with one of the issues concerning sexual and reproductive health (SRH) particularly of Deaf and hard of hearing young Filipinos.

CURRENT STATUS

In 2015, the Philippines Statistics Authority estimated that 3.1% of the country's population over the age of five has a disability. Less than half (49.1%) of all people with disability are women (Lee, Devine, Marco et al., 2015).

On the surface, the Philippines seems progressive in responding to the SRH issues of Filipinos, including of persons with disability (PWDs) like Deaf people.
In 2008, for example, it ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD) that has provisions related to recognition of reproductive rights (Article 23); access of PWDs to SRH information and services (Article 25); and the rights and empowerment of women (Article 6), with Article 32 emphasizing the importance of including PWDs in development.

This ratification was followed by the development of legal frameworks to promote the rights of Filipino women with disabilities to sexual and reproductive health and protection from violence, including the Magna Carta for Women, Magna Carta for Persons with Disability, and the Responsible Parenthood and Reproductive Health Act of 2012 or the RH Law (PARE, 2012).

The RH Law, in particular, mandates universal access to family planning, including contraception, education and maternal care.

ONGOING CHALLENGES

Overall, however, the implementation of SRH efforts in the Philippines continues to be challenging.

Various issues affect SRH efforts, including: opposition against the RH Law particularly by larger faith-based institutions affected its implementation (Lee, Devine, Marco et al., 2015); lack of resources; issues with procurement of supplies; and limited capacity of service providers to provide inclusive services (Likhaan Center for Women's Health, 2014).

There are also laws that still exist that affect SRH - e.g. the Philippines is one of the countries in the world with the most restrictive laws on abortion, so that in 2012 alone, over 100,000 women were hospitalized and 1,000 women died due to unsafe abortion complications.

BIGGER IMPACT ON DEAF FILIPINOS

Deaf and hard of hearing young people are among those badly affected by the SRH limitations in the Philippines.

As it is, people with disability are already stigmatized and discriminated against; and because of the conservative socio-political context in the Philippines, sex is also not openly discussed. When the two are mixed, therefore, many service providers have particular difficulty discussing the SRH needs of people with disability; even while PWDs themselves do not ask about SRH due to shame. Suffice it to say, the disadvantage of PWDs in the Philippines is "not just because of their impairment, but also due to the intersection of discrimination based on gender, disability and poor socio-economic status" (Lee et al, 2015).

In 2017, a study reported on the barriers encountered by women with disabilities when accessing SRH, including limited availability of accessible services; women's limited awareness about sexual and reproductive health and when and how to access appropriate information and services; negative attitudes of service providers and communities in relation to disability and sexual and reproductive health; and experiences of violence and abuse (PARE, 2012; Likhaan Center for Women's Health, 2014; Devine, Ignacio, Prenter et al, 2017).

Particular to Deaf Filipinos, issues with access to SRH were also affected by financial barriers both of Deaf people and the service providers to provide appropriate services; lack of trained sign language interpreters to assist service providers; the need to allocate additional time to Deaf Filipinos, which is difficult in under-resourced workplaces; and lack of IEC materials for the Deaf (Lee et al, 2015).

THERE'S HOPE YET

There are various recommendations on how to make SRH efforts more Deaf-inclusive. First, service provider education and capacity development can help improve the

ability of health workers to communicate effectively with Deaf clients (Lee et al, 2015). As such, this should be given attention.

Second, and related to the first point, SRH service providers can benefit from "disability sensitization to increase their awareness of factors undermining equity of access to services for women with disability" (Lee et al, 2015). Here, the inclusion of disability sensitization into the curriculum and initial training of service providers could improve their capacity to include those with disability in mainstream SRH services.

Third, there is a need to increase the the number of sign language interpreters, as well as resources for alternative communication.

Fourth, studies on the SRH experiences of Deaf Filipinos should be done to gather more data on this, including their experiences of violence (Lee et al, 2015).
Lastly, there is need to strengthen the engagement with Deaf people's organizations both to make SRH efforts more inclusive, but also - in the long run - to give Deaf people ownership of SRH issues.

It is exactly because of the last recommendation that Bahaghari Center and Y PEER developed the three PSAs on HIV in 2018.

But the effort did not stop there. In 2019, as a follow-up to the PSAs, over 50 Deaf and hard of hearing young Filipinos from the cities of Makati, Cebu and Davao were trained to conduct HIV screening. The idea was for Deaf Filipinos to stop relying on Hearing people if they need to get tested for HIV, or if they needed to access STI treatments/services. At the end of the project, approximately 100 Deaf and hard of hearing young Filipinos, as well as FSL interpreters were certified as HIV screeners. Other NGOs have focused on other SRH issues.

For instance, from 2013-2016, the W-DARE project (Women with Disability taking Action on REproductive and sexual health) implemented 10 peer-facilitated Participatory Action Groups (PAGs) for women with disabilities, including women who were Deaf or hard of hearing. Months after the PAGs, the participants reported increased knowledge on SRHR, on the rights of PWDs, on protection from violence for women and children with disability, and increased confidence and peer support to access to services (Lee et al, 2015).

Obviously, the efforts of Bahaghari Center and Y PEER, as well as the W-DARE remain rare. Also, they only touched on some aspects of SRHR.
However, these efforts still highlight the benefits of inclusive SRHR efforts, just as they show promising initiatives that can be done to help Deaf and hard of hearing young Filipinos access SRHR services.

Ongoing SRHR efforts

Dealing with SRH issues in the Deaf community in Nepal

The number of PWDs, and of Deaf people, in Nepal is noteworthy. According to the National Population and Housing Census 2011, there were a total of 79,307 Deaf and hard of hearing people in the country, totaling 15.4% of the 513,301 Nepalese people with disability.

At least the Deaf and hard of hearing community was, seemingly, even given emphasis by the 2011 census, with the report specifying who belongs to this category. As stated, an individual without hearing capacity of sound above 80 decibels are considered to be a deaf, while hard of hearing individual is someone who can hear sound between 65 to 80 decibels.

Despite the seeming attention given to this community, however, it is still acknowledged that data about this community may not be accurate, since researchers, statisticians and policy makers working in the Nepalese disability sectors presume that the population of PWDs may be higher than documented. Pant (2020) noted that activists working in the disability sector in Nepal argue that the number of PWDs reach three million. Meanwhile, there are estimates that 24.6% of the population in Nepal is deaf, with most of them living in rural areas without access to education or sign language training (Volunteer Society Nepal, 2020).

LAWS FOR PWDS

On the surface, there have been pro-PWD initiatives - including the Deaf and hard of hearing community - done in the country.

In 1981, for instance, Nepal adapted the human rights of people with disability; followed in 1982 by the enactment of the Disabled Protection and Welfare Act; and the signing in 2008 of both the CRPD and the Optional Protocol in 2008 (Baral, 2018). Moreover, constitution of Nepal, in section 31(4) guarantees the citizen with hearing or speaking impairment to get free education through sign language, in accordance with law.

Also, the Disability Rights Act of 2017 incorporated many provisions of CRPD. This law recognizes that PWDs have rights before the law, including the right against GBV, discrimination, and gaining maternal and reproductive health services.

ONGOING EFFORTS

Realization the need, Y-PEER Nepal and Working Group on Disabilities 2030 (WG2030) worked in the "SRHR needs of Young People and People with disabilities "living in Camps and temporary shelter in Kathmandu Valley with support of Circle of Health International and through individual youth funding. UNFPA Nepal and other

Partners were involved in next stage which gave more push to the research.

This was also the first time the need of young people related to SRHR need was collected which directly include the Deaf surveyor's from Y-PEER Nepal. The survey was very helpful to plan for the post-earthquake activities in Nepal focusing on Young People and Young People with disabilities (deaf) but also gave birth to focused plans within Y-PEER and WG2030. The survey recommendations was shared widely among the partners but the real use of it can be traced until the 2020 where these group were affected by COVID19 lockdown.

Some of the young people who were trained and got involved in Y-PEER and WG2030 were selected as particpants in different National and Regional Discussion which happended in Asia Pacific focusing on SDGs, ICPD as well as Comphrensive Sexuality education (CSE).

After the more than year of planning and soon before the COVID19 restrictions, In support of Y-PEER Asia Pacific Center, Robert Carr Funds, NDYC and National Federation of the Deaf Nepal (NDFN) the training was organized by Y-PEER Nepal and Working Group on Disabilities and 2030 Agenda (WG2030). 30 Young Deaf People were selected for the training which was selected form the poll of 400 deaf applicants.

MORE EFFORTS NEEDED

The real condition of PWDs - including Deaf and hard of hearing people - may not be as rosy.

For one, the Nepalese government still has no clear policies regarding the provision of educational facilities for the Deaf population. Nepal Government's effort for the development of deaf and hard of hearing people seems minimal. The Volunteer Society Nepal (2020), for instance, noted that "within Nepal, sign language is relatively new" and that "even at deaf schools, there is no curriculum designed for deaf students."

Second, Nepalese PWDs often encounter discrimination in various aspects of life - e.g. being deprived of education and employment.

Third, young persons with disability in Nepal are more likely to face violence and abuse. UNICEF (n.d.) even noted that women with disability experience domestic violence, rape, accusations of witchcraft and dowry-related violence.
Fourth, Nepali PWDs are often deprived of their SRH rights and have less access to SRH services. They have been subjected to forced sterilization, abortion, removal of reproductive organs and early marriage. Tanabe et al. (2015), for example, cited a Women's Refugee Commission study that found that Bhutanese refugee women with hearing impairments in Nepal were at higher risk of sexual violence, and yet had bitter experience while accessing health and SRH services.

Lastly, despite having legal rights, PWDs in Nepal are still often denied the right to establish relationships and start families. Seventy percent of women with disability are unmarried. Similarly, women with disabilities do not have access to maternal health and quality SRH services, leading to preventable SRH problems like reproductive tract infections, maternal mortality, and uterine prolapse (CEDAW, 2018).

As Pallav Pant (2020) noted in Lokaantar.com, all these issues are often intertwined. Therefore, PWDs in Nepal - including the Deaf and hard of hearing - often encounter layers of issues.

> *"People with disabilities are vulnerable and always in a state of crisis. They have limited access to different areas. Adding to it, poverty and disability are always interconnected. The situation is even worse in Nepal for women, children and indigenous people with disabilities. But Nepal has not developed emergency plan to help persons with disability."*

STEPS FORWARD

Moving forward, Nepal still needs to work on numerous fronts.
These include the establishment of disability-friendly SRH services, which includes availability of sign language interpreters, provision of written text and provision of physical facilities (Gaihre et al., 2015); as well as increasing the rate of maternal health service utilization by women with disability (Devkota *et al.*, 2017).

PART 4 Session Plans

There are nine SRHR topics considered in this manual. For each topic to be extensively tackled, there will be a combination of group activities and discussions. Below is the breakdown of the sessions:

TOPIC	KEY ISSUES TO BE DISCUSSED	ACTIVITY	TIME ALLOCATION
Family planning	1. Definition of family planning 2. Identify the importance of family planning 3. Different forms of family planning 4. Family planning methods, and their advantages and disadvantages 5. Elements that discourage young Deaf and hard of hearing people to access family planning services	1. Group activities 2. Group discussions	TOTAL: Two hours/120 minutes GROUP ACTIVITY: 30 minutes LECTURE AND Q&A: 90 minutes
Infertility services	1. Definition of infertility 2. Causes of infertility 3. Treatments available to deal with infertility 4. Issues Deaf people encounter when accessing services to deal with infertility	1. Group activities 2. Group discussions	TOTAL: One hour/60 minutes GROUP ACTIVITY: 10 minutes LECTURE AND Q&A: 50 minutes
Maternal and newborn health services	1. Maternal health and causes of maternal deaths 2. Pregnancy-related complications among the youth 3. Neonatal care 4. Issues Deaf people encounter when accessing maternal	1. Group activities 2. Group discussions	TOTAL: 1 1/2 hours/90 minutes GROUP ACTIVITY: 30 minutes LECTURE AND

TOPIC	KEY ISSUES TO BE DISCUSSED	ACTIVITY	TIME ALLOCATION
	and neonatal services		Q&A: 60 minutes
Prevention of unsafe abortion and post-abortion care	1. Definition of "abortion" 2. Basic information about abortion 3. Opinions and beliefs about abortion 4. Myths against facts 5. Concerns about talking about abortion and coming up with solutions	1. Group activities 2. Group discussions 3. Quiz	TOTAL: Two hours /120 minutes GROUP ACTIVITY: 30 minutes/15 minutes per activity LECTURE AND Q&A: 90 minutes
HIV and AIDS	1. What is HIV? Is HIV the same as AIDS? 2. Modes of transmission/How can you get infected with HIV? 3. Ways you can not get infected with HIV 4. How can you know if you have HIV? 5. What happens when you have HIV?	1. Group activities 2. Group discussions	TOTAL: Two hours/120 minutes GROUP ACTIVITIES: 15 minutes each LECTURE AND Q&A: 90 minutes
Diagnosis and treatment of STIs	1. What STIs are 2. Diagnosis and treatment of STIs 3. Common STIs 4. Reproductive tract infections 5. Safer sex	1. Group activities 2. Group discussions	TOTAL: Two hours/120 minutes GROUP ACTIVITY: 30 minutes LECTURE AND Q&A: 90 minutes
Sex education	1. Improve communication about sex 2. Understanding the human body 3. Sexual and reproductive rights	1. Group activities 2. Group discussions	TOTAL: 90 minutes/ One hour and 30 minutes GROUP ACTIVITY:

TOPIC	KEY ISSUES TO BE DISCUSSED	ACTIVITY	TIME ALLOCATION
			15 minutes for Activity 1 30 minutes for Activity 2 LECTURE AND Q&A: 15 minutes after Activity 1 30 minutes after Activity 2
Prevention and management of gender-based violence	1. Define gender-based violence 2. Identify different forms of gender-based violence 3. Understand the causes and consequences of gender-based violence 4. Recognize the root cause of gender-based violence	1. Group activities 2. Group discussions	TOTAL: 150 minutes/2 hours and 30 minutes GROUP ACTIVITY: 15 minutes for Activity 1 15 minutes for Activity 2 15 minutes for Activity 3 LECTURE AND Q&A: 30 minutes for Activity 1 30 minutes for for Activity 2 45 minutes for Activity 3
SOGIESC 101	1. SOGIESC concepts 2. Select terminology related to SOGIESC 3. Explain concepts contained in the illustration of the genderbread person 4. Discuss LGBTQIA 5. SRHR issues faced by LGBTQIA people	1. Group activities 2. Group discussions	TOTAL: Two hours/120 minutes GROUP ACTIVITIES: 15 minutes for Activity 1 15 minutes for Activity 2

TOPIC	KEY ISSUES TO BE DISCUSSED	ACTIVITY	TIME ALLOCATION
			LECTURE AND Q&A: 90 minutes
TOTAL			**16.5 HOURS**

If a training/workshop intends to cover all these SRHR topics, a total of 16 hours and 30 minutes have to be allocated, excluding the breaks in between the sessions. As such, it would be ideal to hold a training/workshop for no less than three days. This manual, nonetheless, recognizes various limitations, including:

- Some of the SRHR issues may not be appropriately discussed in some locations;
- Lack of budget;
- Limited time;

Preferences of trainers/facilitators, and participants.

In case any of this is an issue, trainers/facilitators do not have to tackle all the topics. Instead, they can just choose what they think is appropriate at any given time. This way, the training/workshop can be amended to suit various needs.


Seminal Vesicle
Vas Deferens
Bladder
Erectile Tissue
Urethra
Penis
Epididymis
Testis
Scrotum

PART 5 Training Topics

TRAINING TOPIC 1: Family Planning

PURPOSE/OBJECTIVES

At the end of this session, participants should be able to:

1. Define family planning
2. Identify the importance of family planning
3. Identify the different forms of family planning
4. Identify some of the family planning methods, and their advantages and disadvantages
5. Recognize that there are elements that discourage young Deaf and hard of hearing people to access family planning services

TIME ALLOCATION

TOTAL: Two hours/120 minutes
GROUP ACTIVITY: 30 minutes
LECTURE AND Q&A: 90 minutes

MATERIALS

- Flip charts or manila paper or cartolina
- Markers
- Sticky tape
- PowerPoint presentation

SESSION OUTLINE & METHODOLOGIES

Start the session with the group activity.

GROUP EXERCISE: Role play

This exercise aims to uncover existing family planning services that the participants know are available in healthcare centers in their localities, and if these services are accessible to young Deaf and hard of hearing people.

MECHANICS:
Separate the participants into smaller groups.
Assign members in every group to represent: A, B, C. Have the participants play the roles at various times, i.e.

	1st Round	2nd Round	3rd Round
Counselor	A	B	C
Client	B	C	A
Observers	C	A	B

The per-role instructions:

CLIENTS
Separate those who will play the role of the clients from the others, and then tell them their case, i.e.:

The client is a young Deaf person who is in a relationship. He or she has sex with his or her partner, but he or she does not want to have a baby for now. He or she wants to know his or her options. His or her family does not support him or her; they think he or she should already start a family.

The "clients" are given a somewhat free rein to make up the other details of their stories. The instruction, though, is for him or her to check if the counselor will provide information and services he or she needs, or if he or she will be referred to another facility that can provide the family planning services.

COUNSELORS
The counselors just has to provide counseling as they would do, if/when such a client dropped by their centers.

OBSERVERS
The observers are asked to pay attention to the proceedings, particularly noting:

1. What worked or didn't work?
2. If you were the counselor, what would you have done?

For the processing of the results of this exercise:

1. Have A, B, C sit in separate groups.
2. Discuss experiences as: counselors, clients, observers.
3. Ask everyone to form one big circle; share discussions.

The activity can lead to the discussion of family planning.

For the discussion on family planning, prepare a visual presentation (for example, PowerPoint) containing the following information:

1. Definition of family planning
2. Reasons why family planning is important
3. Forms of family planning
4. Family planning methods; and their advantages and disadvantages
5. Elements that affect access to family planning of young Deaf and hard of hearing people

Provide handouts to the participants before the discussion.

The trainer may answer/take in questions during the discussion, or he/she may decide to finish the presentation first before questions are taken/considered. Whatever Q&A format he or she chooses, time should be allocated to answer questions from the participants.

At the end of the session, be sure to summarize the key points.

KEY LESSONS/MESSAGES

What is family planning?

The World Health Organization defines family planning as:

> "the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility" (WHO, 2008)

Importance of family planning

Family planning serves three needs:

1. It helps couples avoid unintended pregnancies
2. It reduces the spread of sexually transmitted infections (STIs); and
3. By addressing the problem of STIs, family planning helps reduce rates of infertility

Family planning also touches on human rights issues, including:

1. Right to life and liberty,
2. Freedom of opinion and expression,
3. Right to work and education,
4. Empowerment for women,
5. Sustainable population growth, and
6. Economic development

What are the different family planning methods?

There are traditional and modern/artificial family planning methods.

Traditional methods include:

- Withdrawal
- Periodic abstinence/rhythm

Modern methods include:

- Pills
- Injectable contraceptives
- Condoms
- Emergency contraceptives
- IUDs
- Implants
- Jelly/foam/sponge
- Female sterilization
- Male sterilization

Family planning methods can be temporary, or permanent.

Not all family planning methods may be good for one person. It is best to speak to a health practitioner about a patient's needs and health conditions to help him/her identify what methods he/she can use.

Choosing any of family planning methods is a personal choice; it must not be imposed on people.

Elements that discourage access to family planning services of young Deaf and hard of hearing people.

Young Deaf and hard of hearing people are not always able to access family planning information and services. This is because of various factors, including:

- Limited access to information
- Existing information are not understandable/sensitive to the Deaf community
- Lack of sign language interpreters in healthcare establishments
- Informal sources - such as friends and family members - may be inadequate or unreliable
- Traditional cultural values that discourage discussion of sex within the family

NOTES

For the definition of some of the family planning methods, and their advantages and disadvantages, see **BELOW**. To present, it may be better to have one method per slide. This way, participants are not overwhelmed with information.

See **REFERENCES** for more readings.

Select family planning methods, and their advantages and disadvantages

TRADITIONAL FAMILY PLANNING METHODS

Withdrawal method

Also called "*coitus interruptus*", this is the practice of withdrawing the penis from the vagina and away from a woman's external genitals before ejaculation to prevent pregnancy. The goal of this is to prevent sperm from entering the vagina.

ADVANTAGES	DISADVANTAGES
• It is free and readily available • It has no side effects • It does not require a fitting or prescription	• Sperm may still enter the vagina if withdrawal is not properly timed, or if pre-ejaculation fluid contains sperm. • It does not offer protection from sexually transmitted infections (STIs).

Periodic abstinence/rhythm method

To use the rhythm method, a woman tracks her menstrual history to predict when she will ovulate (or releases an egg from her ovaries). She can use the rhythm method to determine which days to avoid unprotected sex.

This method is ideal for women whose cycles are consistent.

A woman is most fertile at the time of ovulation, which usually occurs 12 to 14 days before her next period starts. This is the time of the month when she is most likely to get pregnant.

Before a woman can use the rhythm method as birth control, she needs to keep track of the length of her menstrual cycles for at least six periods. She can do this with a regular calendar or use a period tracking app[1].

Here's how to use the rhythm method:

1. Mark the first day of the period (this is Day 1).
2. Then mark the first day of the next period.
3. Count the total number of days between each cycle, or the number of days between the first days of each period.
4. To predict the first fertile day (when a woman can get pregnant) in her current cycle:
    a. Find the shortest cycle in the past record.
    b. Subtract 18 from the total number of days in that cycle.

[1] "Spot on Period Tracker" is available as an app in Google Play and Apple Store: https://www.plannedparenthood.org/get-care/spot-on-period-tracker?pid=ppol&c=learn

c. Count that number from day 1 of the current cycle, and mark that day with an X. Include day 1 when counting.
d. The day marked X is your first fertile day.

5. To predict the last fertile day in the current cycle:
   a. Find the longest cycle in your record.
   b. Subtract 11 from the total number of days in that cycle.
   c. Count that number from day 1 (the first day of the period) of the current cycle, and mark that day with an X. Include day 1 when counting.
   d. The day marked X is the last fertile day.

Note that it is unlikely for a woman to get pregnant just after her period, but this can still happen.

Also, other factors like medications, stress and illness can affect the timing of ovulation. And so the rhythm method may not accurately predict ovulation, particularly if a woman's cycle is irregular.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 SAFE	2	3	4 Period Starts	5	6	7
8	9	10	11 UNSAFE	12	13	14
15	16	17	18	19	20	21
22	23 SAFE	24	25	26	27	28
29	30	1	2 Period Starts	3	5	5

SAMPLE CALENDAR DETAILING WHEN A WOMAN IS MOST FERTILE

This method can only predict what are most likely to be safe and unsafe days. It ca not tell a woman for sure when she is fertile. So it is hard to use this is a woman's cycles are not always the same length.

ADVANTAGES	DISADVANTAGES
• Rhythm method is free and readily available • It has no side effects • It does not require a fitting or prescription	• It puts the responsibility solely on the woman. • It is time consuming as it requires careful record keeping. • It may be inaccurate especially if the woman's cycle is irregular. • It does not offer protection from sexually transmitted infections (STIs).

TRADITIONAL FAMILY PLANNING METHODS

Pills

Combination birth control pills, better known as the pill, are oral contraceptives that contain estrogen and a progestin. Pills keep the ovaries from releasing an egg. Pills also cause changes in the cervical mucus and the lining of the uterus (endometrium) to keep sperm from joining the egg.

Consult a health care provider to help decide which pill is right for you.

ADVANTAGES	DISADVANTAGES
• Decreases risk of ovarian and endometrial cancers, ectopic pregnancy, ovarian cysts, benign breast disease • Improvement in acne • Helps lessen severe menstrual cramps (dysmenorrhea) • Reduces androgen production caused by polycystic ovary syndrome • Reduces heavy menstrual bleeding due to uterine fibroids and other causes, as well as a reduction in related iron iron-deficiency anemia • Relief from premenstrual syndrome (PMS) • Shorter, lighter and more-predictable periods or, for some types of combination pills, fewer periods yearly • Better control of monthly cycle and a reduction in hot flashes for women nearing menopause (perimenopause)	• It puts the responsibility solely on the woman • It does not offer protection from sexually transmitted infections (STIs) • Breakthrough bleeding or spotting (more common with continuous-dosing or extended-cycle pills) • Breast tenderness • Elevated blood pressure • Headaches • Nausea • Bloating

Injectable contraceptives
The contraceptive injection is a shot that contains hormones (either a progestin alone, or a progestin and an estrogen together) that stop the woman's body from releasing eggs. It also thickens the mucus at the cervix.

A woman needs one shot every month or every three months - depending on the type of shot - from a healthcare provider.

ADVANTAGES	DISADVANTAGES
• It does not require daily action • It eliminates the need to interrupt sex for contraception, like when putting on a condom • It decreases menstrual cramps and pain • It lessens menstrual blood flow, and in some cases stops menstruation • It decreases the risk of endometrial cancer	• It puts the responsibility solely on the woman • It does not offer protection from sexually transmitted infections (STIs) • It must be given by a healthcare provider • It may not be available in all healthcare facilities • User may have to pay if availed in private clinic/hospital/facility

Condoms
A male condom is placed over the erect penis. When left in place during sexual intercourse, oral sex or anal sex, male condoms are an effective way to protect yourself and your partner from sexually transmitted infections (STIs). Male condoms are also an effective way to prevent pregnancy.

ADVANTAGES	DISADVANTAGES
• Simple to use • The user doesn't need any physical check up to use condoms • Inexpensive • Widely available • Available with or without a lubricant and come in a variety of lengths, shapes, widths, thicknesses and colors; some condoms even have textures to increase sensation	• Condoms can trigger a latex allergy, with reactions to latex including rash, hives, runny nose, and in severe cases tightening of the airways and loss of blood pressure • Condoms can break so there is still a risk of getting STI or becoming pregnant

Emergency contraceptives
Emergency contraception refers to methods that can be used to prevent pregnancy after sexual intercourse. These are recommended for use within five days. They are more effective the sooner they are used after the act of sex.

Emergency contraception can be used in the following situations:

1. Unprotected sexual intercourse
2. Concerns about possible contraceptive failure - for example, if a woman missed her pill, or if a condom breaks during sex
3. Incorrect use of contraceptives
4. Sexual assault if without contraception coverage

ADVANTAGES	DISADVANTAGES
• It does not require daily action • It decreases menstrual cramps and pain • It lessens menstrual blood flow, and in some cases stops menstruation • It decreases the risk of endometrial cancer	• It puts the responsibility solely on the woman • May not be readily available in some settings • It does not offer protection from sexually transmitted infections (STIs) • It must be given by a healthcare provider • Possible nausea • Possible vomiting • Slight irregular vaginal bleeding • Fatigue

IUDs
"IUD" stands for "intrauterine device." Shaped like a "T" and a little than a coin, an IUD fits inside a woman's uterus. It prevents pregnancy by stopping sperm from reaching and fertilizing the eggs.
A doctor or trained healthcare professional will insert the IUD. He/she will put your feet in stirrups. He/she will then place a speculum in the vagina to hold the vagina open. The IUD will be placed in a small tube that will be inserted into your vagina. The doctor will move the tube up through the cervix and into the uterus, and then push the IUD out of the tube and pull the tube out. Strings attached to the IUD will hang 1-2 inches into the vagina.

The procedure can be uncomfortable, and a woman may experience cramps and bleeding, or feel lightheaded from the pain.

A woman can have most IUDs placed at any time in her cycle.

An IUD last from three to 10 years, depending on what kind of IUD a woman gets.

The IUD may be removed by a doctor or trained healthcare professional.

ADVANTAGES	DISADVANTAGES
• They last a long time • It is reversible • They're mostly hassle-free; once you have one inserted, you don't have to think about it, and neither does your partner • If offered with a fee, the cost is one-time and upfront • They're safe to use if you're breastfeeding	• It puts the responsibility solely on the woman • It does not offer protection from sexually transmitted infections (STIs) • It must be placed and removed by a trained healthcare provider • It may not be available in all healthcare facilities • User may have to pay if availed in private clinic/hospital/facility • Headache • Acne • Breast tenderness • Irregular bleeding, which can improve after six months of use • Mood changes • Cramping or pelvic pain

Implants

The contraceptive implant is a small flexible plastic rod placed by a doctor, nurse or trained healthcare provider under the skin in the woman's upper arm. The impact releases the hormone progestogen into the woman's bloodstream to prevent pregnancy. It lasts for three years.

ADVANTAGES	DISADVANTAGES
• It does not require daily action, lasting for up to three years • It eliminates the need to interrupt sex for contraception, like when putting on a condom • It immediately works • It can be removed any time, with pregnancy occurring after removal	• It puts the responsibility solely on the woman • It does not offer protection from sexually transmitted infections (STIs) • It must be given by a healthcare provider • It may not be available in all healthcare facilities • User may have to pay if availed in private clinic/hospital/facility • The device must be removed after three years

Jelly/foam/sponge

Jellies, foams and sponges are considered barrier methods of birth control that contain spermicide (or a chemical that kills sperm). Spermicidal jellies and foams, and vaginal sponges prevent pregnancy by killing sperm and blocking the opening of the cervix. These methods stop any sperm from entering the uterus and reaching an egg.

Foams and jellies will dissolve in the vagina, but a woman but physically remove a vaginal sponge.

ADVANTAGES	DISADVANTAGES
• They start working immediately • They do not cause any changes to the woman's body • There is no need to see a healthcare provider to get them • A woman only uses these when they need to • They are generally harmless, rarely causing vaginal or penile irritation	• It puts the responsibility solely on the woman • It does not offer protection from sexually transmitted infections (STIs) • User may have to pay to avail of them • It might irritate the vaginal area or cause a yeast infection • A woman needs to put them in every time she has sex • They are messy • A woman can't use them if she or her partner is allergic to spermicide

Female sterilization

Female sterilization is a permanent procedure that prevents pregnancy by blocking the fallopian tubes. This prevents the egg from reaching the uterus. It also keeps the sperm from reaching the egg. Without fertilization of the egg, pregnancy ca not occur.

There are two main types of female sterilization: surgical and nonsurgical.

The surgical procedure is tubal ligation. Here, the fallopian tubes are cut or sealed. The procedure is usually performed using a surgery called laparoscopy.

With nonsurgical procedures, devices are placed in the fallopian tubes to seal them. The devices are inserted through the vagina and uterus.

ADVANTAGES	DISADVANTAGES
• Safe and highly effective approach to prevent pregnancy • It lasts a lifetime, so the woman does not need to worry about birth control ever again • Fast recovery is quick • There are usually no significant long-term side effects • It is private; a woman doesn't have to inform her partner of the decision not to have a baby	• It is permanent • It does not offer protection from sexually transmitted infections (STIs) • It must be done by a healthcare provider • There are some risks of infection, pain or bleeding • There are cases in tubal ligation when the fallopian tubes grow back together. When this happens, there is a risk for ectopic pregnancy (or a pregnancy outside of the uterus), which is a life-threatening condition • With tubal implant, a woman may have nickel allergy, an autoimmune disease, or a pelvic infection • Some women may later wish they could have a child or additional children, and they may regret the decision to sterilize

Male sterilization

Also called vasectomy, male sterilization is a form of surgical contraception that involves cutting and tying the two tubes (each called a vas deferens) that carry sperm from the testes (testicles) to the penis. It provides permanent contraception.

ADVANTAGES	DISADVANTAGES
• This is reliable • It is a quick and simple procedure • It has no affect on sexual intercourse, and it does not interfere with erection, sexual potency, hormone production or ejaculation	• It is permanent • It is not effective immediately, and may take 2-3 months (or 16-20 ejaculations) before all sperm are cleared from each vas deferens • There may be short-term discomfort including pain, bruising or swelling following the procedure • Some complications may happen, such as bleeding, infection or an inflammatory reaction to sperm leakage • It does not offer protection from sexually transmitted infections (STIs) • It must be done by a healthcare provider • User may have to pay if availed in private clinic/hospital/facility • Some men may later wish they could have a child or additional children, and they may regret the decision to sterilize • In rare cases, the ends of the vas deferens may re-connect and the man may become fertile again. In these cases, vasectomy can be repeated

Illustration of Contraceptive Pills

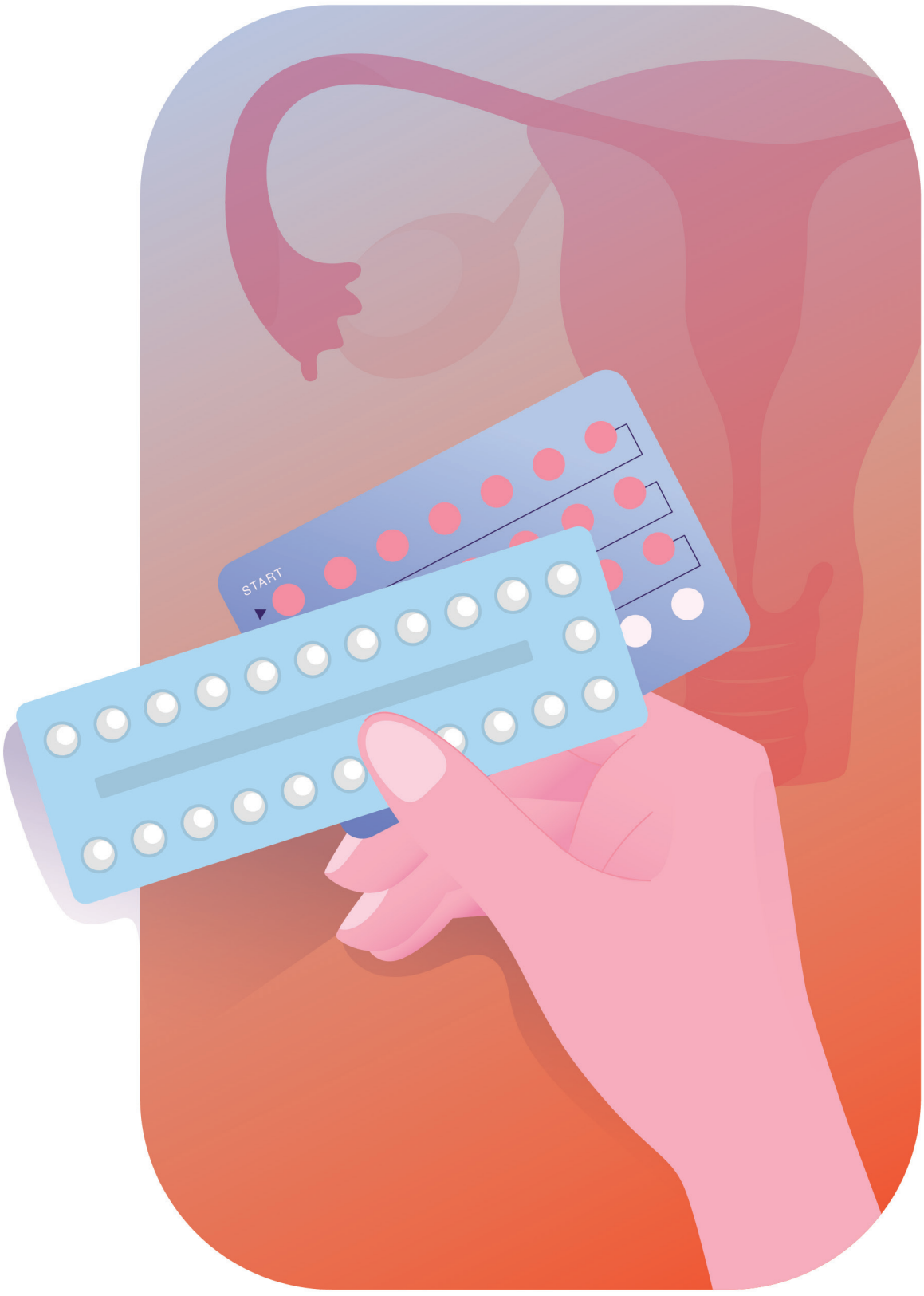


Illustration of Injectable Contraceptives

Illustration of Male Condom

Illustration of Female Condom

Illustration of IUDs

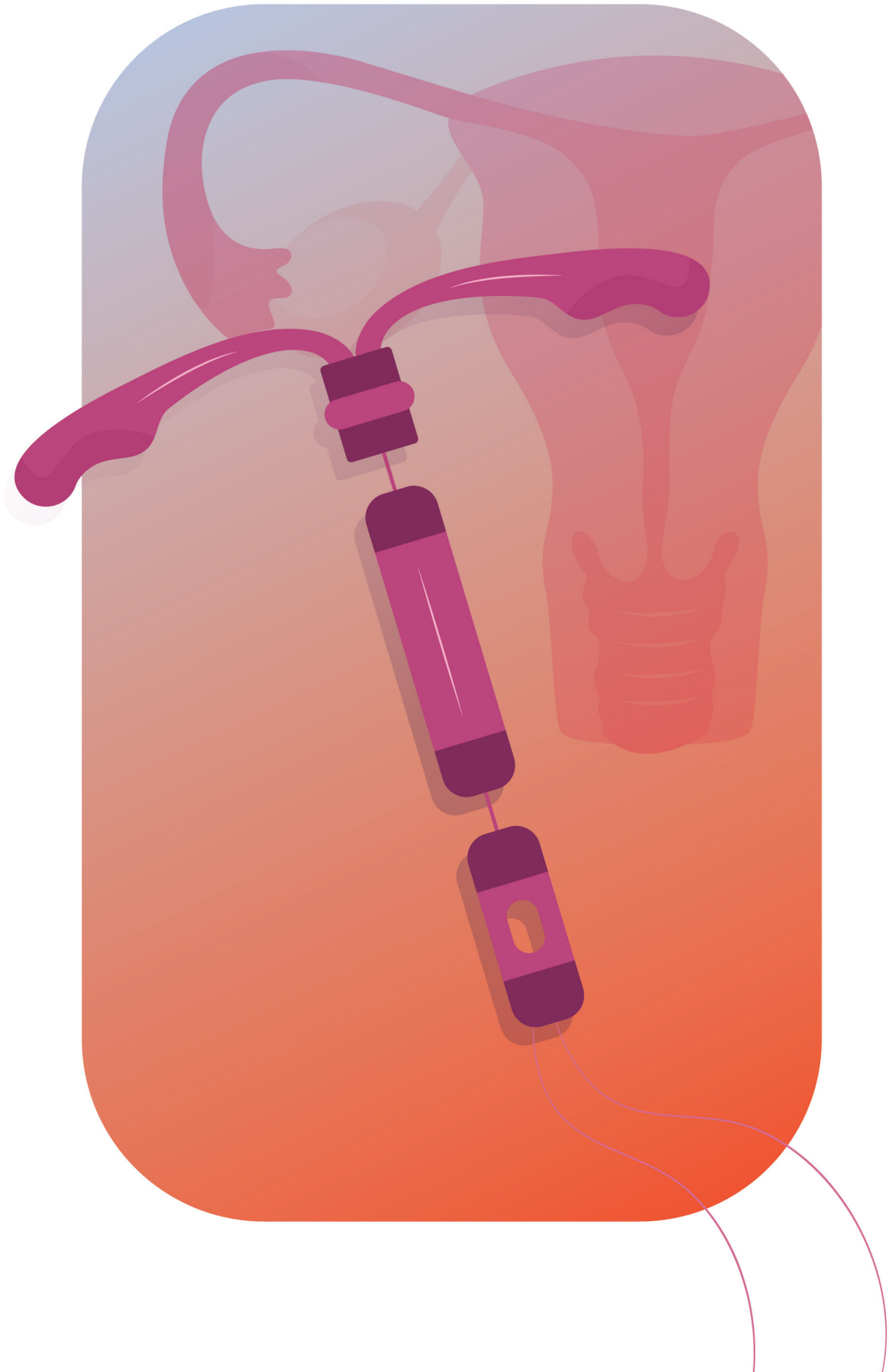


Illustration of Implants

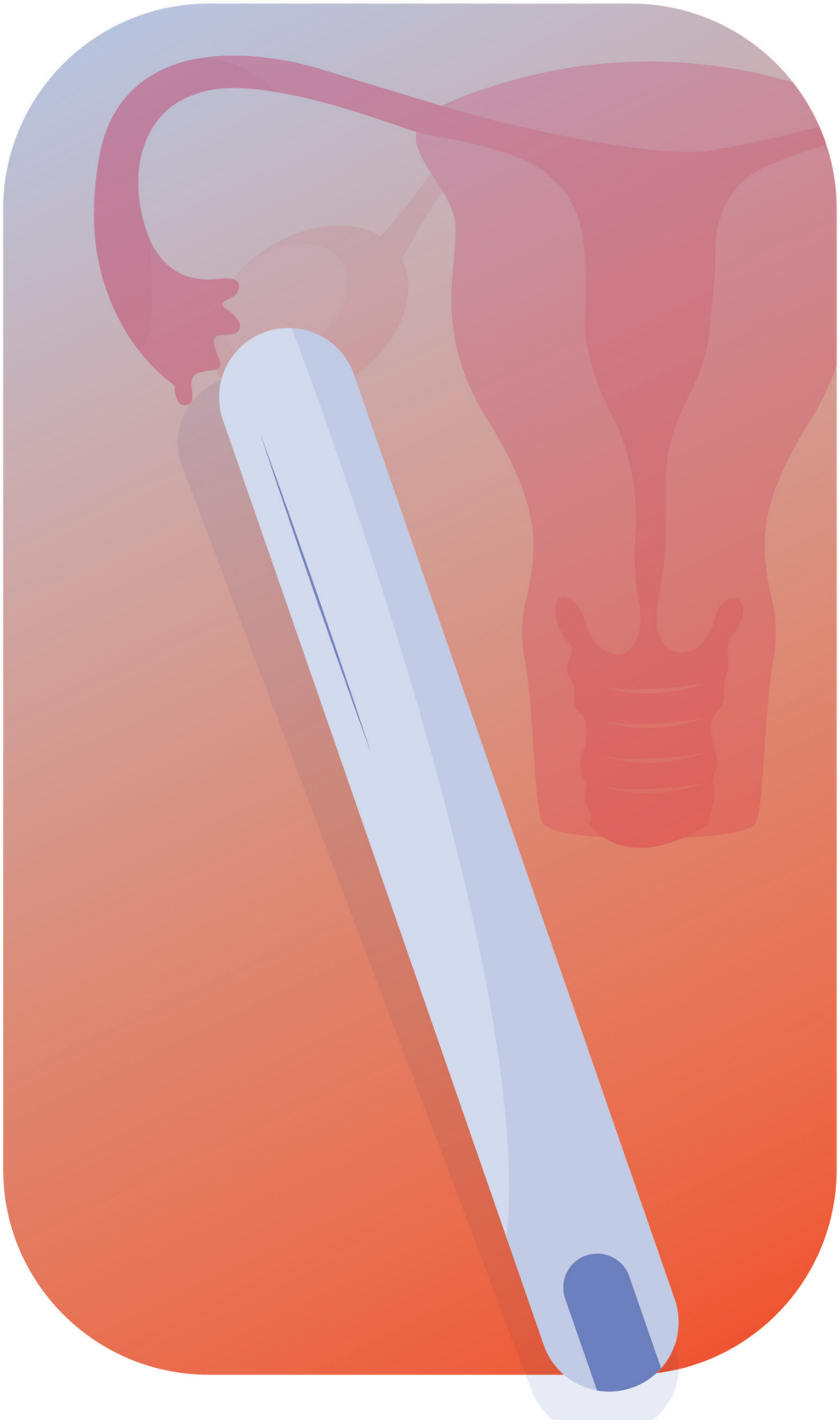


Illustration of Jelly/foam/sponge

Illustration of Female Sterilization

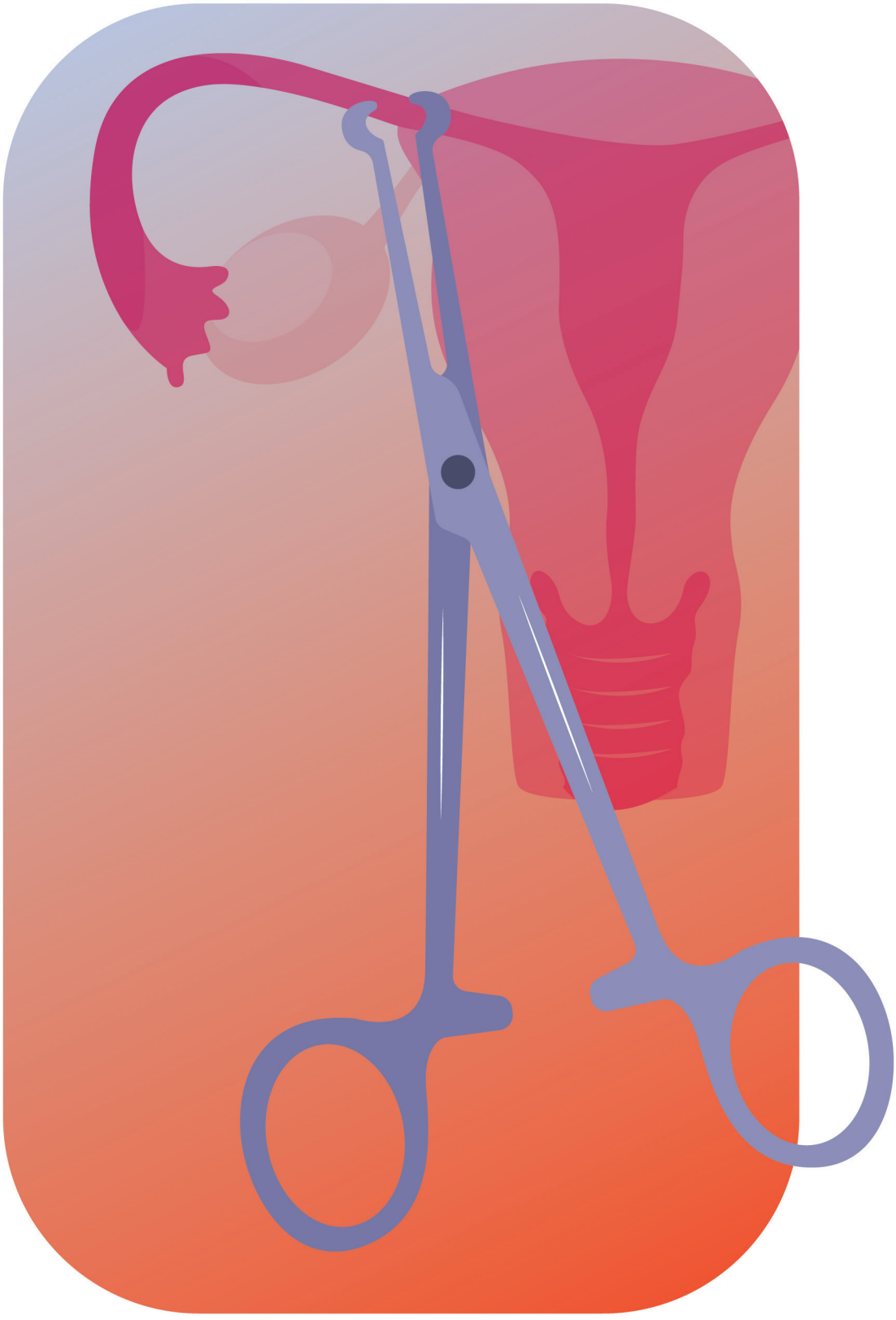
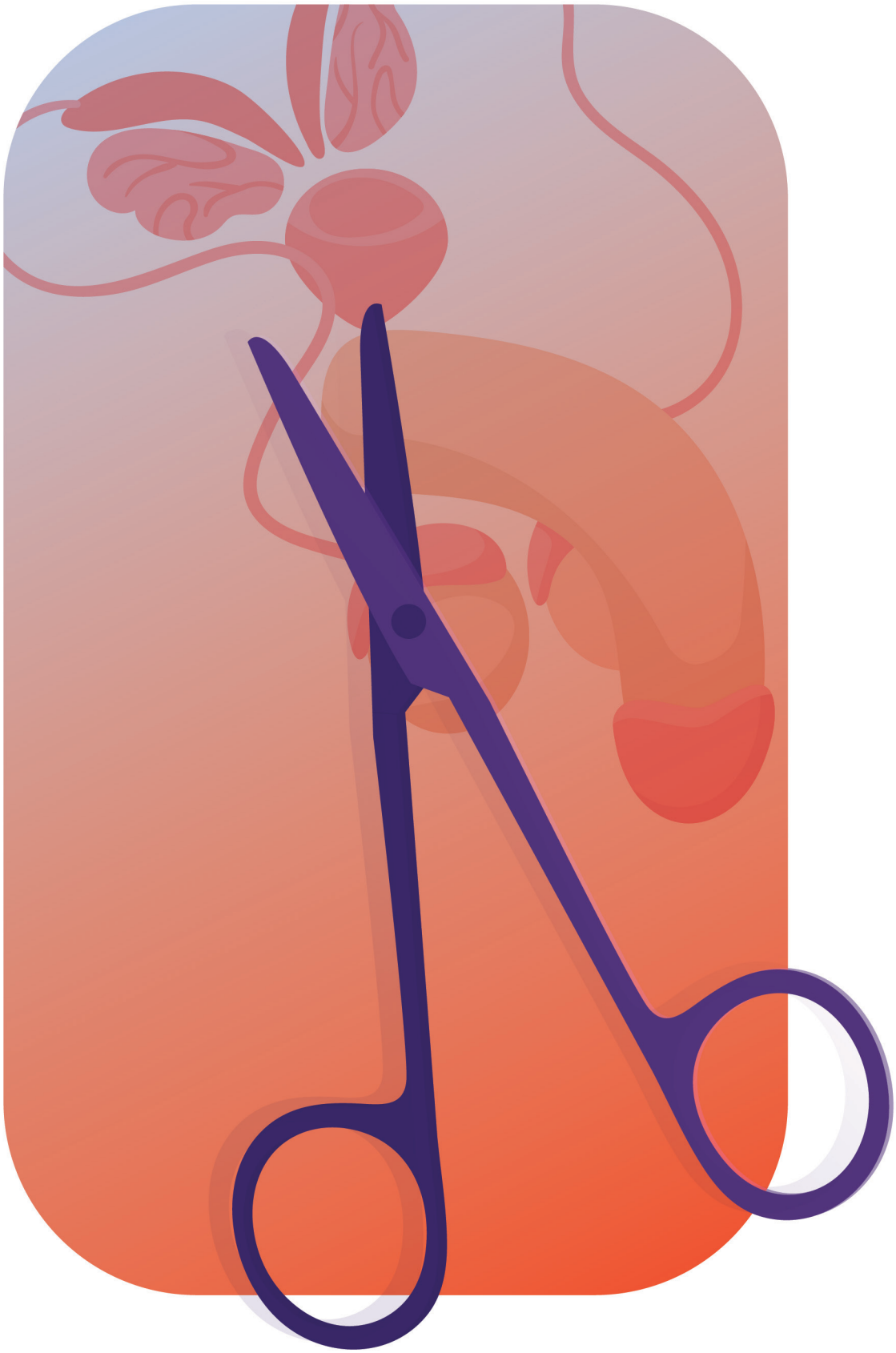


Illustration of Male Sterilization



TRAINING TOPIC 2: Infertility services

PURPOSE/OBJECTIVES

At the end of this session, the participants are expected to know and be able to discuss the following:

1. Definition of infertility
2. Causes of infertility
3. Treatments available to deal with infertility
4. Issues Deaf people encounter when accessing services to deal with infertility

TIME ALLOCATION

TOTAL: One hour/60 minutes
GROUP ACTIVITY: 10 minutes
LECTURE AND Q&A: 50 minutes

MATERIALS

- Flip charts or manila paper or cartolina
- Markers
- PowerPoint presentation

SESSION OUTLINE & METHODOLOGIES

Start the session with a group activity.

GROUP EXERCISE: Brainstorming

This exercise aims to ascertain if participants are familiar with infertility, related treatments, and the issues that young Deaf and hard pf hearing people may encounter when accessing these treatments.

MECHANICS:

1. Ask the participants if they know what infertility means. List down their answers.
2. Ask the participants to identify causes of infertility. List down their answers.
3. Ask the participants to identify treatments to deal with infertility. List down their answers.
4. Ask the participants to identify what issues they think Deaf people will encounter when accessing these treatments. List down their answers.

To process the answers provided by the participants in this exercise, proceed to the discussion of Infertility services. Prepare a visual presentation (for example, PowerPoint) containing the following information:

1. Definition of infertility
2. Causes of infertility

3. Treatments available to deal with infertility
4. Issues Deaf people encounter when accessing services to deal with infertility

Be sure to discuss the answers of the participants during the brainstorming, dealing with misconceptions, etc.

Provide handouts to the participants before the discussion.

The trainer may answer/take in questions during the discussion, or he/she may decide to finish the presentation first before questions are taken/considered.

At the end of the session, be sure to summarize the key points.

KEY LESSONS/MESSAGES

What is infertility?

Infertility means not being able to become pregnant after one year or more of regular unprotected sexual intercourse. If a woman can get pregnant but she keeps having miscarriages or stillbirths, that is also called infertility.

Infertility in a male can be evaluated using different clinical interventions, and also from a laboratory evaluation of semen.

Causes of female infertility

- Ovulation disorders that affect the release of eggs from the ovaries.
- Uterine or cervical abnormalities such as abnormalities with the cervix, polyps in the uterus or the shape of the uterus.
- Fallopian tube damage or blockage.
- Endometriosis that happens when endometrial tissue grows outside of the uterus, affecting the function of the ovaries, uterus and fallopian tubes.
- Early menopause, or when the ovaries stop working and menstruation ends before age of 40.
- Cancer and cancer treatment.

Causes of male infertility

- Abnormal sperm production or function.
- Problems with the delivery of sperm due to sexual problems.
- Overexposure to certain environmental factors, such as pesticides and other chemicals, and radiation. Fertility is also affected by cigarette smoking, alcohol, marijuana, anabolic steroids, and taking medications to treat bacterial infections, high blood pressure and depression.
- Frequent exposure to heat - for example, saunas or hot tubs - can raise body temperature and may affect sperm production.
- Damage related to cancer and its treatment.
-

ADAPTED FROM MAYO CLINIC

Risk factors of infertility

- Age. Women's fertility declines with age, even dropping rapidly after the age of 37. Meanwhile, men over the age of 40 may be less fertile than younger men.
- Smoking tobacco or marijuana may reduce the likelihood of pregnancy, not to mention increases the risk of miscarriages. For men, smoking can increase the risk of erectile dysfunction and a low sperm count.
- Alcohol use.
- Being overweight.
- Being underweight.
- Exercise issues that contribute to obesity.

ADAPTED FROM MAYO CLINIC

Infertility diagnosis and treatments

A doctor can conduct an infertility testing, which will include understanding the patient's sexual habits and making recommendations to improve the chances of getting pregnant.

Infertility evaluation can be expensive, and may involve uncomfortable procedures.

There are also no guarantees that they will work.

Issues Deaf people encounter when accessing infertility services

Infertility also affects Deaf people, but accessing related services may be harder for them. Some the challenges include:

- Limited access to information
- Existing information are not understandable/sensitive to the Deaf community, particularly with the use of medical jargon
- Lack of sign language interpreters in healthcare establishments
- Informal sources - such as friends and family members - may be inadequate or unreliable
- Traditional cultural values that discourage discussion of sex within the family
- There may be deaf health issues linked with infertility - for example, sensorineural deafness is linked with male infertility (a condition characterized by hearing loss and an inability to father children)

NOTES

See REFERENCES for more readings.

TRAINING TOPIC 3: Maternal and newborn health services

PURPOSE/OBJECTIVES

After this session, the participants should have an understanding and be able to discuss:

1. Maternal health and causes of maternal deaths
2. Pregnancy-related complications among the youth
3. Neonatal care
4. Issues Deaf people encounter when accessing maternal and neonatal services

TIME ALLOCATION

TOTAL: 1 1/2 hours/90 minutes
GROUP ACTIVITY: 30 minutes
LECTURE AND Q&A: 60 minutes

MATERIALS

- Flip charts or manila paper or cartolina
- Markers
- PowerPoint presentation

SESSION OUTLINE & METHODOLOGIES

Start the session with a group activity.

GROUP EXERCISE: Role play
This exercise aims to ascertain if participants are familiar with infertility, related This exercise aims to ascertain the level of knowledge and awareness of the participants on maternal and neonatal health and service; and see if the participants can properly communicate health-seeking behaviors particularly to access maternal and neonatal health and services.
MECHANICS:

1. Divide the participants into smaller groups.
2. Assign members in every group to represent: A, B, C. Have the participants play the roles at various times, i.e.

	1st Round	2nd Round	3rd Round
Counselor	A	B	C
Client	B	C	A
Observers	C	A	B

The per-role instructions:

CLIENTS
Separate those who will play the role of the clients from the others, and then give them one of the following cases:

CASE 1: *The client is a young Deaf woman who just fond out she is pregnant. She visits a healthcare facility to ask what she should be doing for her health, and the baby she is carrying.*

CASE 2: *The client is a young Deaf man whose girlfriend is pregnant. The girlfriend refuses to have herself checked, and continues to smoke and drink alcohol. He wants to know how he can help her look after their baby.*

CASE 3: *The clients are a young Deaf couple with a newborn/baby. Their parents are very superstitious when it comes to raising their child, and they want to know if how to properly do so.*

The "clients" may make up the other details of their stories. The instruction, though, is for them to check if the counselor can provide information and services that they need, or if they will be referred to another facility that can provide the maternal and neonatal services.

COUNSELORS
The counselors have to provide counseling, answering the inquiries of the clients who dropped by their center.

OBSERVERS
The observers are asked to pay attention to the proceedings, particularly on whether the participants are familiar with the topics.

For the processing of the results of this exercise:

1. After the role playing, gather all the participants again.
2. Discuss their experiences as: counselors, clients and observers.

The activity can lead to the discussion of maternal and newborn health services.

For the discussion, prepare a visual presentation (for example, PowerPoint) containing the following information:

Maternal health and causes of maternal deaths
Pregnancy-related complications among the youth
Neonatal care
Issues Deaf people encounter when accessing maternal and neonatal services

Provide handouts to the participants before the discussion.

The trainer may answer questions during the discussion, or he/she may decide to finish the presentation before questions are taken. Whatever Q&A format he or she chooses, time should be allocated to answer questions from the participants.

At the end of the session, be sure to summarize the key points.

KEY LESSONS/MESSAGES

Maternal, perinatal and newborn health

Based on WHO-Regional Office for Europe (n.d.) definitions:

- Maternal health is the health of women during pregnancy, childbirth and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to ensure a positive and fulfilling experience, and reduce maternal morbidity and mortality.
- Perinatal health refers to health from 22 completed weeks of gestation until seven completed days after birth.
- Newborn health refers to babies' first month of life. A healthy start during the perinatal period influences infancy, childhood and adulthood.

Pregnancy-related complications among the youth

Prenatal and postpartum maternal health is critical to a mother's physical and mental well-being. This also contributes to her ability to render loving, proper care to her newborn child at birth and the years thereafter.

The WHO recommends four or more antenatal care visits during pregnancy to ensure the wellbeing of mothers and newborns.

If proper prenatal and postpartum maternal care is not provided, complications could happen. Some of the complications include:

- Severe bleeding (mostly bleeding after childbirth)
- Infections (usually after childbirth)
- High blood pressure during pregnancy (pre-eclampsia and eclampsia)
- Complications from delivery
- Unsafe abortions

According to UNICEF (n.d.), pregnancy-related complications are the number one cause of death among girls between 15 and 19 years of age. This is because adolescent girls are still growing themselves, and so they are at greater risk of complications if they become pregnant.

Neonatal care

The word "neonatal" means newborn. It refers to the first 28 days of life.

Neonatal care is the type of care given to a baby born premature or sick. Hospitals have neonatal units that provide care for babies who are born prematurely (before 37 weeks' gestation), with a medical condition that needs treatment, or at a low birthweight.

Many deaths occur in babies born too early and too small, babies with infections, or babies asphyxiated around the time of delivery.

Labor, birth and the immediate postnatal period are the most critical for newborn and maternal survival.

Care of the newborn often include:

- Feeding/breastfeeding - A baby needs to be fed within one hour after birth. If/when possible, early and exclusive breastfeeding is encouraged.
- "Kangaroo Mother" care, or skin-to-skin contact.
- Immunization (BCG, polio and hepatitis shots are given soon after birth in most countries).

Issues Deaf people encounter when accessing maternal and neonatal services

- Limited access to information
- Existing information are not understandable/sensitive to the Deaf community, particularly with the use of medical jargon
- Lack of sign language interpreters in healthcare establishments
- Informal sources - such as friends and family members - may be inadequate or unreliable
- Traditional cultural values that discourage discussion of sex within the family
- Discrimination, abusive treatment and negative attitudes toward Deaf people.

NOTES

See **REFERENCES** for more readings.

TRAINING TOPIC 4: Prevention of unsafe abortion and post-abortion care

PURPOSE/OBJECTIVES

At the end of the session, participants will be able to:

1. Define the term "abortion."
2. Discuss basic information about abortion
3. Consider different opinions and beliefs of abortion.
4. Weigh myths against facts
5. Identify concerns about talking about abortion and begin to come up with solutions

TIME ALLOCATION

TOTAL: Two hours /120 minutes
GROUP ACTIVITY: 30 minutes/15 minutes per activity
LECTURE AND Q&A: 90 minutes

SESSION OUTLINE & METHODOLOGIES

This session will be divided into two parts.

The first part will introduce the definition of abortion to the participants, while the second part will tackle safe and unsafe abortion.

The two parts will have separate activities.

PART 1: SAFE ABORTION
GROUP EXERCISE: <u>DEFINE 'ABORTION'</u>
Via brainstorming and interactive presentation, this part eyes to:

1. Introduce the concept of abortion to the participants
2. Inform them about the different beliefs about abortion, including myths and facts

MATERIALS:

- Flip charts or manila paper or cartolina
- Markers
- PowerPoint presentation

TIME ALLOCATION:
TOTAL: 45 minutes
GROUP ACTIVITY: 15 minutes
LECTURE AND Q&A: 30 minutes

MECHANICS:

1. Write down the word "abortion" in the center of a flip chart.
2. Explain the term. Be sure to clarify the difference between abortion and miscarriage. Give the participants enough time to be familiar with the terms

introduced.

3. Ask the participants to sign or say words that come into their head after knowing the term.
4. Write all the words down, and place a question mark after each word.
5. When the paper is filled, ask participants for their first impressions of the brainstorm.

To process this exercise:

1. Definition of infertility
2. Discuss the facts about abortion - for example, existing laws about abortion, and medical information.
3. Discuss how values affect concepts of abortion. These values will be different for different people.
4. Make it clear to the participants that when discussing abortion, it is important not to confuse facts and values.
5. Use examples from the brainstorming activity to clarify factual information and giving more detail on any words or phrases that are not clear to the group.

PART 2: WHEN IS ABORTION SAFE OR UNSAFE?
At the end of this part, the participants should be able to:

- Explain about safe and unsafe abortion
- Describe the effects of unsafe abortion

GROUP EXERCISE: QUIZ ON ABORTION
Via brainstorming and interactive presentation, this part eyes to:

1. Introduce the concept of abortion to the participants
2. Inform them about the different beliefs about abortion, including myths and facts

MATERIALS:

- A printed copy of the QUIZ
- Flip charts or manila paper or cartolina
- Markers
- PowerPoint presentation

TIME ALLOCATION:
TOTAL: 75 minutes
GROUP ACTIVITY: 15 minutes
LECTURE AND Q&A: 60 minutes

MECHANICS:

1. Give each participant a printed copy of the quiz. Ask them to complete the quiz.
2. Be sure to answer any additional questions raised.

3. Divide the participants into 2-3 groups (depending on the number of participants). Conduct the quiz by asking a question to each team consecutively. Assign signs for 'True' and 'False'. Give a score to the team with the correct answer. The team with the highest score wins.
4. Now, give a PowerPoint presentation about safe and unsafe abortion.

KEY LESSONS/MESSAGES

What is abortion?

Abortion is a procedure to end a pregnancy.
It uses medicine or surgery to remove the embryo or fetus and placenta from the uterus.
The procedure should be done by a licensed health care professional.

What is miscarriage?

Also known as spontaneous abortion and pregnancy loss, this is the natural death of an embryo or fetus before it can survive independently.

Safe abortion

WHO recommends three methods of safe abortion, depending on how far along the pregnancy is.

1. Medical abortion
   The use of mifepristone and misoprostol pills, or misoprostol pills alone, to induce an abortion.
   This method can be used up to 24 weeks of pregnancy.
   Different doses and regimens apply, depending on the duration of pregnancy.

2. Manual vacuum aspiration
   Involves evacuation of the contents of the uterus, either manually by the use of a hand-held plastic aspirator or with an electric vacuum pump.
   This method has a success rate of 95-100% up to 14 weeks of pregnancy.
   Depending on the duration of pregnancy, this takes from 3 to 10 minutes to complete, and can be performed at primary level on an outpatient basis using a local anesthetic.

3. Dilatation and evacuation
   Requiring a skilled, experienced provider, this is used in the second trimester usually after 14 weeks of pregnancy.

Preventing unsafe abortion

One main reason for women considering unsafe abortion is legal restriction. Other reasons include the inability to pay, lack of social support, delays in seeking healthcare, providers' negative attitudes, and low quality of services.
Unsafe abortion has life-threatening impacts, so it should be avoided at any cost.
This is a big issue among young Deaf women because of unplanned pregnancies.

This is because even when effective contraceptive methods are available, these may not be accessible to unmarried women, and there are usually no interpreters in health care facilities.

Unsafe abortion can be prevented through:

- Comprehensive sexuality education
- Provision of safe, legal abortion
- Dealing with stigma linked to having an abortion
- Easy access to Deaf and hard of hearing youth-friendly abortion services and facilities
- Prevention of unintended pregnancy through the use of effective contraception, including emergency contraception

Post-abortion care

- After an abortion, there may be some side effects and complications, including: pain, bleeding, fever, nausea, vomiting, diarrhea, and pelvic infection. These may last from 1 to 2 weeks.
- If signs of pregnancy like nausea and sore breasts continue, consult a health worker right away as the woman may still be pregnant and the abortion is unsuccessful.
- Normal monthly bleeding should start about 4 to 6 weeks after an abortion.

Care for yourself after an abortion

- Talk about feelings with someone you trust.
- Take antibiotics as prescribed to avoid infection
- Avoid sex or putting anything into your vagina for at least two days after bleeding stops.
- If you have cramps or pains, rest and use a hot water bottle on your abdomen. Or take paracetamol or ibuprofen. Take medical advice if pain persists for a long time.
- To lessen pain and bleeding, rub or massage your lower abdomen often. It helps the womb to squeeze down to normal size and lessen bleeding.
- Drink plenty of liquids to help you recover faster.
- You can go back to your usual activities as soon as you feel well, usually within a day.

NOTES

The trainer/facilitator is encouraged to use pictures/images/illustrations.

Familiarize yourself with existing laws/regulations, as well as services related to abortion in the context of where the training/workshop is being given.

For the quiz, refer to the questionnaire.

See ANNEX 2 for additional information on abortion.

Questions for the Quiz

1. It is safe to abort by putting objects like sticks, wire, or plastic tubing into the vagina and womb?

True **False**

2. The main purpose of safe abortion is to minimize the mortality and morbidity from unsafe abortion.

True False

3. Abortion is completely illegal in most of the countries.

True **False**

**There are five countries that do not permit abortion in any circumstances (Dominican Republic, El Salvador, Nicaragua and Malta). Most of the countries allow abortion to preserve the physical and/or mental health of the woman.*

4. An abortion is safe when performed after 14 weeks.

True **False**

5. Abortion is safe when it is performed by trained and experience health worker.

True False

6. Unsafe abortion is absolutely harmless.

True **False**

7. Gender identifying abortion should not be done.

True False

8. Medical method is performed using medicines within 9weeks of pregnancy.

True False

9. Abortion can be done for 28 weeks pregnancy in cases like force compulsion sex, incest or rape and complications (like genetic defects, threats to the mother)

True False

10. Vacuum aspiration is the recommended technique of surgical abortion for pregnancies of up to nine weeks of gestation.

True **False**

TRAINING TOPIC 5: HIV and AIDS

PURPOSE/OBJECTIVES

After this session, participants should learn about, and be able to teach the following:

1. What is HIV? Is HIV the same as AIDS?
2. Modes of transmission/How can you get infected with HIV?
3. Ways you can not get infected with HIV
4. How can you know if you have HIV?
5. What happens when you have HIV?

TIME ALLOCATION

TOTAL: Two hours/120 minutes
GROUP ACTIVITIES: 15 minutes each
LECTURE AND Q&A: 90 minutes

MATERIALS

- Flip charts or manila paper or cartolina
- Markers
- PowerPoint presentation

SESSION OUTLINE & METHODOLOGIES

Start with the group activity.

ACTIVITY 1: Risks and Risk-taking

This exercise aims to:

- Tackle risky behaviors that put people at risk for HIV infection
- Open the minds of the participants for them to see that everyone takes risks
- Inform participants that even if everyone takes risks, some sectors of society are discriminated for taking the same risks as others

MECHANICS:

1. Ask the participants to name general risky practices/behaviors that they know of, or may have personally done. List these down.
2. After the participants named risky behaviors, ask all of them to stand. While the participants are standing, call out the risky behaviors that they mentioned one by one. Ask the participants who - at any point in their lives - have done the risky behaviors to take a seat. Stress the key message at this point that everyone takes risks.
3. Ask the participants to give reasons why they take the risky practices/behaviors they mentioned. Write the answers provided.
4. Ask the participants to cite reasons why people take risks.
5. Discuss how the reasons for risk-taking could be similar; but the treatment

of people of those who take risks vary, such as when dealing with LGBTQIA people, sex workers, youth and seniors.

Link risk-taking to sexual behaviors; that there are also risky sexual behaviors that put everyone at risk, and yet some sectors are more stigmatized and discriminated not because of their risk-taking but because of other factors like their identity, work, and so on.

Do a PowerPoint presentation on HIV. With the presentation, make use of illustrations to better get the messages across.

End the session with another group activity.

ACTIVITY 1: Call out the risk

This exercise aims to:

- Check if the participants understood the discussion
- Further open the minds of the participants for them to understand stigma and discrimination related to HIV
- Encourage HIV testing

MECHANICS:

1. Ask the participants to answer questions given to them, including:
2. Is HIV the same as AIDS? (For the definition of HIV)
3. Can you get infected with HIV from mosquito bites? (Modes of transmission)
4. If you share clothes with someone with HIV, will you get infected? (Modes of transmission)
5. Is there a treatment for HIV? (ARVs/medication)
6. Can you tell if a person has HIV by looking at him or her? (HIV testing)
7. With every question, provide a brief recap of the answers.

KEY LESSONS/MESSAGES

At the end of this session, participants should know and be able to discuss the following:

1. What is HIV? Is HIV the same as AIDS?
2. Everyone can be infected with HIV.
3. Modes of HIV transmission/How you can get infected with HIV
4. You can not get infected with HIV from…
5. How can you know if you have HIV?
6. What is ARV?
7. What is VCT?

What is HIV?

HIV (or Human Immunodeficiency Virus) is a virus that attacks cells that help the body fight infections. When these cells are compromised, a person is more

vulnerable to other infections and diseases.

If not treated, HIV can lead to AIDS (Acquired Immunodeficiency Syndrome).

There is no cure for HIV. Meaning, if you have HIV, you have it for life.

Is HIV the same as AIDS?
HIV and AIDS are not the same thing.

HIV is the virus that causes AIDS. AIDS is the late stage of HIV infection that occurs when the body's immune system is badly damaged because of the virus.

People with HIV do not always have AIDS.

How can you get infected with HIV?
Anyone can be infected with HIV.

The virus is transmitted in bodily fluids, particularly:

1. Blood
2. Semen
3. Vaginal and rectal fluids
4. Breast milk

For transmission to occur, the HIV in these fluids must get into the bloodstream of a person without HIV through a mucous membrane (found in the rectum, vagina, mouth, or tip of the penis); open cuts or sores; or by direct injection.

HIV is not spread by:

- Air or water
- Mosquitoes, ticks or other insects
- Saliva, tears or sweat that is not mixed with the blood of a person with HIV
- Shaking hands; hugging; sharing toilets; sharing dishes, silverware, or drinking glasses;
- Engaging in closed-mouth or "social" kissing with a person with HIV
- Drinking fountains
- Other sexual activities that don't involve the exchange of body fluids (for example, touching).
- HIV can't be passed through healthy, unbroken skin.

How can you know if you have HIV?
The only way to know for sure if you have HIV is to get tested.

What is ARV?
There is no cure for HIV.
However, a person with HIV must HIV medicine (called antiretroviral medicine or

ARV), so he or she can live a long and healthy life.
ARV can also help him or her prevent transmitting HIV to his or her sexual partners.

What is VCT?
VCT stands for "voluntary counseling and testing".

VCT usually usually involves:

1. Pre-test counseling, when a counselor discusses with you HIV, other STIs, your reason for getting tested, and the process of testing
2. Actual HIV screening or testing, where the counselor uses a method that will ascertain if you have HIV; and
3. Post-test counseling, where the counselor discusses with you the next steps you can take if you are HIV-positive, or getting another test if you are HIV-negative at the time of testing, as well as steps you can take to avoid getting HIV infection.

As its name states, VCT should always be voluntary.

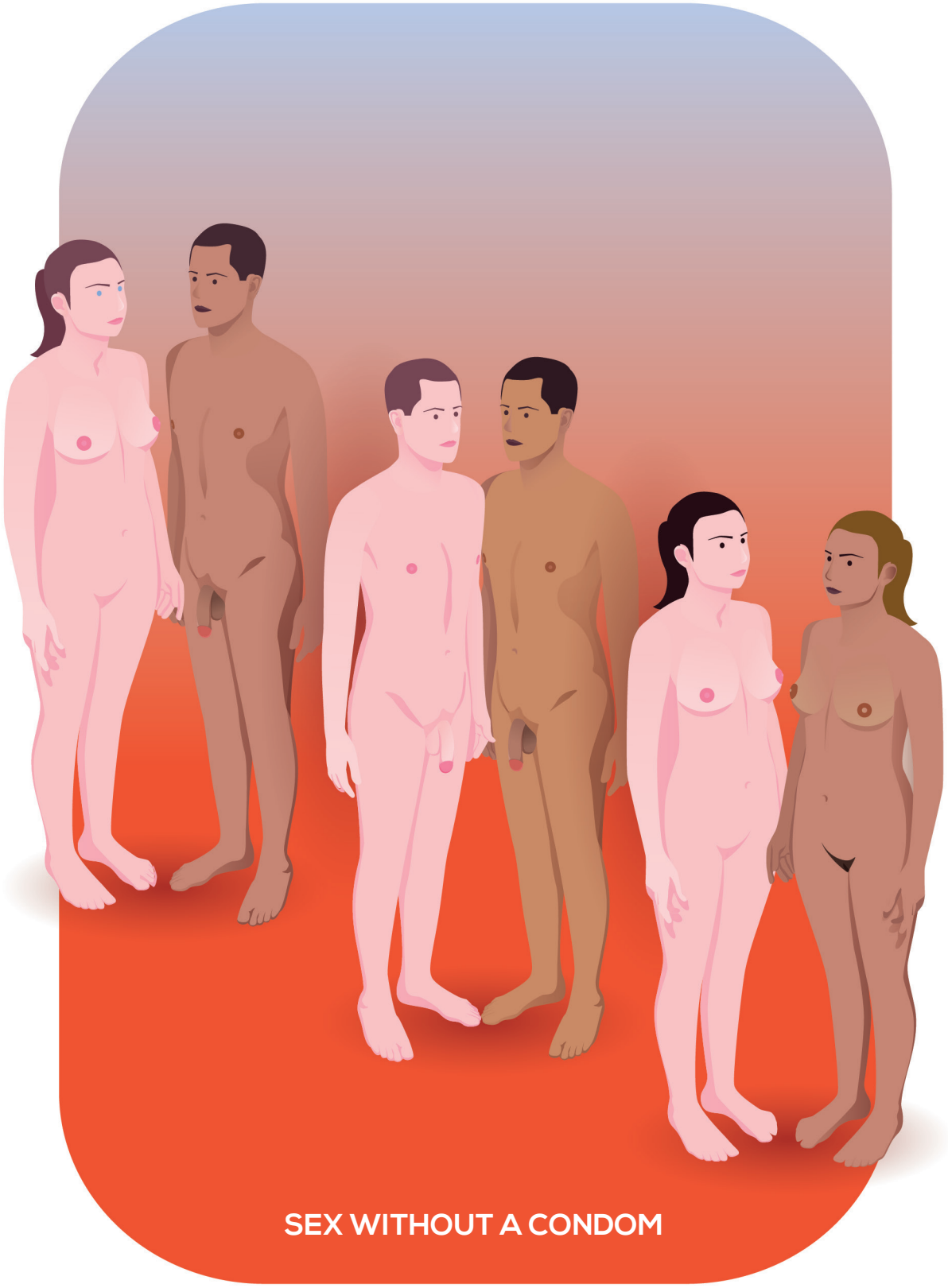
Issues Deaf people encounter when accessing HIV services

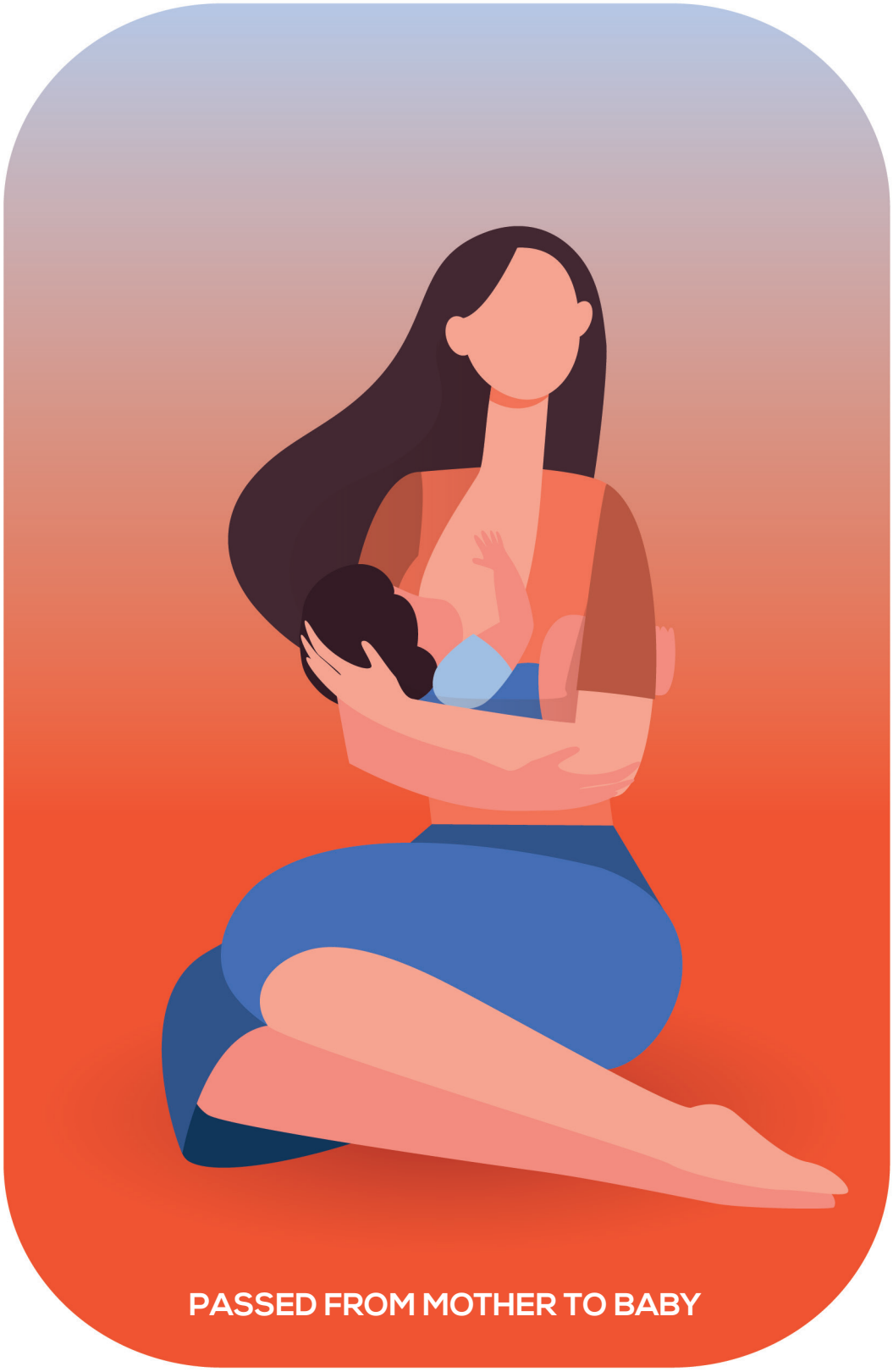
- Limited access to information
- Existing information are not understandable/sensitive to the Deaf community, particularly with the use of medical terms
- Lack of sign language interpreters in healthcare establishments offering HIV testing
- Informal sources - such as friends and family members - may be inadequate or unreliable
- Traditional cultural values that discourage discussion of sex within the family

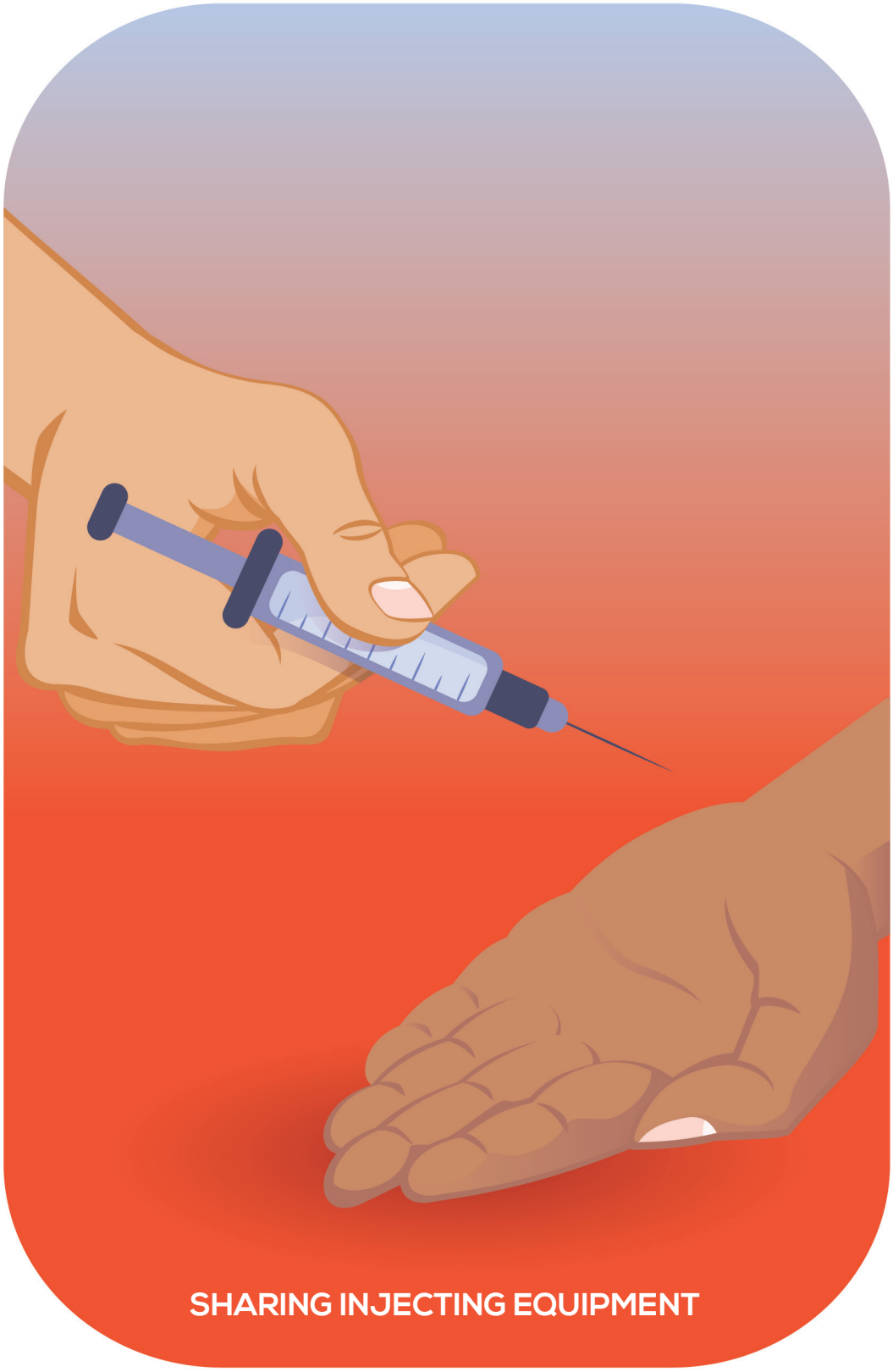
NOTES
Refer to illustrations on:

1. Modes of HIV transmission
2. Activities that do not put people at risk for HIV infection
3. How HIV testing is done

Modes of HIV Transmission



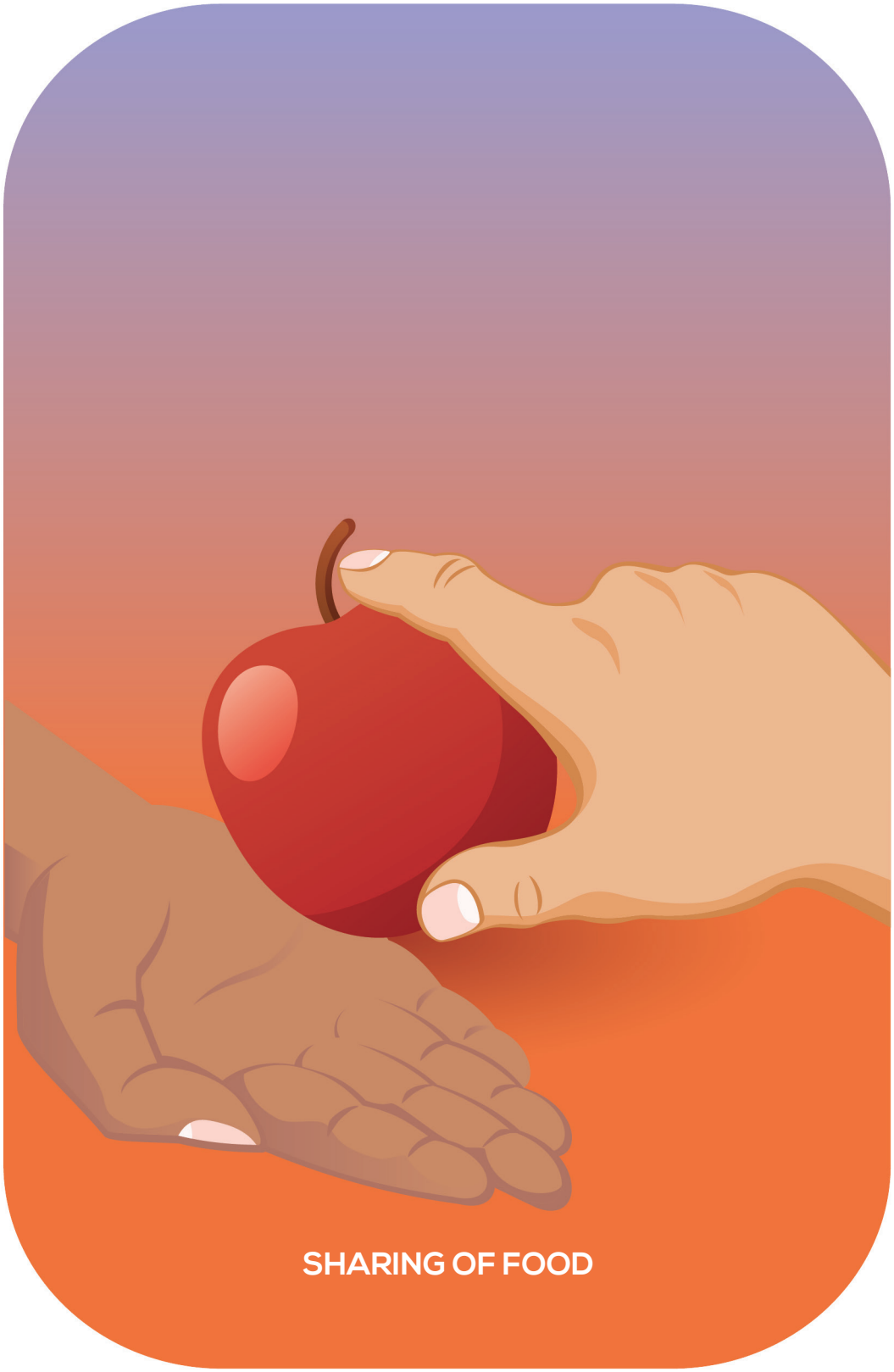

PASSED FROM MOTHER TO BABY



SHARING INJECTING EQUIPMENT


CONTAMINATED
BLOOD TRANSFUSION &
ORGAN DONATION

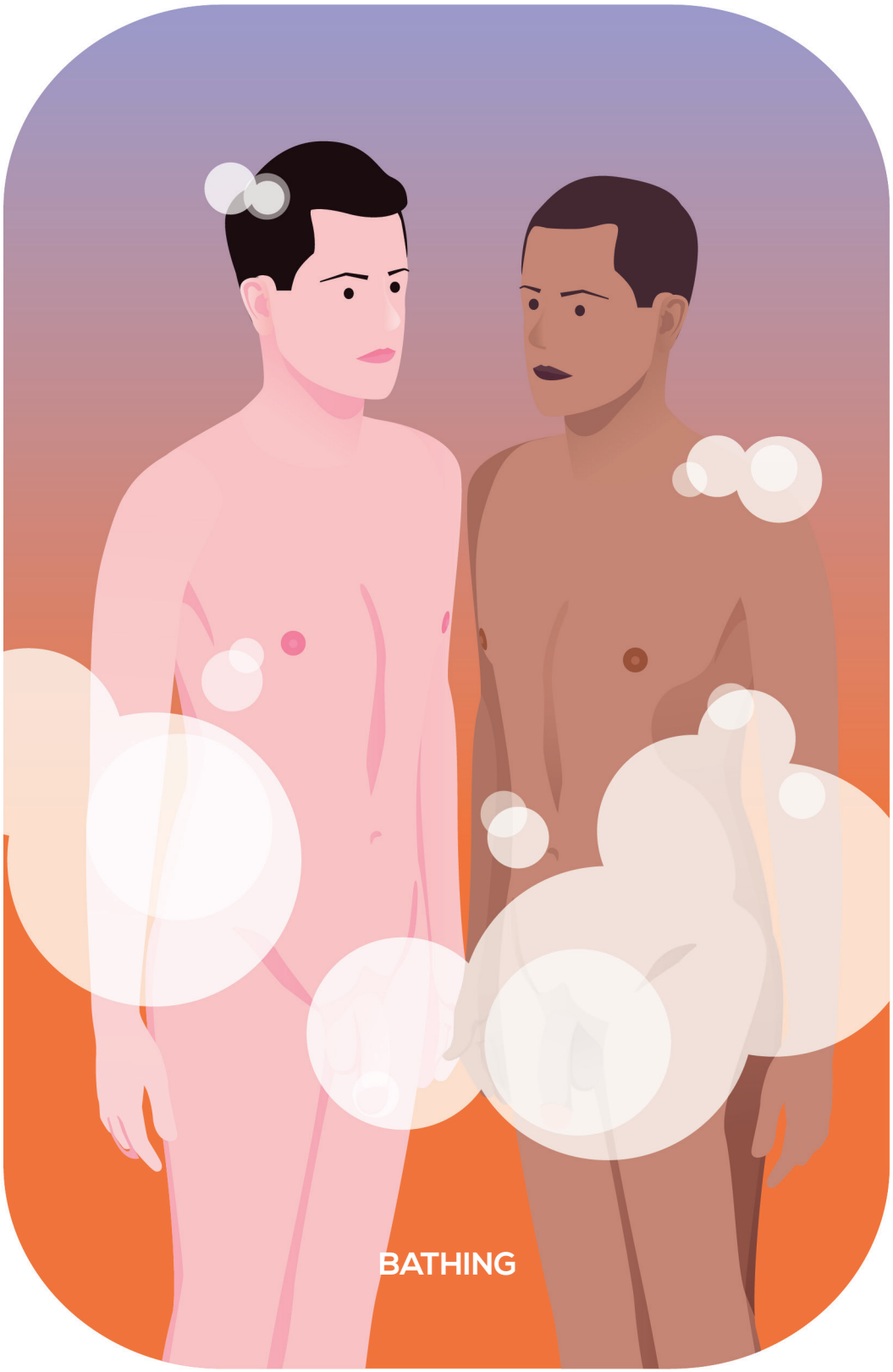
Activities that do not put people at risk for HIV infection

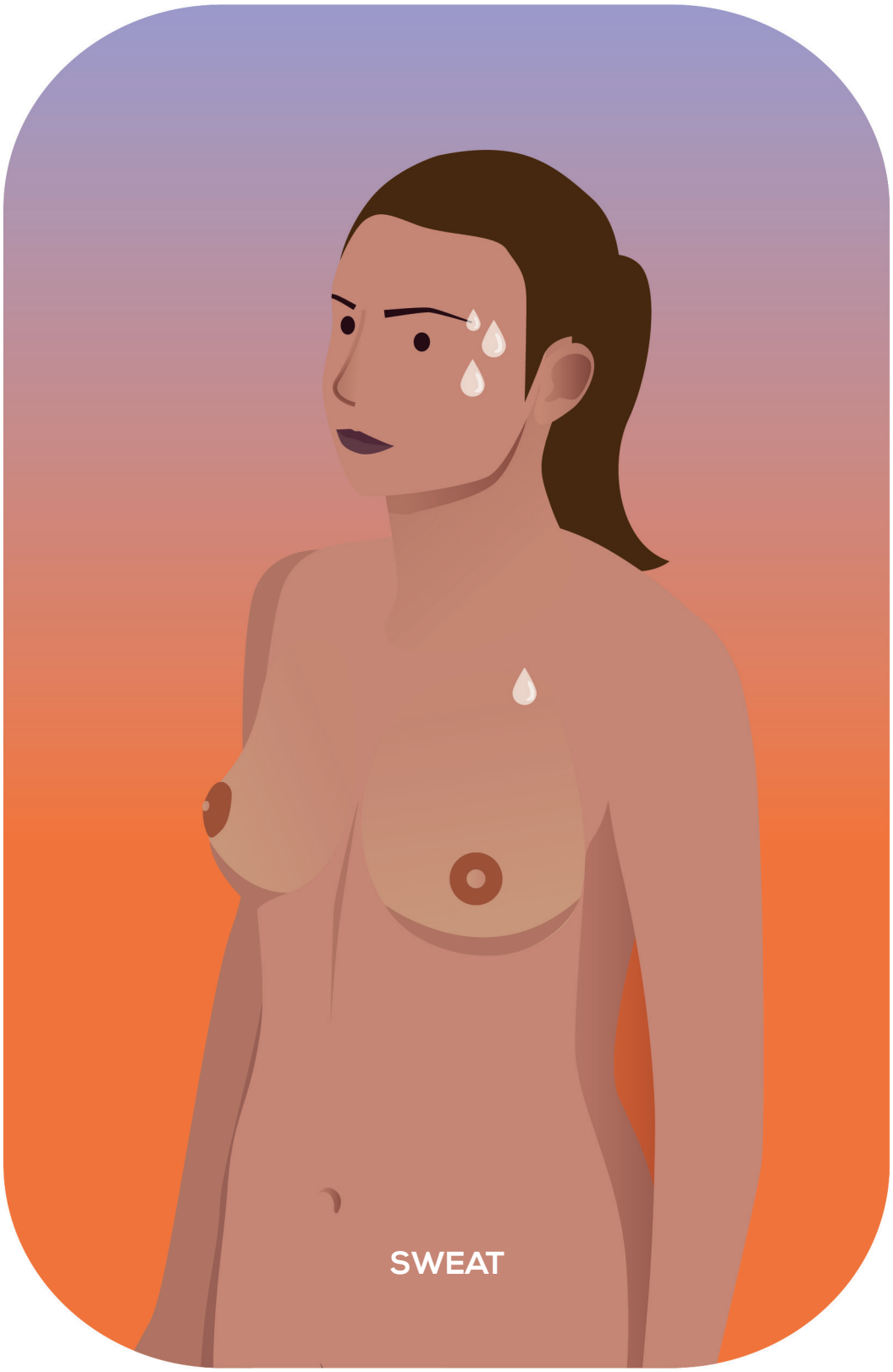


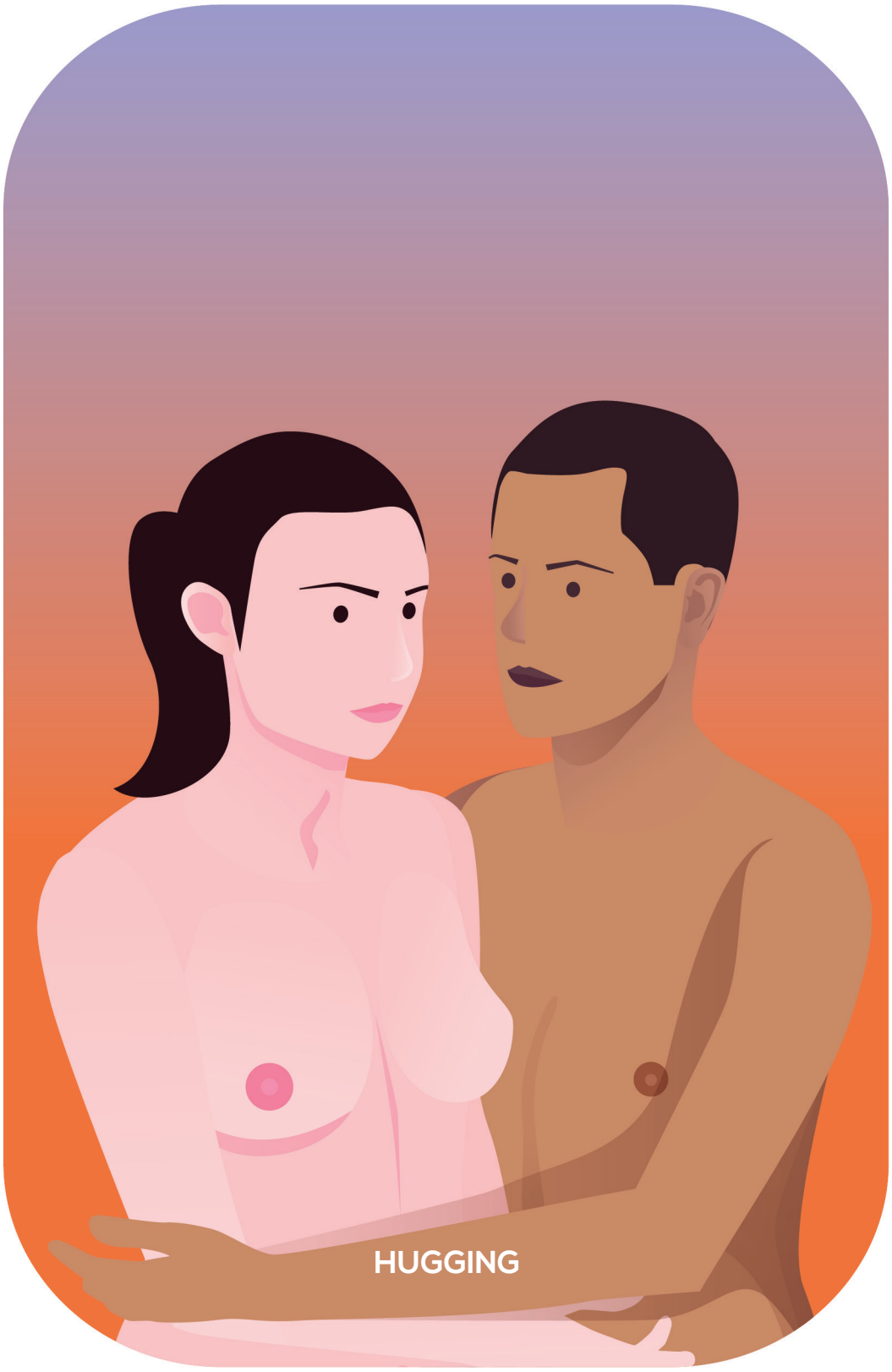
SHARING OF FOOD


MOSQUITOES, TICKS OR
OTHER INSECTS BITES

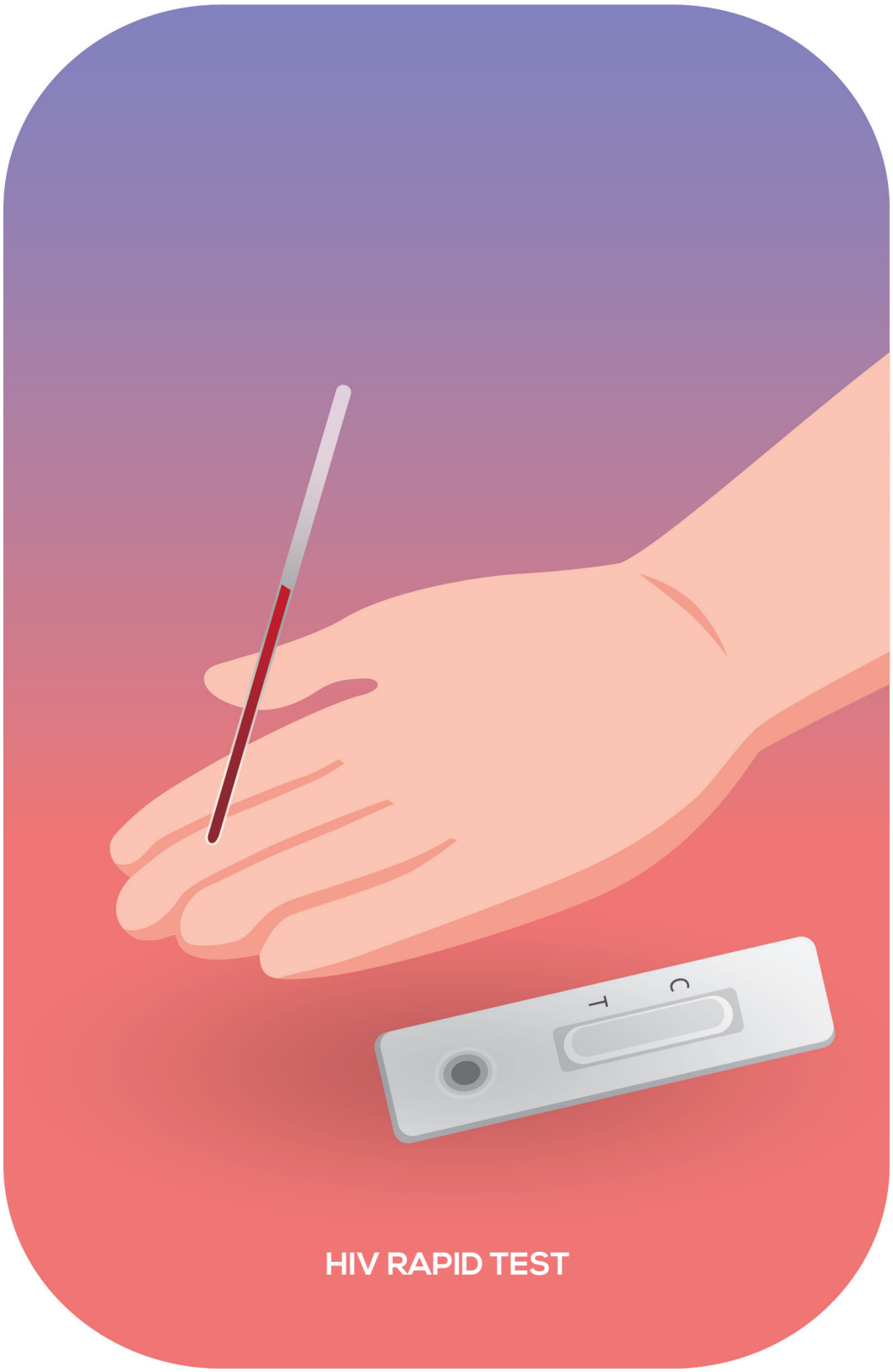

SNEEZES AND
COUGHS


BATHING

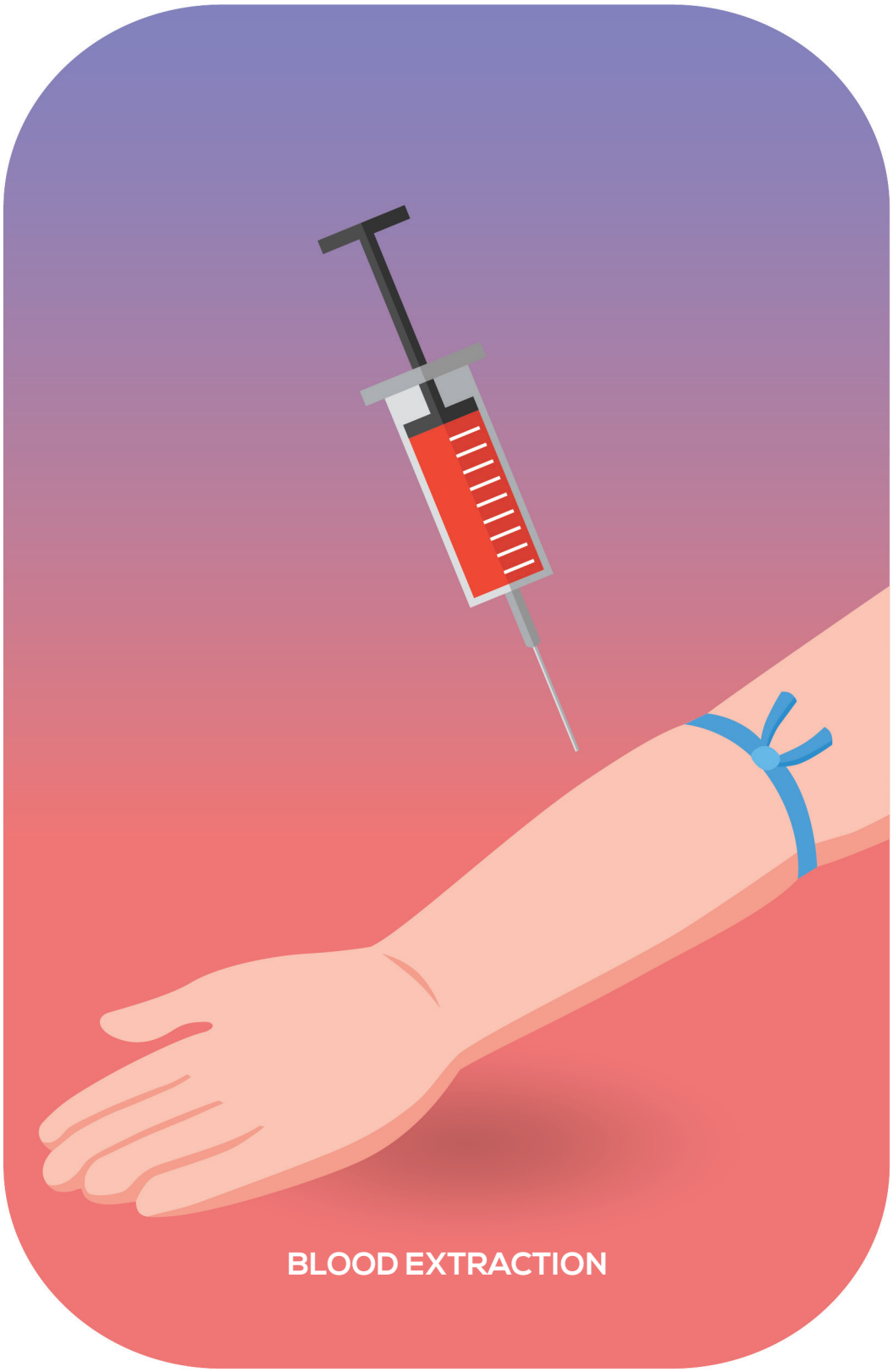

SWEAT


HUGGING

How HIV Testing is done




ORAL SWAB


BLOOD EXTRACTION

TRAINING TOPIC 6: Diagnosis and treatment of STIs

PURPOSE/OBJECTIVES

At the end of this session, the participants should learn more and be able to discuss:

- What STIs are
- Diagnosis and treatment of STIs
- Common STIs
- Reproductive tract infections
- Safer sex

TIME ALLOCATION

TOTAL: Two hours/120 minutes
GROUP ACTIVITY: 30 minutes
LECTURE AND Q&A: 90 minutes

MATERIALS

- Flip charts or manila paper or cartolina
- Index cards
- Pens and markers
- PowerPoint presentation
- Handout on STIs

SESSION OUTLINE & METHODOLOGIES

Start with the group activity.

GROUP ACTIVITY: <u>STI transmission</u>
This exercise aims to open the minds of the participants for them to see that everyone takes risks in one way or another, and so everyone may be infected with STIs.

MECHANICS:

1. Prepare index cards, one per learner.
2. On one side of the index cards, write one of the following letters (without telling the participants what they mean):
    - 2 cards – write "S" (which stands for STI)
    - 1 card – write "A" (which stands for Abstinence)
    - 2 cards – write "M" (which stands for Monogamy, meaning having sex faithfully with only one partner after both have been tested)
    - 2 cards – write "C" (which stands for condom)
    - All remaining cards – write "U" (which stands for unprotected)
3. Introduce the purpose of this activity by stating the following:
    - STIs are infections that are spread primarily through person–to–person contact.

- There are steps people can take to avoid getting infected with STIs.

4. Ask the participants to move around. Write their names on the index cards of the other participants. Every index card should have three names.
5. Ask them to return to their seats when this is done.
6. Call out one letter at a time. After calling out one letter, ask the participants whose names are on the index card to stand. Discuss how - in the context of this exercise - they have been exposed to what the letter stands for.

To process this activity, discuss:

- People may not know they have STIs. Some feel just fine even if they have STIs.
- Everyone is at risk to be infected.
- There are different ways to be exposed.
- There are different ways to deal with STIs.

KEY LESSONS/MESSAGES

What are STIs?

STI stands for "sexually transmitted infections."
These are infections you can get by having sex with someone who has an infection.

- These infections are usually passed from person to person through:
- Vaginal intercourse
- Anal sex
- Oral sex
- Skin-to-skin contact
- Blood/blood products

Diagnosis and treatment of STIs

Majority of STIs have no symptoms or only mild symptoms that may not be recognized as an STI.

Common symptoms of STIs include:

- Vaginal discharge
- Urethral discharge or burning in men
- Genital ulcers
- Abdominal pain

Anyone with signs/symptoms of STIs should be referred to health personnel for diagnosis and treatment.

Common STIs

There are more than 30 different bacteria, viruses and parasites known to be transmitted through sexual contact.

Eight of these are linked to the greatest incidence of sexually transmitted disease.

Of these 8 infections, 4 are curable: syphilis, gonorrhoea, chlamydia and trichomoniasis.

The other 4 are viral infections that are incurable: hepatitis B, herpes simplex virus (HSV or herpes), HIV, and human papillomavirus (HPV).

Reproductive tract infections (RTIs)
This refers to 3 different types of infections affecting the reproductive tract:

1. Endogenous infections that result from an overgrowth of organisms normally present in the vagina, including include candidiasis and bacterial vaginosis. These infections can be easily treated and cured.
2. Iatrogenic infections that ccur when the cause of infection (bacteria or other microorganism) is introduced into the reproductive tract via a medical procedure, such as menstrual regulation, abortion, insertion of an IUD or during childbirth.
3. STIs

STIs can also have reproductive health consequences beyond the immediate impact of the infection itself. For instance, STIs can cause infertility or mother-to-child transmission.

RTIs can have serious consequences, including infertility, ectopic pregnancy, chronic pelvic pain, abortion, cervical cancer, menstrual disorders, pregnancy loss, babies with low birth weight and increased risk of HIV transmission.

Safer sexual practices
Transmission of STIs may be hindered with the use of safer sexual practices. Safer sex means sexual activities that you can do even if one person is infected, and they definitely won't pass it on to the other person.

Numerous activities may be considered safer sexual practices. These include:

1. Celibacy or at least abstaining from sex
2. Non-penetrative acts like cuddling, massaging and mutual masturbation; and with no exchanges of body fluids happening
3. Use of condoms for penetrative sex

NOTES
Refer to the illustration on the correct use of condom.

TRAINING TOPIC 7: Sex Education

PURPOSE/OBJECTIVES

At the end of this session, participants will be able to

- Improve communication about sex
- Set boundaries
- Overcome embarrassment

SESSION OUTLINE & METHODOLOGIES

This topic is to be divided into three parts: Communicating about sex, human body, and sexual and reproductive rights.

For the first part, a group work is suggested.

GROUP ACTIVITY 1: Group work

This exercise aims to familiarize everyone with sex and sex-related signs used by members of the Deaf community.

TIME ALLOCATION
TOTAL: 30 minutes
GROUP ACTIVITY: 15 minutes
LECTURE AND Q&A: 15 minutes

MATERIALS

- Index cards
- Pens and markers
- Envelopes

MECHANICS:

1. Ask participants to create two circles, an inner and outer circle. Have them sit in pairs facing each other. Make sure there is enough space between the pairs so that each pair can have a private conversation.
2. Give each pair an envelope with an index card containing questions.
3. Ask the people sitting in the inner circle to start by picking a question card from the envelope and ask the person in the outer circle to answer the question.
4. The person sitting in the outer circle can answer or pass.
5. The pairs take turns, with the person in the outer circle picking a card from the envelope and asking the question.
6. After 10 minutes, ask the people sitting in the outer circle to change places by moving along three places to the left to form new pairs. Repeat at least three times.

To process, ask the participants to return their seats to their more formalized

arrangement, facing the trainer/facilitator. Ask some of the participants to share what they have learned, and whether this is something known to everyone or is new knowledge.

The next part will tackle the human body via body mapping.

GROUP ACTIVITY 2: Body Mapping

This aims to promote knowledge of the human body, its parts and functions; as well as allow the participants to improve their knowledge about the human body and sexual parts.

TIME ALLOCATION
TOTAL: One hour/60 minutes
GROUP ACTIVITY: 30 minutes
LECTURE AND Q&A: 30 minutes

MATERIALS
- Flip charts or manila paper or cartolina
- Pens and markers
- Sticky tape
- Scissors
- Diagrams of the male and female reproductive systems

MECHANICS:
1. Separate the participants into smaller groups.
2. Instruct each group to draw the male or female reproductive system.
3. After the allotted time, ask to quickly present.
4. Ask them to return to their seats when this is done.

To process this activity, discuss:
- Present a diagram of the male and female reproductive systems.
- Discuss what the participants got right or wrong.

The last part for this topic deals with sexual and reproductive rights. At the end of this part, the participants should be able to:
- List down some of the sexual rights issues of young Deaf and hard of hearing people, and
- Start to optimize the situation.

GROUP ACTIVITY 2: Focus Group Discussion

This aims to promote sexual and reproductive rights; as well as allow the participants to improve their knowledge about these rights.

TIME ALLOCATION
TOTAL: One hour/60 minutes
GROUP ACTIVITY: 30 minutes
LECTURE AND Q&A: 30 minutes

MATERIALS
- Board
- Pens and markers
- Sticky tape
- Scissors
- Printed copy of ANNEX 6

MECHANICS:
1. Divide the board/wall into positive (left) and negative (right) sides.
2. Give the participants Post-its.
3. Ask the participants to write down:
4. Positive examples: Which sexual and reproductive rights do we respect?
5. Negative examples: Which sexual and reproductive rights are not respected (enough)?
6. Ask participants to stick their Post-it to the wall where they think they belong.

To process, ask the participants the following:
1. Where are most examples: on the positive or negative wall?
2. Are there any striking examples? In a good and bad sense?
3. Are there ways of optimizing the situation? What can you do to start?
4. How do we continue what goes well?

KEY MESSAGES
Sexual and reproductive rights are human rights.

Deaf and hard of hearing young people have the same SRH-related needs and rights as their peers without disabilities. If they are not aware of human rights, they cannot take appropriate steps to access them and reduce negative health outcomes, such as HIV infections and unsafe abortions.

Peer educators, service providers and policy makers play a big role in ensuring that Deaf and hard of hearing people are aware of their human rights and are able to access services.

According to the IPPF Charter on Sexual and Reproductive Rights (2008), sexual and reproductive health issues fall within the scope of twelve basic human rights. These are:
1. The right to life
2. The right to liberty and security of the person

3. The right to equality and to be free from all forms of discrimination
4. The right to privacy
5. The right to freedom of thought
6. The right to information and education
7. The right to choose whether or not to marry and to found and plan a family
8. The right to decide whether or when to have children
9. The right to health care and health protection
10. The right to the benefits of scientific progress
11. The right to freedom of assembly and political participation
12. The right to be free from torture and ill treatment

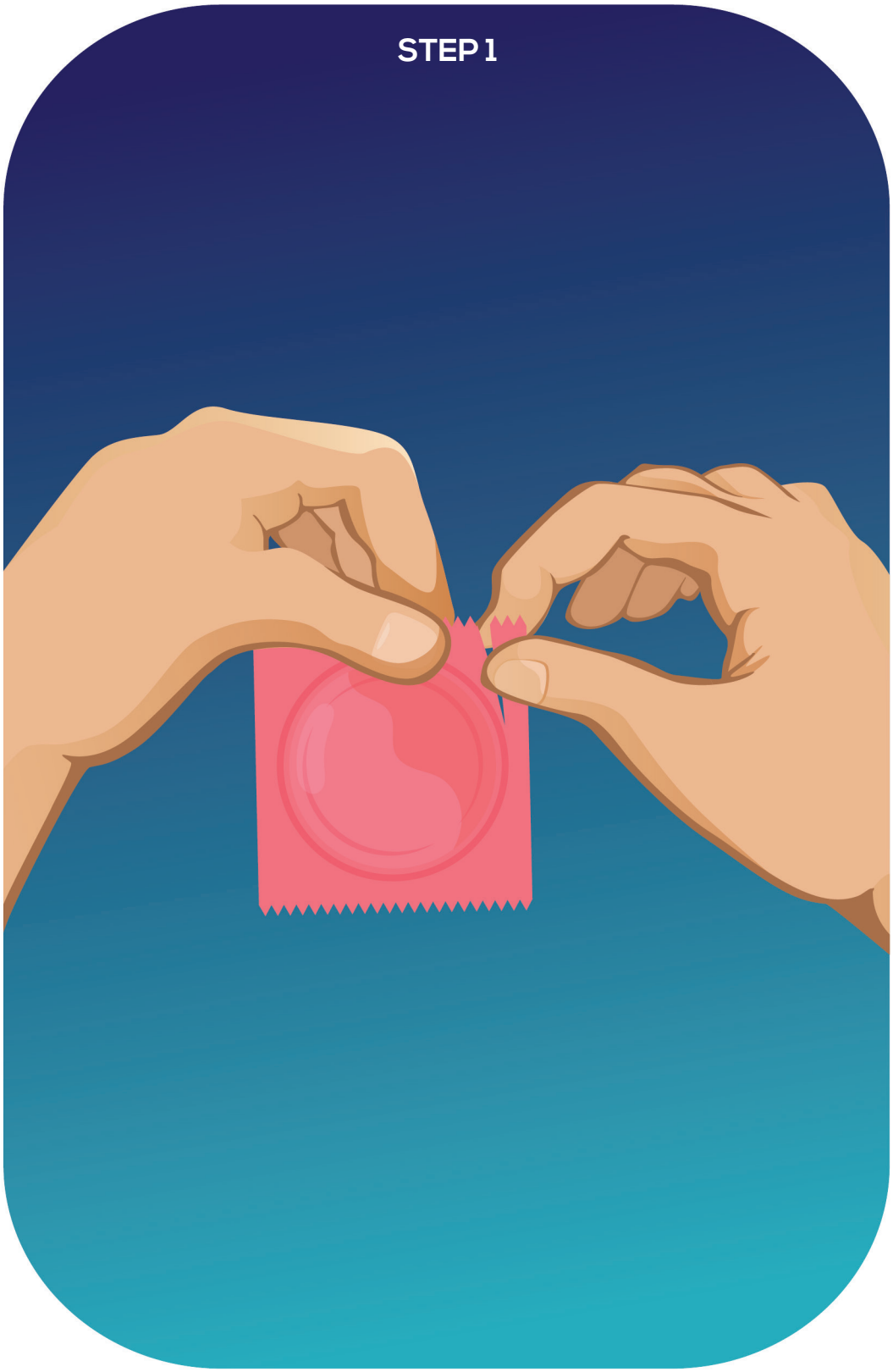
NOTES

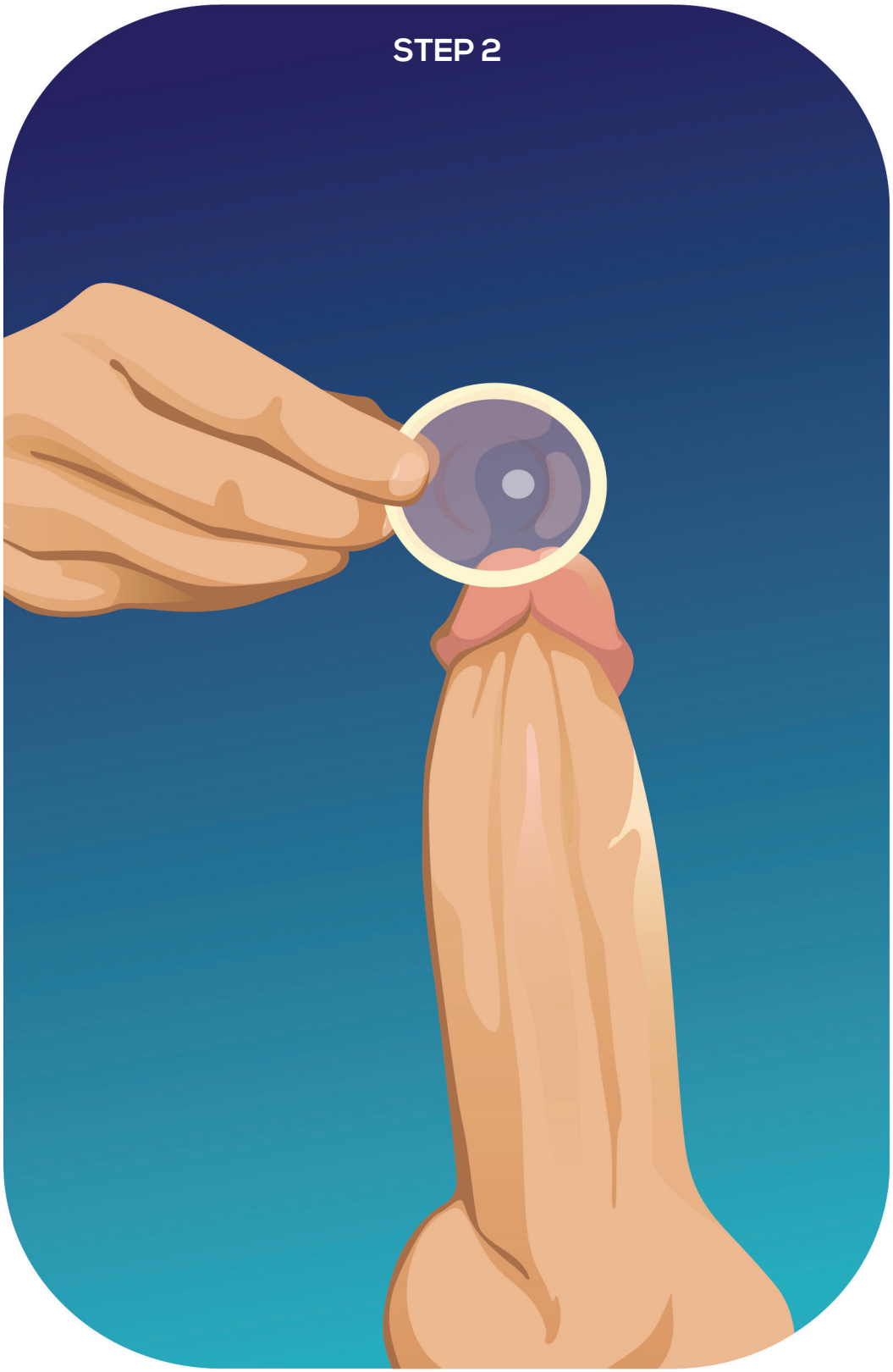
Refer to the illustration on how to properly put on male condom

Refer to alternative exercise, Condom Relay Race, in Annex 1

Refer to illustrations of male and female reproductive organs

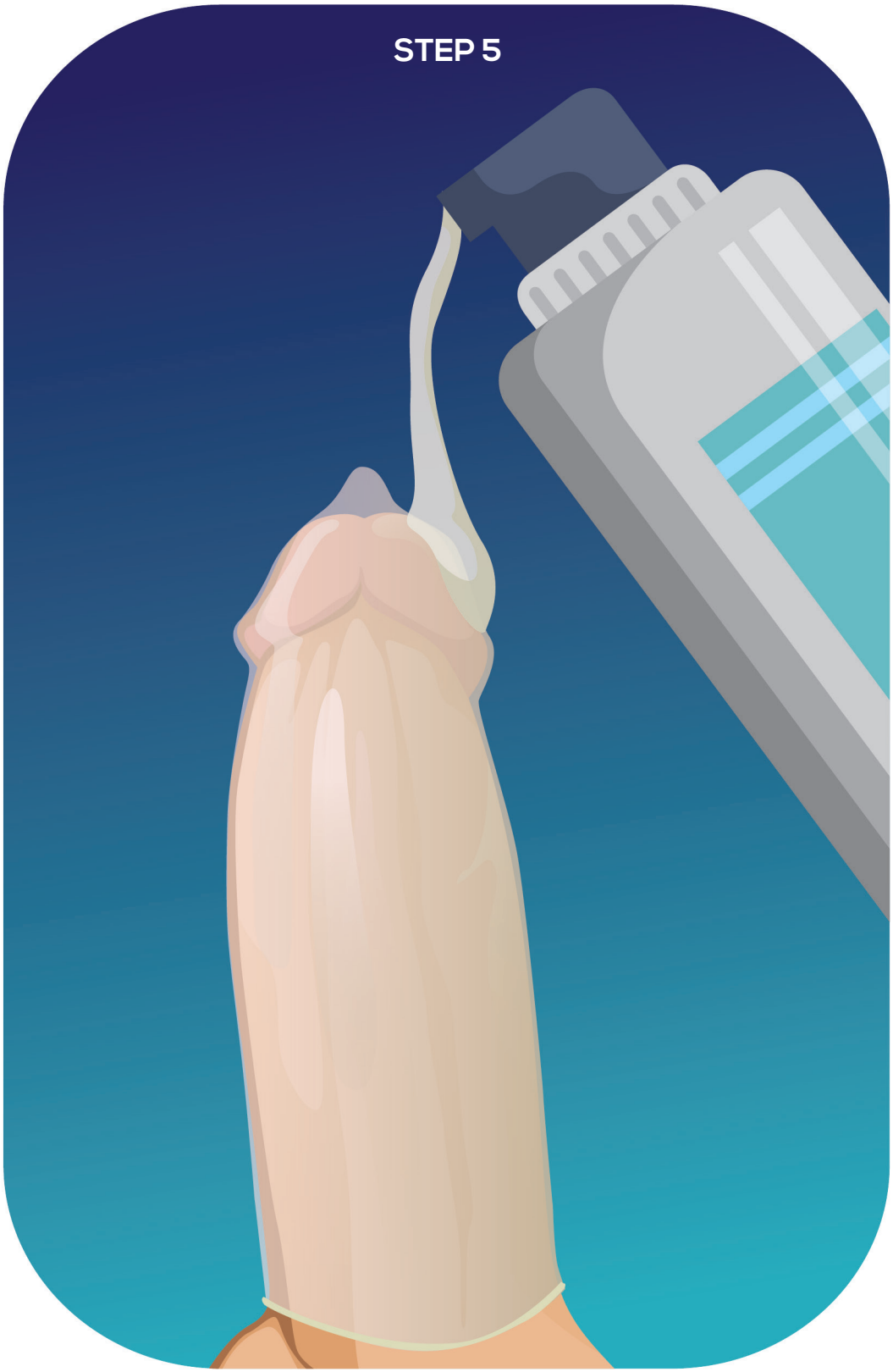
How to properly put on male condom

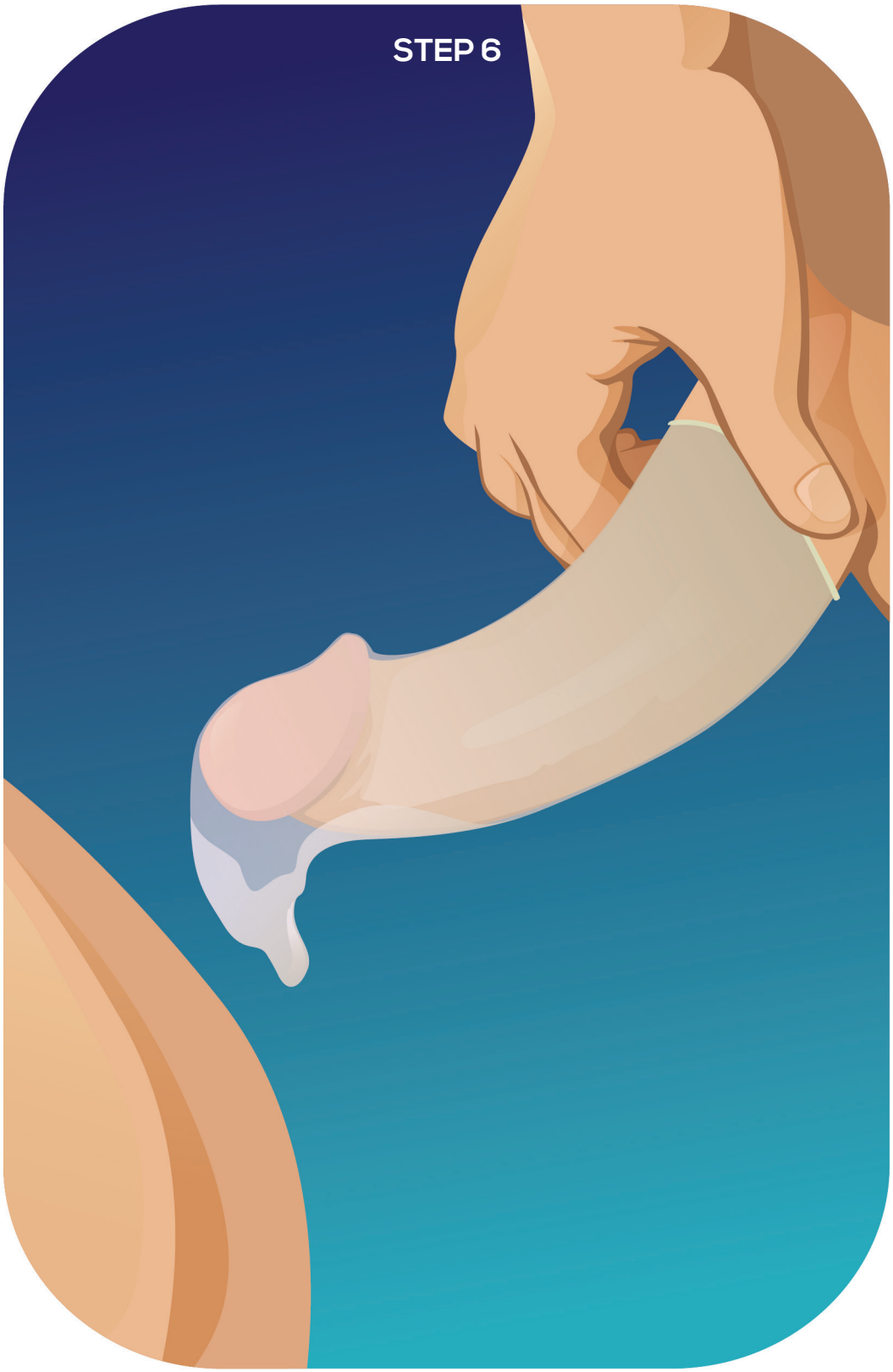



STEP 2


STEP 3


STEP 4

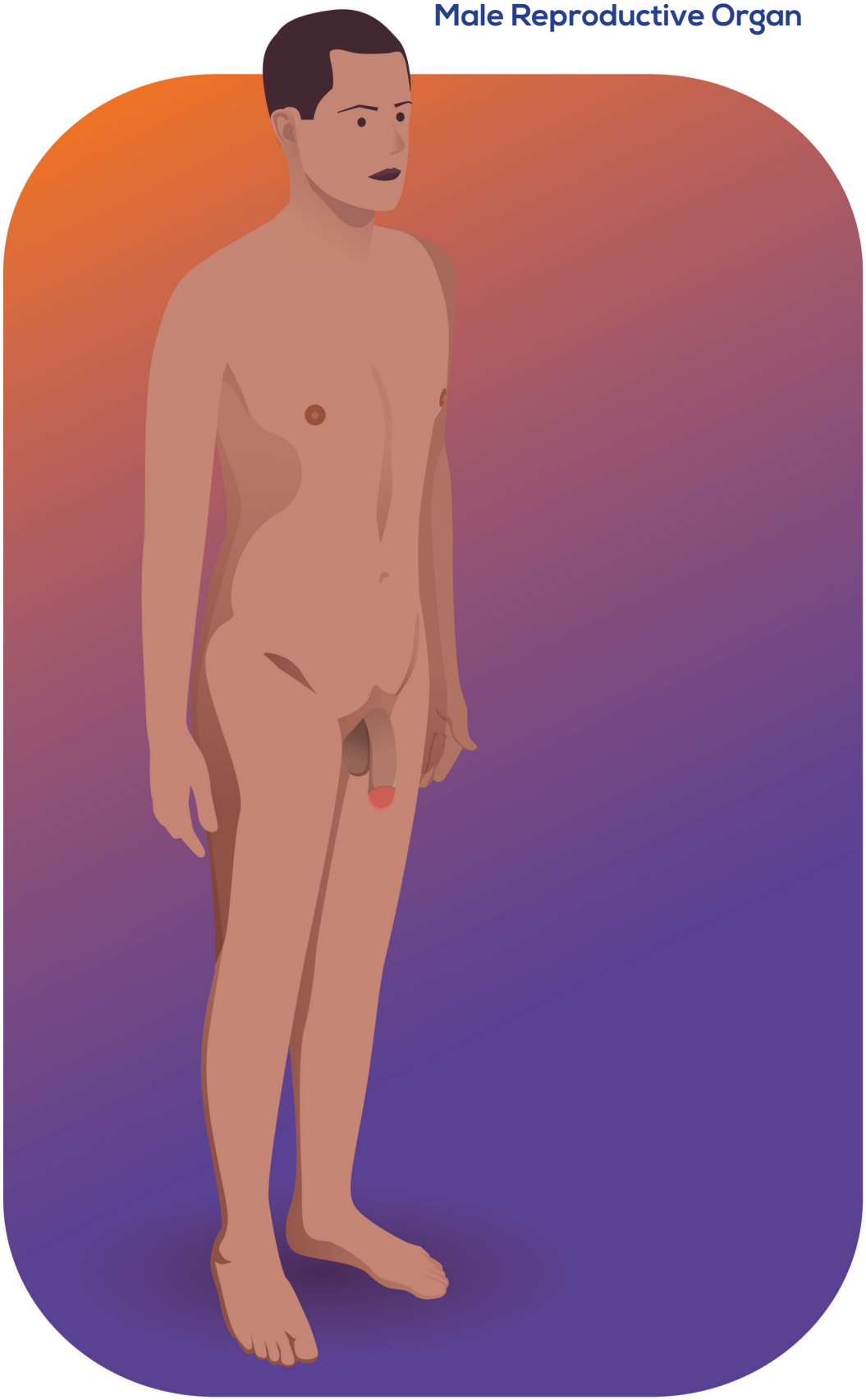

STEP 5


STEP 6

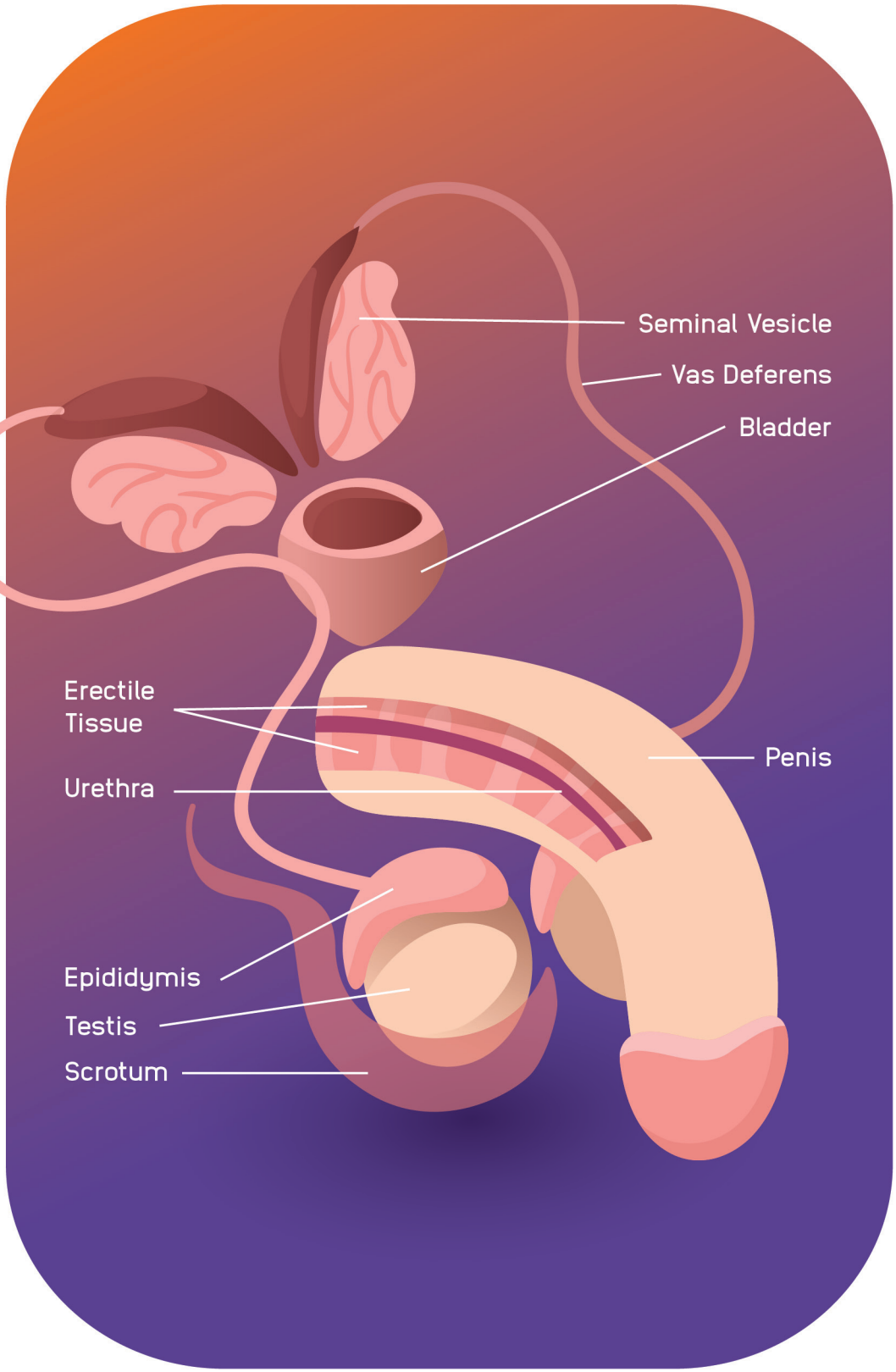

STEP 7


STEP 8

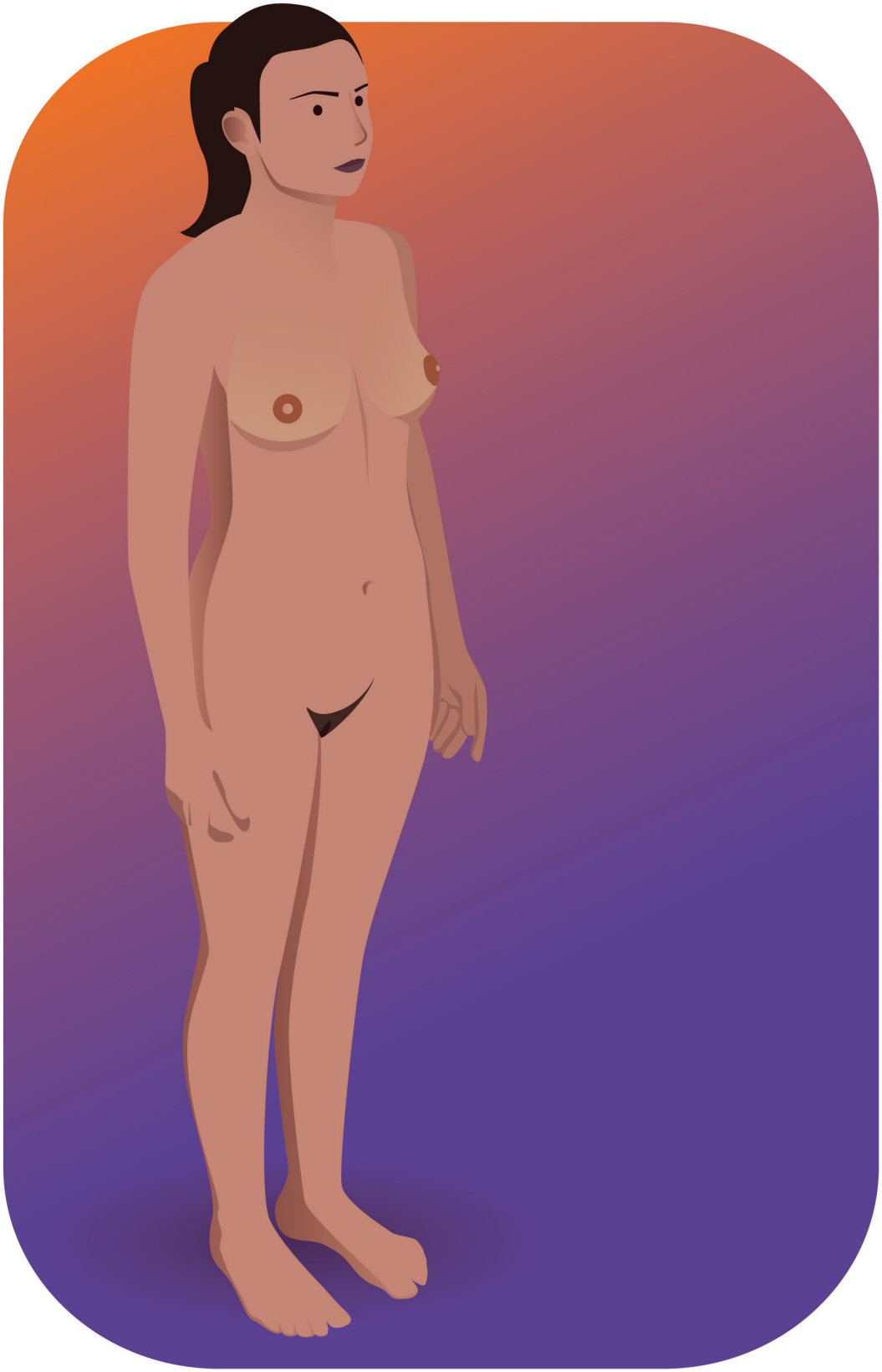
Male Reproductive Organ



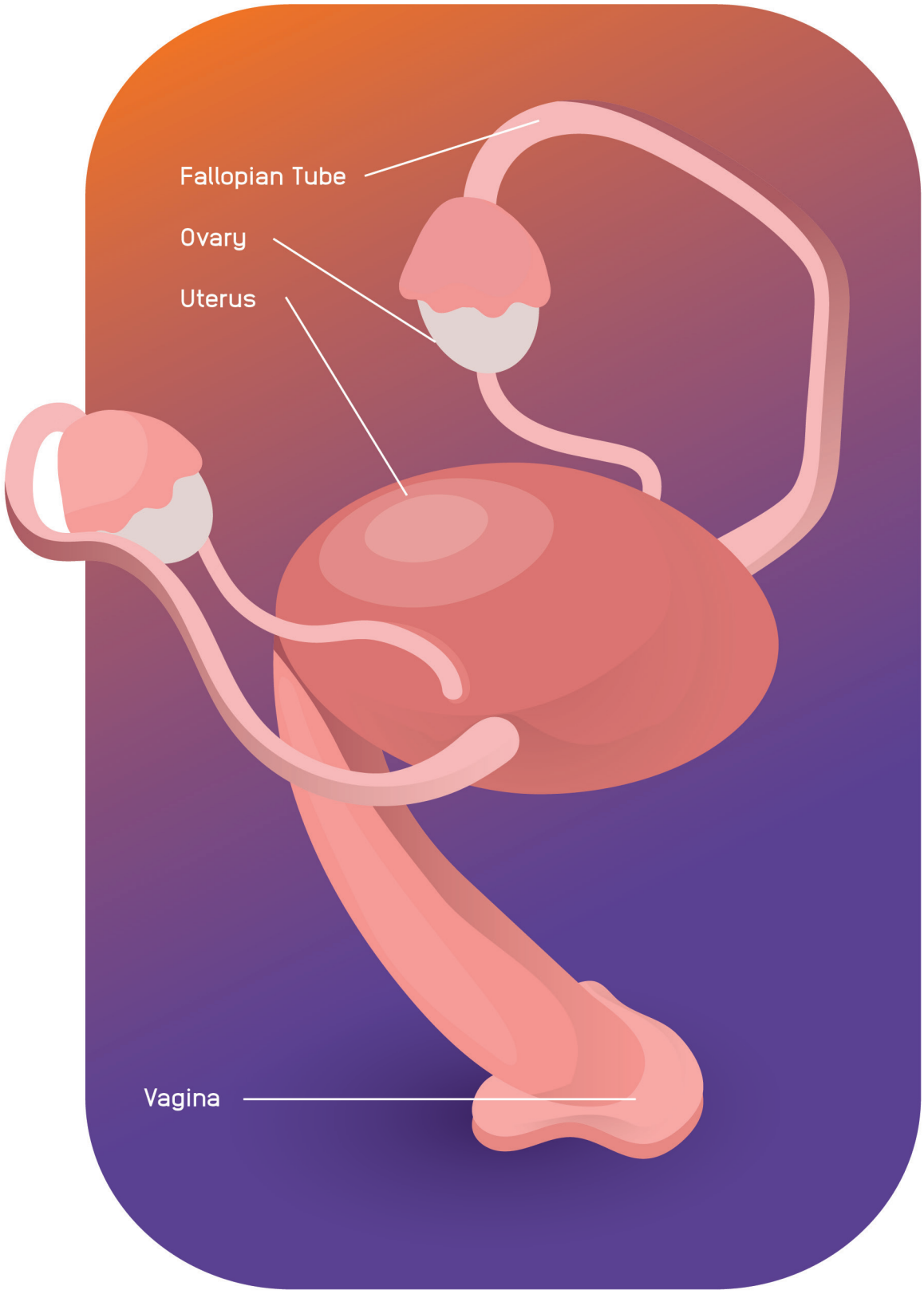
Male Reproductive Organ



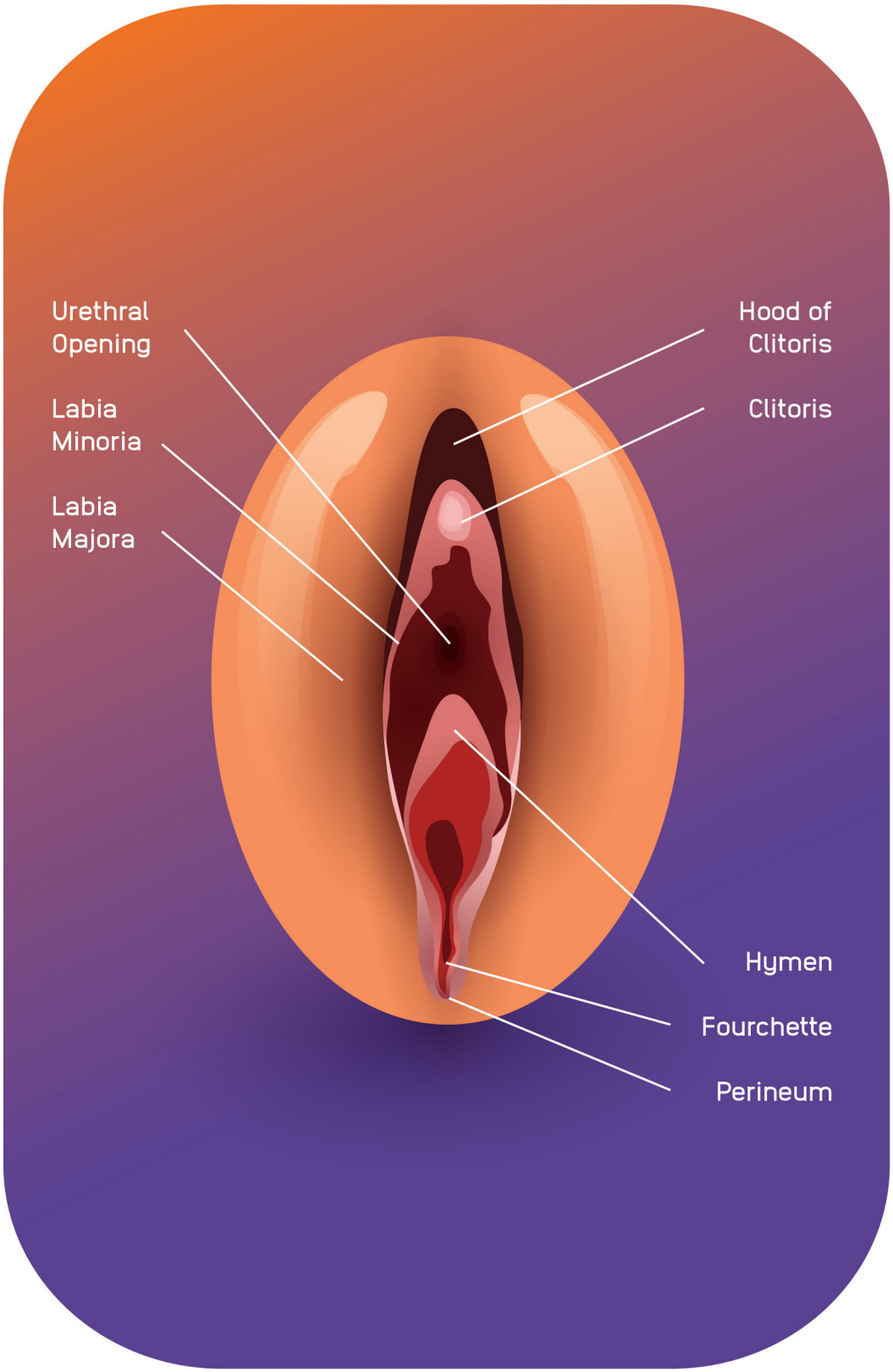
Female Reproductive Organ



Female Reproductive Organ



Female Reproductive Organ



TRAINING TOPIC 8: Prevention and management of gender-based violence

PURPOSE/OBJECTIVES

At the end of this session, the participants should be able to:

1. Define gender-based violence
2. Identify different forms of gender-based violence
3. Understand the causes and consequences of gender-based violence
4. Recognize the root cause of gender-based violence

SESSION OUTLINE & METHODOLOGIES

This topic is to be divided into three parts:

1. Defining gender-based violence and identifying their forms
2. Causes and consequences of gender-based violence
3. Preventing gender based violence

Each part will have separate group activity.

The first part aims to introduce gender-based violence and its various forms to the participants.

GROUP ACTIVITY 1: Interactive presentation

This exercise aims to familiarize everyone with sex and sex-related signs used by members of the Deaf community.

TIME ALLOCATION
TOTAL: 45 minutes
GROUP ACTIVITY: 15 minutes
LECTURE AND Q&A: 30 minutes

MATERIALS

- Board
- Flip charts or manila paper or cartolina
- Pens and markers
- Printed copy of ANNEX 6

MECHANICS:

1. Ask the participants what they understand about "gender-based violence."
2. Write the answers on a flip chart, or on the board.
3. On a flip chart, draw a simple tree.
   Use only the top 2/3 of the page.
   Leave the bottom 1/3 of the page for the participants to write contributing factors/causes later.
4. Now, ask the participants to identify some forms of gender-based violence.
5. As participants identify different forms of gender-based violence, list each

example at the trunk of the tree.

To process, explain that gender-based violence is physical, mental or social abuse which is directed against a person based on gender or sex.
Explain that every individual can be a target of violence regardless of their gender.
Also, emphasize that although violence takes many forms, gender inequality is the root cause.
Stress that gender-based violence often victimizes people with disability.

The second part of this session will introduce to the participants to the causes ad consequences of gender-based violence.

GROUP ACTIVITY 2: <u>Causes and consequences of gender-based violence</u>

TIME ALLOCATION
TOTAL: 45 minutes
GROUP ACTIVITY: 15 minutes
LECTURE AND Q&A: 30 minutes

MATERIALS
- Flip charts or manila paper or cartolina
- Pens and markers

MECHANICS:
1. Start by telling the participants that gender-based violence may be organized into four general areas:
    a. Health
    b. Emotional
    c. Social and psychosocial, legal/justice system and community
    d. Physical safety and security
2. Divide the participants into four groups representing each of these four areas.
3. Ask the participants in their groups to:
    a. Review the various forms of gender-based violence (from step one).
    b. List and discuss all of the consequences/outcomes of gender-based violence for their sector.
    In their list, tell them to include individual consequences to the victims, as well as the outcomes for others (such as the community, family, government, and so on).
    c. Prepare a flipchart paper with your group's list of consequences.
    d. As each group reads their lists aloud, the trainer/facilitator writes the examples at the top of the tree drain in GROUP ACTIVITY 1 (above), forming the branches.

To process, ask the participants to identify the causes and contributing factors

of gender-based violence. Using the bottom 1/3 of the page below the tree, list the causes and contributing factors that the participants mention. Discuss the answers with the group.

The third part will inform the participants of the preventive methods that can be used to deal with gender-based violence.

GROUP ACTIVITY 3: Preventing gender-based violence

TIME ALLOCATION
TOTAL: 60 minutes
GROUP ACTIVITY: 15 minutes
LECTURE AND Q&A: 45 minutes

MATERIALS
- Flip charts or manila paper or cartolina
- Pens and markers

MECHANICS:
1. Ask the participants to brainstorm ideas to prevent gender-based violence in their communities.
2. Write down all answers on a flip chart.

To process, present a PowerPoint presentation on "Prevention and management of gender-based violence."

KEY LESSONS/MESSAGES
Gender-based violence is violence directed against a person because of their gender. Both women and men experience gender-based violence but the majority of victims are women and girls.

Gender-based violence is rooted in gender inequality.

Gender-based violence can in the form of:
- Child marriage, and forced marriage
- Sexual harassment
- Female genital mutilation
- Honor killings, and other punishments directed at women for defying cultural norms
- Trafficking for sex or slavery
- Intimate partner violence, battery
- Emotional abuse
- Physical punishment
- Sexual, emotional or psychological violence
- Denial of education, food and clothing to girls/women because of their sex

Preventing and responding to gender-based violence against young persons with disabilities is contained in international documents, such as the Convention on the Rights of Persons with Disabilities (CRPD), Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), and Convention on the Rights of the Child (CRC).

Young persons with disabilities, especially young women and girls with disabilities, are more vulnerable to violence than their peers without disabilities. However, they face inequalities in accessing services, including SRHR services.

To respond to gender-based violence, different approaches need to be made. They should also complement each other. These include: developing legal frameworks, governance, oversight and accountability, resources and financing, training and workforce development, monitoring and evaluation, and developing and implementation of gender-sensitive policies and practices.

Some strategies to respond to gender-based violence particularly of young Deaf and hard of hearing people include:

- Awareness of the rights of young Deaf and hard of hearing people.
- Encouraging young Deaf and hard of hearing people to become peer educators and help increase awareness about gender-based violence.
- Train educators about healthy relationships, gender-based violence, and about consent during sexual contact.
- Working with Deaf organizations.
- Implementation of laws and policies aimed at the elimination of gender-based violence.
- Address inclusion of Deaf and hard of hearing people in gender-based violence policies, laws, and budgets.
- Campaigns and programs to improve understanding and visibility of gender-based violence against young Deaf and hard of hearing people
- Youth friendly and disability inclusive gender-based violence prevention programs

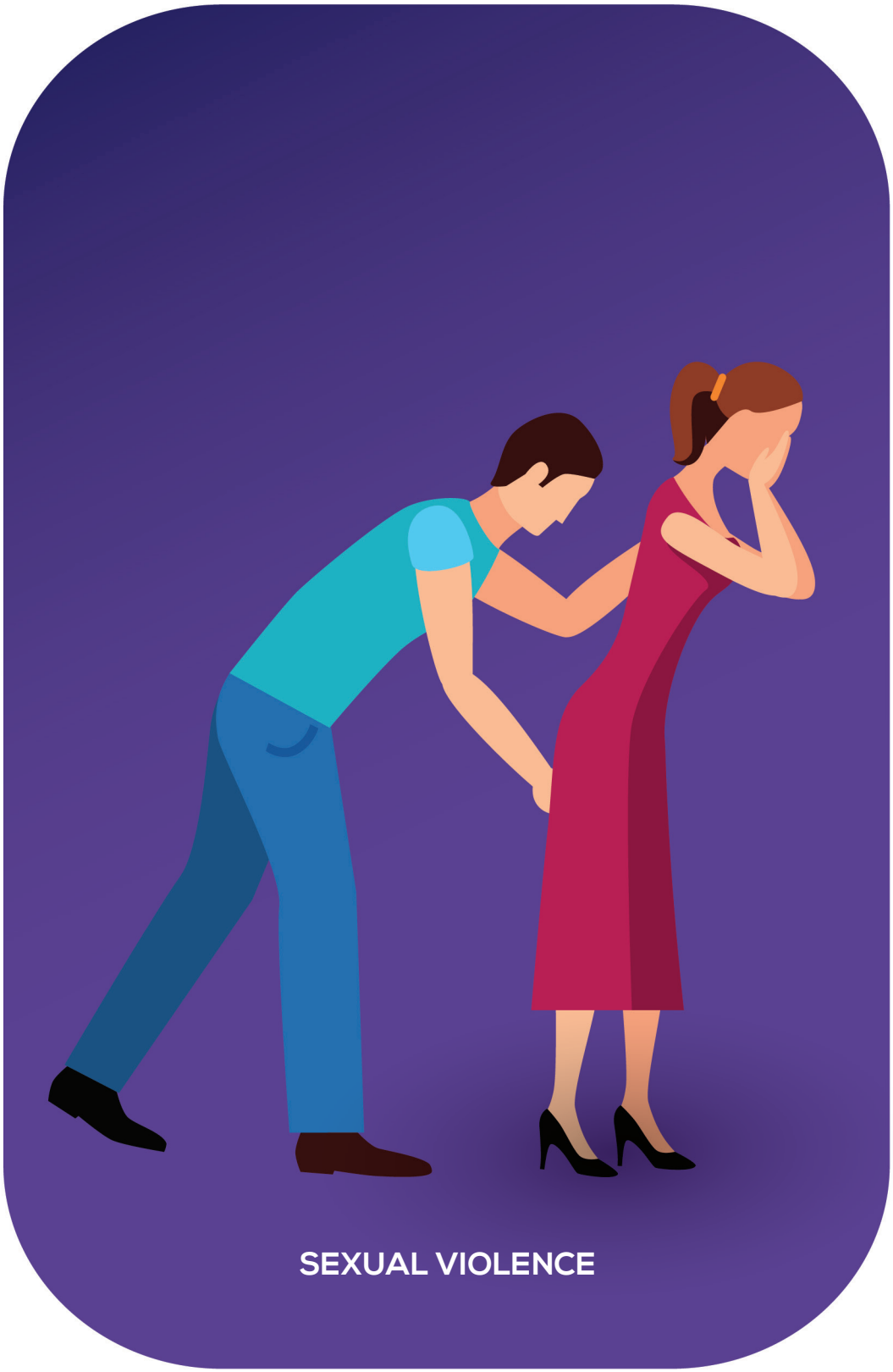
NOTES

Refer to illustrations on types of GBV

See **ANNEX 4 (GENDER-BASED VIOLENCE RESPONSE FRAMEWORK)**

Types of Gender-based Violence

PHYSICAL VIOLENCE



SEXUAL VIOLENCE


EMOTIONAL AND
PSYCHOLOGICAL VIOLENCE


SOCIOECONOMIC VIOLENCE

TRAINING TOPIC 9: SOGIESC 101

PURPOSE/OBJECTIVES

At the end of this session, the participants should know of SOGIESC concepts - including LGBTQIA - and should be able to discuss and even train others about the same.

More specifically, they should be able to:

1. Explain SOGIESC; discuss select terminology related to SOGIESC
2. Explain concepts contained in the illustration of the genderbread person
3. Discuss LGBTQIA
4. Tackle some of the SRHR issues faced by LGBTQIA people

TIME ALLOCATION

TOTAL: Two hours/120 minutes
GROUP ACTIVITY: 15 minutes per activity (30 minutes total)
LECTURE AND Q&A: 90 minutes

MATERIALS

- Exercise 1:
    - Printout of the various versions of the gender bread person
    - Metacards containing the SOGIESC concepts/terms
    - Markers (to write additional concepts/terms on empty metacards)
    - Double-sided sticky tapes

- Exercise 2:
    - Metacards containing the SOGIESC concepts/terms
    - Metacards containing the meanings of the SOGIESC concepts/terms
    - Markers (to write additional concepts/terms on empty metacards)

- Discussion/Presentation:
    - PowerPoint

SESSION OUTLINE & METHODOLOGIES

Start the session with the first exercise.

EXERCISE 1: Pin the Genderbread Person

This exercise eyes to identify the familiarity of the participants with SOGIESC concepts.

MECHANICS:

1. Group the participants into two, according to where they geographically came from.
2. Have each group's members count from one to 11; and then have those with

similar numbers partner (i.e. all one's, all two's…).
3. Give each pair two metacards containing key terms; have them match these terms to key concepts in separate metacards.
4. Have the participants sit in a circular set-up to discuss the terms and definitions.

Proceed to the discussion of SOGIESC, including LGBTQIA.

Discuss some of the issues

After the discussion, assess the retention of knowledge with another exercise.

EXERCISE 2: <u>What does it mean?</u>

This exercise:

MECHANICS:
1. Ask the participants to form two lines/rows. Each line/row should have an equal number of participants. In case of odd number of participants, a member of the secretariat could join in to even the numbers.
2. Give the participants in one row a metacard containing key SOGIESC terms.
3. Give the participants in the other row with a metacard containing the meanings of the SOGIESC terms.
4. Tell the participants to pair the words with their right meanings as discussed in this session.
5. When they have teamed up, ask if the participants got the right pairing of terms and meanings. Read out the correct pairing, and correct the wrong pairing.

Proceed to Q&A, and then close this topic.

KEY LESSONS/MESSAGES

A baby is not born a man or a woman.
When a baby is born, it is the doctor or the midwife who says: "It's a boy!" or "It's a girl!". This is often based on what he/she sees (the external genitalia).

Doctors/midwives do not always get it right.
Everyone has sex characteristics, or physical features relating to sex. These include the genitalia and other sexual and reproductive anatomy, chromosomes and hormones. But these characteristics also include secondary physical features that only emerge from puberty.

A person may be identified as a baby as "boy" by a doctor/midwife, but when growing up, female secondary sex characteristics may appear. This person may have an intersex condition.

An intersex person should have the right to decide how to identify him or herself as.

Sex is different from gender.
Sex is what's between your legs.
Gender is what's between your ears.

Sex is based on characteristics that are biologically defined (for example, the penis or the vagina).
Meanwhile, gender is based on socially constructed features.

Not all people identify with the sex they have at birth. This means that they have a different way of perceiving themselves. Because of this, they may also express or behave in ways that are not aligned with the sex assigned at birth.

Gender expression is how a person expresses him or herself. It has nothing to do with sexual orientation or gender identity.
For example, many societies assume that a woman should wear a skirt. But there are cultures where men also wear skirts. No culture is superior; so these differences in expressions should be respected.

Behavior is different from identity.
Just because a man wears a skirt, does not mean he is gay or transgender.
Just because a man has sex with another man, does not mean he is gay.

Only a person can say what his or her gender identity is.
Gender identity is how a person sees himself or herself. It is very personal.

Respect self-identity.
Also, respect the pronouns that go with the person's identity - for example, if a person who was assigned male at birth now self-identifies as a woman (transgender woman), use the pronouns for women (she, her).

Identities are layered.
For example, a transgender person may identify as a straight man or woman, gay, lesbian, bisexual or none of these. When in doubt, ask.

Emphasize to the participants that all the terms need not be memorized. There are many other terms related to SOGIESC, and they differ depending on the language, culture, ethnic, time, and so on.

The best way to know about gender is to ask a person how he, she or they identify as.

Read articles related to SOGIESC to keep learning.

SRHR issues faced by LGBTQIA people because of who they are/who they love

- For example, more members of the LGBTQIA community - particularly gay and bisexual men, and transgender women - get infected by HIV.
- Sex education often does not discuss sexual activities involving LGBTQIA people. Instead, this focuses on heterosexual sexual acts.
- There are healthcare service providers that do not serve people in same-sex relationships. and only accept heterosexual couples.

*The trainer may also ask the participants what other issues may be included here.

Issues Deaf LGBTQIA people encounter when accessing SRHR services

- Limited access to information
- Existing information are not understandable/sensitive to the Deaf community, particularly with the use of medical terms
- Lack of sign language interpreters in healthcare establishments offering SRHR testing
- Informal sources - such as friends and family members - may be inadequate or unreliable
- Traditional cultural values that discourage discussion of sex within the family

*The trainer may also ask the participants what other issues may be included here.

NOTES

Refer to:

- List of select SOGIESC concepts
- Select SOGIESC terminology
- Various illustrations of the genderbread person

List of select LGBTQ concepts

1. The trainer/facilitator may cut these separately
2. Give to the participants
3. Ask the participants to place where in the genderbread person they think the concepts should go
4. After the metacards have been placed on the genderbread person, ask the participants if they agree with their placement
5. Discuss the SOGIESC concepts

GAY	LESBIAN
PENIS	VAGINA
FEMININE	MASCULINE
BISEXUAL	TRANSGENDER
INTERSEX	ANDROGYNOUS
MALE	FEMALE

SOGIESC Terminology

Androgynous
The combination of masculine and feminine characteristics into an ambiguous form. Androgyny may be expressed with regard to biological sex, gender identity, gender expression, or sexual identity.

Asexual
A person who does not have sexual attraction to others, or have low or absent interest in or desire for sexual activity. It may be considered a sexual orientation or the lack thereof.

Bisexual
A person attracted to and/or has sex with both men and women.
This attraction is not necessarily equal. Meaning, a bisexual person is not equally attracted to men and women.

The bisexual person may or may not act upon this attraction (for example, a bisexual man may not have sex with another man and only have sex with a woman; or a bisexual woman may marry a man and not have sex with another woman). As long as a person's identifies as bisexual, then he or she is considered bisexual.

Gay
The term can refer to same-sex sexual attraction, same-sex sexual behavior and same-sex cultural identity.
More often, it is used to refer to a man attracted to other men.

Gender identity
Gender identity refers to a person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth.

Gender expression
The way a person publicly expresses or presents himself/herself.
This can include behavior (the way a person acts) and outward appearance like the dress, hair, make-up, body language, and voice.
The chosen name and pronoun are also common ways of expressing gender.

Heterosexual
People who have sex with and/or attracted to people of the opposite sex.

Homosexual
Refers to people who have sex with and/or sexual attraction to people of the same sex.

Intersex
Refers to a variety of conditions in which a person is born with a reproductive or sexual anatomy that does not seem to fit the typical definitions of female or male. For example, one person may be born appearing to be female on the outside, but have mostly male-typical anatomy on the inside.
While intersex is an inborn condition, intersex anatomy does not always show up at birth.

Sometimes a person only finds out he or she is intersex at the age of puberty, or finds himself an infertile adult, or dies of old age and is autopsied.
For some, they live and die with intersex anatomy without anyone (including themselves) ever knowing.

Lesbian
A woman attracted to other women.
A lesbian woman may or may not be having sex with women, and a woman having sex with women may or may not be a lesbian.

Sex
The anatomical classification of people as male, female or intersex, usually assigned at birth.

Sexual orientation
Refers to each person's capacity for profound emotional, affectional and sexual attraction to (and intimate and sexual relations with) individuals of any sex.

Transgender
People whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth.

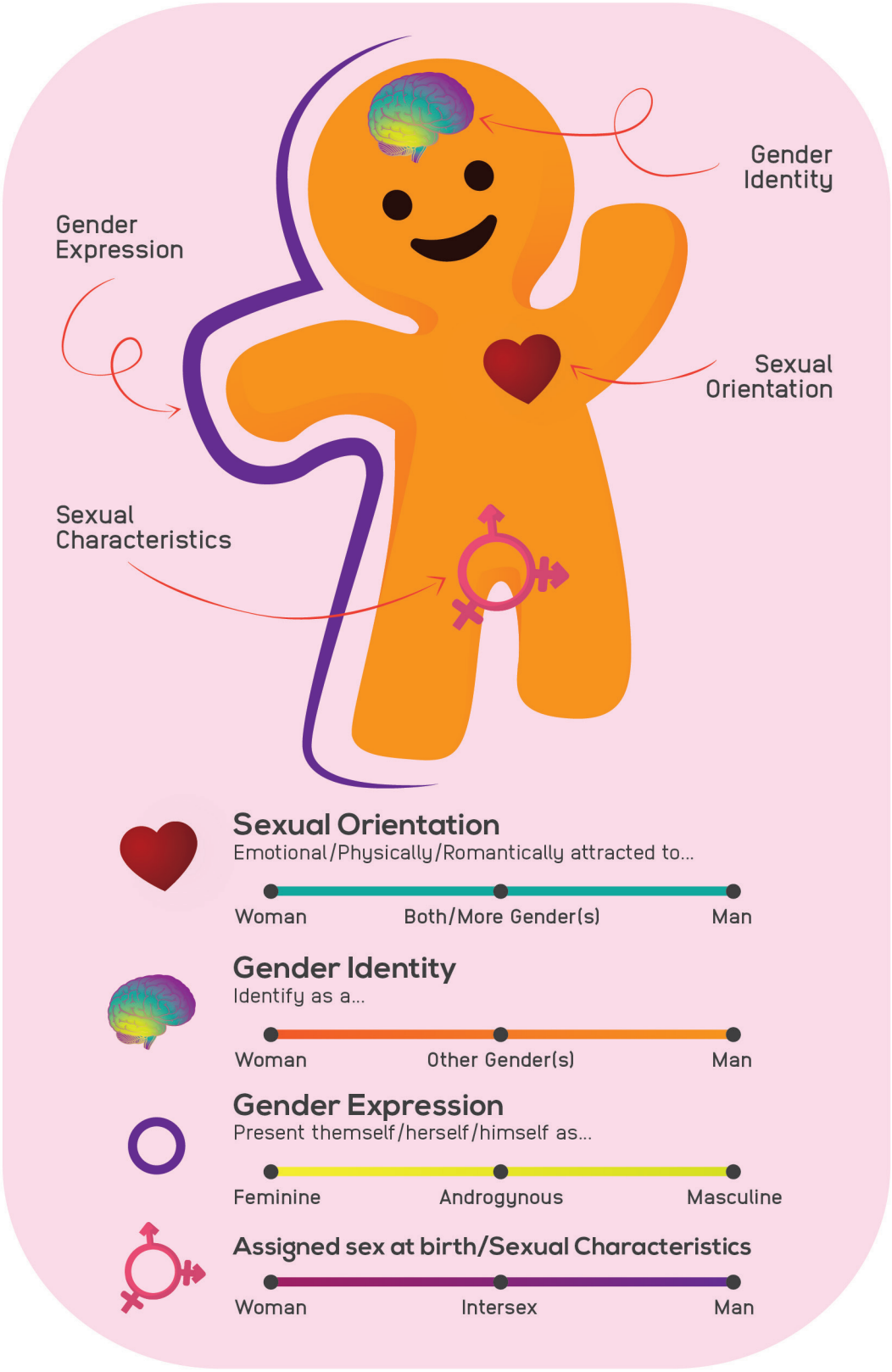
Transgender people include individuals who have received gender affirmation surgery, individuals who have received gender-related medical interventions other than surgery (like hormone therapy), and individuals who identify as having no gender, multiple genders or alternative genders.

Transgender people may self-identify as transgender, female, male, transsexual, hijra, kathoey, waria or one of many other transgender identities. They may express their genders in a variety of masculine, feminine and/or androgynous ways.

It is best to ask a trans person how he or she identifies as. This will help avoid derogatory terms.

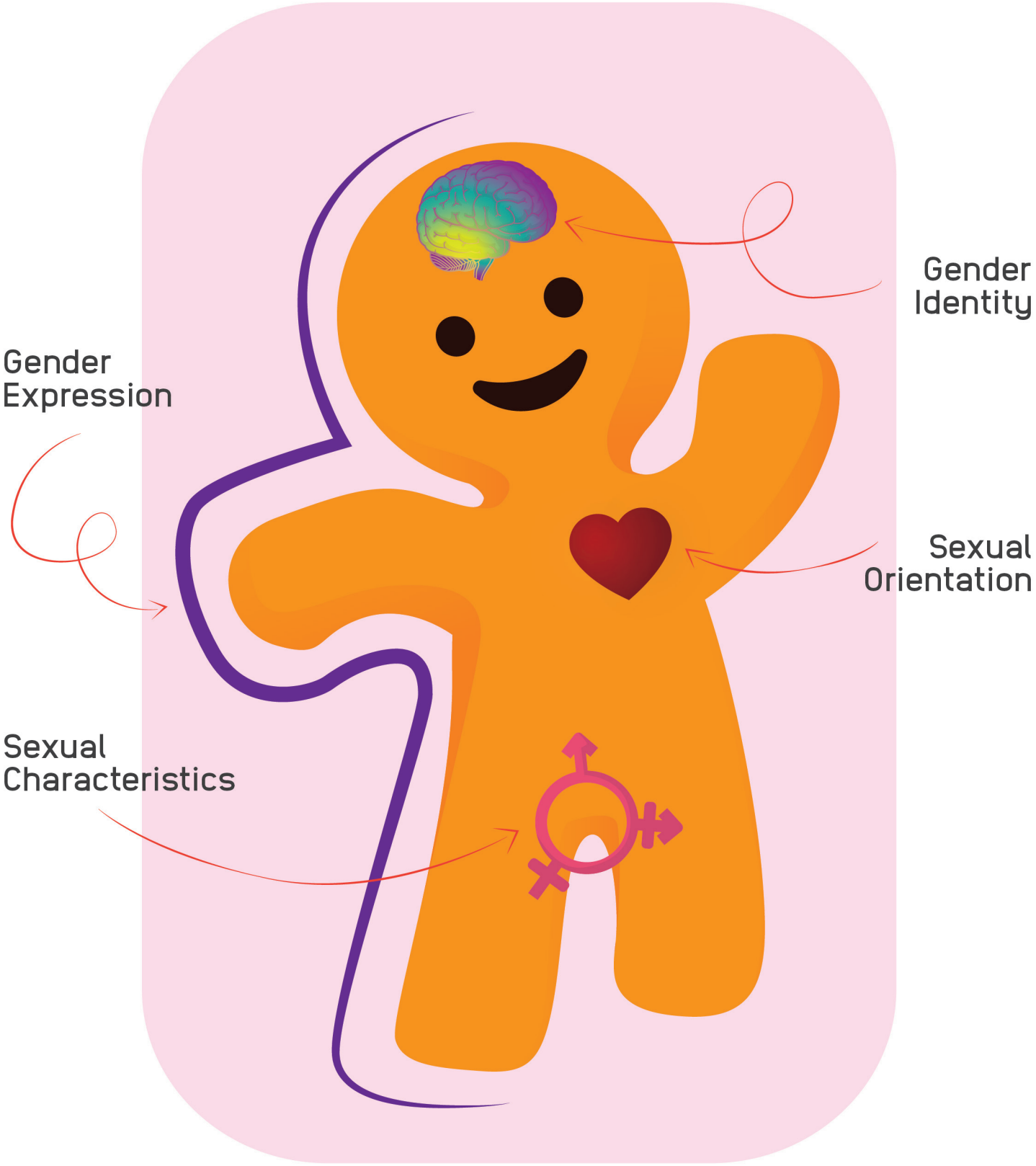
Sources:
UNAIDS Terminology Guidelines (2015).
Ontario Human Rights Commission (n.d.
Intersex Society of North America (2008)

The Genderbread Person



The Genderbread Person

The Genderbread Person



PART 6

Additional and support materials

Awareness. Analysis. Action. Sexual and reproductive health and rights in the Pacific.
A manual produced by the Secretariat of the Pacific Community in 2015 to tackle SRHR particularly among young women in the Pacific.
Available from https://pacificwomen.org/wp-content/uploads/2017/09/SRHR-in-the-Pacific-Manual.pdf

Deaf peers' education manual: A training manual
Developed by the Kenyan Peer Education Network in 2007, this training manual on AIDS particularly references the needs and concerns of the Deaf community. While not specifically for Deaf children and adolescents, information in this manual provides a good starting place for reaching this community.
Available from http://www.sahaya.org/graphics/kenya_deaf_manual.pdf

Preventing gender-based violence: A training manual.
In 2014, Health Policy Project released a training manual to raise awareness and sensitize training participants on the concepts and interlinkages among gender inequality, HIV, and gender-based violence. Though the manual was designed for the Mozambican context, it provides basic know-how on how to tackle GBV.
Available from https://www.healthpolicyproject.com/pubs/367_MozambiqueGBVManualFINAL.pdf

Public service announcements on HIV using Filipino Sign Language.
Three PSAs produced in 2019 by Bahaghari Center for SOGIE Research, Education and Advocacy, Inc. with Y Peer to tackle:
HIV basics
How to get tested for HIV
What happens after HIV testing happens
Available from:
https://www.youtube.com/watch?v=0gyFsYq2J7U
https://www.youtube.com/watch?v=otFgk450ZNY
https://www.youtube.com/watch?v=TMfglXPm9tg

SOGIE Training Manual.
ISEAN developed this SOGIE package in 2015 for use by organizations that focus on the issue of sexuality and sexual health, as well as by other organizations that consider this issue is important to be institutionalized in their organizations.

Available from https://www.apcom.org/storage/2017/02/SOGIE-Training-Manual_EN.pdf

Training Manual on Gender-Based Violence.
Produced by Justice for Children in 2014, this training manual enables trainers to conduct a three or more day training and planning workshop. The topics include: basic GBV concepts and principles; consequences of GBV; survivor support services; and development of effective prevention strategies.
Available from https://namati.org/resources/training-manual-on-gender-based-violence/

Volunteer Manual & Training Curriculum for Adolescent Sexual and Reproductive Health Counselling.
A service manual and sexual and reproductive health volunteer training manual developed by the Healthy Child Manitoba Office in 2002, based on available evidence, best practice and community experience.
Available from https://www.gov.mb.ca/healthychild/mcad/had_volunteermanual.pdf

PART 7

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WE ARE ALL BORN EQUAL

PART 8 Annexes

ANNEX 1: Additional Group Activities and Exercises, and Ice Breakers

GROUP EXERCISE: Fishbowl Analysis of a Person in Need
A manual produced by the Secretariat of the Pacific Community in 2015 to tackle
This exercise aims to ascertain how the participants may respond to a client. This exercise uses a fishbowl method. A facilitator acts as a patient visiting health workers (acted out by the participants) who are asked to respond to his or her concerns.

MECHANICS:

1. Have the participants sit in a circle.
2. The facilitator presents the case to the participants; he/she then acts out the character presented in the case.
3. The facilitator moves from one participant to another, to deal with the issues encountered as the supposed patient being considered in the case. The discussions will be continuous, so that all the patient's issues are dealt with.
4. After the exercise, the facilitator will discuss with the participants what worked and what didn't work, and recommendations to deal with these.

GROUP ACTIVITY: Condom relay race
At the end of this exercise, participants should be able to know the proper way to put on a condom.

TIME ALLOCATION
30 minutes

MATERIALS

- Two condom demonstration models (e.g., bananas or penis models)
- Flipchart or manila or caroline
- Marker
- Masking tape

MECHANICS:

1. Form two teams. If male and female participants are equal in number, make single-sex teams. Ask two volunteers to stand in a straight line, and hold the two penis models.
   Explain that these volunteers will serve as judges and that they will

determine whether others have completed the exercise correctly.

2. Illustrate the correct steps of condom use and summarize these steps on a flipchart:
    a. Check the expiry date printed on the package.
    b. Open the package carefully so that the condom does not tear. Do not unroll the condom before putting it on.
    c. Squeeze the tip of the condom, so that you leave a centimeter of space at the top for semen.
    d. Still holding the tip, unroll the condom until it covers the entire erect penis.
    e. After ejaculation, pull the penis out before erection is lost, holding the rim of the condom to prevent spilling.
    f. Dispose of the condom in a safe place.
3. Tell the teams that each member will briefly demonstrate correct condom use. In turn, each participant should open a condom package, put the condom on the model, and then remove it. The winning team is the first to have everyone complete the task. Lots of cheering and encouragement make this exercise fun.
4. When the relay is over, ask the judges if everyone correctly demonstrated how to open the package and put on and take off the condom.
5. Now, point out some mistakes people made in the condom relay. Use this opportunity to reinforce the correct steps. Tell the group that with a little practice, a condom can be put correctly and very quickly.

GROUP ACTIVITY: Hierarchy of Needs

Abraham Maslow's "hierarchy of needs" is a concept based on the need to satisfy basic needs first before self-actualization is attained.

From the bottom of the hierarchy upwards, the needs are: physiological, safety, love and belonging, esteem, and self-actualization.

In this exercise, the pyramid is used. However, this exercise will deal with a specific topic and identify the other needs that people may need to satisfy first before dealing with this topic in particular.

For example, if HIV needs are located at the highest position of the pyramid, ask the participants what issues they may need to deal with first under the other categories (physiological, safety, love and belonging, esteem). A sex worker may need to consider his or her client's demands first before thinking of HIV prevention, particularly if he or she will be paid more by engaging in unprotected sex.

MECHANICS:

1. Divide the participants into smaller groups.
2. Ask the participants to identify needs that fall into the five hierarchies. Be sure that the responses are specific to the topics at hand.

3. Ask the participants to do a presentation.

ICE BREAKER: Seat swap

MECHANICS:

1. Gather the participants in a circle. Everyone - but one - should be seated.
2. The remaining participant without a seat signs specific words.
3. The words signed will require the participants to change seats.
4. At least one word will force everyone to change seats by moving to their right.
5. Another word will force them to change seats by moving to their left.
6. And another word will make them change seats by moving across.
7. After the swapping of seats, all but one of the participants will end up without a chair, so he/she becomes the "It", and the game is repeated.

ICE BREAKER: Yes/No/Maybe

MECHANICS:

1. Gather the participants in a circle. Everyone - but one - should be seated.
2. The participant who has no seat is the "It". What he/she does is ask any one of the other seated participants a question, i.e. "Are you a Deaf person?"
3. If the answer is "yes", all participants change seats, moving to the seats at their right. If it's a "no", move to the seats at their left.

ANNEX 2: Additonal information on abortion

Generally speaking, abortion is process of terminating pregnancy or to emerge, release or medically withdraw an embryo in womb. This may be done in either natural or artificial method.

Abortion is not the same as miscarriage, which is when a pregnancy ends naturally.

Abortion is also sometimes referred to as "termination" or "termination of pregnancy".

Safe abortion

- An abortion is considered to be safe when it is done:
- with consent of pregnant woman
- by a trained and experienced health worker
- with the proper instruments
- under clean conditions (anything that goes into the vagina and womb must be sterile or without any germs)
- up to 3 months (12 weeks) after the last monthly bleeding

"Reproductive health rights rights rest on the recognition of the basic right of

all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. " International Conference on Population and Development(ICPD), Cairo, 1994, Section 7.

Methods of safe abortion

1. Safe abortion can be performed in the following ways:
2. Medical abortion is performed using medicines prescribed by doctors and health workers. This method is desirable for pregnancies of gestational age up to 9 weeks.
   Vacuum aspiration (MVA) or electric vacuum aspiration, which can be used for abortion in pregnancy of 12-14 weeks. Here, pregnancy is removed by suction using a special tube (cannula) that is put into the womb through the vagina and cervix.
3. Dilatation and evacuation (D&E), which can be performed by any one of these two techniques only if the period of the pregnancy is 13 weeks or more, according to the wishes/consent of the woman, according to the opinion of the doctor, and as stated by law

Unsafe abortion

According to WHO, unsafe abortion is a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both. Many young women are forced to choose unsafe abortion when they cannot access safe abortion due to various reasons. These reasons include restrictive laws, poor availability of services, high cost, stigma, and lack of confidentiality and youth-friendly services.

Abortion is unsafe when it is done:

- by an untrained individual
- with the wrong instruments and medicines
- under unclean/infected environment
- after 12 weeks of pregnancy, unless it is done in health centers or hospitals with special equipment

Every year, between 4.7% to 13.2% of maternal deaths can be attributed to unsafe abortion.

Complications/Consequences of unsafe abortion

An unsafe abortion can cause various complications like infection, hemorrhage,

sepsis, trauma to the cervix, vagina, uterus and abdominal organs, lasting pain, infertility, and death.

According to WHO (2014), about 20–30% of unsafe abortions cause reproductive tract infections and
20–40% of these result in infection of the upper genital tract.
Also, one in four women who undergo an unsafe abortion is likely to develop temporary or lifelong disability requiring medical care. These women also experience high physiological, financial and emotional costs.

Preventing unsafe abortion
Since unsafe abortion has life-threatening impacts, its practice should be avoided at any cost.

Some measures that can prevent unsafe abortion are:

- Sexuality education
- Provision of safe, legal induced abortion
- Lifting of legal restrictions and stigma linked to having an abortion
- Easy access to Deaf and hard of hearing youth-friendly abortion services and facilities
- Availability of effective contraceptive for preventing unintended pregnancies

ANNEX 3: Sexual and Reproductive Rights

Sexual rights relate to a person's sexuality, sexual orientation, gender identity, sexual behaviors and sexual health. Sexual rights are like other human rights. They are universally indivisible, inalienable, interrelated and interdependent.

Reproductive rights relate to a person's fertility, reproduction, reproductive health and parenthood. Every individual has the right to make his or her own choices about his or her sexual and reproductive health. This means that people should be able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when and how often to do so.

Sexual Rights:

1. The right to equality
2. The right to participation
3. The right to life and to be free from harm
4. The right to privacy
5. The right to personal autonomy and to be recognized as an individual before the law
6. The right to think and express oneself freely
7. The right to health
8. The right to know and learn
9. The right to choose whether or not to marry or have children
10. The right to have your rights upheld

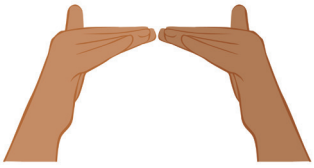
Sexual and Reproductive Health and Rights (SRHR) encompasses both.

As proposed by the Guttmacher–Lancet Commission (Starrs, et al, 2018), SRHR covers sexual health, sexual rights, reproductive health and reproductive rights. It reflects an emerging consensus on the services and interventions needed to address the sexual and reproductive health needs of all individuals.

SRHR also addresses issues such as violence, stigma and respect for bodily autonomy, which affect the individuals' psychological, emotional and social well-being.

By addressing the needs of neglected groups (e.g. adolescent girls, LGBTQIA individuals, and those with disabilities), SRHR offers a comprehensive framework to guide governments, donor agencies, civil society and other stakeholders involved in designing policies, services and programs that address all aspects of SRHR effectively and equitably.

There are fifty articles of CRPD advocating rights of people with disability. Five of these articles are related to deaf people. It is necessary to know these in order to better understand how inclusión can be achieved with sign language



WITH SIGN LANGUAGE,
I AM EQUAL

The articles are:
Article 2: Definition
Article 9: Accessibility
Article 21: Freedom of expression and opinion, and acess to information
Article 24: Education
Article 30: Participation in cultural life, recreation, leisure and sports.

SOURCES:
World Federation of the Deaf: Know and achieve your human rights Toolkit (2016)
Sexual Right:IPPF Declaration
UNFPA SRHR: An essential element of universal coverage (2019)
IPPF Exclaim!Young people's guide to "Sexual rights: an IPPF declaration" (2011)

ANNEX 4: Gender-based violence response framework

ANNEX 5: Sample pre-training questionnaires

Pre-training Questionnaire on SRHR

The answers you provide will help us identify the level of your knowledge about SRHR. We respect your privacy, so your answers will only be used to guide the trainers/facilitators on the lessons to be taught.

DATE: .....
NAME/CODE NAME: .....
GENDER: .....
AGE: .....

1. How long have you been working in SRHR?
   ____ Years
   ____ Months

2. What is your primary role or function in your job? (Select one)
   - ☐ Manager
   - ☐ Trainer
   - ☐ Peer educator
   - ☐ Other (Please specify): _____

3. In the next statements, choose whether they are TRUE or FALSE. Encircle your answer.
   - Human rights are universal.
     (True/False)
   - Sex and gender are the same.
     (True/False)
   - Peer education is the process where well-trained and motivated young people undertake informal, educational activities with their peers (those similar to themselves in age, background, or interests).
     (True/False)
   - Sexual orientation refers to masculine and feminine.
     (True/False)
   - For HIV treatment, ARV stands for antiretroviral medicine.
     (True/False)

4. What do the following acronyms stand for?

SOGIE:_____
SRHR:_____
YKP:_____
PrEP:_____
ARV :_____
YFHS:_____
PMTCT:_____

5. Among the choices, choose an answer that you think will best complete the sentence.

A. Sex refers to:
   1. Biological differences between males and females
   2. A person's identity - for example, when one sees himself/herself gay or lesbian
   3. Something that can be changed over time

B. Gender refers to:
   1. A person's assigned sex organ
   2. Socially constructed roles, responsibilities, and expectations of males and females
   3. Physiology, and are generally permanent and universal

C. Reproductive health is defined as:
   1. A state of complete, healthy well-being without any disease and infirmities
   2. A human right only given to people with interest in family planning
   3. A state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes

4. What is your understanding of sexuality?

5. What do you understand about Comprehensive Sexuality Education (CSE)?

General Pre-training Questionnaire

Welcome to this training!

We would like to know a bit more about, including your background, your peer education knowledge and skills level, and your expectations of and opinion about this training.

There is no right or wrong answers. We are interested only in knowing your opinion.

Please tick the appropriate box, or fill in the blanks.
Note that you do not need to give your name or address.
Thank you!

Date:
Name (Optional):

1. Are you:
   ☐Male ☐Female ☐Other

2. How old are you? _____

3. What is the highest level of schooling that you have completed?
   ☐Primary school ☐Secondary school ☐University or postgraduate

4. In your job, what is your primary function? (Select one)
   ☐Manager ☐Trainer ☐Peer educator
   ☐Other (Please specify): _____

5. How many years have you been working in peer education? (Enter 0, if no experience)
   _____ years

6. How likely is it that you will use the knowledge and skills learned in this training to train your peers?
   ☐Highly likely ☐Somewhat likely ☐Not likely Unsure at this time

On a scale of 1 to 5 (1 being the lowest, and 5 being the highest), please rank the following statements.

QUESTIONS		1	2	3	4	5
7.	How do you rank your confidence in being able to conduct a training program for youth in peer education?					
8.	On a scale of 1 to 5 (1 being the lowest; 5 being the highest), how do you rank your knowledge of and ability to describe a comprehensive model for peer education programs?					
9.	How do you rank your knowledge about the difference between gender and sex and how gender may affect sexual and reproductive health in a population?					
10.	How do you rank your confidence in being able to conduct a training program for youth in peer education?					
11.	How do you rank your confidence and skills in setting up and conducting role-play exercises for peer educations?					
12.	How confident and comfortable are you in bringing a speaker living with HIV to a workshop for youth?					
13.	How well do you think you know at least three different ways to teach factual information in a training?					
14.	How do you rank your confidence in being able to conduct a training program for youth in peer education?					
15.	How well do you think you know at least three different motivational techniques to use in a peer education training?					
16.	How well do you think you know at least five different life skills to address in a health education program?					
17.	How strongly do you feel that you would involve a person living with HIV/AIDS in the design and implementation of your peer education program?					
18.	How do you rank your confidence in providing services related to the areas discussed in this training?					
19.	How do you rank the usefulness of this training for your work?					

20. Please specify two to three critical challenges related to peer education programs in your work. Feel free to write in your language of choice.

21. Do you have additional comments or recommendations about this training (e.g., your expectations)?

Thank you for completing this form!

ANNEX 6: Sample Post-training Questionnaire

Post-training Questionnaire

As the last activity of this training, we would like you to complete this questionnaire. Your answers will be used to evaluate the training.
You do not need to give your name or address.
We encourage you to express yourself as honestly as you can.

Thank you!

Date:
Name (Optional):

1. Are you:
   ☐Male ☐Female ☐Other

2. How old are you? _____

3. What is the highest level of schooling that you have completed?
   ☐Primary school ☐Secondary school ☐University or postgraduate

4. In your job, what is your primary function? (Select one)
   ☐Manager ☐Trainer ☐Peer educator
   ☐Other (Please specify): _____

5. How many years have you been working in peer education? (Enter 0, if no experience)
   _____ years

6. How likely is it that you will use the knowledge and skills learned in this training to train your peers?
   ☐Highly likely ☐Somewhat likely ☐Not likely Unsure at this time

On a scale of 1 to 5 (1 being the lowest, and 5 being the highest), please rank the following statements.

QUESTIONS	1	2	3	4	5
7. How do you rank your confidence in being able to conduct a training program for youth in peer education?					
8. How do you rank your knowledge of and ability to describe a comprehensive model for peer education programs?					
9. How do you rank your knowledge about the difference between gender and sex and how gender may affect sexual and reproductive health in a population?					
10. In your own words, how would you define "gender"?					
11. In your own words, how would you define "sex"?					
12. How do you rank your confidence and skills in setting up and conducting role-play exercises for peer educations?					
13. How confident and comfortable are you in bringing a speaker living with HIV to a workshop for youth?					
14. How confident are you in conducting at least three team-building exercises for peer educators?					
15. Name three team-building exercises:					
16. How well do you think you know at least four icebreaker exercises?					
17. Name four icebreaker exercises:					
18. How well do you think you know at least three different ways to teach factual information in a training?					
19. List three different ways to teach factual information in a training:					

QUESTIONS	1	2	3	4	5
20. How well do you think you know at least three different motivational techniques to use in a peer education training?					
21. List three different motivational techniques to use in a peer education training:					
22. How well do you think you know at least five different life skills to address in a health education program?					
23.. List five different life skills to address in a health education program:					
24. How strongly do you feel that you would involve a person living with HIV/AIDS in the design and implementation of your peer education program?					
25. How do you rank your confidence in providing services related to the areas discussed in this training?					
26. How do you rank the overall quality of this training?					
27. How do your rank the usefulness of this training for your work?					

28. Please specify two to three critical challenges related to peer education programs in your work. Feel free to write in your language of choice.

29. Please feel free to write additional comments about any topic related to this training (e.g.,your expectations, observations, interactions).

Thank you for completing this form!

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THE GLOBAL GOALS For Sustainable Development
Y-PEER
Y-PEER Asia Pacific Center