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National Manual on Boys and Men Engagement

Partnership and Advocacy Department

National Syndemic Diseases Control Council

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NATIONAL SYNDEMIC DISEASES CONTROL COUNCIL

National Manual on Boys and Men Engagement

Training Manual

For

Male Engagement

DRAFT MANUAL

May 2025 Edition

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FOREWORD

Douglas O. Bosire, CEO

The National Syndemic Diseases Control Council (NSDCC) remains steadfast in its mandate to coordinate Kenya's multisectoral response to HIV, tuberculosis, sexually transmitted infections and related syndemics. A key priority in this response is the recognition of boys and men as central actors in advancing gender equality, improving health outcomes and strengthening community resilience.

For too long, men and boys have remained on the periphery of prevention, care and treatment programmes, despite being disproportionately affected by HIV, tuberculosis and substance use disorders. The data underscores this reality: in 2023 only 28 percent of adults tested for HIV were men, yet their positivity rate was higher at 1.6 percent compared to 1.2 percent among women. Antiretroviral therapy coverage among boys aged 10 to 14 stood at 75 percent, while among young men aged 20 to 24 it was as low as 53 percent. Although men and boys represent 35 percent of all people living with HIV, they account for 48 percent of AIDS-related deaths. Further, 69 percent of all tuberculosis cases in 2022 were among men aged 25 to 44, a highly productive age group. These statistics highlight the urgent need for deliberate interventions targeting men and boys in order to save lives and sustain development gains.

It is in this context that NSDCC has developed this Training Manual for Male Champions. This document provides practical guidance, structured interventions and advocacy approaches for engaging men and boys as allies in HIV prevention and gender transformative action. By equipping Male Champions with knowledge and tools, the Manual seeks to dismantle stigma, address silence and promote positive masculinity while reinforcing the role of men as influential partners within their families and communities.

The Manual aligns with the Kenya AIDS Integration Strategic Framework (KAISF) 2025 to 2030 and builds upon the Council's Action Framework for Ending AIDS and related syndemics. It is a deliberate effort to consolidate gains, scale up male engagement and accelerate progress towards universal health coverage, Vision 2030 and the global goal of ending AIDS as a public health threat by 2030.

I therefore call upon all stakeholders, including government agencies, county governments, development partners, civil society and community actors, to embrace this Manual and actively support the Male Champions in their work. Together we can create a future where boys and men are not only beneficiaries but also champions of health, equality and social transformation.

Douglas O Bosire
CEO, NSDCC.

ACKNOWLEDGEMENTS

Ms Angella Lan'gat, DD-PPRM

The National Syndemic Diseases Control Council (NSDCC) gratefully acknowledges the contributions and commitment of all partners and stakeholders who supported the development of this Male Champions Training Manual for Boys and Men Programmes. This Manual is the result of collaborative efforts aimed at advancing male engagement in health and gender equality initiatives in Kenya.

We extend our sincere appreciation to the drafters of the toolkit: Fredrick Naga, Catherine Githae, Dr. Murugi Micheni, Reuben Musundi, Joab Khasewa, Caroline Ngare and Jenny Gaki from NSDCC; Faith Nashipae from TCA; Phillip Nyakwana and Michael Onyango from the Male Engagement Technical Working Group (TWG); Rashid Alex Sened of Truth Mentorship Society (AYP Male Champion); and Malcolm X Andrew (AYP Male Champion).

Special acknowledgement goes to Mercy Chiyumba Khasiani for her thorough review, editing, and layout of the document, as well as to Dr. Murugi Micheni and Joshua Gitonga for their insight and facilitation in ensuring the alignment of this Training Manual with the Kenya AIDS Integration Strategic Framework (KAISF) 2025–2030 and broader boys' and men's health priorities.

We also wish to recognise the Male Engagement Technical Working Group at NSDCC for their invaluable input, review and constructive feedback that enriched this toolkit. NSDCC is deeply appreciative of the collective dedication and expertise that made the development of this Manual possible. It is our hope that it will serve as a practical resource for Male Champions and all stakeholders working to engage boys and men in creating healthier, more equitable communities.

Ms Angella Lang'at
Director Partnership Planning and Resource Mobilization

Background

Male engagement is integral to the successful implementation of the national health response, including HIV, TB and Malaria programmes. There is growing recognition that the involvement of boys and men in prevention, care, and treatment has benefits for men, women, and children.

Boys and men's vulnerability to poor health outcomes is heightened by a range of human rights and gender related barriers. Patterns of behaviour, modes of socialization, peer pressure, prevailing concepts of masculinity, alcohol and drug use, violence, hostile environments, cultural practices and norms, contribute to their poor health-seeking behaviour. Additionally, boys and men can create barriers that limit women, girls and children's access to services.

Over the years, boys and men have not realized significant benefits or targeted investments in HIV, TB and Malaria services including prevention, care and treatment. Although 79.5% of Kenyans aged 15-64 who tested positive knew their HIV status, the percentage of men was lower at 72.6 % compared to women at 82.7 % (KENPHIA, 2018). Similar gaps in timely health seeking behaviour, service uptake continue to undermine TB and Malaria outcomes including delayed diagnosis and poorer treatment completion.

The purpose of this toolkit is to provide a structured framework for training of male champions to effectively engage boys and men in the National HIV, TB and Malaria response.

The rationale for targeting boys and men

Boys and men play a critical role in TB, HIV, and Malaria responses as clients, allies, and agents of change, particularly in addressing gender- and human rights–related barriers to health. As clients, boys and men often experience delayed health-seeking due to harmful gender norms related to masculinity, such as expectations of strength, self-reliance, and risk-taking. These norms contribute to late diagnosis, delayed treatment, and poorer health outcomes. Targeted, male-friendly, and rights-based services are therefore essential to improve early access, retention in care, and treatment outcomes.

As allies, boys and men can actively support women's and girls' access to prevention, testing, treatment, and adherence services by promoting shared decision-making, challenging stigma and discrimination, preventing and responding to gender-based violence, and supporting caregiving and treatment roles within families and communities. As agents of change, boys and men when meaningfully engaged as champions, peer educators, community leaders, and policy advocates can help transform unequal power relations, model positive and non-violent masculinities, increase uptake of TB, HIV, and Malaria services, and strengthen community ownership of health programmes.

This manual responds to existing gaps in the engagement of boys and men within national HIV, TB, and Malaria responses. It provides practical content and strategies for policymakers, programmers, and communities to support meaningful male engagement at multiple levels. Engaging boys and men is essential to achieving

equitable, effective, and sustainable outcomes across HIV, TB, and Malaria prevention, treatment, and care. Boys and men experience distinct vulnerabilities shaped by gender norms, socialization, and structural barriers that influence health-seeking behaviour and access to services.

Targeted engagement improves health outcomes by increasing uptake of testing, early diagnosis, and treatment for HIV and TB, as well as timely prevention and care for Malaria. It also strengthens health systems by improving service utilization, building community trust, and reducing preventable disease transmission. Importantly, male engagement must be grounded in a human rights based and gender-responsive approach. This includes promoting dignity, informed consent, confidentiality, accountability, and inclusion, while actively addressing power imbalances and preventing unintended harm. Male engagement should transform not reinforce unequal gender norms, in ways that advance gender equality and improve health outcomes for all.

Meaningful engagement of boys and men is therefore not optional; it is a strategic necessity for achieving national and global goals on HIV, TB, and Malaria, and for building healthier, more equitable communities. It contributes not only to improved health outcomes across the three diseases and beyond, but also to greater gender equality, respect for human rights, and more resilient, inclusive health systems.

How to capture interests of men

To capture and interest men in health services, it is crucial to adapt approaches that address cultural norms around masculinity and convenience, focusing on actionable, problem-solving interactions and preventive care education. Work with male champions who are well, respected, known, influential and who the men are confident with the following strategies can be applied:

- **Reframe health discussions**: Frame healthcare in terms of strength, resilience, performance, and longevity, rather than weakness or vulnerability. Highlight how proactive health measures enable them to stay strong for their family and work.
- **Use direct, action-oriented communication**: Men prefer clear, direct communication that avoids jargon. Provide precise information about next steps, diagnosis, and the physical benefits of a treatment plan.
- **Improve accessibility and convenience**: Offer flexible time and options to accommodate busy schedules.
- **Leverage available men targeted community meetings** for sustainability and take advantage of community resources.
- **Meet and provide messages/services in non-traditional "male-friendly" settings** like workplaces, community centres, sports venues, or faith organizations.
- **Create male-friendly environments:** In clinics, consider gender-neutral décor, male-oriented reading materials, and posters featuring men in non-

stereotypical settings. Ensure visibility of male staff and provide options for choosing a male healthcare provider if preferred.

- **Leverage already existing community and peer networks**: Collaborate with sports teams, special interest groups, and community organizations to broaden reach.
- Establish male health champions or support groups where men can share experiences in a "safe space" and receive peer support.
- **Leverage platforms popular** with men, such as YouTube and Facebook, to deliver targeted messages.
- **Integrate with other agenda that interest men** e.g. entrepreneurship major sporting events or use humour in campaigns, like the "check your balls" campaign, to break the ice.
  Capitalize on men awareness and events like Men's Health Week and November for timely campaigns.
- **Encourage men, be empathetic**, avoid judgemental statements
  Take full advantage of the time you have with the men

Key considerations for increasing awareness and demand for Health Services among Boys and Men. Summary of key considerations when creating demand for utilization of health products and services among boys and men include:

Understanding your Audience

1. ***Primary and Secondary Audiences***

Audiences can be primary and secondary

Primary	Secondary
The primary audiences are individuals whose behaviour is targeted for change. These could include those directly impacted and expected to adopt the desired behaviour, or those in decision-making roles for individuals who would benefit from the SRH product or service, such as young men's parents (for VMMC). **Examples:** Boys and Men, Healthcare providers: Community health workers, Parents or caregivers of adolescent males (males under 18 years of age) etc.	Secondary audiences comprise individuals who directly or indirectly engage with and exert influence on the primary audience. **Examples:** Female partners (wives, girlfriends, etc.), Peers, Co-workers and employers, Health providers, Community health workers Community leaders, Traditional leaders, religious leaders, Media and journalists

2. ***Segment Audiences for Better Messaging***
   - Select effective communication channels targeting boys and men based on geography, age and settings.

- Breaking down the primary and secondary audiences into smaller and distinct groups with similar characteristics such as interests, attitudes and needs related to male SRH promotes more effective message targeting and channel selection.
- When a group shares common characteristics, then they are more likely to respond to communication intervention.
- Segmentation allows for strategic resource allocation to reach audiences that will drive increased demand and utilization, ensuring activities are tailored for maximum effectiveness.

Segmentation can be informed by:

1. **Demographic Characteristics**: Sex, Age, Education, Occupation, Marital status, Ethnicity, Religion, Socioeconomic status, Geographic location.
2. **Psychographic Characteristics:** Attitudes, Knowledge, Beliefs, Values, Hopes, Aspirations, Preferences, Interests, Personality, Perceived social and gender norms.
3. **Age stage approach to Boys and Men SRH**

Life Stage	Channel Selection	Messaging
Adolescent Men (10 to 18 years old) Time of sexual debut and exploration	• School-based programs • Social media • Radio • Community outreach with parents and caregivers of adolescent men	• Benefits of (specific) services/products • Education about (specific) services/products.
Young Adult Men (19 to 25 years old) Most men are unmarried or in non-committed relationships	• School-based programs (tertiary level) • Social media • TV • Community outreach to men	• Benefits of (specific) services/products • Education about (specific) services/products.
Adult Men (Aged 26 and older) Most men are married and have children	• Employer-based programs • TV and radio • Community outreach to men and wives/female partners	• Benefits of (specific) services/products • Education about (specific) services/products.

Managing Sensitive Issues in Boys' and Men's Engagement Programming

Discussions on boys' and men's engagement in HIV, TB, and Malaria prevention, care, and treatment often touch on sensitive and deeply personal issues. These may include gender norms and masculinity, sexual behaviour, power relations, stigma and discrimination, violence, alcohol and substance use, disclosure of health status, and experiences of trauma. Facilitators must therefore be adequately prepared to manage sensitive issues in a manner that is safe, respectful, rights-based, and gender-responsive.

Creating a Safe and Respectful Learning Environment

At the start of the training, facilitators should establish clear ground rules to ensure discussions remain constructive and do not escalate into hostility or conflict. These ground rules should be agreed upon collectively with participants and revisited throughout the training. Facilitators should also clarify that there will be opportunities to "park" contentious or emotionally charged issues for later discussion. This allows participants time to reflect and helps ensure that difficult conversations are addressed calmly and productively.

Acknowledging Emotions and Lived Experiences

Facilitators should openly acknowledge that discussions related to HIV, TB, Malaria, violence, gender inequality, stigma, and discrimination can evoke strong emotions such as anger, shame, fear, or sadness. Participants should be informed in advance that some sessions may be emotionally challenging and that support mechanisms will be available. It is important to recognize that some participants and facilitators may themselves be survivors of violence, discrimination, or serious illness. Facilitators should therefore adopt a **trauma-informed approach**, allowing participants to step out, take breaks, or seek private support when needed.

Promoting Mutual Support and Collective Responsibility

Facilitators should encourage the group to agree on how they will support one another during sensitive discussions. This may include allowing space to express feelings, suggesting short breaks when emotions run high, and offering the option to speak privately with a facilitator or designated support person. Emphasizing collective responsibility helps build trust and reinforces the importance of solidarity in advancing men's health and wellbeing.

Upholding Human Rights and Gender Principles

Facilitators must ensure that all discussions are grounded in human rights and gender equality principles, particularly the right to health, dignity, non-discrimination, confidentiality, and informed choice. The facilitator must ensure not to impose their beliefs and biases to the learners. While participants may hold diverse cultural, religious, or personal values, facilitators should guide discussions toward evidence-based information and public health goals, while safeguarding the best interests of individuals and communities.

Core Facilitation Principles (Ground Rules)

Facilitators should model and consistently uphold the following principles:

Confidentiality:

All personal stories, disclosures, and discussions shared during training sessions must remain confidential. Participants should be reminded not to share identifiable information outside the training space.

Non-judgement and Respect:

Facilitators should avoid imposing personal beliefs or values. When differing opinions arise, they should be addressed respectfully, recognizing that individual values and experiences vary. There should be no ridicule, shaming, or blaming.

Do No Harm:

Discussions should not reinforce stigma, discrimination, harmful gender norms, or misinformation related to HIV, TB, Malaria, or masculinity.

Evidence-Based and Rights-Focused Dialogue:

While allowing participants to express their views, facilitators should ensure that discussions are informed by accurate evidence and aligned with national policies, public health standards, and human rights obligations.

Participant Safety and Wellbeing:

Facilitators should remain alert to signs of distress and be prepared to pause sessions, refer participants to appropriate services, or adjust facilitation methods as necessary.

Role of the Facilitator

Facilitators play a critical role in balancing open dialogue with safety and respect, while ensuring the terminologies used are safe for age and population diversities. They should actively manage group dynamics, challenge harmful narratives constructively, and redirect discussions when they risk reinforcing inequality, stigma, or rights violations. By doing so, facilitators help create an enabling environment that supports meaningful engagement of boys and men in HIV, TB, and Malaria responses while advancing gender equality and human rights.

Barriers Affecting Men's Access to HIV, TB, and Malaria Services

When engaging men in HIV, TB, and Malaria training, facilitators should be aware of the multi-layered barriers that limit access to prevention, testing, and treatment. Understanding these barriers helps tailor interventions, address misconceptions, and create a supportive environment for male engagement. Table 1 below shows the multi-layered barriers men face in accessing HIV, TB, and Malaria services among other available opportunities/services, with descriptions and disease-specific examples:

Barrier Level	Barrier Description	Example
Gender & Social Norms	Expectations of masculinity discourage help-seeking Cultural beliefs associate illness with weakness Peer pressure reinforces avoidance.	A man delays Malaria testing because he feels admitting illness is "unmanly."
Stigma & Discrimination	Fear of judgment or ostracization HIV- or TB-related stigma Confidentiality concerns.	A man will avoid attending HIV-related support groups to prevent neighbours from knowing.
Health System Barriers	Clinic hours conflict with work hours Facilities perceived as female-oriented Unfriendly staff Long wait times Lack of privacy Limited male-focused services.	A man with malaria symptoms avoids the clinic because it feels crowded with women and children, lacks privacy, and he fears personal questions in public.
Knowledge & Awareness	Low awareness of symptoms, prevention, and treatment. Misconceptions about disease severity or treatment Limited understanding of health rights.	A man ignores persistent fever, not realizing it may indicate malaria or TB.
Economic & Structural Barriers	Transport costs, lost income, health fees Remote or informal settlements	A daily wage worker cannot afford to miss a day of work just to attend a hospital visit.

Barrier Level	Barrier Description	Example
	Inconsistent access for migrant or seasonal workers. Prioritizing income earning activities over going to hospital	
Behavioural & Lifestyle Factors	Alcohol/substance use. Risky sexual or occupational practices Delay until severe illness.	A man ignores TB symptoms while working in dusty environments due to alcohol use and fear of missing work.
Psychosocial & Emotional Barriers	Fear, denial, stress Past negative experiences with healthcare Trauma or mental health challenges.	A man with previous discrimination at a clinic avoids HIV care.

Proposed approaches for delivering training modules

Effective male engagement training requires flexibility, relevance, and inclusivity. A staggered, life-stage–responsive approach ensures that all modules are delivered participants to attend a continuous five-day training. A modular and adaptive delivery model is therefore recommended.

1. Modular and staggered delivery

- Break the five-day curriculum into **stand-alone modules** that can be delivered independently.
- Each module should have clear objectives, core content, and practical activities.
- Deliver modules through **short sessions (2–4 hours)** spread across days or weeks.
- Use attendance tracking and learning logs to ensure participants complete all modules over time.

2. Life-stage and audience-specific delivery

Life stage	Preferred channels	Delivery focus
Adolescent Boys (10–18 yrs)	Schools, social media, comic books, radio, community sessions with parents/caregivers	Puberty, consent, prevention, healthy norms; short, interactive sessions with safeguarding measures.
Young Adult Men (19–25 yrs)	Tertiary institutions, social media, TV, community outreach	Risk awareness, testing, treatment, relationships, peer influence, and shared responsibility.
Adult Men (26+ yrs)	Workplaces, TV/radio, community and couple-based outreach	Family health, provider roles, early care-seeking, partner support, and treatment adherence.

3. Population and work-based adaptation

- **Formal sector:** Workplace-based or after-hours sessions.
- **Informal sector:** Short, repeated sessions at gathering points or low-work periods.
- **Rural or mobile populations:** Align sessions with outreach clinics, market days, or community meetings.

4. Intersectional considerations

Training delivery should account for overlapping factors such as disability (use of sign language and braille), mobility, urban informal settings, ASAL (Arid and Semi-Arid Lands), literacy levels, faith and cultural contexts, and language preferences. Use inclusive facilitation methods, visual aids, local languages, and trusted community structures.

5. Blended learning approaches

- Combine face-to-face sessions with **radio programmes, WhatsApp groups, short videos, and job aids**.
- This allows continuity for participants who miss sessions and reinforces learning between modules.

6. Ensuring Completion of All Modules

- Use a **module completion checklist or learning passport** for each participant.
- Schedule periodic recap or integration sessions to reinforce linkages across modules.
- Engage male champions or peer facilitators to support follow-up and reinforcement.

Mapping Training Modules to Life Stages of Boys and Men

Life Stages Covered while respecting men's time, responsibilities, and diverse lived realities thus ultimately strengthening outcomes for HIV, TB, and Malaria. Given the diversity in age, population groups, nature of work, and availability, it may not be feasible for

All Adolescent Boys: 10–18 years
Young Adult Men: 19–25 years
Adult Men: 26 years and above

Legend ✓ = full delivery, ◐ = introductory/adapted delivery

Module–Life Stage Mapping Table

Module	Adolescent Boys (10–18 yrs)	Young Adult Men (19–25 yrs)	Adult Men (26+ yrs)
Module 1: Introduction (Gender, HR & Health)	✓ Core concepts simplified; rights, dignity, and respect	✓ Full content	✓ Full content with leadership lens
Module 2: Gender and Power	✓ Strong focus on norms, identity, peer pressure	✓ Full module	✓ Focus on power, decision-making, accountability
Values Clarification	✓ Age-appropriate values & respect	✓ Full	✓ Full
Sex vs Gender	✓ Core concepts	✓ Full	✓ Full
Act like a Man/Woman	✓ High priority	✓ High priority	✓ Adapt to roles & leadership
Gender & Power	◐ Intro level	✓ Full	✓ Full

Module	Adolescent Boys (10–18 yrs)	Young Adult Men (19–25 yrs)	Adult Men (26+ yrs)
Module 3: Communication, Decision-making & Relationships	✓ Confidence, self-esteem, peer influence	✓ Relationships, decision-making	✓ Marriage, parenting, leadership
Self-esteem	✓ High priority	✓ Priority	◐ Optional
Three Cs Decision-making	✓ Simplified	✓ Full	✓ Full
Healthy Relationships	✓ Strong focus	✓ Full	✓ Couple-focused
Fatherhood	◐ Introduction	✓ Emerging fatherhood	✓ High priority
Module 4: Gender-Based Violence (GBV)	✓ Prevention, respect, conflict skills	✓ Full	✓ Full with accountability
What is GBV	✓ Prevention focus	✓ Full	✓ Full
Causes & Factors	◐ Simplified	✓ Full	✓ Full
Effects & Consequences	✓ Age-appropriate	✓ Full	✓ Full
Conflict & Anger Management	✓ High priority	✓ High priority	✓ High priority
Module 5: HIV, TB & Malaria	✓ Prevention, testing awareness	✓ Full continuum	✓ Full continuum
HIV Basics	✓ Prevention	✓ Full	✓ Full
Condom Use	✓ Age-appropriate	✓ Full	✓ Full
Treatment & Care	◐ Awareness	✓ Full	✓ Full
Stigma & Discrimination	✓ Values focus	✓ Full	✓ Full
TB	✓ Symptom awareness	✓ Full	✓ Full
Malaria	✓ Prevention	✓ Full	✓ Full
Module 6: Sexuality & Reproductive Health	✓ Puberty, consent, rights	✓ Full SRH	✓ Family-focused
Human Sexuality	✓ High priority	✓ Full	◐ Optional
Reproductive System	✓ Basic	✓ Full	◐ Optional
STIs	✓ Prevention	✓ Full	✓ Full
SRHR	✓ Rights awareness	✓ Full	✓ Full
Family Planning	◐ Intro	✓ Shared responsibility	✓ High priority
Module 7: NCDs	◐ Awareness only	✓ Prevention	✓ Full

Module	Adolescent Boys (10–18 yrs)	Young Adult Men (19–25 yrs)	Adult Men (26+ yrs)
NCD Overview	◐ Basic	✓ Full	✓ Full
Diabetes	◐ Awareness	✓ Full	✓ Full
Prostate Cancer	—	◐ Awareness	✓ High priority
Module 8: Mental Health	✓ Emotional wellbeing	✓ Full	✓ Full
Mental Health Basics	✓ High priority	✓ Full	✓ Full
Alcohol & Substance Use	✓ Prevention	✓ Full	✓ Full

Key Notes for Facilitators

- All modules are relevant, but depth and emphasis must vary by life stage.
- Adolescents: Focus on prevention, identity, norms, rights, and life skills.
- Young adult men: Focus on relationships, decision-making, risk, and responsibility.
- Adult men: Focus on leadership, family health, accountability, and chronic conditions.
- Sensitive topics should always be delivered using age-appropriate language and safeguarding principles.

Sample Agendas

Training of Boys and Men on HIV Prevention and Response

5 Days' Training Agenda

Day 1: Setting the Stage, Gender and Power	
Time	**Session /Activity**
8:30 -9: 30 am	• Introductions • Expectations/Group Norms • Workshop Objectives • Review of Agenda
9: 30 – 9: 45am	Pre-test
9: 45 - 10: 15 am	Welcome and Opening Remarks
10: 15 – 10: 45 am	**Health Break**
10:45 – 11:30 am	Key Concepts and Terminologies in Health, Gender and Male Engagement
11:30 -12:15 pm	Values clarification on Gender and Health
12: 15 – 1.00 pm	Building Consensus on Sex and Gender
1:00 -2:00 pm	**Lunch Break**
2.00 – 3.00 pm	Gender Norms: Act like a Man; Act like a Woman
3:00 – 4:00 pm	Gender and Power
4: 00 – 4:15 pm	**Health Break**
4.15 – 5.00 pm	Confidence, Self-Awareness and Self-Esteem
5.00 – 5: 15 pm	Wrap-Up of Day 1

Day 2: Communication, Relationships and Gender-Based Violence	
Time	**Session/Activity**
8:30 - 9:00 am	Recap of Day 1
9: 00 – 9: 30 am	Three C's to Good Decision Making
9:30 -10: 30 am	Healthy and Unhealthy Relationships
10: 30 – 11: 00 am	**Health Break**
11:00 -12:00 Noon	Thinking about Fatherhood
12.00 -1:00 pm	What is Gender-Based Violence?
1:00 – 2:00 pm	**Lunch Break**
2:00 – 3: 00 pm	Causes and Contributing Factors to GBV
3:00 – 3: 45 pm	Effects and Consequences of GBV
3: 45 – 4: 00 pm	**Health Break**
4: 00 – 4: 45 pm	Conflict and Anger Management among Boys and Men
4: 45 – 5:00 pm	Wrap Up
Day 3: Men, HIV and Human Sexuality	
Time	**Session/Activity**
8: 30 - 9:00 am	Recap of Day 2
9:00 - 10.00 am	Basics Facts about HIV and AIDS, TB and Malaria.
10: 00 – 10: 30 am	HIV prevention Correct and Consistent use of Condom
10:30 -11:00 am	**Health Break**
11:00 -12:00 Noon	HIV Related Stigma and Discrimination
12:00 -1: 00 pm	Access to HIV Treatment and Care
1: 00 -2: 00 pm	**Lunch Break**
2: 00 - 2:45 pm	Sexually Transmitted Infections
2: 45 - 3: 45 pm	Sexual and Reproductive Health and Rights
3: 45 – 4:00 pm	**Healthy Break**
4:00 – 5:00 pm	Human Reproductive System
5: 00 - 5:15 pm	Wrap-Up of Day 3
Day 4: Reproductive Rights, Family Planning, STIs and Non-Communicable Diseases	
Time	**Session/Activity**
8:30- 9:00 am	Recap of Day 3
9: 00 - 9: 45 am	Learning about Tuberculosis
9: 45 - 10:30 am	Introduction to Human Sexuality
10:30 -11:00	**Health Break**
11:00 -12:00 Noon	Role of Men in Family Planning
12:00 -1:00 pm	Introduction to Non-Communicable Diseases (NCDs)
1: 00 – 2: 00 pm	**Lunch Break**
2: 00 - 2:45 pm	Diabetes: Signs and Symptoms
2: 45 – 3: 30 pm	Prostate Cancer
3: 30 – 4:00 pm	**Health Break**
4: 00 – 5: 00 pm	Introduction of Mental Health and Mental Disorders
5: 00 - 5:15 pm	Wrap-Up of Day 4
Day 5:	
8:30- 9:00 am	Recap of Day 4
9: 00 – 10:00 am	Alcohol, Drugs and Substance Abuse
10:00 – 10: 30 am	Risk Factors and Signs of Mental Disorders
10:30 -11:00 am	**Health Break**
11:00 – 12: 00 pm	Promoting Mental Health Wellness
12:00 - 12: 30 pm	Training Evaluations
12:30 -1:00 pm	Close of Training
1:00 – 1:15 pm	Post Test

1: 15 – 2: 15 pm	**Lunch Break**
2: 15	**Training Reflections and Bonding /Departure**

Training of Men and Boys on HIV Prevention and Response

3 Days' Training Agenda

Day 1: Setting the Stage, Gender and Self-Esteem	
Time	**Session /Activity**
8:30 -9: 30 am	• Introduction • Expectations/Group Norms • Workshop Objectives • Review of Agenda
9: 30 – 9: 45am	Pre-test
9: 45 - 10: 15 am	Welcome and Opening Remarks
10: 15 – 10: 45 am	**Health Break**
10:45 – 11:30 am	Key Concepts and Terminologies in Health, Gender and Male Engagement
11:30 -12:15 pm	Building Consensus on Sex and Gender
12: 15 – 1.00 pm	Gender Norms: Act like a Man; Act like a Woman
1:00 -2:00 pm	**Lunch Break**
2.00 – 3.00 pm	Gender and Power
3:00 – 4:00 pm	Confidence, Self-Awareness and Self-Esteem
4: 00 – 4:15 pm	**Health Break**
4.15 – 5.00 pm	Thinking about Fatherhood
5.00 – 5: 15 pm	Wrap Up of Day 1
Day 2: Gender Based Violence, HIV and Condom Use	
Time	**Session/Activity**
8:30 - 9:00 am	Recap of Day 1
9: 00 – 9: 30 am	What is Gender Based Violence?
9:30 -10: 30 am	Causes and Contributing Factors to GBV
10: 30 – 11: 00 am	**Health Break**
11:00 -12:00 Noon	Effects and Consequences of GBV
12.00 -1:00 pm	Conflict and Anger Management among Boys and Men
1:00 – 2:00 pm	**Lunch Break**
2:00 – 3: 00 pm	Basics facts about HIV and AIDS
3:00 – 3: 45 pm	HIV Prevention - Correct and Consistent use of Condom
3: 45 – 4: 00 pm	**Health Break**
4: 00 – 4: 45 pm	Men HIV, TB and Malaria
4: 45 – 5:00 pm	Wrap Up
Day 3: STIs, Non-Communicable Diseases, Mental Health and Closing	
Time	**Session/Activity**
8: 30 - 9:00 am	Recap of Day 2
9:00 - 10.00 am	Sexually Transmitted Infections
10: 00 – 10: 30 am	Role of Men in Family Planning
10:30 -11:00 am	**Health Break**
11:00 -12:00 Noon	Introduction of Mental Health and Mental Disorders
12:00 -1: 00 pm	Alcohol, Drugs and Substance Abuse
1: 00 -2: 00 pm	**Lunch Break**
2: 00 – 3.00 pm	Introduction to Non-Communicable Diseases (NCDs)
3: 00 - 4: 00 pm	Promoting Mental Health Wellness
4: 00 – 4:15 pm	**Healthy Break**

4:15 – 4:30 pm	Post Test
4:30 – 5:00 pm	Training Evaluations
5:00 – 5: 15 pm	**Close of Training**

Training of Men and Boys on HIV Prevention and Response

1 Day Training Agenda

Day 1: Setting the Stage, Gender and Self-Esteem	
Time	**Session /Activity**
8:30 -9: 00 am	• Introduction • Expectations/Group Norms • Workshop Objectives • Review of Agenda
9: 00 – 9: 15 am	Pre-test
9: 15 - 9: 30 am	Welcome and Opening Remarks
9: 30 – 10:00 am	Key Concepts and Terminologies in Health, Gender and Male Engagement
10: 00 – 10: 30 am	Building Consensus on Sex and Gender
10: 30 – 11: 00 am	**Health Break**
11:00 – 11:30 am	What is Gender-Based Violence?
11:30 am – 12:15 pm	GBV Causes and Contributing Factors
12: 15 – 1.00 pm	Basics Facts About HIV and AIDS
1:00 -2:00 pm	**Lunch Break**
2:00 – 2: 30 pm	HIV Prevention - Correct and Consistent use of Condom
2.30 – 3.00 pm	Introduction of Mental Health and Mental Disorders
3:00 – 3:45 pm	Alcohol, Drugs and Substance Abuse
3: 45 – 4:00 pm	**Health Break**
4.00 – 5.00 pm	Confidence, Self-Awareness and Self-Esteem **(Boys)** Or Role of Family Planning **(Men)**
5:00 – 5:15 pm	Post Test
5.15 – 5: 30 pm	**Evaluation and Wrap-Up**

Basic facts About HIV or AIDS

Module 1: Introduction

Session 1.1: Key Concepts and Terminologies in Gender, Male Engagement and Health

Goal: To review and explain the key concepts and terminologies used in gender and development.
Objectives: By the end of the session participants should be able to:
Define the key concepts and terminologies commonly used in gender, male engagement and health.
Relate the concepts and terminologies to their work.
Time: 45 minutes

Materials: Flipchart, Markers, Masking tape
Target Audience: Boys and Men

Advance Preparation

Select the terminologies and concepts from the list below that the participants need to know depending on their level of understanding and write them on a Flipchart paper.

1. Sex 2. Gender 3. Gender Equality 4. Equity 5. Gender Equity 6. Gender Sensitive: 7. Gender Responsive 8. Gender Based Violence 9. Gender Stereotypes 10. Gender Relations	11. Gender Disaggregated Data 12. Gender Mainstreaming 13. Practical Gender Needs 14. Strategic Interests 15. Masculinity 16. Femininity 17. Feminism 18. Discrimination 19. Patriarchy	20. Culture 21. Abuse 22. Coercion 23. Power 24. Perpetrator 25. Sexuality 26. Sexual orientation 27. Sexual Rights 28. Sexual Health 29. Affirmative Action

Facilitator's Notes

It is important to note that participants may have some idea about some of the concepts which might be true or false. Men are sensitive to blame, please don't admonish anyone who has not given the correct answers as this is likely to lead to withdrawal among the participants which can affect participation.

There is a possibility of participants getting bored if the session is very long. Blend the session with energizers and allow room for light moments.

Steps

1. Identify the terminologies/concepts that the participants need to define based on their level of understanding.
2. Depending on the number of participants, allocate each one or two terminologies/concepts which you had written earlier on a flipchart paper.
3. Ask them to pair up (groups of two participants) and define the terminologies together. (Allow not more than 10 minutes for this).

4. After each pair has given their definition, proceed to give the correct definitions using the information in the resource "Sheet 1: Definitions of Terms and Key Concepts" in case they did not get it right or mixed up the definition.
5. End the sessions by informing the participants that these concepts will be explained further during the training.

Resource Sheet 1.1: Definition of Terms and Key Concepts

The key definitions and concepts in this module provide the foundational concepts and shared language that guide the entire Male Engagement Manual. These definitions are not included for academic purposes, but to ensure that all facilitators, champions, and implementers have a common understanding of gender, human rights, power, inclusion, and ethical engagement before applying them in specific health contexts.

The concepts introduced in this module form the conceptual backbone of the manual. They explain:

- *why* boys and men experience different health outcomes,
- *how* gender norms and power relations shape behaviour and access to services, and
- *what* is required to engage boys and men in ways that are rights-based, gender-transformative, safe, and effective.

How to Use the Definitions in This Module

Facilitators and implementers are expected to:

- Understand the meaning and intent of each concept
- Apply the concepts in practice, not simply recite definitions
- Use the concepts to:
    - reflect on personal attitudes and biases
    - design respectful and inclusive engagement activities
    - identify harmful norms and practices
    - promote positive masculinity and shared responsibility
    - protect dignity, safety, and rights

These concepts should be revisited throughout the manual, as they are applied in real-life scenarios across different health and social contexts.

Core Gender & Social Concepts

This introduces the basic building blocks for understanding how societies organize roles, responsibilities, expectations, and power between girls, women, boys, and men. These concepts explain how gender is socially constructed, how power operates in relationships, and how culture and patriarchy shape everyday behaviour.

Understanding these concepts helps:

- distinguish between biological differences (*sex*) and socially learned behaviours (*gender*)
- recognize how masculinity and femininity are constructed and reinforced
- understand how power and culture influence decision-making, health-seeking behaviour, and relationships

The following are the key definitions under this group:

- **Sex:** Refers to the biological attributes of females and males, including anatomical, physiological, and genetic characteristics. These attributes may influence health outcomes but do not determine social roles, behaviours, or rights.
- **Gender:** Refers to the social, cultural, economic, political and religious attributes that are associated with being male or female. Gender roles and responsibilities of men and women are created in our families, our societies and our cultures. Gender roles and expectations are learned or acquired during the socialization process. They can change over time, and they vary within and between cultures. Systems of social

differentiation, such as political status, class, ethnicity, physical and mental disability, age and more, modify gender roles.

- **Equality**: Refers to the state in which all people have the same rights, legal status, and opportunities, and are treated with equal respect and fairness under the law. It is a fundamental human right.
- **Equity:** This refers to the fair sharing and distribution of resources, opportunities and benefits according to the framework given. It is one of the measures of equality but not the only one. The development challenge in every case is to identify barriers to the opportunities that exist, and custom design the adjusted interventions that will lead to equality of outcome.
- **Gender Equality:** Refers to the state in which women and men, girls and boys, enjoy equal rights, responsibilities, and opportunities, and are equally valued by society. Achieving gender equality often requires gender-equitable measures to address historical and structural disadvantages. **Equity is a means; equality is the result.**
- **Gender Equity:** refers to fairness in the treatment of boys, men, girls, and women according to their respective needs. To achieve fairness, measures may be required to compensate for historical and social disadvantages that prevent women and men from operating on a level playing field. Gender equity is a means to achieve gender equality.
- **Gender Roles:** Gender roles refer to the socially and culturally defined expectations, responsibilities, behaviours, and tasks that a society considers appropriate for women, men, girls, and boys. These roles are learned through socialization within families, communities, institutions, and media, and they influence how individuals are expected to behave, work, relate to others, and participate in decision-making. Gender roles are not fixed or biologically determined; they can change over time and vary across cultures and contexts. Unequal gender roles often result in imbalances of power, access to resources, and health outcomes, while more equitable and shared gender roles promote respect, cooperation, and wellbeing for individuals, families, and communities.
- **Gender Stereotypes:** A set of characteristics that a particular group assigns to women or men (e.g. domestic work does not belong to men's responsibilities).
- **Gender Relations:** Refers to the way men and women relate in terms of the distribution of power between the two genders, for example in decision-making, sharing of resources and in sharing responsibilities. Gender relations are also the communication, consideration and dialogue that is required in a relationship.
- **Power:** Is the capacity to make decisions. All relationships are affected by the exercise of power. When power is used to make decisions regarding one's own life, it becomes an affirmation of self-acceptance and self-respect that, in turn, fosters respect and acceptance of others as equals. When used to dominate, power imposes obligations on, restricts, prohibits and makes decisions about the lives of others.
- **Culture:** The shared values, beliefs, norms, practices, customs, and ways of life of a group of people that shape behaviours, relationships, and social expectations. Culture is learned, shared, and dynamic, and can change over time in response to social, economic, and environmental influences.
- **Patriarchy:** This is the male domination of power, leadership, ownership and control over resources that maintains the system of gender discrimination. It is maintained by an assertion of male superiority that claims to be based on biological differences between women and men, on cultural values or religious doctrines. Patriarchy is the belief in male supremacy (the rule of the fathers). It is also a system that maintains male privilege and supremacy over female.
- **Masculinity:** Masculinity refers to the socially constructed attributes, roles, behaviours, and expectations that a society associates with men and boys. These expectations are learned through socialization within families, communities, institutions, and cultures, and they vary across time and context. In many societies, boys and men are socialized to value strength, competitiveness, bravery, self-reliance,

and emotional restraint, and to assume leadership or provider roles within households and communities. Such norms can discourage emotional expression, care-seeking, and shared responsibility, and may contribute to harmful behaviours, including risk-taking and violence. Economic insecurity, unemployment, and limited livelihood opportunities can undermine men's ability to meet socially prescribed expectations, leading to stress, loss of self-worth, and strained relationships. These pressures can increase vulnerability to poor health outcomes and, in some contexts, contribute to the escalation of gender-based violence. Masculinity is not fixed or inherently harmful. It is socially constructed and can be expressed in both harmful and positive ways. **Positive expressions of masculinity** promote respect, responsibility, emotional wellbeing, non-violence, care-seeking, and shared decision-making, and support healthier relationships, gender equality, and improved health outcomes for all.

- **Femininity:** Refers to ideas about how individuals gendered as women should see themselves in a given society. Most societies socialize their female children to accept a lower status than boys, to be service providers and to aspire to domestic roles and to be subordinate to men.

Human Rights & Ethics in Health

This establishes the manual as rights-based, not only gender-aware. It clarifies that access to health services, dignity, confidentiality, and participation are entitlements, not Favors. These concepts help understand:

- that all people have the right to health and dignity
- that services must be voluntary, confidential, and non-discriminatory
- that communities have a right to participate and hold systems accountable

The following are the key definitions under this group:

Human Rights: Universal, inalienable rights and freedoms to which all people are entitled by virtue of being human, including the rights to dignity, equality, non-discrimination, participation, and access to essential services.

- **Non-Discrimination:** The principle that no individual should be excluded, disadvantaged, or treated unfairly in accessing health services or opportunities based on sex, gender, age, health status, disability, socioeconomic status, or any other characteristic.
- **Right to Health:** The right of every individual to enjoy the highest attainable standard of physical and mental health, including access to available, accessible, acceptable, and quality (AAAQ) health services without discrimination

Dignity: The inherent worth of every person that must be respected and protected in all health and social interactions, ensuring individuals are treated with respect, compassion, and fairness.

- **Equality Before the Law:** The principle that all individuals are entitled to equal protection and benefit of the law, including fair treatment within health systems and protection from discrimination or abuse.
- **Informed Consent:** The voluntary agreement to a medical or programmatic intervention given freely, based on clear, accurate, and sufficient information, without coercion, pressure, or manipulation.
- **Confidentiality & Privacy:** The obligation to protect personal and health information from unauthorized disclosure and to ensure private, respectful interactions during service delivery and community engagement.
- **Participation:** The right of individuals and communities to meaningfully engage in decisions that affect their health, wellbeing, and access to services.
- **Accountability:** The responsibility of duty bearers (governments, health systems, implementers) to explain, justify, and take responsibility for their actions, and to address grievances and rights violations.

- **Access to Justice / Remedy:** The ability of individuals to seek redress, protection, or corrective action when their rights are violated, including through legal, administrative, or community-based mechanisms.

Gender & Programming Approaches

This explains how male engagement should be done. It distinguishes between approaches that:

- transform harmful norms, and
- those that unintentionally reinforce inequality or harm.

These concepts help prevent:

- men being positioned as gatekeepers rather than partners
- reinforcement of dominance, control, or coercion
- gender-blind or exploitative programming

The following are the key definitions under this group:

- **Male Engagement:** The intentional involvement of men and boys as beneficiaries, partners, allies, and agents of change in promoting health, gender equality, and human rights—without reinforcing dominance or control over others.
- **Positive Masculinity:** Norms and behaviours that promote respect, non-violence, emotional openness, accountability, shared responsibility, and support for gender equality and wellbeing.
- **Gender-Transformative Approach:** An approach that actively challenges and changes harmful gender norms, power imbalances, and inequalities, promoting equitable relationships, shared responsibility, and lasting social change.
- **Gender Accommodation:** Adjustments made to programs to reduce immediate gender-related barriers without challenging the underlying norms or power structures that create inequality.
- **Gender Blindness:** The failure to recognize gender differences, power relations, and inequalities, often resulting in programs that unintentionally reinforce existing disparities.
- **Gender-Exploitative Practices:** Interventions that reinforce harmful gender norms, stereotypes, or power imbalances, or that use gender inequality to achieve program outcomes.
- **Do No Harm Principle:** A commitment to ensure that interventions do not cause unintended harm, reinforce inequality, expose individuals to risk, or undermine the rights and safety of women, children, or vulnerable populations.
- **Gender Mainstreaming:** It is an approach that incorporates both women's and men's perspectives and needs into the planning, execution, monitoring, and evaluation of policies and programs across all political, economic, and social sectors, ensuring equal benefits for both genders and preventing the reinforcement of inequality. The goal is to achieve gender equality.
- **Gender Sensitive:** Properly aware of the different needs, roles, and responsibilities of men and women. Understand that these differences can result in variations between genders.
- **Gender Responsive:** Aware of gender concepts, disparities and their causes, and takes action to address and overcome gender-based inequalities.
- **Practical Gender Needs:** These are the immediate and concrete needs of girls, women, boys, and men that can be met without challenging existing gender roles or power relations. These needs are often essential for daily survival and relate to areas where women or men have primary responsibilities, such as access to food, health care, water, sanitation, security, shelter, education for children, and income. Practical gender needs are generally easy to identify, short-term in nature, and felt by most family or community members. Addressing them can improve living conditions and access to services for women and men; however, on their own, they do not address the underlying causes of gender inequality.

- **Strategic Interests:** These are longer-term and less visible issues that address the underlying causes of gender inequality. Meeting strategic interests enables girls, women, boys, and men to have equal opportunities and contributes to lasting changes in gender relations and power structures. When strategic interests are addressed, there are improvements in decision-making, sharing of responsibilities, access to resources, and equality before the law—for example, removal of discriminatory legal and social barriers, equitable sharing of domestic work, and equal participation in household and community decision-making. Strategic interests for girls and women arise from their historically subordinate position in society and are closely linked to empowerment and the realization of rights. Strategic interests for boys and men relate to transforming patriarchal norms, restrictive mindsets, and conservative attitudes that limit emotional wellbeing, shared responsibility, and equitable relationships. Addressing strategic interests influences attitudes, behaviours, and institutions, and supports improved wellbeing and equality for all.

Violence, Power & Consent

This equips all to:

- recognize violence, abuse, and coercion
- understand consent beyond sexual contexts
- engage communities safely and ethically

These concepts are critical to prevent harm, respond appropriately to disclosures, and uphold dignity. The following are the key definitions under this group:

- Gender-Based Violence- the full definition of GBV, see Module 4, Resource Sheet 4
- **Technology-Facilitated Gender-Based Violence and Abuse (TFBVA):** Refers to acts of violence, harassment, intimidation, control, or exploitation carried out through digital technologies, including mobile phones, social media, messaging platforms, and online forums. TFBVA may affect people of all genders and ages and includes behaviors such as cyber bullying, online harassment, non-consensual sharing of images, threats, stalking, and hate speech. When such acts are directed at individuals because of gender or sexuality, they constitute Technology-Facilitated Gender-Based Violence.
- **Abuse:** The misuse of power or authority by an individual or institution that causes physical, sexual, emotional, psychological, or economic harm, or creates fear of such harm. Abuse limits a person's ability to make free and informed choices and can occur in personal, community, or institutional settings.
- **Coercion:** Any act of forcing, pressuring, manipulating, or threatening a person to do something against their will. Coercion may involve physical force, intimidation, emotional pressure, deception, cultural expectations, or misuse of authority or economic power.
- **Consent (sexual & non-sexual):** A clear, voluntary, and informed agreement to participate in an activity, which can be withdrawn at any time and must be respected in all contexts.
- **Perpetrator:** A person, group, or institution that commits, supports, or enables acts of violence, abuse, discrimination, or other forms of harm. Perpetrators often hold real or perceived power or authority over the person or group affected.
- **Discrimination:** Unfair or unequal treatment of individuals or groups based on characteristics such as sex, gender, age, health status, disability, ethnicity, religion, socioeconomic status, or any other identity, which limits their access to rights, opportunities, or services.

Inclusion & Diversity

This introduces the understanding that men and boys are not a homogeneous group. Age, disability, poverty, social status, health conditions, and stigma shape different experiences and vulnerabilities.
These concepts help:

- avoid one-size-fits-all approaches
- recognize who is most at risk and why
- tailor engagement strategies appropriately

The following are the key definitions under this group:

- **Gender Disaggregated Data:** Refers to the collection and analysis of data that is broken down to show differences and patterns among women, men, girls, and boys, including across different age groups. This data is used to inform policy development, planning, monitoring, and impact evaluation. In addition to sex, data should be disaggregated by other relevant factors such as age, geographic location, socioeconomic status, disability, ethnicity, and other variables in order to identify inequalities, understand diverse experiences, and support inclusive and equitable programming.
- **Intersectionality:** A framework that recognizes how multiple social identities (e.g., gender, age, disability, poverty, ethnicity) interact to shape experiences of advantage or disadvantage.
- **Vulnerability:** Increased exposure to risk or reduced capacity to protect oneself due to social, economic, health, or structural factors.
- **Marginalization:** The social process through which individuals or groups are excluded from access to resources, opportunities, and decision-making.
- **Priority Populations:** Groups that face heightened vulnerability to poor health outcomes due to social, economic, or structural factors and require targeted support.
- **Key Populations:** Groups that are disproportionately affected by HIV, TB, or related conditions due to legal, social, or structural barriers and stigma.
- **Adolescents and Young People (AYP):** Individuals aged 10–24 years whose health behaviours, identities, and gender norms are actively forming and require age-appropriate, rights-based engagement.
- **Disability (Gender & Disability Lens):** An approach that recognizes how gender and disability intersect to influence access to services, exposure to discrimination, and health outcomes

Session 1.2: Human rights–based male engagement in health

Goal: To build the capacity of participants to understand and apply a human rights-based and gender-responsive approach to engaging boys and men with HIV, TB, and Malaria prevention, care, and treatment.

Session Objectives

1. By the end of this session, participants will be able to:
2. Define human rights and the right to health and related rights.
3. Explain how human rights and gender norms influence health-seeking behaviour among boys and men.
4. Identify legal protections, rights, and obligations related to accessing and providing health services.
5. Describe what Human Rights–Based Male Engagement is and is not.

Time: 1 hour

Materials: Flipchart, Markers, Masking tape
Target Audience: Boys and Men

Advance Information for the Facilitator
This session addresses sensitive issues related to gender norms, masculinity, health, and human rights, which may evoke strong emotions or personal experiences among participants. Facilitators should create a safe, respectful, and non-judgmental learning environment, apply a trauma-informed approach, and be prepared to manage sensitive discussions while grounding all dialogue in human rights, gender equality, and evidence-based public health principles.

Session 1.2.1: Introduction to human rights and health (15 minutes)
Facilitator Activity
Brainstorm: The facilitator asks the participants to buzz in groups of 2-3 to discuss their understanding of
What are human rights?
What does the right to health mean for men and boys in your community?
Then, in plenary the facilitator leads the participant in understating the key concepts.

Key Concepts
Human Rights (HR): Human rights are universal, inalienable, indivisible, and interdependent rights and freedoms to which all people are entitled by virtue of being human, without discrimination.
Right to Health: The right to the highest attainable standard of physical and mental health, including access to timely, acceptable, affordable, and quality health services.

- Related rights relevant to health
- Right to dignity and respect
- Right to non-discrimination and equality
- Right to information and informed consent
- Right to privacy and confidentiality
- Right to participation
- Right to accountability and redress

Session 1.2.2 How human rights and gender norms affect access to health for men and boys (20 minutes)
Key Discussion Points

- Harmful gender norms and expectations of masculinity discourage help-seeking, testing, and treatment adherence.
- Stigma, discrimination, and fear of judgment limit access to HIV testing, TB diagnosis, and Malaria treatment.
- Structural barriers (clinic hours, provider attitudes, lack of privacy) undermine men's ability to realize their right to health.
- Violations of confidentiality and dignity reduce trust in health systems.
- Marginalized groups of men (adolescents, men with disabilities, men in informal settlements, key populations) face compounded barriers.

Facilitator Activity

Small group discussion: Identify human rights barriers men face when accessing HIV, TB, or Malaria services.

Session 1.2.3: Legal Protections, Rights, and Obligations in Health Service Use (15 minutes)

Key Content

- Rights of Clients
- Access services without discrimination
- Receive accurate information and counselling
- Give informed consent
- Privacy and confidentiality of health information
- Participate in decisions about their health
- Obligations of Clients
- Respect health workers and other clients
- Adhere to treatment and follow-up where possible
- Provide accurate information to enable appropriate care
- Use services responsibly and ethically
- Duties of Health Providers and Systems
- Provide equitable, respectful, and quality services
- Protect confidentiality and dignity
- Ensure non-discrimination
- Provide referral and continuity of care
- Be accountable for rights violations
- Facilitator Activity

Case scenario: A man refuses TB testing due to fear of stigma—discuss rights, obligations, and provider responsibilities.

Session 1.2.4: What Is human rights–based male engagement? (10 minutes)

Definition

Human Rights–Based Male Engagement refers to the intentional and meaningful involvement of men and boys in the design, implementation, and evaluation of programmes particularly in health, gender equality, and development—grounded in human rights principles and gender equality.

Key Characteristics

- Goes beyond engaging men as beneficiaries only
- Addresses harmful gender norms and unequal power relations
- Encourages reflection and transformation of harmful masculinities
- Positions men as partners, allies, and advocates for:
- HIV, TB, and Malaria prevention and care
- Women's and girls' rights
- Gender equality and shared responsibility for health
- Human Rights Principles Applied

Participation: Boys and men are actively involved in decision-making processes that affect their health, ensuring their voices, experiences, and perspectives inform the design and delivery of services.

Accountability: Health systems, service providers, and programmes are answerable for upholding human rights standards and addressing violations that affect access to HIV, TB, and Malaria services.

Non-discrimination: All boys and men are able to access health services without stigma, exclusion, or unequal treatment based on gender, age, health status, disability, or social background.

Empowerment: Boys and men are supported with information, skills, and confidence to claim their rights, make informed health decisions, and engage positively in their own and others' wellbeing.

Legality: Health services and male engagement interventions are grounded in national laws, policies, and international human rights obligations that protect the right to health and related rights.

Facilitator Activity
Group work: Identify examples of rights-based male engagement in HIV, TB, or Malaria programming.

Session 1.2.5: What Rights-Based Male Engagement Is Not (10 minutes)
Clarifying misconceptions

- Rights-based male engagement does not mean:
- Prioritizing boys and men over girls and women
- Controlling or limiting women's health choices
- Reinforcing patriarchal or authoritarian leadership
- Creating men-only spaces without accountability to gender equality
- Excusing harmful behaviour under the guise of culture or masculinity

Session 1.2.6: Application and Reflection (15 minutes)

- What harmful gender norms and expectations limit men's access to health services?
- How can men be engaged as partners and allies while upholding and strengthening women's and girls' rights?
- In what ways does a human rights-based approach improves prevention, care, and treatment outcomes for HIV, TB, and Malaria?

Facilitator Note:
Guide participants to link responses to real-life examples from their communities and health facilities and emphasize that effective male engagement must promote gender equality, protect human rights, and improve health outcomes for all.
Key take-home messages

- Human rights and gender equality are central to improving health outcomes for men, women, and children.
- Rights-based male engagement strengthens, rather than competes with, women's and girls' rights.
- Engaging men as informed partners and advocates improves prevention, treatment adherence, and health system accountability.

- Respecting dignity, confidentiality, and non-discrimination builds trust and increases service uptake.

Module 2: Gender and Power

Session 2.1. Values Clarification on Gender and Health

Goal: To help participants recognize and become aware of their own values and attitudes regarding Gender and Health to appreciate how they influence their behaviour and respect the diversity of opinions within the community.

Objectives: By the end of the Session, participants should be able to:

1. Assess boys' and men' s attitudes and values about gender and health.
2. Question their own attitudes and values and change them as they get new information.

Time: 45 minutes

Materials: Flipchart, Markers, Masking tape

Target Audience: Both Men and Boys

Advance Preparation:

- Prepare two pieces of flipchart paper by writing "Agree" on one of them and "Disagree" on the other. Post the "Agree" and "Disagree" signs on opposite sides of the room.
- Arrange the training room so that there is adequate open space for participants to assemble in the middle or on opposite sides of the room.
- Select a list of value statements that you will use

Value Statements for Boys

i. It is easier to be a Boy than a Girl in Kenya
ii. More boys than girls are infected with HIV, TB and Malaria
iii. Boys need to have sex after circumcision to prove their manhood
iv. A boy who has many girlfriends is more respected in the community
v. Boys perform better in school than girls

Value Statements for Men

i. It is easier to be a Man than a woman in Kenya
ii. Condoms are for those who are not faithful to their Sexual Partner
iii. A man is more of a "man" if he has many sexual partners
iv. Men need more sex than women
v. If a person's wife has been tested HIV, TB or Malaria, he does not need to go for a test
vi. Men are not interested in accessing HIV, TB or Malaria services
vii. Preventing child-mother-to-child transmission of HIV, TB or Malaria is the mother's whole responsibility
viii. Women are better caregivers than men

Facilitator's Notes

- During this exercise, it is important to emphasize that there are no "right" or "wrong" answers. We all respond to the statements based on our own beliefs and values and the purpose of this activity is to help explore these differences in where they exist.
- Using a mosquito net every night is important for the whole family, including men.'; 'If a man has a fever, he should go to the clinic straight away rather than waiting to see if it gets better on its own.'
- It is important for the facilitator to remain neutral throughout the exercise and to maintain a balance between the different viewpoints expressed.
- To explore a range of issues, you may need to limit the discussion of each statement to comments from one or two participants representing each position.
- Do not clarify the meaning of the statements, as this may influence the results. Simply read the statement again if participants ask for clarification.
- It is important to remember that transformation will take time, therefore, discussions on gender norms must be facilitative o transformation, not to dictate what that should loo
- If everyone moves to one side of the room (e.g., everyone "agrees" with the statement), you can ask the group how a person with the opposite opinion might defend their position. Alternatively, trainers can step into that spot and speak out on that position, explaining that they are just stating the rationale for that position directly and straightforwardly.
- If is not enough time to read all the statements, try to use statement **I and select others that you consider very important for your audience.**

Steps

1. Explain that this exercise will help us understand viewpoints that are different from our own and how differing viewpoints might impact.
2. Ask the participants to stand in the centre of the room. Direct their attention to the "Agree" and "Disagree" signs.
3. Explain that you will be reading a series of value statements. After you read a statement aloud, the participants will decide whether they agree or disagree with the statement. Those who agree with the statement will stand under the "Agree" sign. Those who disagree with the statement will stand under the "Disagree" sign. Let participants know that if they hear something that causes them to change their minds during the activity, they may move from one area to another.
4. Read the first statement. Repeat it to ensure all participants hear it. After everyone has moved to the area of the room that reflects their opinion, they invite comments from the Agree and Disagree locations. The facilitator remains neutral but can provide facts to clarify matters as needed. After hearing a representative from each position, give

participants the option of switching positions, if they wish. When participants move, ask them what prompted their decision to change.

5. Repeat this process until you have read all the statements if time allows.
6. Ask the participants to return to their seats. Facilitate a group discussion using the questions below.
    i. Which statements, if any, do you find it challenging to form an opinion about? Why?
    ii. How did it feel to express an opinion that was different from those of some of the other participants?
    iii. How do you think people's attitudes about the statements might affect the way they relate with men (boys) and women (girls) in their lives?
    iv. How do you think people's attitudes about the statements help or do not help prevent HIV, TB or Malaria infection?
    v. How do you think people's attitudes about the statements can contribute to the spread of HIV, TB or Malaria?

Conclusion

- By exploring and becoming aware of our beliefs and attitudes about sensitive topics we can have a chance to examine them and change as we get new information.
- Our values and beliefs are influenced by many factors such as family, cultural and religious backgrounds.
- We can learn to respect other people's values and beliefs even if we do not personally agree with them.

Session 2.2: Building Consensus on Sex and Gender

Goal: To increase an understanding of gender and related terminologies.

Objectives

By the end of the session participants will be able to:

1. Explain the difference between "sex" and "gender."
2. Define other common terms related to gender

Time: 45 minutes

Materials:

- Flipchart, Masking tape, and Markers
- Handout 1.1: Gender Game

Target Audience: Boys and Men

Steps

1. Make three columns on a flip chart. Label the first column "Woman "and leave the other two blank.

Woman/Girl		

2. Ask participants to identify **physical** and **personality traits**, **abilities** and **roles** (attributes) that are often associated with women. *These may include stereotypes prevalent in the participants' communities or their ideas*. Ask them what comes to their mind when they see the word 'woman'.

3. Next label the third column "Man" and ask the participants to again make a list of physical and personality traits, abilities and roles (attributes) that are often associated with men. These may include stereotypes prevalent in participants' communities or their ideas. Ask them what comes to their mind when they see the word 'man'.

Woman/Girl		**Boy/Man**

4. Now reverse the headings of the first and the third columns by writing Man above the first column and Woman above the third column. Working down the list, ask the participants whether there are any terms (attributes) in the lists that cannot be reversed or interchanged. Those attributes usually not considered interchangeable are placed in the middle column that is then labelled "Sex".

Man/Boy **Woman/Girl**	**Sex**	**Woman/Girl** **Boy/Man**

Conclusion

❖ Explain that all the words in the man and woman columns refer to gender.

Gender refers to socially and culturally constructed differences between men and women. The social construct varies across cultures, societies and time. Gender Roles are interchangeable between the different genders.

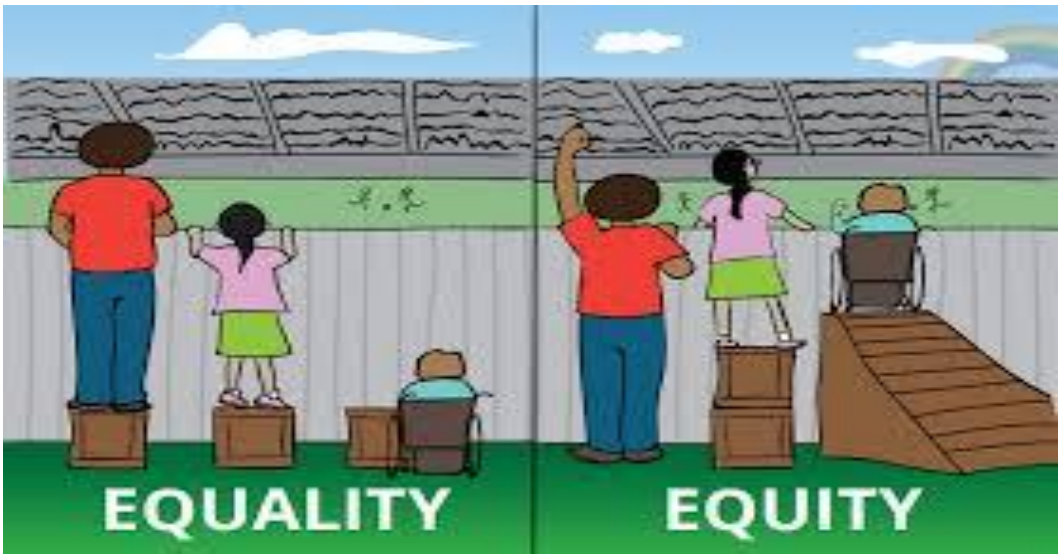
Sex refers to the biological differences between males and females. These differences can be *anatomical* (e.g. Penis, testes, vagina, breasts); *physiological* (e.g. Spermatogenesis/Ejaculation, menstrual Cycle, Ovulation,) and *genetic* (XX, XY).

Sex is also a synonym for sexual intercourse (Penile-Vaginal, Oral and Anal)

- ❖ People often associate sex with gender and the word "gender" is often used inappropriately instead of "sex" e.g. When people are asked their gender instead of their sex on forms.
- ❖ Stereotyped ideas about female and male qualities can be damaging because they limit our potential to develop the full range of possible human capacities. If we agree to accept stereotypes as guides for our behaviour, it prevents us from determining our interests and skills, discourages men from participating in" women's work" such as care and support for the sick and restricts women from choosing roles that are "traditionally" men's".

Other Key Gender Concepts

- **Gender Equality:** means that women and men enjoy the same status and have equal conditions for realising their full human rights and potential to contribute to national, political, economic, social and cultural development and to benefit from the result.
- **Gender Equity:** is the process of being fair to women and men. To ensure fairness, measures must often be available to compensate for historical and social disadvantages that prevent women and men from operating on a level playing field.



Source: Equity tool

Handout 2.1: The Gender Game

Review the statements below and indicate whether the statement refers to **"Gender" or "Sex"** by ticking as appropriate, in the space provided.

GENDER	SEX	
		1. Women give birth to children.
		2. Many women do not have the freedom to make decisions about their lives.
		3. Men's voices change during puberty.
		4. Boys and men graze cattle.
		5. Women breastfeed babies.
		6. Girls and women sweep the compound.

		7. Women or girls are responsible for taking children to hospital.
		8. Men are the breadwinners in most families.
		9. The number of women with HIV infection and AIDS has increased steadily worldwide.
		10. Globally women or girls are the primary caregivers for sick family members.

Resource Sheet 2.1: Gender Game Answer

GENDER	SEX	
	X	1. Women give birth to children; men don't.
X		2. Many women do not have the freedom to make decisions about their lives, especially regarding sexuality and relationships with their partners.
	X	3. Men's voices change during puberty; women's voices don't.
X		4. Boys and men graze cattle.
	X	5. Women breastfeed babies.
X		6. Girls and women sweep the compound.
X		7. Women or girls are responsible for taking children to hospital.
X		8. Men are the breadwinners in most families.
X	X	9. The number of women with HIV infection and AIDS has increased steadily worldwide.
X		10. Globally women or girls are the primary caregivers for those sick family members

Session 2.3: Gender Norms- Act like a Man; Act like a Woman

Goal: To increase awareness of the differences between rules of behaviour for men/boys and women/girls and understand how gender roles affect the lives of men/boys and women/girls.

Objectives

By the end of the session participants will be able to:

1. Identify unhealthy messages on gender stereotypes that put both men/boys and women/girls at risks
2. Explain how these behaviours can contribute to gender inequality, HIV, addictions and lack of respect for human rights.

Time: 60 minutes

Materials: Flipcharts, markers, masking tape OR Blackboard and chalk

Target Audience: Men and Boys

Facilitator's Notes

This activity is a good way to understand perceptions of gender norms. Remember that these perceptions may also be affected by class, race, ethnicity, and other differences. It is also important to remember that gender norms are changing in many communities. It is getting easier, in some places, for men and women to step outside of their "boxes." If there is time, discuss with the group what makes it easier in some places for women and men to step outside of the box.

Steps

1. Ask the participants if they have ever told someone or heard someone being told to "Act or "Behave" like a Man. Ask them to share some experiences of someone saying this or something like them. Ask: "Why do you think they said this?"
2. Now ask participants if they have ever been told to "Act or behave like a woman." Ask them to share some experiences of someone saying this or something similar. Ask: "Why do you think they said this?" "How did it make them feel?"
3. Tell the participants that you want to look more closely at these two phrases. Explain that by looking at them, we can begin to see how society creates very different rules for how men and women are supposed to behave. Explain that these rules are sometimes called "gender norms" because they define what is "normal" for men and women to think, feel, and act. Explain that these rules restrict the lives of both women and men by keeping men in their "Act like a Man" box and women in their "Act like a Woman" box.
4. In large letters, print on one sheet of flipchart paper the phrase "Act Like a Man." Ask participants what men are told in their community about how they should behave. Write these on the sheet. Check the examples in Resource Sheet 2 to see the kinds of messages that are often listed and introduce them into the discussion if they have not been mentioned.
5. When the group has no more to add to the list, ask the discussion questions listed below.
    - Which of these messages can be potentially harmful? Why? (Place a star next to each message and discuss it one by one.)
    - How does living in the box impact a man's health and the health of others?
    - How does living in the box limit men's lives and the lives of those around them?
    - What happens to men who try **not** to follow the gender rules (e.g. "living outside the box")? What do people say about them? How are they treated?
    - How can "living outside the box" help men to prevent GBV and STIs including HIV?
6. Print on another sheet of flipchart paper the phrase "Act like a Woman." Ask participants what women are told in their community about how they should behave. Write these messages on the sheet. Check the examples to

see the kinds of messages that are often listed. Incorporate these in the discussion if they have not been mentioned.

7. When the group has no more to add to the list, ask the discussion questions listed below:
    - Which of these messages can be potentially harmful? Why? (Place a star next to each message and discuss one by one)
    - How does living in the box impact a woman's health and the health of others including exposure to violence?
    - How does living in the box limit women's lives and the lives of those around them?
    - What happens to women who try not to follow the gender rules? What do people say about them? How are they treated?
    - How can "living outside the box" help women avoid GBV and STIs including HIV?
8. Next, draw another table that has both a column for men and women. Label it "Transformed Men/Women." Ask the participants to list characteristics of men who are "living outside the box." Record their answers. Once you get seven or so responses, ask the same about women who are "living outside the box." **Help the participants recognize that, in the end, characteristics of equitable gender-equitable men and women are similar.**
9. Ask participants the following questions:
    - Are your perceptions about the roles of men and women affected by what your family and friends think? How?
    - Do the media affect gender norms? If so, in what way(s)? How do the media portray women? How do the media portray men?
    - How can you, in your own lives, challenge some of the non-equitable ways men are expected to act? How can you challenge some of the non-equitable ways that women are expected to act?
10. End the discussion by asking participants what they have learnt from this activity and how they are going to use the knowledge.

Conclusion

Throughout their lives, men and women receive messages from family, media, and society about how they should act as men and how they should relate to women and other men. As we have seen, many of these differences are constructed by society and are not part of our nature or biological make-up. Many of these expectations are completely fine and help us enjoy our identities as either a man or a woman. However, we all identify unhealthy messages as well as the right to keep them from limiting our full potential as human beings.

As we become more aware of how some gender stereotypes can negatively impact on our lives and communities, we can think constructively about how to challenge them and promote HIV prevention, and more positive gender roles and relations in our lives and communities. Therefore, we are all free to create our gender boxes and how we choose to live our lives as men and women.

Resource Sheet 2. 2: Example of Flipcharts for Act Like a Man/Woman

Act Like a Man	Act Like a Woman
Be tough Do not cry Be the breadwinner Stay in control and do not back down Have sex when you want it Have sex with many partners Get sexual pleasure from women Produce children Get married Take risks Don't ask for help Use violence to resolve conflicts Drink Smoke Ignore pain Don't talk about problems Be brave Be courageous Make decisions for others	Be passive and quiet Be the caretaker and homemaker Act sexy, but not too sexy Be smart, but not too smart Follow men's lead Keep your man, provide him with sexual Pleasure Don't complain Don't discuss sex Get married Produce children Be pretty Be seen, not heard Cook for the family Be supportive Cry when necessary Don't smoke Don't drink Don't work, stay home Don't wear trousers Don't argue with men Don't fight

Transformed Men	Transformed boys
• Are loving • Are caring • Be an assertive communicator • Express emotions constructively and when appropriate • Remain faithful to one partner • Use contraceptive methods without fearing a partner • Use condoms regularly/protect themselves from getting infected • Delay sexual activities until both partners are ready • Speak out in favour of gender equality • Challenge others to recognize their harmful gender norms and change themselves • Plan their families • Are non-violent	• Respectful • Gender-sensitive (Treat girls and women as equals) • Emotionally intelligent • Responsible decision-makers • Health-conscious • Educated and motivated • Positive role models • Peer influencers • Community-engaged • Non-violent • Open-minded and reflective • Reject gender-based violence and harmful masculinity norms • Delay sexual debut

Session 2.4 Gender and Power

Goal: To define power and types of power.

Objectives: By the end of the session participants will be able to:

1. Recognize that men/boys and women/girls are treated differently in society.
2. Identify the different groups that have power and the groups that are targeted for unfair treatment.
3. Explore the relationship between power and gender.

Time: 60 minutes

Materials: Flipcharts, markers, masking tape OR Blackboard and chalk

Target Audience: Boys and Men

Steps

1. Ask participants what they understand by the term power. After a few responses explain that power is the ability to influence decisions
2. Inform the participants that they are going to discuss gender roles. Gender roles are defined as society's expectations of people based on their gender. Men/boys and women/girls are treated differently in Kenyan society and throughout the world. Ask the participants to give some examples of the different forms of treatment men/boys and women/girls receive.
3. Inform them that in Kenya, men have more power than women do. Often, when the groups have power, they treat those with less power poorly. **This poor treatment of groups with less power is called oppression.** Ask for some examples of powerful groups and targeted groups in society. List them on a sheet of flip chart paper. Help the participants come up with examples of these two groups by suggesting categories that may have power and a target group. These include sex, race, age, religion and financial status. The chart should look like the one that follows:

Powerful	Targeted (remind the participants what targeted means)
Men	Women
Adults	Youth
Wealthy	Poor
Teachers	Students/pupils
Preacher	Congregants
Politicians	Citizens
Police	Community
Parent	Children
Doctor	Patient

4. After participants have completed the chart, use the questions below to lead a discussion.
   - Why do these groups have more power?
   - What are the different sources of power?

- And what bad things can happen because of abuse of these powers? Give examples (low self-esteem, rape, war, land clashes, GBV, neglect, HIV infection, death etc.)

5. Use the information in "Resource Sheet 1. 3: Types of Power" to explain the following four types of Power.
   - Power to
   - Power with
   - Power within
   - Power over
6. Summarize the Session by explaining that power over is harmful to the targeted and can lead to negative consequences including gender-based violence and HIV.

Resource Sheet 2. 3: Types of Power

Empowerment: Empowerment is the process and result of improvement in autonomy, achieved through access to knowledge, skills, resources and opportunities derived from the concept of power. Empowerment is about people both men and women. Empowerment means developing one's ability to collectively and individually take control over their lives, identify their needs, set their own agenda and demand support from their communities and state to see that their interests are responded to. In some cases, the empowerment of women requires a transformation of the division of labour and society.

Empowerment manifests in the following types of power:

- **Power to** which means the power that comes from ability, skills and knowledge,
- **Power with** which is the power that comes from collective action, grouping and teamwork.
- **Power within** is the kind of power that is within the person and can be spiritual, psychological or mental.
- **Power over** the negative use of power through domination, coercion, exploitation and other negative actions

Module 3: Communication, Decision-making and Relationships

Session 3.1 Confidence, Self-awareness and Self-Esteem

Goal: To help the participants build their confidence, self-awareness and self-esteem.

Objectives

By the end of the session participants will be able to:

1. Define s confidence, self-awareness and self esteem
2. Understand their limitations, strengths and develop a positive concept about themselves.
3. Explain how they view themselves and how it affects how other people view them.
4. Understand how to improve their confidence and self-esteem

Time: 45 minutes

Materials: Flipcharts, markers, masking tape OR Blackboard and chalk

Target Audience: Boys and Men

Facilitator's Notes:

Activity 1

1. Provide an activity that will assist the participants to bring out confidence, self-awareness and self esteem
2. Pair up participants, in this activity, participants work in pairs, since it is difficult to draw one's own portrait. By drawing each other's portrait, participants develop a sense of observation and create an atmosphere of appreciation and acceptance of themselves and others which in turn strengthens the relationship between members of the group.

Treasure Chests/Boxes

Activity 2; Treasure Chest/Box (25 minutes)

Steps

1. Explain to the participants that we are born with an empty imaginary treasure chest (treasure box). As people love us, compliment us, appreciate us, play with us, and learn with us, we build up our treasure. As people criticize us, shout at us, and put us down, we lose our treasure.
2. Explain that as the put-downs increase, the treasure chest can lock and that prevents us from feeling good about ourselves and others.
3. Read the following statements aloud one at a time and ask the participants to write a response to each statement:
    - What do you like most about yourself? Encourage them to share the aspects about themselves what and they are comfortable with.
    - What do you think is your greatest personal achievement to date?
    - What do you like most about your family?
    - What do you value most in life?
    - What are the three things you are good at?
    - What is one thing you would like to improve about yourself?
    - If you died today, what would you most like to be remembered for?
    - What do your friends like most about you?

4. Divide the participants into groups of three or four. Ask them to share two or three of their responses and to discuss in their groups how they can give themselves and other people self-esteem treasure.
5. Conclude the activity by emphasizing that we need to build our own treasure chests or boxes and find ways of building those of others as well.

Activity 3: Self-awareness (20 minutes)

Facilitator's Note

Self-awareness is the perception that one has of themselves. It involves knowing and understanding one's physical, intellectual, emotional and spiritual components as well as recognizing one's abilities, talents, role in society, strengths and weaknesses.

Self-awareness as a skill empowers an individual to know and come to terms with their strengths, status, background, culture, needs and feelings. It is also an individual's ability to appreciate the strong and weak points of one's own character. This realization enables one to take actions, make choices and decisions which are consistent with one's abilities.

The skill of self-awareness helps one to discover and accept self, plan for one's future and be able to accept others. It helps in the appreciation and application of all other life skills.

Case Study 1: Mwamba's Story

Mwamba is a handsome fifteen-year-old boy. He is a talented singer and dancer just like his grandfather. His academic performance is exemplary. However, he steals, bullies' others and he is not concerned about other people. Mwamba feels he is too big and old to be in grade seven. His parents enrolled him in school late since there were no schools in his neighbourhood when he attained school age. He also had to look after his family's animals.

Steps

1. Start by asking participants to explain what they understand by "Self-Awareness". After two or three responses, provide the correct definition using information in the Facilitator's Note.

2. Ask a volunteer to read Mwamba's story.
3. Use the following questions to lead a discussion:

   a) What has influenced Mwamba's life positively and negatively?
   b) What are the possible ways of helping Mwamba overcome his negative habits?

4. Ask each participant to reflect on his life and the factors that may have influenced their personality and behaviour and share with the person sitting next to them. (Allow about three minutes). Ask two or three volunteers to share what they have discussed and use the information in Resource Sheet
5. Ask them to share some benefits of self-awareness.
6. Ask them to share with the person seated next to them what their likes and dislikes are, including their physical attributes. You can make them comfortable to share by sharing about yourself as a facilitator.
7. Inform the participants that each person is unique and valuable, hence they need to accept self and others. Encourage the participants to accept what they cannot change like height, complexion etc. and work towards changing what they can. Emphasize that Self-acceptance enhances self-image.
8. Ask them to identify some of the benefits of self-awareness and share in the plenary. Use information in the "Resource Sheet 3.1: Benefits of Self Awareness"
9. Inform the participants that it is important to feel good about oneself and try to solve problems, or to learn something new. This will help them improve their confidence and self-esteem. One should not bully others or make them feel inferior/bad about themselves.
10. Summarize this activity by using the information in the Take Home message.

Conclusion

Individual abilities, gifts, and talents can be enhanced by being aware they exist, accepting and improving them. For instance, knowing that you have the capability to run, play ball games, sing and dance and working towards developing them enables one to become a competent and productive member of society. Utilizing abilities, gifts and talents leads to personal fulfilment and enhanced self-esteem of an individual.
It is important for one to:

- Recognize the weak and strong sides of your own behaviour.
- Recognize the weak and strong sides of your own thoughts and abilities.
- Differentiate what one can do or can't do by themselves.
- Recognize things that cannot be changed and accept them (e.g., hair type, height etc.)
- Whatever people say, each person is different and should value themselves.
- Recognize your unique talents

Resource Sheet 3.1: Benefits of self-awareness and Factors that influence an individual's life

- Helps one to understand oneself better.
- Helps one to accept oneself.
- Empowers one to be in control of one's life.
- Minimizes external influences. You can protect your personal space.

- Enables one to accept feedback.
- Help to improve interpersonal relationships.

Factors that influence an individual's life

Factors that influence personality development include:

- **Culture:** The culture a person comes from contributes a great deal to his or her current situation (positively or negatively.
- **Family values**: Positive and negative family values shape individuals' attitudes and behaviour.
- **Religion**: The beliefs a person upholds affect his or her values and hence day-to-day choices.
- **Education**: The schools attended and the level of education a person has attained do shape a person's life in a way.
- **Peer groups**: Childhood peers and current peer groups have an influence on an individual's choices.
- **Genetic inheritance**. Abilities and talents inherited from our parents and grandparents tend to enhance personal growth if they are developed.
- **Environment:** Rural/urban set up influences' individuals' life.
- **Economic status:** Lack/inadequate basic needs influences personality.

Human beings are products of both genetics and the environment. Self-awareness entails asking oneself the following questions:

- Who am I and how do I relate with myself (intra-relationship)?
- Where do I come from? What is my family background and its impact on my life?
- Where do I want to go in life - what is my passion?
- What steps should I take to get to my desired destination in life?

When necessary, one can access guidance and counselling to deal with psychological challenges associated with their past.

Session 3.2 Three Cs to Good Decision-Making

Goal: To help the participants in making good decisions.

Objectives: By the end of the session participants will be able to:
1. Identify the key considerations for good decision making
2. Identify the people they could turn to for help in making good decisions

Time: 30 minutes

Materials
- Flipcharts, markers, masking tape OR Blackboard and chalk.
- Handout 3.1: "Three Cs To Good Decision Making"

Target Audience: Boys and Men

Steps

1. Explain that making decisions and knowing the consequences are important skills people need.
2. Ask the group members to take out a blank piece of paper and write down a serious decision that they or someone they know is currently facing. The decisions can be about anything - school, a job, a family situation, or a social situation. Instruct them to choose a decision where the consequences matter, instead of something that will not make much difference. **Assure them that what they write will remain confidential.**
3. Collect the papers in a basket or hat. Read them quickly and choose five or six that are tough decisions. Write them on the flipchart paper, editing them as necessary to keep confidentiality.
4. Explain to the group that these are the kinds of challenges many people face, especially as they become independent. People must make decisions and learn to live with the consequences.
5. Using a flipchart paper, display the "Three Cs to Good Decision Making" showing the words, **challenges, choices, and consequences,** and distribute the "Handout 3.1 "Three Cs To Good Decision Making". Point to the word "challenges" (as illustrated in the handout) and ask them to define what that means (something that is difficult). Ask the participants to choose one of the challenges listed on the flipchart paper and then write it on the first line of their handout.
6. Now point to the word "choices" on the flipchart paper. Again, ask them to define "choices" (things you can opt to do in a particular situation). Ask the group to brainstorm several choices or options that a person making this decision has. List those beside the word "choices" and add any others that you can think of. Be sure there are at least three choices.
7. Point to the word "consequences," and ask what that means (something that happens as a result of doing something, either positive or negative). Ask them to think of possible negative and positive consequences for each choice. Add any obvious consequences the group may leave out, especially negative ones. Point out that the number of choices should not determine the best choice. You should note the intensity or weight of each choice.

8. Tell the group to look at the choices and consequences and make a choice together. Try consensus or take a vote to determine the outcome. Clarify that although an individual usually does decision-making, people may seek other people's opinions before deciding.
9. Summarize what is on the flipchart and help learners to articulate the three steps in making a good decision when facing a challenge and lead a discussion using the questions below.

Discussion Questions

- What do you think about the "three C's"? How effective do you think it will be when you are back in your day-to-day life?
- What are some of the most powerful influences in our lives when we make decisions?
- How does it feel when we decide to do something that disagrees with any of those influences?
- When facing a tough challenge, and unsure of the decision to take, who could you turn to for help and why?

10. End the session by highlighting the information in the conclusion.

Conclusion

When it comes to making decisions regardless of what a person's values may be, there are some questions that a person should ask before making the decision. Decisions about sexual behaviours are some of the important ones that people make. Making decisions about sex is related to "who you are" and "what you believe in."

This influences "how you behave." It is important to recognize that all individuals have a right to make their own decisions about sex. No one can make those decisions for him or her. In the end, individuals will do what they value. It is illegal in Kenya for Children below 18 years of age to engage in sex in case it happens it should be reported to the authorities

Handout 3.1: Three Cs to Good Decision-Making

1. Challenge or decision you are facing:

……

……..……

2. Choices you have:

Choice1:…….……

Choice2: ……...……

Choice 3: ….....……

3. Consequences of each choice:

Positive	Negative
1)…….	1)……
2)…….	2)……...……..

3)…… 3)……...……..

Your decision is: …..……

Your reason(s) is/are: ……..

4. Consultation: Who can you consult for advice or guidance?

……..

5. Commitment: Make the decision and take responsibility for the action you choose.
……..

Session 3.3: Healthy and unhealthy health behaviours

Goal: To understand and identify healthy and unhealthy relationships.

Objectives: By the end of this session participants should be able to:
1. Identify healthy and unhealthy behaviours that exist within relationships.
2. Explain the effects of unhealthy behaviours in a relationship.
3. Identify ways of changing from unhealthy to healthy relationships and maintaining them.

Time: 30 minutes

Materials: Flipchart, paper, markers, cards, and masking tape

Target Audience: Men and Boys

Advance Preparation
Print in large letters **"Healthy", "Unhealthy",** and **"Depends"** on separate pieces of flipchart paper or cards and place these signs on the wall.
Write the following statements on small cards (one statement per card):

- The most important thing in a relationship is sex.
- You never disagree with your partner.
- You spend some time by yourself without your partner.
- You have fun being with your partner.
- Your partner is still close to his or her ex-boyfriend or ex-girlfriend.
- You feel closer and closer to your partner as time goes on.
- You will do anything for your partner.
- Sex is not talked about.
- One person usually makes every decision for the couple.
- You stay in a relationship because it is better than being alone.
- One person hits the other to have this person obey him or her.
- The partners are members of the same religious denomination.
- The partners are from the same ethnic group.
- The partners are members of different religious denominations.
- The partners are from different ethnic groups.
- You talk about problems when they arise in the relationship.

- You argue and fight often.
- One partner is much older than the other.

Resource Sheet 3.2: Card Placement Answers

- The most important thing in a relationship is sex. **(Unhealthy)**
- You never disagree with your partner. **(Depends)**
- You spend some time by yourself without your partner. **(Healthy)**
- You have fun being with your partner. **(Healthy)**
- Your partner is still close to his or her ex-boyfriend or ex-girlfriend. **(Unhealthy)**
- You feel closer and closer to your partner as time goes on**. (Healthy)**
- You will do anything for your partner**. (Unhealthy)**
- Sex is not talked about. **(Unhealthy)**
- One person usually makes every decision for the couple**. (Unhealthy)**
- You stay in a relationship because it is better than being alone. **(Unhealthy)**
- One person hits the other to have this person obey him or her. **(Unhealthy)**
- The partners are members of the same religious denomination. **(Depends)**
- The partners are from the same ethnic group. **(Depends)**
- The partners are members of different religious denominations. **(Depends)**
- The partners are from different ethnic groups. **(Depends)**
- You talk about problems when they arise in the relationship. **(Healthy)**
- You argue and fight often. **(Unhealthy)**
- One partner is much older than the other. **(Depends)**

Steps

1. Pass out the cards to the participants.
2. Tell the participants that romantic relationships can be healthy or unhealthy. **In healthy relationships, both individuals are happy to be with the other person. In unhealthy relationships, one or more partners are unhappy in the relationship because of one or more problems.**
3. Ask the participants to think about the relationship situation on their card and determine if they fall under the category of "Healthy," "Unhealthy," or "Depends." Have the participants move to the front of the room and place their cards under the sign they think is most appropriate.
4. After all the cards have been placed, review each card and discuss with the entire group whether the situations fall into the "Healthy," "Unhealthy," or "Depends" category. Use the Facilitators "Resource Sheet 3.1: Card Placement Answers" to help on this.

Facilitator's Note

If you do not have cards, you can simply read aloud each situation to the participants and ask them to determine if that situation falls in the "Healthy", "Unhealthy", or "Depends" category. The key purpose of this activity is to distinguish between what behaviours within relationships are healthy and unhealthy. When the participants are divided on this issue, they remind them of the qualities of a healthy relationship (faithfulness, respect, equality, responsibility, honesty, and happiness) and see if these apply to the situation.

5. Conclude this activity by asking the group the following questions:
   - Why do you think people stay in unhealthy relationships?

- How can friends and family help people in unhealthy relationships?
- Who else can help people in unhealthy relationships?
- Can relationships get better? Can they change from unhealthy to healthy over time?
- Can relationships get worse? Can they change from healthy to unhealthy over time?
- Who is more likely to stay in an unhealthy relationship, men or women? Why?

Conclusion
Healthy relationships are based on effective communication and mutual respect. Decisions are made together and neither person dominates the relationship. Unhealthy relationships, on the other hand, often suffer from poor communication and unequal decision-making, which makes open talk about non-violence and sexual behavior extremely difficult and thus puts one or both partners at greater risk.

Session 3.4 Healthy and Unhealthy Health-Seeking Behaviors-Malaria

Goal
To understand and identify healthy and unhealthy health-seeking behaviors towards malaria prevention, testing, and treatment for boys and men.
Objectives
By the end of this session, participants should be able to:
1. Identify healthy and unhealthy health-seeking behaviors.
2. Explain the effects of unhealthy malaria health-seeking behaviors on individuals, families, and communities.
3. Identify ways of changing from unhealthy to healthy health-seeking behaviors and maintaining them.

Time: 30minutes
Materials: Flipchart, paper, markers, cards, masking tape
Target Audience: Men and Boys
Advance Preparation
1. Print in large letters “Healthy and Unhealthy,” on separate pieces of flipchart paper or cards and place them on the wall.
2. Write the following malaria health-seeking behavior statements on small cards (one statement per card):

Card Statements
- You seek malaria testing immediately when you have fever or flu-like symptoms.
- You wait to see if malaria symptoms go away on their own before seeking care.
- You complete the full dose of malaria treatment even when you start feeling better.
- You stop taking malaria medication once symptoms reduce.
- You sleep under a long-lasting insecticide-treated net (LLIN) every night.
- You only use a mosquito net during the rainy season.
- You believe malaria is caused by cold weather or eating certain foods.
- You seek advice from a qualified health worker when sick with suspected malaria.
- You rely on herbal remedies only for malaria treatment.

- You encourage family members to get tested for malaria when they are sick.
- You delay seeking malaria treatment because you are “strong” or “not used to hospitals.”
- You discuss malaria prevention and treatment openly with your partner or family.
- One person decides whether others in the household can seek malaria treatment.
- You go for malaria testing before buying malaria medicine from a chemist.
- You share malaria medication with others who have similar symptoms.
- You believe malaria is not serious and does not need medical treatment.
- You support pregnant women and children to attend malaria clinics promptly.

Resource Sheet: Card Placement Answers (Facilitator Guide)

- You seek malaria testing immediately when you have fever or flu-like symptoms. (Healthy)
- You wait to see if malaria symptoms go away on their own before seeking care. (Unhealthy)
- You complete the full dose of malaria treatment even when you start feeling better. (Healthy)
- You stop taking malaria medication once symptoms reduce. (Unhealthy)
- You sleep under a long-lasting insecticide-treated net every night. (Healthy)
- You only use a mosquito net during the rainy season. (Unhealthy)
- You believe malaria is caused by cold weather or eating certain foods. (Unhealthy)
- You seek advice from a qualified health worker when sick with suspected malaria. (Healthy)
- You rely on herbal remedies only for malaria treatment. (Unhealthy)
- You encourage family members to get tested for malaria when they are sick. (Healthy)
- You delay seeking malaria treatment because you are “strong” or “not used to hospitals.” (Unhealthy)
- You discuss malaria prevention and treatment openly with your partner or family. (Healthy)
- One person decides whether others in the household can seek malaria treatment. (Unhealthy)
- You go for malaria testing before buying malaria medicine from a chemist. (Healthy)
- You share malaria medication with others who have similar symptoms. (Unhealthy)
- You believe malaria is not serious and does not need medical treatment. (Unhealthy)
- You support pregnant women and children to attend malaria clinics promptly. (Healthy)

Steps

1. Pass out the cards to participants.
2. Explain that health-seeking behaviours related to malaria can be healthy or unhealthy.

- Healthy behaviours help prevent malaria, ensure early diagnosis, and lead to complete treatment.
- Unhealthy behaviours delay care, increase complications, and contribute to malaria transmission.

3. Ask participants to read their card and decide whether the behaviour is "Healthy," or Unhealthy,"
4. Participants place their cards under the chosen category on the wall.
5. Review each card together and facilitate discussion, using the Resource Sheet to guide placement and learning.

Facilitator's Note

If cards are not available, read each statement aloud and ask participants to raise hands or move to the category they choose.

Emphasize that healthy malaria health-seeking behaviours are based on:

- Timely testing
- Correct treatment
- Completion of medication
- Prevention practices (LLIN use)
- Shared decision-making and support

When opinions differ, guide participants to reflect on how each behaviour affects health outcomes, costs, productivity, and family wellbeing.

Group Discussion Questions

- Why do some men delay seeking malaria testing and treatment?
- How do harmful beliefs and myths affect malaria outcomes?
- How can families and peers encourage healthy malaria health-seeking behaviours?
- What role can men and boys play in protecting their households from malaria?
- Can unhealthy malaria health-seeking behaviours change? How?
- What are the consequences of continuing unhealthy behaviours over time?

Conclusion

Healthy malaria health-seeking behaviours involve early testing, correct and complete treatment, consistent prevention, and supportive decision-making. Unhealthy behaviours—such as delaying care, self-medication, incomplete treatment, and harmful myths—can lead to severe illness, increased transmission, and preventable deaths. Boys and Men play a critical role in modelling and supporting positive malaria health-seeking behaviours within families and communities.

Session 3.5. Healthy and Unhealthy Health-Seeking Behaviours in Relation to Tuberculosis (TB)

Goal

To understand and identify healthy and unhealthy health-seeking behaviours related to TB prevention, testing, and treatment for boys and men.

Objectives

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

- Identify healthy and unhealthy health-seeking behaviours.
- Explain the effects of unhealthy health-seeking behaviours.
- Identify ways to change from unhealthy to healthy health-seeking behaviours.

Time: -30 minutes
Materials: Flipchart, paper, markers, cards, masking tape
Target Audience: Men and Boys

Advance Preparation

1. Print in large letters "Healthy and Unhealthy," on separate flipchart papers and place them on the wall.
2. Write the following TB health-seeking behavior statements on small cards (one statement per card):

Card Statements (TB Context)

- You go to a health facility for TB testing when you have a cough of any duration .
- You delay TB testing because you fear stigma or being judged.
- You complete the full TB treatment as advised by the health worker.
- You stop taking TB medicine once you start feeling better.
- You encourage family members with TB symptoms to seek testing.
- You hide TB medication to avoid being isolated or excluded.
- You take TB medicine every day at the same time as instructed.
- You share TB medicine with another person who is coughing.
- You attend scheduled TB clinic appointments and follow-ups.
- You rely only on traditional or herbal remedies for TB treatment.
- Everyone who has TB has HIV

Resource Sheet: Card Placement Answers (Facilitator Guide)

- You go to a health facility for TB testing when you have a cough of any duration . (Healthy)
- You delay TB testing because you fear stigma or being judged. (Unhealthy)
- You complete the full TB treatment as advised by the health worker. (Healthy)
- You stop taking TB medicine once you start feeling better. (Unhealthy)
- You encourage family members with TB symptoms to seek testing. (Healthy)
- You hide TB medication to avoid being isolated or excluded. (Unhealthy)
- You take TB medicine every day at the same time as instructed. (Healthy)
- You share TB medicine with another person who is coughing. (Unhealthy)
- You attend scheduled TB clinic appointments and follow-ups. (Healthy)
- You rely only on traditional or herbal remedies for TB treatment. (Unhealthy)
- Having TB does not mean you are HIV positive (Healthy)

Steps

1. Distribute the cards to participants.
2. Explain that TB health-seeking behaviours can be healthy or unhealthy.
3. Healthy behaviours support early diagnosis, cure, and prevention of TB spread.
4. Unhealthy behaviours delay treatment, increase transmission, and can lead to drug-resistant TB.
5. Ask participants to decide whether the behaviour on their card is Healthy or Unhealthy and place it under the appropriate sign.
6. Review each card together, allowing brief discussion and clarification.

Facilitator's Note

If cards are unavailable, read the statements aloud.

When opinions differ, guide participants to consider:

- Risk of TB transmission
- Treatment duration and completion
- Consequences of missed or shared medication
- Impact on family and community health

Emphasize that TB is curable when treatment is taken correctly and fully.

Group Discussion Questions (Reduced)

• Why do some men delay TB testing and treatment?
• What happens when TB treatment is not completed?
• How can men and boys support healthy TB health-seeking behaviors at home and in the community?

Conclusion

Healthy TB health-seeking behaviors include early testing, daily and complete treatment, clinic follow-ups, and openness about symptoms. Unhealthy behaviors such as delaying care, stopping treatment early, hiding illness, or sharing medicine can lead to continued illness, drug-resistant TB, and further spread of the disease. Men and boys play a vital role in breaking TB transmission and supporting treatment adherence.

Session 3.4: Thinking about Fatherhood

Goal: To increase understanding of the positive role of men in fatherhood.

Objectives: By the end of the session participants should be able to:

1. Describe the benefits of the presence of a father figure in a family.
2. Describe actions men can take to become better fathers.
3. Explain the qualities of a good father.

Time: 45 minutes

Materials: Flipchart, markers, masking tapes, paper, pencils and pens

Target Audience: Boys and Men

Facilitator's Notes

This can be a difficult activity because it involves sharing a lot of personal information. As a facilitator, it will be important for you to share your personal information so that the participants will feel comfortable doing the same. Explain that everyone has the right to say as little or as much as they want to. No one is required to disclose his story, and everyone has the right not to say anything about themselves if they wish not to. The activity asks participants to think about their relationships with other men, particularly their fathers. This helps the group to talk about the meaning of fatherhood.

Many men you will be working with have not had close relationships with their fathers. This may make it difficult for them to be loving fathers to their children, even though they want to be. At the same time, you mustn't assume all participants have had poor relationships with their fathers. If men begin to express a lot of negative feelings about their fathers or other adults during this activity, remind them that they have the capacity to heal, grow, and make different choices. The fact that they have made it this far is a testimony to their strength and resilience.

Participants may raise issues around paternity and DNA testing. Acknowledge that such concerns exist, but guide the discussion toward responsible fatherhood, trust, and the wellbeing of children. If you are working with both men and boys, it will be better to separate the two. This will help to create more safety for participants to be open about their experiences and feelings.

Preparation for the session write the following questions on a piece of flipchart paper:

Ourselves and our fathers

- What is your age?
- What are the names and ages of your children? (**for fathers only**)
- Who raised you?
- How many children were in the family?
- How would you describe yourself as a boy?
- What kind of parent was your father?
- What did you learn from your father about being a parent?
- How would you like to be a different kind of parent from your father?

Resource Sheet 3.3: Fatherhood

A responsible father plays several vital roles in the lives of his children and family. These include:

1. **Role Model**: Fathers serve as role models for their children, demonstrating positive behaviours, values, and attitudes. They instill important life lessons through their actions, such as honesty, integrity, hard work, and resilience.
2. **Nurturer**: Responsible fathers are emotionally supportive and nurturing towards their children. They provide love, encouragement, and guidance, helping their children develop self-confidence, emotional intelligence, and a sense of belonging.
3. **Teacher**: Fathers play a crucial role in their children's education and development by teaching them essential skills, knowledge, and values. This includes academic learning, as well as practical skills, such as problem-solving, decision-making, and conflict resolution.
4. **Protector**: A father protects his family from physical, emotional, and psychological harm. This includes creating a safe and secure environment at home, teaching children about safety measures, and being vigilant about potential dangers.
5. **Provider**: A responsible father ensures the financial stability of the family by providing for their basic needs such as food, shelter, education, and healthcare. This involves working diligently to earn income and managing finances wisely.
6. **Disciplinarian**: While being loving and supportive, responsible fathers also establish clear rules, boundaries, and expectations for their children(s) behavior. They enforce discipline fairly and consistently, helping their children learn accountability and self-control.
7. **Listener and Communicator**: A father who actively listens to his children's thoughts, feelings, and concerns fosters open communication and trust within the family. Effective communication allows fathers to understand their children better and address any issues that arise.
8. **Playmate and Mentor**: Fathers engage in recreational activities and spend quality time with their children, fostering bonding and creating cherished memories. They also serve as mentors, guiding their children through life's challenges and helping them discover their passions and talents.

9. **Supportive Partner**: In addition to their role as a parent, responsible fathers are supportive partners to their spouses or co-parents. They collaborate in decision-making, share household responsibilities, and provide emotional support to maintain a healthy and harmonious family dynamic.

Steps

1. Start the activity by asking participants what it means to be a father in their community. (Follow-up values, practices and other experiences coming up). Summarize their responses and present the objective of the activity.
2. Put up the prepared flipchart on "Ourselves and Our Fathers." Ask participants to take a few minutes to answer these questions themselves. Explain that they can make notes, if they wish.
3. Ask participants to find two other partners to form groups of three. Explain that each person has five minutes to discuss their answers with their two partners. Ask the partners to simply listen and not interrupt. Tell the participants that you will keep time strict so that everyone has the same time to speak. Explain that you will clap your hands when it is time for the next person to share his answers.
4. When each group of three has finished, bring everyone back together. Lead a general discussion using the questions below:
   - What are the challenges of being a father? How can these challenges be addressed?
   - What is the positive side of being a father? What are the benefits of being a father?
   - What are the benefits for a child who has a father active in his or her life?
   - What are the benefits of a man having a good relationship with the mother of his child?
   - What do men need to become better fathers?
   - Are there positive role models of fathers in your community? What can be learned from them?
   - What role can a father-figure play in a family which has no father?

5. Ask the participants to identify different roles that fathers can play in the lives of their children and family. Use information in the "Resource Sheet 3.2: Fatherhood" to add what they might have left out.
6. Before closing, ask participants what they have learnt from this activity and what they are going to do differently as men.

Conclusion

A responsible father should not only involve himself in income-generating activities but should also engage himself in child caring. Men who are more active in caring for their children report more satisfaction in their relationships with their partners and in their daily lives. It is important to consider that if boys interact with men (fathers, uncles, family friends, etc.) in a caregiving situation, they are more likely to view men's caregiving as part of the male role. Children will be able to observe their parents' behavior and learn a broader meaning of what it means to be men and women.

Module 4: Gender-Based Violence - GBV

Session 4.1. What is Gender-Based Violence?

Goal: To understand the broad concept of Gender Based Violence and its consequences.
Objectives: By the end of the session participants will be able to: 1. Define Gender Based Violence 2. Describe the different forms of gender-based violence, ways of preventing and reporting. 3. Explain how men and women experience violence differently.
Time: 60 minutes
Materials Required: Flipchart, Markers, Masking Tape, VIPP Cards
Target Audience: Men and Boys

Facilitator's Notes

Before the sessions on gender-based violence, it is important to have information concerning violence, including existing laws and social support for those who inflict and/or suffer from violence. It is also important to be prepared to refer a participant to the appropriate services if s/he reveals that s/he is a survivor of violence or abuse and to clarify any ethical and legal aspects related to dealing with situations that might come up during the discussions on violence.

This activity may be very emotional, and the facilitator should be prepared to manage the reactions of participants. During the activity, you might notice that it is easier for participants to talk about the violence they have suffered outside their homes than the violence they have suffered inside their homes or the violence they have used against others. They might not want to go into detail about these experiences, and mustn't pressure them to do so.

Being a survivor of interpersonal violence is frequently associated with committing acts of violence later in life. Moreover, in talking about violence they've committed, the participants might seek to justify themselves, blaming the other person for being the aggressor. Helping them to grasp this connection and think about the pain that violence has caused them is a potential way of interrupting the victim-to-aggressor cycle of violence.

As the facilitator, you can assist the group in this discussion by:

- Explaining that this is a safe space to talk about their own experience if they wish to, but those who do not want others inside the group to know about it can choose to talk about the violence that "people like them" or "people they know" experience
- Being aware of people's reactions, and body language, and reminding the group of the importance of people taking care of themselves (e.g., it is okay to take a break).

- Challenging participants who try to deny or reduce the significance of gender-based violence in general.
- Explaining that you can talk to participants after the session to tell them about available support services

Steps

Part 1 – What Does Violence Mean to Us? (Allow 15 minutes)

1. Ask the group to sit in a circle and to think silently for a few moments about what violence means to them.
2. Invite a few participants to share with the group what violence means to them. (Write the responses on flipchart paper if time allows and if you have flipcharts).
3. Discuss some of the common points in their responses, as well as some of the unique points. Review the definitions in the "**Resource Sheet 4.1:** What is Gender Based Violence?" below and tell the participants that there is not always a clear or simple definition of violence.

Part 2- Types of Violence (Allow 30 minutes)

1. Ask the participants to identify types and forms of Gender Based Violence that they know. Write their responses on a flip chart as you clarify what they mention using "Resource Sheet 4.1: What is Gender Based Violence?" And "Resource Sheet 4.2: Forms of Gender-Based Violence" below.
2. Use the following questions to summarize the discussion on the types of Violence:

- What kinds of violence most often occur in intimate relationships and families between men and women? What causes this violence? (Examples may include physical, emotional, and/or sexual violence that men use against girlfriends or wives, violence women use against their boyfriends or husbands as well as the physical, emotional, or sexual violence used by Parents against children or other types of violence between family members.)
- What kinds of violence most often occur outside relationships and families? What causes this violence? (Examples may include physical violence between men, gang or war-related violence, stranger rape, and emotional violence or stigmatizing certain individuals or groups in the community)
- What is the most common type of violence inflicted on women and girls?
- What is the most common type of violence inflicted against men and boys?
- Are only men violent, or can women also be violent? What is the most common type of violence men use against others? What is the most common type of violence that women use against others?
- Does a man or woman ever "deserve" to be hit or suffer violence?
- What are the consequences of violence on individuals? On relationships? On communities?
- What can you and other women /girls do to stop or avoid violence in your community?

Resource Sheet 4.1: What is Gender-Based Violence?

This module builds on the foundational definition of Gender-Based Violence introduced in Module 1 and focuses on understanding the forms, impacts, and appropriate responses to GBV in community and health settings.

Gender-Based Violence (GBV) refers to any act that results in, or is likely to result in, physical, sexual, psychological, or emotional harm or suffering to women and men, girls and boys, including threats of such acts, coercion, or arbitrary deprivation of liberty. GBV arises from unequal power relations based on gender and can occur in public, private, institutional, community, or digital spaces.

Survivor/Victim: Any individual adult or child who has experienced violence. A child who has experienced violence is a child survivor. The terms are used interchangeably in the document. Some sectors such as health, children and educational sectors prefer to use the term 'survivor', while sectors in the criminal justice system, including the National Police Service, the Judiciary and the Office of the Director of Public Prosecutions, prefer the term 'victim'.

Survivor-Centered Approach: This is a way of responding to gender-based violence that prioritizes the rights, safety, dignity, needs, and choices of the survivor at all times. It recognizes survivors as experts in their own experiences and ensures that support is provided without judgment, blame, coercion, or discrimination.

In a survivor-centered approach:

- The survivor's **safety and wellbeing come first**
- Survivors are supported to make **informed decisions** about their own lives
- Services respect **confidentiality and privacy**
- Participation in reporting, referral, or services is **voluntary**
- Responses are guided by **do no harm** principles

Core Principles of a Survivor-Centered Approach

1. **Safety**
   Take steps to protect survivors from further harm, retaliation, or exposure, including emotional and digital harm.
2. **Confidentiality**
   Do not share information without the survivor's informed consent, except where legally required to protect life or a child.
3. **Respect and Dignity**
   Treat survivors with empathy and respect, avoiding judgment, blame, or pressure.
4. **Informed Choice and Consent**
   Survivors decide what actions to take, including whether to disclose, seek services, or report the incident.
5. **Non-Discrimination**
   Support is provided regardless of gender, age, disability, sexual orientation, socioeconomic status, or health condition.

What a Survivor-Centered Approach Means for Male Engagement

A survivor-centered approach means that:

- Boys and men should not act as investigators, mediators, or decision-makers in GBV cases where there is a conflict of interest or where their involvement could compromise survivor safety, confidentiality, or impartiality.
- Survivors should never be pressured to disclose, reconcile, or report. All decisions must be voluntary and led by the survivor.
- Engagement activities do not excuse or justify violence under culture, religion, or masculinity
- Survivors' voices, safety, and autonomy are respected at all times Male engagement should focus on:
- prevention of violence
- accountability for behaviour
- challenging harmful norms
- supporting referral pathways, not replacing professional services

Gender Based Violence can be Physical, Sexual, Emotional/Psychological and Economic.

- ***Physical violence:*** *Using physical acts such as pushing, hitting, slapping, biting, beating, pulling hair, twisting arms, burning, etc.*
- ***Sexual violence:*** *Pressuring or forcing someone to perform sexual acts from kissing to sexual intercourse against their will (Rape or Defilement) or making sexual comments that make someone feel humiliated or uncomfortable. It does not matter if there has been prior consenting sexual behaviour. It also includes unwanted touching, grabbing sexual parts of the body, unfaithfulness, refusing to have protected sex etc.*
- ***Emotional/psychological violence:*** *This is often the most difficult form of violence to identify. It may include humiliating or causing embarrassment, criticizing, threatening physical violence or hurting children or partner, shouting, insulting, pressuring, expressing jealousy or possessiveness (e.g., by controlling decisions and activities), locking out of the house, threatening to leave, constant monitoring of the other person's activities etc.*
- ***Economic violence:*** *Examples include enticing people for sexual favours, withholding family finances, preventing the partner from working outside the home, forcing the partner to beg or humiliate themselves for money, spending family resources without consulting the partner, dispossession, neglect or failing to provide, preventing a partner from owning property etc.*

Other Categories of GBV

Domestic violence: This is violence against a person, or threat of violence or imminent danger to a person, by any other person with whom that person is, or has been, in a domestic relationship. This can take the form of **abuse** (FGM, *forced marriage, forced wife inheritance, interference from in-laws, sexual violence within marriage, virginity testing, denying a person access to his home),* ***damage of property, defilement, economic abuse, emotional abuse, incest, stalking, intimidation and verbal abuse.*** *(PADV ACT 2015).*

Intimate Partner Violence (IPV): This is domestic violence that occurs between a current or a former spouse or partner in an intimate relationship against the other spouse or partner. It can take several forms including physical, verbal, emotional, economic and sexual abuse. The effects of intimate partner violence reach beyond those who are direct victims or perpetrators. Those who are exposed to it are children within the family or household where IPV occurs. Children who grow up in families where they are exposed to violence may suffer a range of behavioural and emotional disturbances. Exposure can also be associated with perpetrating or experiencing violence later in life.

Harmful traditional practices: They include female genital mutilation (FGM), gum cutting/scrubbing, sex slavery, denial of rights to control one's fertility, sex discrimination, early/forced marriages, dowry-related murder, selective malnourishment of female children and infanticide.

Online / Technology-Facilitated Gender-Based Violence (TFGBV):

Technology-Facilitated Gender-Based Violence refers to acts of violence, abuse, harassment, intimidation, control, or exploitation that are committed, assisted, or aggravated through digital technologies. These technologies include mobile phones,

text messages, emails, social media platforms, online forums, gaming platforms, and other information and communication technologies.

Technology-Facilitated Gender-Based Violence arises from unequal power relations and can cause significant psychological, emotional, social, and physical harm. It affects girls, women, boys, and men, and is particularly prevalent among adolescents and young people.

Common forms of Technology-Facilitated Gender-Based Violence include:

- **Cyber bullying:** The repeated use of digital platforms to harass, threaten, intimidate, or humiliate a person through messages, images, or online interactions.
- **Non-consensual sharing of intimate images or messages:** The distribution or threat to distribute sexual or intimate images, videos, or messages without the consent of the person depicted, regardless of how the material was originally obtained.
- **Doxing:** The deliberate public release or sharing of a person's private, personal, or identifying information online with the intent to intimidate, harass, threaten, or cause harm.

Violence against children: This includes all forms of violence against people under 18 years old, whether perpetrated by parents or other caregivers, peers, romantic partners, or strangers. For infants and younger children, violence mainly involves child maltreatment (i.e. physical, sexual and emotional abuse and neglect) at the hands of parents and other authorities. Boys and girls are at equal risk of physical and emotional abuse and neglect, and girls are at greater risk of sexual abuse. According to WHO, six main types of interpersonal violence that tend to occur at different stages in a child's development include:

(a) Maltreatment (including violent punishment) involves physical, sexual and psychological/emotional violence; and neglect of infants, children and adolescents by parents, caregivers and other authority figures, most often in the home but also in settings such as schools and orphanages.

(b) Bullying (including cyber-bullying) is unwanted aggressive behavior by another child or group of children or adults.. It involves repeated physical, psychological or social harm, and often takes place in schools and other settings where children gather, and online.

(c) Youth violence is concentrated among children and young adults aged 10–29 years, occurs most often in community settings between acquaintances and strangers, includes bullying and physical assault with or without weapons (such as guns and knives) and may involve gang violence with fatal outcomes.

(d) Intimate partner violence (or domestic violence) involves physical, sexual and emotional violence by an intimate partner or ex-partner. Although males can also be victims, intimate partner violence disproportionately affects females. It commonly occurs against girls in child marriages and early/ forced marriages. Among romantically involved unmarried adolescents it is sometimes called "dating violence".

(e) Sexual violence includes non-consensual completed or attempted sexual contact and acts of a sexual nature not involving contact; acts of sexual trafficking committed against someone unable to consent or refuse; and online exploitation.

(f) Emotional or psychological violence includes restricting a child's movements, denigration, ridicule, threats and intimidation, discrimination, rejection and other non-physical forms of hostile treatment.

Resource Sheet 4.1: Forms of Gender-Based Violence

The summaries below present examples of different forms of violence and their descriptions. It is important to note that many of the examples overlap categories, and the typologies are only for analysis

Sexual violence

Sexual violence remains the most common form of GBV. Worldwide, it is estimated that 35 per cent of women have experienced physical and/or sexual intimate partner violence or sexual violence by a non-partner (not including sexual harassment) at some point in their lives, while some national studies show that up to 70 per cent of women have experienced physical and/or sexual violence from an intimate partner in their lifetime A multi-country study conducted by WHO in ten developing countries found that 15 to 71 per cent of the women reported experiencing either intimate partner or sexual violence at some point in their lives.

Types of sexual violence are listed in the accompanying table. Other offences under the Sexual

Offences Act includes trafficking for sexual exploitation:

- *Child sex tourism*
- *Child defilement*
- *Child pornography*
- *Exploitation of prostitution*
- *Rape and defilement of people with mental disabilities*

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5 World Health Organization, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, South African Medical Research Council (2013), *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence*.

Type of Sexual Violence	Description
Sexual assault	When a person unlawfully causes penetration of another person's genital organs using any part of their own body, another person's body, or an object (except where such penetration is carried out for legitimate medical or hygienic purposes) or when a person intentionally manipulates their own body or the body of another to bring about penetration of the genital organs into or by any part of another person's body.
Rape	A person commits rape if he or she intentionally and unlawfully commits an act which causes penetration with his or her genital organs and the other person does not consent to the penetration or the consent is obtained by force or by means of threats or intimidation of any kind.(This applies to 18 years and above). **A person guilty of an offence under this section is liable upon conviction to imprisonment for a term which shall not be less than ten years but which may be enhanced to imprisonment for life.**
Attempted rape	Any person who attempts to unlawfully and intentionally commit an act which causes penetration with his or her genital organs. **A person guilty of an offence under this section is liable upon conviction to imprisonment for a term of not less than ten years but which may be enhanced to imprisonment for life.**
Defilement	• A person intentionally and unlawfully engages in sexual penetration with a child, that is, any person under the age of 18 years. • A person who commits an offence of defilement with a child aged 11 years or less shall upon conviction be sentenced to imprisonment for life. • A person who commits an offence of defilement with a child between the age of 12 and 15 years is liable upon conviction to imprisonment for a term of not less than 20 years. • A person who commits an offence of defilement with a child between the age of 16 and 18 years is liable upon conviction to imprisonment for a term of not less than fifteen years.
Attempted defilement	Attempted defilement is a criminal offence where a person intentionally tries to penetrate the genital organs of a child (a person under 18 years) but does not succeed in completing sexual penetration. **A person who commits an offence of attempted defilement with a child is liable upon conviction to imprisonment for a term of not less than ten years.**

Indecent act	An indecent act is any intentional sexual act or behavior that is offensive to modesty or decency, carried out without consent, and does not involve sexual penetration. A person who commits indecent act is guilty of an offence and is liable upon conviction to imprisonment for a term which shall not be less than five years.
Incest	Incest is a sexual relationship or sexual activity between close family members where such relations are legally or culturally prohibited. Test of relationship – In cases of incest, 'brother' and 'sister' include half-brother, half-sister, and adoptive brother and adoptive sister; 'father' includes a half-father and an uncle of the first degree. 'Mother' includes a half-mother and an aunt of the first degree, whether through lawful wedlock or not. 'Uncle' means the brother of a person's parent and 'aunt' has a corresponding meaning; 'nephew' means the child of a person's brother or sister and 'niece' has a corresponding meaning; 'half-brother' means a brother who shares only one parent with another; 'half-sister' means a sister who shares only one parent with another; and 'adoptive brother' means a brother who is related to another through adoption, and 'adoptive sister' has a corresponding meaning.
Gang rape	Rape or defilement in association with another or others, or any person who, with common intention, is in the company of another or others who commit the offence of rape or defilement. A person who commits the offence of rape or defilement is guilty of an offence termed gang rape and is liable upon conviction to imprisonment for a term of not less fifteen years but which may be enhanced to imprisonment for life.
Promotion of sexual offences with a child	Manufacturing or distributing any article that promotes or is intended to promote a sexual offence with a child; or supplying or displaying to a child an article which is intended to be used in the performance of a sexual act, to encourage or enable that child to perform such sexual act. A person is guilty of an offence of promoting child sex tourism and is liable upon conviction to imprisonment for a term of not less than ten years and where the accused person is a juristic person to a fine of not less than two million shillings.
Sexual harassment	Any person who, being in a position of authority or holding a public office, persistently makes any sexual advances or requests which he or she knows, or has reasonable grounds to know, are unwelcome, is guilty of the offence of sexual harassment. Any offender shall be liable to imprisonment for a term of not less than three years or to a fine of not less than one hundred thousand shillings or to both.

Cultural and religious sexual offences	Any person who for cultural or religious reasons forces another person to engage in a sexual act or any act that amounts to an offence under the Sexual Offences Act. Any person who for cultural or religious reasons forces another person to engage in a sexual act or any act that amounts to an offence under this Act is guilty of an offence and is liable upon conviction to imprisonment for a term of not less than ten years.
Sexual offences relating to positions of authority and persons in positions of trust	Sexual offences relating to positions of authority or trust – minimum sentence of ten years.
Deliberate transmission of HIV or any other life-threatening sexually transmitted disease	Any person with actual knowledge that he/she is infected with HIV, or any other life-threatening sexually transmitted disease intentionally, knowingly, and willfully does anything or permits the doing of anything which he/she knows or ought to reasonably know will infect or is likely to lead to the infection of another person with HIV or any life-threatening or other sexually transmitted disease. Note: A person convicted of any other offence under the Sexual Offences Act proved to have been infected with HIV or other life-threatening sexually transmitted disease at the time of committing the offence, whether he/she was aware of the infection, and notwithstanding any other sentence, shall be liable to 15 years to life imprisonment.
Administering a substance with intent	Any person commits an offence if he intentionally administers a substance to or causes a substance to be administered to or taken by another person to stupefy or overpower that person to enable any person to engage in sexual activity with that person.

Offences under the section offence act

Offence	Ingredients	Liable upon conviction	Sentence (summary)
Rape	(1) A person commits the offence termed rape if— (a) he or she intentionally and unlawfully commits an act which causes penetration with his or her genital organs; (b) the other person does not consent to the penetration; or (c) the consent is obtained by force or by means of threats or intimidation of any kind.	A person guilty of an offence under this section is liable upon conviction to imprisonment for a term which shall not be less than ten years but which may be enhanced to imprisonment for life.	Ten (10) Years
Attempted rape	Any person who attempts to unlawfully and intentionally commit an act which causes penetration with his or her genital organs is guilty of the offence of attempted rape.	A person guilty of the offence of attempted rape and is liable upon conviction for imprisonment for a term which shall not be less than five years but which may be enhanced to imprisonment for life.	NOT less than FIVE (5) YEARS. May be enhanced depending to the circumstances to life imprisonment
Sexual assault	(1) Any person who unlawfully— (a) penetrates the genital organs of another person with— (i) any part of the body of another or that person; or (ii) an object manipulated by another or that person except where such penetration is carried out for proper and professional hygienic or medical purposes; (b) manipulates any part of his or her body or the body of another person so as to cause penetration of the genital organ into or by any part of the other person's body; is guilty of an offence termed sexual assault.	A person guilty of an offence under this section is liable upon conviction to imprisonment for a term of not less than ten years but which may be enhanced to imprisonment for life.	NOT LESS THAN TEN (10) YEARS May be enhanced to life imprisonment

Offence	Ingredients	Liable upon conviction	Sentence (summary)
Compelled or induced indecent acts	A person who intentionally and unlawfully compels, induces or causes another person to engage in an indecent act with— (a) the person compelling, inducing or causing the other person to engage in the act; (b) a third person; (c) that other person himself or herself; or (d) an object, including any part of the body of an animal, in circumstances where that other person— (i) would otherwise not have committed or allowed the indecent act; or (ii) is incapable in law of appreciating the nature of an indecent act, including the circumstances is guilty of the offence termed compelled or induced indecent acts.	A person guilty of this offence is liable upon conviction to imprisonment for a term which shall not be less than five years.	NOT LESS THAN FIVE (5) YEARS
Acts which cause penetration or indecent acts committed within the view of a family member, child or person with mental disabilities	A person who intentionally commits rape or an indecent act with another within the view of a family A member, a child or a person with mental disabilities is guilty of an offence.	A person who commits this offence is guilty and is liable upon conviction to imprisonment (not less than ten years).	NOT LESS THAN TEN (10) YEARS

Offence	Ingredients	Liable upon conviction	Sentence (summary)
Defilement	A person who commits an act which causes penetration with a child is guilty of an offence termed defilement.	(1) A person who commits an offence of defilement with a child between the age of twelve and fifteen years is liable upon conviction to imprisonment for a term of not less than twenty years. (2) A person who commits an offence of defilement with a child between the age of sixteen and eighteen years is liable upon conviction to imprisonment for a term of not less than fifteen years	Ages 12-15 NOT LESS THAN TWENTY (20) YEARS Ages 16=18 years NOT LESS THAN FIFTEEN (15) YEARS
Attempted defilement	A person who attempts to commit an act which would cause penetration with a child is guilty of an offence termed attempted defilement.	A person who commits an offence of attempted defilement with a child is liable upon conviction to imprisonment for a term of not less than ten years.	NOT LESS THAN TEN (10) YEARS
Gang rape	Any person who commits the offence of rape or defilement under this Act in association with another or others, or any person who, with common intention, is in the company of another or others who commit the offence of rape or defilement is guilty of an offence termed gang rape.	A person guilty of the offence of gang rape is liable upon conviction to imprisonment for a term of not less than fifteen years but which may be enhanced to imprisonment for life.	NOT LESS THAN FIFTEEN (15) YEARS MAY BE ENHANCED TO LIFE IMPRISONMENT
Indecent act with child or adult	Any person who commits an indecent act with a child is guilty of the offence of committing an indecent act with a child.	A person found guilty of this offence is liable to imprisonment for a term of not less than ten years.	NOT LESS THAN TEN (10) YEARS
Indecent act with adult	Any person who commits an indecent act with an adult is guilty of an offence.	A person found guilty of this offence is liable to imprisonment for a term not exceeding five years or a fine not exceeding fifty thousand shillings or both.	IMPRISONMENT FOR A TERM NOT EXCEEDING FIVE (5) YEARS OR A FINE NOT EXCEEDING KES.50,000

Physical violence

These are forms of violence that attack and harm the body, including: physical assault, beating, battering, trafficking, slavery, murder, detention, inflicting wounds, or administering drugs, substances, or alcohol with intent to abuse.

Type of Physical Violence	Description
Assault	Roughing up a person, e.g. one's wife or husband.
Battering	Whipping and beating up, e.g. kicking, slapping, boxing, knocking down, etc.
Killing	Ending the life of another by poisoning, strangling, decapitation, etc.
Maiming	Causing someone permanent injury and disability, e.g. cutting off limbs, burning, piercing the eyes of elderly people alleged to be witches or wizards, etc.
Dismembering	Chopping off part of someone's body, e.g. a woman cutting off the husband's sexual organs.
Disfiguring and mutilation	Destroying someone's appearance and physically changing the original appearance of the body, e.g. pouring acid on the face, scalding, scarification, genital modification, etc.

Economic abuse/violence

These are forms of violence related to income, support, employment, and means of living. Economic abuse/violence includes deprivation of basic needs, unreasonable deprivation of economic or financial resources that one is entitled to, including household necessities, medical expenses, school fees, rent, mortgage, etc.; deprivation of inheritance; disposal of property without consent; withholding financial support; denial of employment; and denial of resources or opportunities or service

Type of Economic Abuse	Description
Enticement	Asking someone for sexual favours in return for employment or other benefits; luring children into sex with money and material benefits.
Trafficking	The recruitment, transportation, transfer, harbouring, or receipt of a person, employing threat or use of force or other forms of coercion, for exploitation, e.g. as domestic workers, sexual workers, or forced labour.
Dispossession	Taking away what rightly belongs to another person, e.g. taking away from widows the property of the deceased person
Servitude	Giving someone too much work or making one work like a slave.
Vandalism	Deliberate destruction of someone's property, e.g. a wife breaks utensils or burns the house or her husband's car to show her displeasure.
Confiscation	Keeping one's pay cheques, credit cards, or other sources of funds; a husband, for example, keeping certain items owned by his wife (e.g. keys, property) and thereby preventing access to means of mobility and livelihood and other necessities.
Neglect	Failing to provide food, shelter, health care, education, and protection to one's dependents, e.g. a woman who only gives birth to girls being neglected by her husband, girls being denied education, and older persons being denied health care and food.
Denial of resources	Taking away the money, the woman earns so the male partner has absolute control over the family income. Denying a wife access to land and other productive resources.
Economic blackmail	Using financial power over the spouse who has fewer resources.

Emotional/psychological violence

These are forms of violence that cause disturbance to one's mind and feelings. This includes the following: abuse/humiliation; stalking; sexual harassment and confinement; lack of support that may cause harm to the health, safety, and well-being of a person entitled to the support; name calling; intimidation; threats; and intimate partner violence. The accompanying table shows examples and explains some aspects of emotional/psychological violence. Over 1 in 4 men (**28%**) reported that their partner displayed three or more specific controlling behaviours (KDHS 2022).

Type of Emotional/ Psychological Violence	Description
Verbal insults	Use of offensive words against someone.
Humiliation	Making someone feel ashamed or useless, e.g. being beaten up in public or front of one's children, being undressed in public, being forced to do a sexual act in public, or being forced to witness the rape of one's spouse, child, or parent.
Intimidation	Installation of fear through threats, bullying, and pressure to do or not do something, e.g. defiled children being threatened with death if they report their defilers.
Confinement and immobilization	Denying someone freedom of movement, e.g. a husband locks his wife in the house and keeps her incommunicado, or breaking one's legs to prevent escape, etc.
Silence	Refusing to talk to one's husband or wife as a way of punishing him/her.

Harmful traditional practices/cultural forms of violence

These are rooted in traditions and customs. These kinds of GBV constitute a breach of the fundamental right to life, liberty, security, dignity, equality between women and men, non-discrimination, and physical and mental integrity. They include female genital mutilation, forced circumcision, early marriage, forced marriage, infanticide and/or child neglect, widow inheritance, and disinheritance. The accompanying table presents some examples and explains some aspects of harmful traditional practices/cultural forms of violence.

6 Draft National Policy on Prevention of and Response to Gender-based Violence and *Keeping the Promise: End Gender-based Violence*

Harmful Traditional Practices/Cultural Forms Of Violence	Description
Genital mutilation	The act of cutting, sewing up, or disfiguring genital organs, usually as a rite of passage but sometimes as a form of retaliation, punishment, or military or cultural domination.
Scarification	The act of etching physical marks on one's body, usually as a rite of passage.
Forced and/or arranged marriage	The act of forcing someone to marry a person not of their own choice, e.g. families forcing their daughters to marry rich old men able to pay fatter bride price and betrothing children and marrying them off to pre- determined suitors.
Early/child marriage	The act of making children (i.e. those below 18 years of age) marry.
Abduction	Physical removal of a person from one place to another by force or trickery, e.g. girls carried away by their suitors.
Forced widow inheritance	Marital union with a widow against her will in the name of culture.
Discrimination	Biased treatment against someone because of his/her sex, e.g. denying girls education and women property.
Honor killing or maiming	Injury or death caused by family members or their agents against one of their own to preserve the family's honor, e.g. abduction and killing of girls who have sexual relations outside of wedlock or relationships with people of a lower social class or from a different race or ethnic group.
Derogatory folklore	Folktales, proverbs, riddles, and songs that depict certain groups as inferior or encourage/glorify violence against them.
Objectification and commoditization	Treatment of someone as property, e.g. regarding women as property or sexual objects available through purchase or for use to meet ritualistic purposes.
Ghost marriage	Acquisition of a wife for a son who died before getting married died at war or disappeared in his youth. The woman is kept by the boy's family and arrangements are made for her to have children for the dead or lost boy by proxy.

Gender-Based Violence in Politics

GBV in politics includes political harassment committed against those in active public life. It can take many other forms, including physical, sexual, and psychological violence, threats, harassment, and intimidation. GBV in politics also includes sexist stereotypes and images in the media that focus on bodies, sexuality, and traditional social roles, as well as undue pressure to quit posts based on gender.

The table below presents some examples and explains some aspects of GBV in politics. Table 5 shows an analysis of forms of violence reported to the HAK 1195 Helpline between 2015 and October 2018.

Type of Gender-Based Violence in Politics	Description
Sexist stereotypes	Emphasizing bodies, sexuality, and traditional social roles rather than focusing on a candidate's competence, capacity, and contribution as a leader.
Intimidation	This can take the form of pressure to resign from posts or relinquish ambitions on the basis of gender.

Protection of sexual abuse

Protection against domestic violence Act – This law provides for the protection of survivors of domestic violence. It defines what a domestic relationship is, provides for procedures for securing protection orders and other rights and reliefs survivors of domestic violence have.

Witness Protection Act – This law establishes a witness protection agency whose mandate is to ensure witnesses who are giving evidence in sensitive matters are protected from threats and/or the possibility of being coerced so that they can safely give relevant evidence.

Victim Protection Act – The law aims to uphold the rights and dignity of all victims, offering support, compensation, and protection during the justice process.

SGBV Courts – these are specialized court divisions, primarily established to provide a survivor-centered, efficient justice system for victims of SGBV, handling cases like sexual offenses, domestic violence, and abuse by ensuring dedicated resources, trained officers, and streamlined processes to reduce stigma and improve access to justice.

Session 4.2. Causes and Contributing Factors of Gender Based Violence

Goal: To understand the causes and contributing factors of Gender Based Violence.
Objectives: By the end of the session participants should be able to: 1. Outline causes gender-based violence. 2. Identify Predisposing and contributing factors to Gender-Based Violence.
Time: 60 minutes
Materials Required: Flipchart, Markers, Masking Tape
Target Audience: Boys and men

Advance Preparation

Before the session, post six pieces of flipchart paper on different positions of the wall. On each paper, write one of the six categories below:

- Root Causes of GBV
- Individual Factors contributing to GBV
- Relationship Factors contributing to GBV
- Community level Factors contributing to GBV
- Societal level Factors Contributing to GBV
- Environmental Factors contributing to GBV

Facilitators Notes

Steps

1. Start the session by explaining to participants that the purpose of this activity is to think about the root causes of GBV, the contributing factors and its different effects.
2. Divide the participants into **six groups** and assign each group one of the above categories (Root Causes of GBV, Individual Factors Contributing to GBV, Relationship Factors contributing to GBV, Community Level Factors contributing to GBV, Societal Level Factors Contributing to GBV and Environmental Factors contributing to GBV). Ask each group to brainstorm on their category for 5-10 minutes and to write their responses on the flipcharts earlier prepared.
3. After each group has posted their responses on the flipchart, ask them to rotate in a clockwise direction and have a gallery walk to see what the other groups have written. Each group should not spend more than 3 minutes at each station. Ask them to add any other information that might have been omitted by the other group using a different colour of felt pen.
4. After the groups have returned to their original flipchart, let them appreciate what the other groups have added before returning to their seats.
5. Once the participants have returned to their seats, lead a plenary discussion on the **six categories** using "**Resource Sheet 4.3**: Causes and Contributing Factors of GBV" to add or correct any misinformation. to state the consequences or effects of GBV
6. Conclude the session by explaining that for us to deal with the consequences of GBV which is largely manifested around us, then we must target the root causes and contributing factors first otherwise, GBV will keep recurring

Resource Sheet 4.3: ***Causes and Contributing Factors of GBV***

a) Root Causes of GBV:

- Male and /or societal attitudes of disrespect or disregard towards the weaker person
- Lack of belief in equality of human rights for all
- Social/Cultural norms of inequality
- Abuse of Power (One seeking to exact their power and authority over another)

NB: The Main cause of GBV is purely Power i.e., one seeking to exert their power and authority over another.

- The low status assigned to females and acceptance of aggression as a masculine trait creates tolerance for acts such as spousal battery, marital rape, and denial of property.
- People in positions of power can use it to exploit and abuse others.
- Personal levels of education and awareness determine the ability to recognize what is or is not GBV and what the available redress mechanisms are.
- Legalized, historical, economic, or other sanctioned forms of domination of one section of society by another create risks for GBV. For instance, a dominant group can enforce its cultural practices on the dominated or abuse them by humiliation, intimidation, ethnic/ racial purification, and revenge.
- Those with weapons can easily force their will upon others, intimidate them into silence, maim them, or even kill them.

b) Contributing and predisposing factors to Gender-Based Violence

GBV often results from power hierarchies and structural inequalities created and sustained by belief systems, cultural norms, and socialization processes. However, some factors increase exposure to GBV. The factors outlined below cover contexts that directly or indirectly lead to GBV.

1) Individual Factors: Refer to biological and personal history factors among both victim/survivor & perpetrator e.g.

- History of violence in the family of the perpetrator or victim/survivor
- Alcohol and drug abuse
- Personality disorders
- Age and disability Factor (The elderly & children are more vulnerable)

2) Relationship Factors: These are proximal social relationships between intimate partners, within families. E.g.

- Family dysfunction,
- Marital conflicts
- Dominance in the family
- Economic stress (Poverty and Riches)
- Imbalance in home responsibilities and roles
- Social pressure for family cohesion can lead to low reporting of incest and spousal battery to protect family honour.
- Friction over women's empowerment etc.

3) Community Level Factors: Which refers to the Community context where social relationships are embedded e.g.

- Weak community sanctions against GBV
- Lack/inadequate shelters for refuge
- Traditional gender norms

- Religious precepts of gender power relations are often used to justify domination and subtle forms of GBV.
- Normalization of violence
- Lack of mechanisms to settle disputes

4) **Societal Level Factors:** Larger societal factors that create an acceptable environment for violence or reduce inhibitions against violence e.g.
   - Imbalance in economic and decision-making power between men and women
   - Social norms that justify violence against women,
   - Women's lack of legal rights in some sexual matters (no marital rape)
   - Lack /weak criminal sanctions against perpetrators of violence
   - High levels of crime normalize domestic violence
   - Armed conflicts leading to family instability
   - Impunity (freedom from punishment or consequences) for perpetrators of violence.
   - Inaccessibility to legal justice due to economic factors, complicated procedures, and hostility of the system can discourage reporting and encourage impunity.

5) **The environment**
   - Topography and vegetation can provide cover for perpetrators to waylay their targets who are going to farms, markets, or missions to look for services.
   - Certain social conditions can create a potential atmosphere for the perpetration of GBV. For instance, pubs, discos, and parties that serve alcohol are common platforms for date rape.
   - Specific times of the day when there is darkness provide cover for perpetrators.
   - Life in a multicultural context can create the potential for the imposition or adoption of alien forms of behavior, some of which can constitute GBV – e.g. forced sodomy, prostitution, trafficking in persons, and forced sexual encounters.
   - Reduced economic opportunities may make boys and men resort to commercial sex as a survival mechanism and increase children's susceptibility to GBV such as trafficking, sodomy, prostitution, early marriage, and exploitative labour.
   - Dependency can make people vulnerable to abuse because of the fear of losing the support provided.
   - Some kinds of work can expose people to conditions that can create vulnerability. For instance, the physical isolation of people fetching firewood or herding cattle gives opportunity to perpetrators, Including gym instructors, boda boda riders are vulnerable.

Session 4.3: Effects and Consequences of Gender Based Violence

Goal: To help participants understand the effects and consequences of Gender Based Violence.
Objectives: By the end of the session participants should be able to: Describe effects and consequences of sexual and gender-based violence.
Time: 45 minutes
Materials Required: Flipchart, Markers, Masking Tape
Target Audience: Boys and men

Facilitators' Notes

GBV has serious, far-reaching consequences. GBV survivors are at high risk of severe and long-lasting health problems and even loss of life. At the societal level, GBV can lead to social stigma, rejection, break-up of families, homelessness, dispossession, and destitution. Apart from GBV survivors' human rights being violated, they must direct their resources towards medical, legal, and psychosocial services.

Family members of GBV survivors spend disproportionate time and resources securing reprieve for GBV survivors. At the national level, GBV affects the Kenyan economy, as working hours are lost and financial resources are directed towards mitigating the cost of GBV.

In politics and public life, GBV limits aspirants' political opportunities and discourages or prevents them from exercising their political rights, including their rights as voters, candidates, party supporters, or public officials. It also negates the gains made in the quest to enhance gender equality in politics and threatens democracy. Each form of GBV has its consequences, although there are various overlaps among them.

Steps

1. Start the session by explaining to participants that the purpose of this activity is to think about the effects and consequences of GBV at different levels.
2. Divide the participants into 6 groups and assign each group one of the categories below. Ask each group to brainstorm on their category for 5-10 minutes and to write their responses on the flipcharts.
    - Sexual and reproductive health consequences of GBV
    - Physical consequences of GBV
    - Economic Consequences of GBV
    - Emotional/psychological consequences
    - Social and cultural consequences
    - Consequences of gender-based violence in politics
3. After each group has posted their responses on the flipchart, ask them to rotate in the clockwise direction and have a gallery walk to see what the other groups have written. Each group should not spend more than 5 minutes at each station. Ask them to add any other information that might have been omitted by the other group using a different color of felt pen.
4. After the groups have returned to their original flipchart, let them appreciate what the other groups have added before returning to their seats.
5. Once the participants have returned to their seats, lead a plenary discussion on the effect and consequences of GBV using "Resource Sheet 4.4: Consequences and Effects of GBV" to add or correct any misinformation.
6. Conclude the session by explaining that the consequences and effects of GBV impact negatively in all aspects of our lives. It is therefore important to prevent GBV from occurring and to respond immediately if it occurs to mitigate its effects/consequences.

Resource Sheet 4.4: Consequences and Effects of Gender-Based Violence.
Sexual and reproductive health consequences

GBV has grave sexual and reproductive health consequences. It can deter survivors from seeking reproductive health and family planning services. There is a cyclic link between

GBV and HIV among persons living with HIV and AIDS and members of key and vulnerable populations such as prisoners; men who have sex with men; lesbian, transsexual, and intersex persons; and sex workers. GBV can expose survivors to HIV; conversely, people living with HIV, are likely to experience GBV when they disclose their status to spouses. The Kenya Demographic and Health Survey 2022 indicated that 34% of women and 27% of men aged 15-49 have experienced physical violence since the age of 15. 16 % of women and 10 percent of men aged 15 -49 experienced physical violence often or sometimes in the 12 months before the survey.:

- Unplanned pregnancies and children
- Induced, unsanitary, and unsafe abortions
- Sexually transmitted infections, including HIV
- Bareness due to disease and injury
- Sexual dysfunction
- Injury to reproductive organs, leading to lifelong malfunctions
- Early pregnancy
- Destabilization of the menstrual cycle

Other Health consequences

- Survivors of GBV may be prevented from using insecticide-treated nets (ITNs) due to controlling or abusive partners.
- Displacement due to GBV (fleeing abusive homes) often leads to sleeping in unsafe, mosquito-prone environments.
- Abusive partners may restrict movement preventing timely care-seeking.

Physical consequences of GBV

- Injury
- Bleeding
- Disability
- Permanent disfigurement
- Death
- Stunted physical growth (for children)
- Fistula

Economic consequences of GBV

The cost of GBV is enormous. A study on the economic cost of GBV by the National Gender and Equality Commission estimates that the annual total out-of-pocket medical-related expenses (money that survivors or their families paid out of their own financial resources) were estimated at a staggering KES 10 billion. Gender-based violence (GBV) imposes a severe economic burden on Kenya at both national and private sector levels. At the macroeconomic level, GBV is estimated to cost the country between 7.8% and 10% of its Gross Domestic Product (GDP) annually, with recent findings from the 2025 Nancy Baraza Taskforce indicating that Kenya loses approximately KES 41 billion each year due to GBV and femicide alone. This burden is disproportionately high when compared to the global estimate by UN Women, which places the economic cost of GBV at about 2% of global GDP. Beyond the national impact, GBV also significantly affects the private sector. A 2025 International Finance Corporation (IFC) report estimates that gender-based violence and harassment cost Kenyan businesses approximately KES 95.5 billion annually, equivalent to about 1% of national GDP, largely driven by productivity losses from absenteeism and presenteeism (KES 67 billion) and direct human resource costs related

to staff turnover, recruitment, and legal compliance (KES 28.5 billion), (Nancy Baraza Taskforce, 2025)

Private sector

A 2025 landmark report by the International Finance Corporation (IFC) highlights the substantial economic burden of gender-based violence and harassment (GBVH) on Kenya's private sector. The report estimates that GBVH costs businesses approximately KES 95.5 billion annually, representing about 1% of the country's GDP. These losses reflect both direct and indirect costs that significantly undermine business performance and economic productivity.

The largest share of this cost arises from productivity losses, estimated at around KES 67 billion per year, largely due to absenteeism and presenteeism, where employees are physically present at work but unable to perform effectively because of trauma. In addition, businesses incur approximately KES 28.5 billion annually in direct human resource costs, including recruitment, staff turnover, and legal compliance related to GBV incidents. At the individual level, the impact is equally severe, with victims of workplace harassment losing an average of 24.3 working days each year, further compounding productivity and economic losses, (IFC report 2025)

The following are some of the economic consequences of GBV:

- Reduced economic opportunities and productivity due to illness, impairment, depression, etc.
- Increased burden due to medical costs, unplanned for children, abortions etc.
- Diversion of resources for treatment and care
- Extra burden, especially for women, who bear the burden of care for family members with HIV and AIDS and very often assume the responsibility of children orphaned by AIDS
- Severe strain on health services as they struggle to cope with illnesses resulting from violence and its consequences (e.g. HIV and AIDS), which are essentially preventable
- Loss of productivity in the workforce, which compromises the delivery of services in different sectors and eventually reduces gross national product
- Reduced investments as savings are diverted to medical treatment
- Diversion of labour to care for the sick, hence a loss in productivity that leads to reduced food security and standards of living

Emotional/psychological consequences

- Fear, timidity, shame, and self-hate
- Trauma, depression, introversion, hopelessness and suicidal tendencies
- Loss of self-esteem and confidence
- Teasing and humiliation by peers
- Internalization, tolerance, and acceptance of future violence.

- Inability to trust others, especially in cases of intimate partner violence.
- Emotional detachment.
- Sleep disturbance
- Post-traumatic stress disorder
- Nervousness/ uneasiness
- Drug and alcohol abuse
- Antisocial behaviour
- Fear of intimacy
- Flashbacks/Replaying assault in the mind
- Depression
- Suicidal tendencies

Social and cultural consequences

- Alienation and rejection
- Loss of respect and dignity among peers, family, and community
- Rejection, stigmatization, and neglect of children resulting from rape or incest
- Identity crisis for children born out of sexual violation
- Emergence of new family set-ups, e.g. street families
- Early marriage in a bid to reclaim family's honour
- Loss of children's right to education as a result of early marriage
- Exclusion of victims from important communal events such as burial rites
- Poor performance and increased dropping out of school
- Slow rate of development due to withdrawal syndrome and limited interaction with peers
- Development of deviant and criminal tendencies
- Stigma and discrimination in life
- Repeat violation due to perceived vulnerability
- Breakdown in heterosexual relationships, including marriage
- Restricted access to services
- Strained relationships
- Blaming of victim/survivor
- Isolations/neglect of survivors
- Restricted access to services
- Strained employers/ employees
- Strain on health services
- Aggressive behaviour of survivors.
- Incarceration of perpetrators
- Stigma for the perpetrator after jail

Consequences of gender-based violence in politics

- Restricted ambition
- Loss of respect among peers
- Loss of good leaders
- Perpetuation of gender discrimination and gender stereotypes
- Poor governance
- Shunning of politics by good leaders
- Governance and leadership gap

Session 4.4: Conflict and Anger Management among Boys and Men

Goal: To understand how to manage conflict and anger.

Objectives: By the end of the session participants should be able to:
1. Distinguish between anger and violence.
2. Identify negative and positive ways of reacting when angry.
3. Explain positive ways of expressing anger.

Age: Youth or adults; Men; **Literacy:** Any level

Time: 45 minutes

Materials: Flipchart, masking tapes, papers, pens, tape.
- Enough copies of "Handout 4.1: Reflection Sheet for all participants"

Target Audience: Boys and Men

Facilitator's Notes

It is important to note that participants may have some idea about some of the concepts which might be true or false. Men are sensitive to blame, please don't admonish anyone who has not given the correct answers as this is likely to lead to withdrawal among the participants which can affect participation

Steps

1. Explain to the group that the purpose of the activity is to discuss how individuals express anger.
2. Inform the group that many men confuse anger and violence, thinking they are the same things. Explain that anger is a natural and normal emotion that every human being feels at some point in life, while violence is a way of expressing anger**.** But there are many other better and more positive ways of expressing anger.
3. Pass out the "Handout 4,1 Reflection Sheet for all Participants". Read aloud each question and ask the participants to answer the questions individually, allowing two or three minutes for each question. For low-literacy groups, read the questions aloud and have the participants discuss in pairs.
4. After filling in the sheet, divide participants into groups of four or five participants at most. Ask them to briefly comment on the others in the group about what they wrote. Allow 10 minutes for this group work.
5. With the small groups, hand out a flipchart and ask them to make a list of:

- Negative ways of reacting when angry
- Positive ways of reacting when angry

6. Allow the small groups for 5 minutes to make their lists and then ask each group to present their answers to the whole group.
7. Some of the "Positive Ways" list might include: taking a breath of fresh air, or counting to 10 and using words to express what we feel without offending. It is important to stress that to "take a breath of fresh air" does not mean going out and jumping into the car (if that is the case) and driving around at high speed, exposing oneself to risk, or going to a bar and taking up on alcohol. If the two tactics proposed here are not on any of the lists presented, explain them to the group. To take a breath of fresh air is simply to get out of the situation of conflict and anger, to get away from the person towards whom one is feeling angry. One can count to 10, breathe deeply, walk around a bit, or do some other kind of physical activity, in an attempt to cool down and keep calm. Generally, it is important for the person who is angry to explain to the other person that he is going to take a break because he is feeling angry, something like, "I am really angry with you and I need to take a breath of fresh air. I need to do something like go for a walk, so as not to feel violent or start shouting. When I've cooled down and I'm calmer, we can talk things over." To use words without offending is to learn to express two things: (1) To say to the other person why you are so upset, and (2) to say what you want from the other person, without offending or insulting. For example: If your girlfriend arrives late for a date, you can react by shouting, "You're a bitch, it's always the same, me standing here waiting for you." Or you can look for words that do not offend, such as, "Look, I'm angry with you because you're late. I would like you to be on time; otherwise, let me know that you're going to be late."
8. Use the information in "Resource Sheet 4.5 : Anger Management Skills" to add what the groups may have left out as positive strategies to manage anger.
9. Use the following questions to summarize the session:
    - Why is it difficult at times for men to express their anger, without using violence?
    - Often, we know how to avoid conflict or a fight, without using violence, but we don't do so. Why?
    - Is it possible "to take a breath of fresh air" to reduce conflicts? Do we have experience with this activity? How did it work out?
    - What makes it possible to use words without offending?
    - How do men and women react differently and why?
10. At the end of the discussion ask participants what they have learned from this activity and how they will apply this to their lives and relationships. End the session by loudly reading to the participants the conclusion below.

Conclusion

Anger is a normal emotion that every human being feels at some point. The problem is that some people may confuse anger and violence, thinking they are the same thing, and that violence is an unacceptable way of expressing anger. However, there are many other

ways of expressing anger, better and more positive ways. Learning to express our anger when we feel it is better than bottling it up inside. When we allow our anger to build up, we tend to explode.

Resource Sheet 4.5: Anger Management Skills

Anger management skills are crucial for maintaining healthy relationships and coping with stressful situations. Here are some effective strategies to manage anger:

1. **Recognize Triggers**: Identify the situations, people, or events that commonly trigger your anger. Awareness of these triggers can help you prepare and respond more effectively.
2. **Practice Relaxation Techniques**: Engage in relaxation techniques such as deep breathing, progressive muscle relaxation, or mindfulness meditation to calm your mind and body when you feel angry.
3. **Take a Timeout**: When you feel your anger escalating, step away from the situation temporarily. Take a short walk, count to ten, or practice deep breathing before responding. This can help prevent impulsive reactions.
4. **Express Yourself**: Find healthy ways to express your anger assertively rather than aggressively. Use "I" statements to communicate your feelings and needs without blaming others.
5. **Use Humor**: Sometimes, finding humor in a situation can diffuse tension and help you see things from a different perspective. However, be mindful not to use sarcasm or humor in a way that belittles others.
6. **Exercise Regularly**: Physical activity can help reduce stress and anger. Engage in regular exercise such as walking, running, swimming, or yoga to release pent-up energy and tension.
7. **Seek Support**: Talk to a trusted friend, family member, or therapist about your feelings. Sharing your experiences and emotions with others can provide valuable support and perspective.
8. **Practice Problem-Solving**: Instead of focusing on blame or resentment, focus on finding solutions to the underlying issues that are causing your anger.
9. **Set Boundaries**: Establish clear boundaries in your relationships and communicate them assertively. Setting boundaries can help prevent situations that lead to anger and resentment.
10. **Seek Professional Help**: If anger continues to be a significant problem in your life and relationships, consider seeking help from a therapist or counselor who specializes in anger management. They can provide personalized strategies and support to help you manage your anger effectively.

Remember, managing anger is a skill that takes time and practice to develop. Be patient with yourself as you learn and implement these strategies.

Handout 4.1: Reflection Sheet

What do I do when I am angry?

1. Think of a recent situation when you were angry. What happened? Write a short description here of the incident (in one or two sentences).

_____

_____

_____

2. Think about this incident and try to remember what you were thinking and feeling. List one or two thing(s) that you felt in your body when you were angry:

_____

_____

_____

3. We often react with violence when we feel angry. This can even happen before we realize we are angry. Some men react immediately, by shouting, throwing something on the floor, or hitting something or someone. Sometimes, we can even become depressed, silent and introspective. How did you demonstrate your anger during this incident? How did you behave? (Write a sentence or a few words about how you reacted and what you did when you were angry).

_____

_____

Module 5: Men HIV, TB and Malaria
Session 5.1: Basic facts About HIV or AIDS

Goal
To raise awareness on HIV or AIDS

Objectives
By the end of the session participants will be able to:

1. Understand basic information about transmission, risks and vulnerabilities to HIV and ways to protect themselves from acquiring HIV
2. Deconstruct the myths and misconception surrounding HIV
3. Gain knowledge on HIV prevention strategies

Time: 60 Minutes

Materials

- Flipchart, Small Pieces of Paper, Tape, Markers, 26 HIV-related Behavior Statements

Target Audience: Boys and Men

Advance Preparation

- Print out/write out the 26 statements to ensure that each participant receives a statement.
- If the group size is more than 26, allow 2-3 people to discuss one or more statements.
- The facilitator should read Resource Sheet 5.1: HIV and AIDS: Some Basic Facts and the key message to familiarize him/herself with possible responses to HIV prevention statements**.**

Steps

1. Begin the session by asking the participants questions on Resource Sheet 5.1:" HIV and AIDS: Some Basic Facts".
2. After the participants provide their answers, make sure to clarify any misconceptions that they have using Resource Sheet 5.1.
3. Assign each participant one of the **HIV-related behaviour statements below** and ask them to read loudly and expound on whether it is a form of HIV prevention and why, or why not.
4. Allow for some discussion/clarification on each of the statements and use Resource Sheet 5.1 to correct any misinformation.
5. End the session by highlighting the points at the conclusion.

HIV-related Behaviour Statements
1. *Having gender equality between sexual partners*
2. *Education*
3. *Valuing one's own health*
4. *Accessing health information, services, and commodities*
5. *Testing for HIV*
6. *Testing for and treating other sexually transmitted infections (STIs)*
7. *Getting injections*
8. *Getting a blood transfusion*
9. *Donating blood*
10. *Preventing mother-to-child transmission before conception*
11. *Preventing mother-to-child transmission during pregnancy*
12. *Preventing mother-to-child transmission after giving birth*
13. *Pre-Exposure Prophylaxis (PrEP)*
14. *Post-Exposure Prophylaxis (PEP) after rape*
15. *Anti-Retroviral Therapy (ART)*
16. *Choosing not to have sex (abstinence)*
17. *Resisting peer pressure to have sex*
18. *Consistent and correct use of the male condom*
19. *Using the female condom*
20. *Voluntary Medical Male Circumcision (VMMC)*
21. *Having only one sexual partner*
22. *Having concurrent multiple sexual partners*
23. *Cross-generational sex*
24. *Transactional sex*
25. *Alcohol and substance abuse*
26. *Poor health-seeking behaviour*

HIV-related Behaviour Statements
27. Undetectable Viral Load=Untransmittable (U=U).

Resource Sheet 5.1: HIV and AIDS: Some Basic Facts

What is HIV?

HIV stands for **H**uman **I**mmunodeficiency **V**irus. This virus attacks the body's immune system, which protects the body against illness. HIV infects only humans.

What is AIDS?

AIDS stands for **A**cquired **I**mmune **D**eficiency **S**yndrome. It is a medical condition that can occur when HIV is not treated over time. HIV affects the immune system. Without treatment, the immune system can become weakened, making it harder for the body to fight certain infections and illnesses. These illnesses are known as opportunistic infections. With early testing and consistent HIV treatment, most people living with HIV do not develop AIDS, can stay healthy, and live long, full lives.

What is the difference between HIV and AIDS?

A person infected with HIV may remain healthy for several years with no physical signs or symptoms of infection. A person with the virus but no symptoms is "HIV-positive."

Without treatment over a long period of time, HIV can weaken the immune system. When this happens, the body may find it harder to fight certain infections and illnesses, known as *opportunistic infections*. These infections occur because the immune system is compromised, not because of the person. AIDS is a clinical definition used to describe this advanced stage of HIV, when the immune system is significantly weakened and specific illnesses such as tuberculosis, certain cancers, or conditions affecting the skin, eyes, or nervous system may occur. With early testing and consistent HIV treatment, the immune system remains strong, opportunistic infections are prevented, and most people living with HIV never develop AIDS.

How can someone become infected with HIV?

HIV is found in an infected person's blood (including menstrual blood), breast milk, semen, and vaginal fluids. HIV can pass from one person to another in the following ways:

- **Unprotected sex** - During unprotected vaginal, oral, or anal sex, HIV can pass from an infected person's blood, semen, or vaginal fluids directly into another person's bloodstream, through the lining of the vagina, through the mucous membranes of the rectum or broken skin in the mouth. The virus transmits much more easily if the skin is broken, such as from a sore or a cut.
- **Transfusion of blood and Blood products** - HIV can be transmitted by HIV-infected blood transfusions or contaminated injecting equipment or cutting instruments. e.g injectable drug users
- **Mother-to-child HIV transmission** - HIV can pass from the mother to a baby during pregnancy, delivery, and breastfeeding.

However, the chances of infecting the baby with HIV can be reduced completely by ensuring that:

- The mother attends all the antenatal visits scheduled and adheres well to ARVs and any other medication prescribed.
- Routinely attends antenatal clinics where any opportunistic infections, condition, or diseases such as malaria, or anaemia are diagnosed and treated. Such conditions compromise the placenta barrier hence easy entry of the virus into the baby's bloodstream.

- Delivery is conducted by a skilled birth attendant at a health facility.
- The baby is put on ARV prophylaxis from birth to 6 weeks after cessation of breastfeeding to prevent entry of the virus into the bloodstream.
- The mother exclusively breastfeeds the baby for the first 6 months of its life or practices replacement feeding after discussing what is feasible with a healthcare provider.
- Practices safer sex (abstinence or use of condoms) to prevent reinfection during and post-delivery.

HIV-related Behaviour Statements

Below are explanations to draw on during the participant feedback.

1. **Having gender equality between sexual partners**
   - Equality between partners builds better communication, decision making and control. Powerlessness increases one's risk of HIV infection e.g. violence against both male and women increases women's risk of HIV because of non-consensual and unprotected sex among others.
2. **Education**
   - Access to education and information increases one's knowledge and improves a person's ability to make informed decisions including sexual and reproduction decisions. Education also promotes independence and power to protect oneself and others from infections and ability to negotiate for safer sex
3. **Valuing one's own health**
   - Someone's health is important and should be valued. It is worthwhile investing time and money in staying healthy and well. It is important to protect ourselves from illness, to seek treatment and to recover well when we are ill.
4. **Access to health information, services and commodities**
   - It's your Constitutional Right to access the highest attainable standards of health services and care
   - We are more likely to have good health if we seek it.
5. **Testing for HIV**
   - If one does not know their HIV status, they should take the important step of getting tested and counselled. This enables them to take preventive measures if they are negative and start treatment early and protect their partners as well.
   - There are two ways or approaches to HIV testing; virologic test and antibody test
     - HIV antibody tests -Detect HIV antibodies e.g. Trinscreen or standard Q (Pregnant women), One-step, and First Response test kits (Provided by the Health care provider) and HIV Self-test kits such as Oraquick.
     - Virological tests -Detect actual HIV virus e.g. HIV DNA Polymerase Chain Reaction (PCR)- mostly conducted for infants.
   - HIV Testing services are voluntary and everyone should receive adequate pre and post Test counseling

HIV self-testing (HIVST)- is a process whereby an individual conducts his or her own HIV test using a simple oral or blood-based test. It is an emerging approach that provides an opportunity for people to test themselves discreetly and conveniently, thereby empowering those who may not otherwise test, particularly among high-risk and hard-to- reach populations to know their HIV status.
Example:
a) People living in remote or rural areas
b) Mobile or nomadic communities
c) Adolescents and young people (especially out-of-school youth)
c) Men with poor health-seeking behavior

d) Key populations (e.g., sex workers, people who inject drugs, men who have sex with men).
e) Vulnerable populations (e.g., people in enclosed settings-prisons, Fisher folks, Long-distance truckers, People in discordant relationships).
f.) Partners of Women attending Antenatal Care clinic

6. **Testing for and treating other sexually transmitted infections**
   - Having an STI makes it easier for HIV to be transmitted. Symptoms of STIs are not always apparent so getting screened and treated for STIs is a positive step one can take to reduce the risk of HIV transmission.
   - Contact screening, testing and treatment for partners of clients diagnosed with STI
7. **Having injections**
   - HIV rates tend to be high amongst people who inject drugs due to needle sharing. Having injections using sterilized needles without sharing them is safe. However, sharing needles (for drug use, and body piercing) increases your risk of contracting HIV. Although HIV deteriorates when exposed to air, it can survive for more than a month in a syringe.
8. **Getting a blood transfusion**
   - The Division of Blood Transfusion is obligated to ensure all Blood Products for transfusion are adequately screened for all infectious diseases before a client receives them
   - Although the chances of being infected through blood transfusion have decreased due to improvements in screening donated blood for HIV, it's important to reduce the need for transfusion by protecting yourself or refusing transfusion when it is not essential.
9. **Donating blood**
   - Blood donation saves lives. One cannot get infected with HIV by donating blood under hygienic conditions. If you are HIV-negative and want to donate blood, insist on the use of new, disposable needles, tubes and collection bags when donating blood. Don't donate blood if you have hygiene concerns.
10. **Preventing mother-to-child transmission (PMTCT) before conception**
    - The couple are obligated to ensure the unborn or breastfeeding baby is protected from HIV infection by adhering to health practices which include; Couple HIV Testing, VMMC efficacy ART to positive partner or PrEP to negative partner, adherence to achieve viral suppression
    - If a couple is planning to get pregnant, they should have an HIV test and if both are negative, they should do what is necessary to stay negative. If one partner is HIV positive, they should prevent the other partner(s) from becoming infected.
11. **Preventing mother-to-child transmission during pregnancy**
    - If one is HIV positive and pregnant, they should get treatment (ARVs) to reduce the risk of the unborn baby becoming HIV positive and should include infant ARV prophylaxis
12. **Preventing mother-to-child transmission after giving birth**
    - The mother is counselled at ANC to ensure safe Pregnancy practices and receives delivery in a health facility of their choice.
    - HIV-positive mothers should receive comprehensive care during both the antenatal (prenatal) and postnatal periods to protect their health and prevent transmission to the infant.
    - If a mother is HIV positive and is breastfeeding, she should continue taking ART to reduce the chances of Mother to child transmission while giving the infant ARV prophylaxis and stay healthy.
    - Ensure the baby is reviewed in hospital immediately after birth within 2 months to receive early infant diagnosis
13. **Pre-Exposure Prophylaxis (PrEP)**

- It is medication taken by HIV-negative people who are at an ongoing substantial risk of being exposed to HIV through sex or injection drug use. These include;
  - Discordant Couples
  - people who have sex for financial gain eg gifts, money or favours
  - Recurrent PEP users
  - History of sex under influence of alcohol
  - Those who engage in sex and unable to negotiate for condom use
  - Clients requesting for PrEP
- PrEP can stop HIV from taking hold and spreading throughout one's body. It reduces the risk of getting HIV from sex by about 99% and from injection drug use by at least 74% but is less effective when not taken as prescribed.
- Since PrEP only protects against HIV, condom use is still important for the protection against STIs.
- Can be taken as Oral Daily PrEP, or Event Driven PrEP and injectable PrEP
- Oral daily PrEP must be taken for at least 7 days before exposure and at least 28 days after to reach optimal levels of protection. PrEP is taken as long as someone is at risk of HIV infection.
- Event -Driven PrEP (For Males) **-**(Also known as **on-demand PrEP**) is an alternative dosing strategy for pre-exposure prophylaxis (PrEP) that allows individuals to take HIV prevention medication only around the time of potential HIV exposure, rather than daily.
- Long acting PrEP which include implants and Injectables - Injectables and Implants such as LEN - Lenecapavir (LEEN), Cabotegravir Long acting- (CAB-LA) and Dapivirine vaginal ring (DVR)

How Oral PrEP Works – The 2-1-1 Dosing Regimen:

1. Take 2 pills of TDF/FTC (Truvada or generic equivalent) 2 to 24 hours before sex.
2. Take 1 pill 24 hours after the first dose.
3. Take another 1 pill 24 hours later (48 hours after the first dose).
4. If sex continues, take 1 pill daily until 48 hours after the last sexual encounter.

Advantages:

- Ideal for people who have sex less frequently.
- Reduces pill burden.
- May be more cost-effective.
- Supports greater autonomy and control.

Key Considerations:

- Requires planning before sex.
- Must adhere strictly to the timing for effectiveness.
- Not effective for unplanned sex if the pre-dosing window is missed.

Contraindications of PrEP

- Clients who are HIV Positive
- Clients with signs of an acute HIV disease
- Clients with known or identified allergies to any PrEP product
- Use of some medications that may interact with PrEP

14. Post-Exposure Prophylaxis (PEP) after rape

- If one is HIV negative and has been exposed to HIV through rape, they need to get a post-exposure prophylaxis (PEP) to try to stop HIV from getting into the body cells. For this to be effective PEP must be taken within 72 hours of possible exposure and to be taken as instructed, for a full month.

15. **Anti-Retroviral Therapy (ART)**
    - ART allows the body's immune system to recover and to keep working to keep one healthy. One is also less infectious when using ART as it lowers the viral load in the blood, breast milk, semen and vaginal secretions.
    - Adherence to ARVs refers to taking your drugs in the right amounts and at the right times.
    - Non-adherence to treatment reduces the benefits of ARVs which predisposes clients to opportunistic infections and increases both the risk of drug resistance and HIV transmission.
16. **Choosing not to have sex (abstinence)**
    - Abstinence from sex protects one from HIV because unprotected sexual intercourse is the main method of transmission from an infected person. It is the surest way of not getting pregnant. A man's sexual ability and health is not damaged if he does not ejaculate regularly, nor are a woman's sexual organs and ability to have children affected if she does not have sexual intercourse regularly.
17. **Resisting peer pressure to have sex**
    - Many young people engage in sex due to peer pressure. If one decides not to have sex, they need determination to stick to the decision, may need to change long-standing habits and to withstand peer pressure. One should be clear in their mind about the decision they have made and how to maintain it.
18. **Consistent and correct use of the male condom**
    - Consistent and correct use of condoms offers dual protection against HIV and pregnancy. One should consider whether their dislike for condoms is more important than their dislike for HIV infection or unplanned pregnancy. Some instructions come with the condom on how to use it and one should follow them or seek information from reproductive health service provider.
19. **Using the female condom**
    - The advantage is that the female condom can be inserted before sex, which suites couples who don't want to interrupt sex at the right time. It also places women in more control, knowing the condom is in place at the onset. A female condom offers more protection than a male condom. Some users report that the outer frame enhances clitoral stimulation, and some men prefer the more natural sensation of a female condom.
20. **Voluntary Medical Male Circumcision (VMMC)**
    - Medical male circumcision reduces the risk of HIV acquisition in HIV-negative men by approximately 60% during vaginal heterosexual intercourse, but it does not provide full protection. Therefore, a circumcised man who has unprotected sex with an HIV-positive partner can still acquire HIV, and the risk is higher than when condoms are consistently and correctly used. Importantly, voluntary medical male circumcision (VMMC) does not reduce the risk of HIV transmission from an HIV-positive man to his sexual partner. For this reason, consistent and correct condom use remains essential regardless of circumcision status, as circumcision is only a partial HIV prevention method and not a substitute for safer sex practices
21. **Having only one sexual partner with known HIV status**
    - The safest number of sexual partners is zero. But as it may not be acceptable to many, having only one sexual partner is the next best thing. If one has only one sexual partner, they should test for HIV and stay negative by remaining mutually faithful to each other or consistently and correctly using condoms.
22. **Having concurrent multiple sexual partners**
    - A person is much more likely to pass on HIV if he or she has more than one sexual partner at the same time. It is easiest to transmit HIV soon after the infection. Sex without using a

condom exposes one to HIV and this increases as the number of sexual partners' increases, along with the number of times one has sex. One increases their risk and that of their partner by having two or more sexual relationships at the same time.

23. Cross-generational sex

- When someone has sex with a partner who is at least 10 years younger than him/her, there is a major imbalance in power. As a result, the younger person may find it difficult to say no to sexual activity and may be unable to negotiate safer sex.

24. **Transactional sex**

- A person who is receiving money, gifts, or services may find it difficult to say no to sexual activity and may be unable to negotiate safer sex.

25. Alcohol and substance abuse

- One may make excellent decisions to prevent HIV transmission when sober but forget them when they are drunk or under the influence of other drugs of abuse. One may also be less able to persuade one's partner to use a condom. Alcohol and other illegal drugs affect a person's self-control.

26. Poor health seeking behavior

- Reluctance to seek medical care, low rates of health screenings including HIV testing and check-ups lead to delayed diagnosis and treatment of health conditions leading to poor treatment outcomes such as death. Men, unlike women, are losing their lives due to poor health-seeking behaviors and difficulties in adhering to treatment.
- Statistics show that despite Kenya having fewer men living with HIV than women, more AIDS-related deaths are recorded among men. This is attributed to poor health-seeking behavior and low uptake of ART among men.

27. Undetectable Viral Load=Untransmittable (U=U).

- **U=U** stands for **"Undetectable = Untransmittable."** It means that people living with HIV who consistently take their antiretroviral therapy (ART), and achieve and maintain an undetectable viral load cannot sexually transmit the virus to others. This concept is a powerful public health message that reduces stigma and encourages adherence to treatment by emphasizing that:
  - Undetectable viral load **=** No risk of sexual transmission.
  - Effective HIV treatment benefits both the individual's health and the health of their partners.
  - U=U is backed by strong scientific evidence from major studies (like PARTNER, HPTN 052, and Opposites Attract).
  - Correct and consistent condom use is recommended for prevention of unintended pregnancy and sexually transmitted diseases.
  - U=U is applicable for sexual mode of transmission. U=U has not been demonstrated in PMTCT and PWID.

28. **Screening, prevention and treatment of opportunistic infections (OIs)**

HIV virus attacks the CD4 cells that provide immunity to the body exposing the client to OIs which must be screened, prevented and treated. As the client starts ARVs the immunity builds up resulting in a rise in immunity.

All clients at enrolment to care have their CD4s tested for major OIs; and on every clinic visit screened and staged using WHO staging (I-IV) to identify and rule of various opportunistic infections which include;

- Herpes Simplex and Herpes Zooster
- Tuberculosis, (Discussed here below)

- Cryptococcal meningitis
- Karposi Sarcoma

Engaging Men and Boys in HIV Prevention, Care, and Support

Men and boys play a critical role in ending the HIV epidemic within their families and communities. As decision-makers in households, community leaders, economic providers, and health service users, men significantly influence health outcomes for themselves, their partners, families, and communities. Regular testing is an essential first step for every man. Men make informed decisions about their health and support their partners to do the same when they know their status. Early diagnosis serves as the gateway to a long, healthy life and acts as a powerful sign of responsibility toward loved ones.

Men lead the way in HIV prevention when they adopt and promote protective behaviors, including the use of condoms, PrEP (Pre-Exposure Prophylaxis), and Voluntary Medical Male Circumcision (VMMC). Seeking immediate medical advice is vital if symptoms of opportunistic infections arise or if a potential exposure occurs. Timely intervention prevents complications and ensures that life-saving treatment begins as soon as possible.

Adhering strictly to Antiretroviral Therapy (ART) is the key to achieving viral suppression for those living with HIV. Taking medication daily as prescribed ensures personal well-being and prevents the transmission of the virus to others (U=U). Men and boys provide vital support to their families and peers in several ways:

They encourage partners and friends to test regularly.
They remain faithful to their partners and regularly use prevention products
They support treatment adherence for family members without judgment.
They challenge HIV-related stigma and harmful gender norms in their social circles.

Conclusion

- Sex is the main way in which HIV is transmitted, though HIV is not transmitted in every sexual act involving someone who is HIV positive.
- The risk for HIV for any one sexual act may be low but that depends on the type of sex and the viral load of the infected partner, but the probability increases with the number of times one has sex.
- Window Period- When a person gets infected it may take 6 weeks or up to 3 months before antibodies to HIV are detected in the blood. The HIV test looks for antibodies. When these antibodies are detected, the person is diagnosed with HIV. A person can be HIV positive, and the test shows negative because the test was done during the window period. HIV infection can be transmitted during the Window during Window period.
- Correct and consistent condom use is one of the best ways to prevent HIV transmission.

Session 5.2: Correct and Consistent Condom use

Goal: To understand the steps of using condoms

Objectives:

By the end of the session participants will be able to:

1. Discuss myths and truths about condoms
2. Provide basic information about correct condom use and disposal

Time: 60 Minutes

Materials Required:

- Small pieces of paper, Pens/pencils, Box or Basket, Male and Female Condoms, Penis Model (if available)

Target Audience: Men

Advance preparation

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

The following statements are written on a separate piece of paper (one paper per statement):

1. *Talk about condom use*
2. *Buy or get condoms*
3. *Store the condoms in a cool, dry place*
4. *Check the expiration date*
5. *The man has an erection*
6. *Establish consent and readiness for sex*
7. *Open the condom package*
8. *Unroll the condom slightly to make sure it faces the correct direction over the penis*
9. *Place the condom on the tip of the penis. Hint: If the condom is initially placed on the penis backwards, do not turn the condom around; throw it away and start with a new one*
10. *Squeeze the air out of the tip of the condom but still leave a bit of room*
11. *Roll the condom onto the base of the penis as you hold the tip of the condom*
12. *The man inserts his penis for intercourse*
13. *The man ejaculates*
14. *After ejaculation, hold the condom at the base of the penis while still erect. The man removes his penis from his partner carefully*
15. *Take the condom off and tie it to prevent spills*
16. *Properly dispose of the condom e.g. throwing it into a pit latrine or burning it*

Steps

Start the session by finding out from participants what they know about condoms, their effectiveness, challenges they face in their use.

Part 1 – Myths and Truths about Condoms (30 Minutes)

1. Give the participants several pieces of paper and ask them to write one statement (or phrase or idea) that comes to mind about condoms on each card. Encourage the participants to think of both positive and negative phrases.
2. Ask each participant to put his paper(s) in the box or basket, which should be placed in front of the group. Then, ask each participant to come forward, take a piece of paper from the box, read its statement out loud, and say if the statement is a myth or a truth.
3. As the statements are being read, use "Resource Sheets 5.2: Myths and Truths about Condoms" and "5.3: Male and Female Condoms" to complement or correct the information given by each participant. Be sure to talk about the female condom as an alternative to pregnancy and as STI/HIV prevention.

4. Give the participants an opportunity to touch the male and female condoms, if available. Reinforce the importance of correct and consistent condom use during sexual intercourse.
5. Give one condom in its packet to each participant. Ask the participants to check that the condom is not past its expiration date. Then ask them to open the packet and take out the condom. Encourage them to stretch and play with the condom.
6. Divide participants into pairs. Ask one member of each pair to place a condom over their hand. (Tell them to beware of sharp fingernails!) Next, tell them to close their eyes and to ask their partner to touch their first with a finger. Ask the participants wearing the condoms:
    a. Can you feel the other person's finger touching you?
    b. How much can you feel through the condom?
    c. How thick do you think the condom is now?

7. Have the participants stretch the condom as much as they can without breaking it. Ask if they can pull it over their arms or feet or blow it up. Ask the participants:
    • How long did the condom stretch?
    • How wide did it get?
    • What happened to the condom when it was stretched? Did it break?

8. Ask participants to sum up what they learned from playing with the condoms.

Emphasize these two key points: The condom is extremely strong and yet sensitive to touch. This makes it a good form of protection from STIs (including HIV) without taking away the pleasure of sex.

Part 2 – Correct Condom Use (30 Minutes)

1. Explain that you now want to talk about the correct steps in using a condom. Randomly distribute the "Condom Use Steps" cards. Then ask the participants to stand up and arrange themselves in the correct order of steps. Discuss these questions:
    - What was challenging about this activity?
    - Were you unsure of the order of any steps? Why? Could some of the steps have gone in more than one place? Could some of the steps have been switched?
    - Do you think most people who use condoms follow these steps? Why or why not?
2. Inform participants that condoms should always be stored in a cool, dry place. Male condoms are made from latex material and using a water-based lubricant like K-Y jelly will decrease the chance of the male condom breaking and may make intercourse more pleasurable. Oil-based lubricants like vaseline, creams, or oils will cause the Male condom to break and should never be used (See Resource Sheet 5.3: Male and Female Condoms)
3. Inform Participants that the Female Condom is made from Polyurethane Material and either water-based or oil-based lubricant may be used (See Resource Sheet 5.3)

4. Ask participants if they learned anything that could be applied to their own lives and relationships.

Resource Sheet 5.2: Myths and Truths about Condoms

MYTH: Condoms have tiny invisible holes through which both sperm and HIV can pass through.

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

MYTH: If a condom slips off during sexual intercourse, it might get lost inside the woman's body (womb).

TRUTH: Because of its size, a condom is too big to get through the cervix (the opening to the womb from the vagina).

MYTH: Condoms take away the pleasure of sex.

TRUTH: Using condoms does not reduce enjoyment or a man's or woman's ability to have an orgasm.

MYTH: Using two condoms at the same time means you are better protected.

TRUTH: Using two condoms can create a lot of friction, which can make the condoms break more easily. People should use only one lubricated latex condom for sexual intercourse.

MYTH: A woman who carries a condom in her purse is "easy" or promiscuous.

TRUTH: A woman who carries a condom with her is acting responsibly and protecting herself against unintended pregnancy, STIs, and HIV/AIDS.

Resource Sheet 5.3: Male and Female Condoms

Condom information: Condoms should always be stored in a cool, dry place. Using a water-based lubricant like K-Y jelly will decrease the chance of the condom breaking and may make intercourse more pleasurable. Oil-based lubricants like Vaseline, creams, or oils will cause the condom to break and should never be used. Female condoms are more expensive than male condoms. It is unlikely that you will be able to obtain enough female condoms for the whole group.

Differences between the female and male condoms: The female condom is a new method of contraception. It is not yet readily available in many countries. But you can buy it from some chemists. It is hoped that female condoms will be available at clinics worldwide shortly. Female condoms are made from a special plastic called polyurethane. But male condoms are made from latex. Since the female condom is made of polyurethane and not latex (like the male condom), a water-based or oil-based lubricant can be used with it.

The female condom comes lubricated on the inside. The female condom can be inserted before sex. The male condom can only be used when the man's penis is erect.

Advantages of the female condom: In many places, women have no say in sexual matters and find it difficult to insist that their male partners use male condoms. The female condom is a method that gives women some control over their bodies. It uses a barrier method that can protect her from STIs, including HIV, and can prevent her from becoming pregnant. The female condom is inserted into the vagina before vaginal sex. So you do not have to stop during foreplay to use it. It is not dependent on the male erection and does not require immediate withdrawal after ejaculation.

Using the female condom: The inner ring of the female condom is used to insert the condom and helps to keep it in place. The inner ring slides into place behind the pubic bone. The outer ring is soft and remains on the outside of the vagina during vaginal sex. This ring covers the area around the opening of the vagina.

When using condoms do not.

- Store them in your wallet as heat and friction can damage them.
- Use nonoxynol-9 (a spermicide), as this can irritate.
- Use oil-based products like baby oil, lotion, petroleum jelly, or cooking oil when using male condoms because they will cause the condom to break.
- Use more than one at a time.
- Re-use it as it will reduce its efficacy rate.

Session 5.3: Access to HIV Treatment and Care

Goal: To explore ways of supporting people to have access to HIV treatment and care

Objectives:
By the end of the session participants will be able to:
1. Understand the importance of starting treatment early when one is diagnosed with HIV
2. Recognize the significance of adherence and disclosure and how to support PLHIV through it

Time: 60 minutes

Materials Required:
- Flip chart, Markers, Masking Tape

Target Audience: Men

Steps
1. Brainstorm with the participants what they have learnt about ARVs in the session on the Basics of HIV and AIDS.
2. Divide the participants into **two** groups.
   - **Group 1:** Adherence- The first group should develop a role play in which a man does not adhere to treatment and how it affects their health
   - **Group 2:** Disclosure- The second group should develop a role play in which a man discloses his HIV status to his partner

   Allow the groups 10 minutes to develop the role-plays. *(Sometimes it is not easy to role play for such situations and the alternative can be a group discussion)* what makes men not adhere to treatment, and ways of promoting treatment adherence.
3. Invite the groups to present the role-plays starting with Group 1
4. Lead a discussion using the questions below:
   - Were the role-plays realistic?
   - In your communities, is it more common for men or women to disclose their HIV-positive status to their partners? Why do you think this is?
   - In your communities, who between men and women is more likely to adhere to ART when they have tested HIV-positive? Why do you think this is?
   - How does disclosure affect adherence to ARTVs?
5. Conclude the session by emphasizing key points in

Resource Sheet 5.4: ARVs, Adherence and Disclosure below:

ARVs -Anti Retro Viral Therapy

- HIV cannot be cured, but there is a very effective treatment (ART) that can make HIV manageable
- It is strongly recommended that ART be started promptly for all people living with HIV, i.e. within seven days of a positive diagnosis, if there are no contraindications. ART will start on the same day that patients are ready to start it.
- ARVs are taken daily and for life as prescribed by a doctor

How do they work?

- Decreases viral load (the amount of virus HIV in the blood)
- Increases CD4 count (cells that protect our bodies from infection)
- Improves overall health
- Reduces chances of transmitting HIV sexually.
- Reduces a person's chances of getting opportunistic infections
- Reduces the risk of HIV transmission from mother to child
- Delays disease progression and prolongs life
- Like any other medication, ARVs have side effects too. These include nausea, dizziness, fatigue, headache and rashes, abdominal discomfort etc. Some side effects can be more severe e.g. anaemia, liver problems etc
- However, it is important to note that the benefits of ARVs outweigh the side effects and adherence to treatment is important as it helps prevent drug resistance

Adherence

Adherence refers to the act of sticking to or following something closely, such as rules, guidelines, plans, or commitments. It often implies a consistent and dedicated effort to comply with or uphold a particular standard, schedule, or course of action.

Drug adherence refers to the extent to which a patient follows a prescribed medication regimen, including taking the correct dose, at the right time, and in the manner specified by a healthcare provider.

Adherence is most difficult during the first few months of treatment: the patient is not yet in the habit of taking their medications every day, they are not familiar with common side effects, and they have more challenges with disclosure and stigma, all of which can interfere with adherence. Poor adherence within the first few months of therapy is also the riskiest period for development of resistance mutations, when the viral load is still high.

Barriers To Adherence

Patient factors	Provider/System Factors
Stigma and non-disclosure (having to hide their ARV pill-taking) · Lack of support systems · Alcohol or drug use · Depression or other psychiatric illness · Loss or grief · Cognitive disorders · Change in daily routine · Chaotic lifestyle; no consistent daily routine	· Side effects (many patients have side effects when they first start their ART, including nausea, headaches, and difficulty sleeping. These side effects almost always resolve with continued use) · Pill burden · Poor patient-provider relationship · Inadequate HIV education · Cost of care (direct and indirect)

· Forgetting to take pills . Feeling better so I do not think the ART is needed any more. · Feeling too sick to take ART · Age (adolescents - impulsive, more susceptible to social pressure; children –caregiver dependent)	· ARV supply-chain limitations (stock-outs, or low stock levels resulting in small refill quantities)

Adherence support interventions

• Participate in adherence counselling and be prepared to adhere fully to ART

• Identify a treatment supporter—disclose HIV status to a family member or a friend willing to provide support.

• Link to psychosocial support groups and other community-based support mechanisms (preferably through direct introduction)

• Enroll to SMS reminder system with their consent or other reminder strategies set a specific time of day to take ART, and to associate ART time with a specific event(s) in their daily schedule, also encourage patient/caregiver to set an alarm on their phone

Importance of adherence

- Treatment Effectiveness: High adherence to ART (typically ≥95%) suppresses HIV viral load, preventing disease progression, maintaining immune function to protect against Opportunistic Infections (OIs)
- Poor adherence can lead to treatment failure and drug resistance, reducing future treatment options Prevention of Resistance: Consistent ART adherence prevents the virus from mutating and developing resistance to medications, which is critical as resistant strains can be transmitted to others.
- Improved Quality of Life: Adherence to ART enables people living with HIV to lead healthier, longer lives by reducing opportunistic infections and HIV-related complications.
- Public Health Impact: Adherent patients with undetectable viral loads are less likely to transmit HIV (Undetectable = Untransmittable, or U=U), contributing to HIV prevention efforts.

Disclosure

This is a voluntary process of revealing a person's HIV status whether positive or negative**.**

Forms of Disclosure

- Non-disclosure: a person does not reveal his or her HIV status to anyone.
- Partial disclosure: a person only tells certain people about his or her HIV status.
- Full disclosure: a person talks openly in public about his or her HIV status

Support for people living with HIV

People living positively with HIV and AIDS face a range of challenges. They can range from the practical (such as losing a job) to the deeply emotional (mental health). We can support people living with HIV by:

- Encouraging them to adhere to their treatment and keep doctors' appointments
- Knowing the facts about HIV and AIDS and avoiding stigma and discrimination
- Helping to reduce stress and stressful situations

There are many possible resources people can use to help them live positively with HIV. They include psychosocial support groups, male-friendly health services, and role models for those who are living positively and openly with HIV.

Session 5.4. HIV, TB and Malaria -related Stigma and Discrimination

Goal: To analyze the causes and effects of HIV stigma and discrimination on people living with HIV

Objectives:

By the end of the session participants will be able to:

1. Describe the different forms of stigma and how it affects people
2. Identify some of the root causes and contributing factors of stigma
3. Identify ways of preventing HIV, TB and Malaria related stigma and discrimination in the community

Time: 30 Minutes

Materials Required:

- Flip chart, Markers, Masking Tape

Target Audience: Men and Boys

Note to the Facilitator

This activity can be very personal and emotional. If the participants do not feel comfortable sharing sensitive information, individuals can do this activity on their own. If the participants do the activity in pairs, stress that the participants can pass on a question and withhold information if they wish.

Advance Preparation

Draw a sample Problem Tree on a flipchart showing the roots, trunk, and leaves/branches to provide an example of how the problem tree is to be populated. Label the Trunk HIV, TB or Malaria Stigma and Discrimination, Write "Causes" next to the roots, "HIV, TB or Malaria Stigma and Discrimination" and "Effects" next to the leaves/ branches

Steps

1. Begin the session by asking participants to define what stigma is. After a few responses, provide the correct definition of "a disgrace or reproach attached to someone." Explain that people who are stigmatized for being HIV-positive are marked out by the rest of society and feared as different and dangerous. The stigma attached to HIV can lead to discrimination. This can involve governments using laws to deny freedoms to people living with HIV, or individuals treating others poorly and unfairly due to their HIV status.
2. Tell the participants that they are going to look at the causes and effects of HIV-related stigma and discrimination using a problem tree analysis method. Show the participants the sample problem tree.
3. Explain to the participants that to deal effectively with HIV-related stigma and discrimination, it is important to understand it in depth.
4. Ask the participants to state some of the causes and contributing factors of HIV-related stigma and discrimination. List their responses in the 'roots' section of the problem tree. two columns on the flip chart paper. Add on to their responses using Resource Sheet 5.5: Causes and Effects of HIV-related Stigma and Discrimination
5. Ask the participants to state some of the effects of HIV-related stigma and discrimination. List their responses in the 'leaves/branches' section of the problem

tree. Add on to their responses using Resource Sheet 8: Causes and Effects of HIV-related Stigma and Discrimination

6. Explain to the participants that to deal with the HIV-related stigma and discrimination problem(s), we must identify the root causes and uproot them otherwise the tree will keep on shooting (HIV-related stigma and discrimination will keep recurring). Ask them to identify the main root causes from the tree as you circle or underline them on the flipcharts. (Mention religious beliefs, gender, fear of infection if they are not mentioned)
7. Lead a discussion with the following questions and highlight the conclusion:
   - If you were infected with HIV, would you understand if people did not want to touch you or eat with you? Why or why not?
   - Who are some of the people/groups of people that often discriminate against PLHIV?
   - How do some health care providers reinforce stigmatization of people living with HIV?
   - How does HIV-related stigma and discrimination impact the efforts to reduce HIV infection and related deaths?
   - What can be done to deal with the root causes they have identified?

Conclusion

- HIV-related stigma is a major factor in keeping people from finding out their HIV status.
- Stigma has serious effects which can compromise an HIV-infected person's life. However, through education and disclosure, stigma can be reduced.

Resource Sheet 5.5: Causes and Effects of HIV-related Stigma and Discrimination

Below is a list of potential causes, forms, and effects to supplement what the group comes up with:

Causes and Contributing Factors

- There's a view that people living with HIV are promiscuous.
- PLWHAs are thought of as being responsible for becoming infected
- Religious beliefs
- Fear of being infected
- Fear of the unknown or death
- Ignorance causes people to fear physical contact with PLHIV.
- Gender where women are more stigmatized than men.
- Peer pressure
- Media exaggerations

Forms of Stigma

- Name-calling
- Finger pointing
- Labelling
- Blaming
- Shaming
- Judging
- Rumour-mongering and gossiping

- Neglecting
- Rejecting, isolating, separating
- Not sharing utensils.
- Hiding. Staying at a distance.
- Physical violence. Abuse.
- Self-stigma by blaming and isolating oneself
- Stigma by association. e.g the whole family or friends are also affected by stigma. Stigma because of looks/appearance.

Effects or Consequences

- Deter people from seeking health services for fear of stigma, judgmental attitudes, or breaches of confidentiality.
- Loss to follow-up and poor adherence to treatment.
- Stigma and discrimination in school settings have profound effects on school retention, self-image, and self-stigma.
- Low self-esteem.
- Deter people from seeking health services for fear of stigma, judgmental attitudes, or breaches of confidentiality.
- Loss to follow-up and poor adherence to treatment.
- Stigma and discrimination in school settings have profound effects on school retention, image self-image, and stigma.
- Low esteem self-esteem, Shame, Denial, Isolation, Loss of hope, Self-blame, Depression. Alcoholism. Anger, Suicide.
- Increases likelihood of Gender Based Violence including physical and emotional abuse

Session 5.5: Learning about Tuberculosis

Goal: To help participants understand prevention, transmission and management of tuberculosis

Objectives:
By the end of the session participants will be able to:
Gain knowledge on TB signs and symptoms, treatment and support of patients newly diagnosed.

Time: 30 Minutes

Materials Required:
Flipchart, Writing Paper/Notebooks, Pens/Pencils, Markers

Target Audience: Men and Boys

Steps

1. Introduce the session by defining Tuberculosis (TB). (Use the definition in Resource Sheet 5.6: Facts about Tuberculosis)
2. Divide the participants into four groups and assign each group one of the following tasks:
   - Group 1: To discuss and list the signs and symptoms of TB
   - Group 2: To discuss and list the groups of people at risk of contracting TB

- Group 3: To discuss and list the strategies of controlling the spread of TB
- Group 4: To discuss and identify the TB preventive therapy

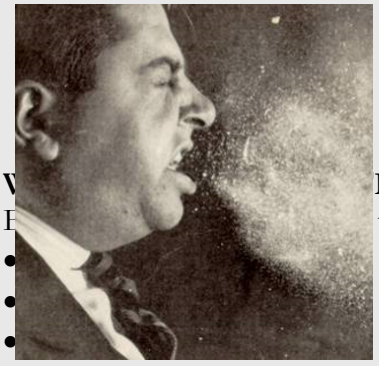
3. Ask them to list their discussion on a flipchart paper and give them 10 minutes for this
4. After the groupwork, ask each group to make their presentation in the plenary. Give each group a maximum of 5 minutes. Use the Resource Sheet 5.6: Facts about Tuberculosis to add the information they might have missed.
5. Conclude the session by asking the participants what they have learnt from the activity.

Resource Sheet 5.6: Facts about Tuberculosis

What is Tuberculosis (TB)

Tuberculosis (TB) is a disease that is caused by a bacterium that commonly affects all parts of the body except the hair, teeth, and nails.
TB bacteria can live in the body without making a person sick; this is called latent TB infection. People with latent TB infection do not have TB symptoms, cannot spread TB bacteria to others, and do not need TB treatment.
Some people with latent TB infection go on to develop TB disease and will need TB treatment. TB affects the young and the old, men and women, the rich and the poor.
In Kenya, boys and men are about twice as likely to have TB as women due to a combination of biological, social, and structural factors, including higher exposure in workplaces, congregating in public spaces, delayed health-seeking behaviour, higher rates of smoking and alcohol use, and gender norms that discourage men from seeking care early when symptoms appear.

How is TB Transmitted
The bacteria that cause TB spread from an infected person to an uninfected person through the air when the person:
Laughs
Talks
Coughs
Sneezes
Spits
Sings



V B?
F the
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•
•
- People living with HIV.

Number of organisms liberated

Talking	0-200
Coughing	0-3,500
Sneezing	4,500-1,000,000

Size of the droplet (Function of air velocity)
Sneeze-3-10ml (75% diameter-10um<25% are droplet nuclei)

- **Large droplets** fall to ground or other horizontal surface relatively fast
- A 1.0 um **droplet nucleus** will settle at a rate of 0.0035 cm/sec or 3m in 24 hours!

- People with diabetes and other chronic illnesses
- People with malnutrition
- People living and working in poorly ventilated and lit houses.
- People living and working in congregate settings

Signs and Symptoms of TB

- A cough for any period
- Fever and night sweats
- Loss of appetite
- Chest pains
- Blood-stained sputum

Weight loss (failure to gain weight in children)

Note: *While pulmonary TB often presents with the above symptoms, extrapulmonary TB (EPTB) may not show these typical signs and can present with non-specific symptoms depending on the organ affected, such as persistent swelling, pain, fatigue, pus, or unexplained illness. Any unexplained or persistent symptoms should prompt referral for further TB assessment.*

Types of TB

Tuberculosis can affect any part of the body, although it most commonly affects the lungs. The main types of TB include:

Pulmonary TB: Affects the lungs and is the most common form. It can cause a persistent cough, chest pain, fever, night sweats, and weight loss, and is spread through the air when an infected person coughs, sneezes, or talks.

Extrapulmonary TB: Affects parts of the body outside the lungs, such as the lymph nodes, bones and joints, brain and nervous system, kidneys, skin, or eyes. It is usually not spread through the air.

Latent TB Infection (LTBI): TB bacteria are present but inactive. There are no symptoms and it is not contagious, but it can become active if the immune system weakens. Preventive treatment can stop this from happening.

Active TB Disease: TB bacteria are active and causing illness. The person has symptoms and may be contagious, especially with pulmonary TB, and requires full TB treatment.

Drug-Susceptible TB (DSTB): This is a form of TB that is sensitive to standard first-line TB medicines, such as isoniazid and rifampicin. This means the disease can be treated effectively using recommended first-line treatment regimens, according to national guidelines.

Drug-Resistant TB (DRTB): Occurs when TB does not respond to standard medicines, often due to interrupted or incomplete treatment, and requires longer, specialized care.

Testing and Diagnosis: Several tests exist for diagnosing TB including new methods for faster and more accurate results. These include:

Sputum Microscopy: This is a laboratory test used to detect TB bacteria in sputum, a thick fluid produced in the lungs and airways. A sputum sample is collected when a person coughs deeply and is examined under a microscope to identify the presence of TB bacteria. This test is commonly used to diagnose pulmonary TB.

GeneXpert: GeneXpert is a rapid molecular test and the recommended initial (gold-standard molecular) test for diagnosing TB for all people. It detects TB bacteria in sputum or other appropriate samples and is more sensitive than sputum microscopy, especially among people at higher risk of TB, such as people living with HIV and those with previous TB. GeneXpert can also detect resistance to

important TB medicines, allowing health workers to identify drug-resistant TB early and guide appropriate treatment. Other rapid molecular tests, such as Truenat, are also used to diagnose TB in some settings, in line with national guidelines.

Chest x-ray: A chest X-ray is used to identify changes in the lungs that may suggest TB. While it does not confirm TB on its own, it helps support diagnosis, especially when combined with other tests. X-rays may also help detect TB affecting other parts of the body, such as the bones. In some settings, artificial intelligence (AI)–supported chest X-ray systems are used to improve detection of TB and to prioritize individuals for further testing. AI-supported chest X-ray does not replace laboratory tests but improves early screening and referral when used alongside recommended diagnostic methods.

People, especially children, who have been in contact with someone who has a persistent cough or known TB disease should get tested for TB.

Is TB Treatable?
TB is treatable, curable, and preventable through early diagnosis, completing the full course of TB medicines as prescribed, and preventing transmission through timely care. Early detection leads to better treatment results.
TB treatment is provided free of charge in all public health facilities.
TB treatment duration varies depending on the type, form, severity, and drug-resistance profile of TB. Treatment for drug-susceptible TB may range from as short as 4 months for eligible patients on shorter regimens to up to 12 months in specific severe clinical forms such as TB meningitis or bone TB. Treatment for drug-resistant TB may range from as short as 6 months for eligible patients on shorter regimens to up to 24 months for more complex cases, including some forms of extensively drug-resistant TB, in accordance with clinical assessment and national guidelines.
Every patient should ensure they complete their TB treatment to prevent development of drug resistance and other complications.
Ensure proper nutrition when taking medication

TB remains a serious and potentially fatal disease if not diagnosed early and treated correctly. Delayed care-seeking, missed doses, or failure to complete treatment increase the risk of severe illness and death, even though TB is treatable and curable.

TB Prevention
Children born in Kenya are immunized against severe forms of TB with BCG at birth
Subsequently all people at higher risk of TB infection are offered TB preventive **therapy**

What is TB Preventive Therapy (TPT)?
TB Preventive Therapy is free treatment given to:
People living with HIV, including children aged 12 months and above, adolescents, and adults
Children under five years of age who are household contacts of a bacteriologically confirmed pulmonary TB patient
All household contacts of a bacteriologically confirmed pulmonary TB patient, regardless of age
People living or working in high-risk congregate settings, including prisons and prison staff

Health care workers and other staff working in health care settings
Clinical risk groups, including:

patients receiving immunosuppressive therapy
patients receiving dialysis
patients preparing for organ or hematological transplant
patients with silicosis
The choice of TB preventive therapy regimen is guided by age, weight, drug interactions, and national guidelines, and should be determined by a qualified health worker.

How can I avoid spreading TB?
Cover your mouth with a clean handkerchief or tissue when you cough or sneeze.
Carefully dispose of used tissue in the toilet and clean your handkerchief with soap and water.
Leave windows open whenever possible to keep rooms and other closed spaces well ventilated.
Ensure that you adhere and complete the entire course of TB medication.

What is Drug Resistant TB (DR TB)?
This is a type of TB that does not respond to standard TB medication.
It is also spread from an infected person to an uninfected person through the air when the person sneezes, coughs, laughs, talks or sings.
Treatment for DR TB involves the use of alternative TB medicines for a longer period.
DRTB is preventable, treatable, and curable. Preventing DRTB begins with taking drug-susceptible TB treatment correctly, exactly as prescribed, and completing the full course. Early diagnosis, treatment adherence, and strong health systems are essential to achieving cure for DRTB**.**
Engaging Men and Boys in TB Prevention, Care, and Support
Boys and men play an important role in protecting their families and communities from tuberculosis (TB) by promoting early care-seeking, prevention, and treatment support within households and communities.
Promoting Early Screening and Diagnosis
Early screening and diagnosis are vital for anyone experiencing symptoms such as a persistent cough, night sweats, unexplained weight loss, fever, or prolonged ill health. Boys and men can support early care-seeking by encouraging themselves and other household members to seek medical attention promptly when symptoms appear. Early diagnosis helps prevent further transmission of TB to children, partners, older family members, and the wider community.
Preventing TB Transmission at Home and Work
Boys and men have a critical role to play in TB prevention and can also help reduce the risk of TB transmission by promoting simple infection-prevention practices, including:
Ensuring homes, workplaces, and shared spaces are well-ventilated by opening windows and doors where possible
Reducing overcrowding and improving airflow in living and working environments
They also play an important role in supporting contact tracing by encouraging all household members and close contacts to get tested when someone is diagnosed with TB. This collective action helps break the cycle of infection within families and communities.
Supporting Treatment Adherence and Recovery
Completing the full course of TB treatment is essential for cure and for preventing drug-resistant TB. TB medicines must be taken exactly as prescribed for the full duration of treatment.
Boys and men can provide practical and emotional support to people on TB treatment by:
Encouraging and reminding family members to take their medicines every day as prescribed
Supporting access to nutritious food to aid recovery during treatment

Offering encouragement and emotional support as treatment supporters, especially when side effects or long treatment duration become challenging

Session 5.6: Learning about Malaria

Goal

To help participants understand the prevention, transmission, diagnosis, and management of malaria**.**

Objectives

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

- Understand what malaria is and how it is transmitted
- Identify common signs and symptoms of malaria
- Describe available malaria testing and treatment options
- Recognize key malaria prevention methods, including consistent use of mosquito nets
- Understand the importance of early testing, adherence to treatment, and supporting family and community members affected by malaria

Time

30 Minutes

Materials Required

- Flipchart
- Writing paper / notebooks
- Pens or pencils
- Markers

Target Audience

Men and Boys

What is Malaria?

Malaria is a life-threatening disease caused by parasites that are transmitted to humans through the bite of an infected female *Anopheles* mosquito. It is common in many tropical and subtropical regions and affects people of all ages.

How is Malaria Transmitted?

Malaria is transmitted when an infected mosquito bites a person and injects malaria parasites into the bloodstream.

Malaria **is not transmitted** through:

- Casual contact (touching, hugging, shaking hands)
- Coughing or sneezing
- Sharing food, utensils, or clothing
- Sexual contact

Who is at Risk of Malaria?

Anyone living in or traveling to malaria-endemic areas can get malaria. Risk is higher in:

- Children under five years
- Pregnant women
- People with weakened immune systems
- People living in malaria endemic areas
- Travelers to endemic regions without immunity

Signs and Symptoms of Malaria

Symptoms usually appear 7–14 days after being bitten but may take longer.

Common symptoms include:

- Fever
- Chills and shivering
- Headache
- Muscle and joint pain
- Nausea and vomiting
- Fatigue and weakness
- Loss of appetite

Severe malaria symptoms may include:

- Severe anemia
- Difficulty breathing
- Confusion or unconsciousness
- Convulsions
- Organ failure
- Severe malaria is a medical emergency and can be fatal if not treated promptly.

Testing and Diagnosis

Early diagnosis is essential for effective treatment.

Malaria is diagnosed using:

Rapid Diagnostic Tests (RDTs): Finger-prick blood tests that give quick results

Microscopy (blood smear): Laboratory examination of blood to confirm malaria and identify the parasite type

Anyone with fever in a malaria-endemic area should seek testing as soon as possible.

Treatment of Malaria

- Malaria is **preventable and curable** when diagnosed early.
- Treatment depends on the type of malaria parasite, severity of illness, age, and pregnancy status
- Most uncomplicated malaria cases are treated with **artemisinin-based combination therapies (ACTs)**
- Severe malaria requires **urgent hospital treatment**, often with injectable medicines
- Malaria treatment is provided **free of charge in public health facilities** in many countries
- Patients must **complete the full dose of medication**, even if they feel better
- Untreated malaria can lead to severe illness or death.

Prevention of Malaria

- Malaria can be prevented by reducing mosquito bites and controlling mosquito breeding environment
- Key prevention methods include:
- Sleeping under **long-lasting insecticide-treated nets (LLINs)**
- Intermittent Preventive Therapy (IPT) for pregnant women in endemic areas
- Indoor residual spraying (IRS)
- Eliminating stagnant water where mosquitoes breed
- Wearing long-sleeved clothing in the evenings
- Using mosquito repellents
- Larval source management
- Malaria Vaccination

Malaria Vaccination

Kenya introduced the malaria vaccine in 2019, focusing on children under two years in areas with high malaria transmission, especially western Kenya and lake-endemic regions. The vaccine is given to children most at risk of severe malaria and malaria-related deaths. It is administered in four doses at 6, 7, 9, and 24 months of age. The malaria vaccine reduces severe malaria, hospital admissions, and child deaths. The vaccine does not replace other prevention methods but works alongside insecticide-treated nets, indoor residual spraying, and timely testing and treatment.

Discrimination in Malaria

Common Forms of Discrimination Related to Malaria

1. **Stigma Against People with Malaria**

· People with malaria may be blamed for being "dirty" or careless
· Individuals with repeated malaria episodes may be labelled as weak or irresponsible
· Children who frequently miss school due to malaria may be stigmatized

2. **Discrimination in Access to Services**

· Poor or remote communities may have limited access to malaria testing and treatment
· Migrant workers, mobile populations, or informal settlement residents may be overlooked during net distribution or spraying campaigns

3. **Gender-Based Discrimination**

-Women may **lack decision-making power** to buy or use insecticide-treated nets (ITNs).
- Fear of violence may prevent women from **negotiating net use** with partners.
-Household resources may be controlled by abusive partners, limiting access to prevention tools.
Impact: Increased malaria risk for women and children.

4. **Economic and Social Discrimination**

· People with malaria may lose income or employment due to illness
· Families affected by malaria may face social exclusion because of frequent sickness

5. **Discrimination in Schools and Workplaces**

· Children recovering from malaria may be treated unfairly for absenteeism
· Workers may be penalized for missing work due to malaria illness

Why Discrimination in Malaria Is Harmful

· Delays testing and treatment
· Increases severe malaria cases and deaths
· Discourages use of prevention tools such as mosquito nets
· Undermines community trust in health services

Addressing Discrimination in Malaria

· Promote accurate information about malaria causes and transmission
· Encourage respectful and non-judgmental attitudes toward people affected by malaria
· Ensure equitable access to prevention, testing, and treatment services
· Integrate human rights principles dignity, equality, and non-discrimination into malaria programs

Common Myths and Facts About Malaria

Myth	Fact
Malaria is caused by eating certain foods	Malaria is caused by parasites transmitted through mosquito bites
Malaria is spread from person to person	Malaria is not spread through contact; only mosquitoes transmit it
Only children get malaria	Malaria affects people of all ages
Malaria will go away on its own	Malaria requires proper testing and treatment
Herbal remedies can cure malaria	Malaria should be treated with approved anti-malarial medicines

Sleeping under a net is only for children	Everyone should sleep under a mosquito net

Engaging Men and Boys in Malaria Prevention, Care, and Support

Men and boys play a critical role in reducing the impact of malaria within families and communities. Early testing is essential in every household. Men can support their families to seek care as soon as symptoms such as fever, chills, or headache appear. Early care-seeking helps prevent severe illness, reduces complications, and limits the spread of malaria.

Adhering fully to prescribed malaria treatment is equally important. Completing the full dose even when symptoms improve ensures complete recovery and helps prevent drug resistance. Beyond personal health, men and boys can provide vital support to their family and community members affected by malaria by encouraging timely testing, supporting treatment adherence and helping reduce stigma. Informed action and shared responsibility can support men and boys to contribute significantly to healthier households and malaria free communities. Key Responsibilities of Men and Boys:

Ensure correct and consistent use of long**-lasting insecticide-treated nets (LLINs)**

Support indoor residual spraying (IRS)

Encourage early testing for fever

Support pregnant partners to attend ANC and receive Intermittent Preventive Therapy for prevention

Reduce mosquito breeding sites around the home

Malaria Burden Classification

Malaria burden in Kenya is classified by levels of transmission to guide targeted prevention and control efforts. No transmission is reported in Nairobi. Counties with a very low burden include Embu, Kirinyaga, Kitui, Laikipia, Lamu, Machakos, Makueni, Mandera, Murang'a, Nyandarua, Nyeri, and Wajir, while low-burden counties include Bomet, Garissa, Isiolo, Kajiado, Kiambu, Marsabit, Meru, Nakuru, Taita Taveta, and Tharaka Nithi. Moderate burden counties are Elgeyo-Marakwet, Mombasa, Narok, Nyamira, Samburu, Tana River, and Uasin Gishu. Moderate-to-high burden counties include Baringo, Kericho, Kilifi, Kisii, Nandi, and Trans Nzoia. The high-burden counties are Bungoma, Homa Bay, Kwale, Turkana, and West Pokot, while very high-burden counties mainly in western Kenya include Busia, Kakamega, Kisumu, Migori, Siaya, and Vihiga.

Trainer Tip

Use **local malaria data**, **county-specific examples**, and **participant stories** to ground discussions. Where possible, link discussions to **community health promoters (CHPs)** and existing malaria campaigns to reinforce continuity of care.

Module 6: Sexuality and Reproductive Health

Session 6.1: Introduction to Human Sexuality

Goal: To understand the broad concept of human sexuality.

Objectives:

By the end of the session participants should be able to:

1. Distinguish sexuality from sex.
2. Describe the components (circles) of sexuality
3. Examine areas of their lives that involve sexuality.

Time: 60 minutes

Materials Required:

- Flipcharts, markers and masking tape

Target Audience: Men and Boys

Advance Preparation

- Write "Sex" and "Sexuality" in separate columns on a flipchart.
- Prepare a flip chart with the circle of sexuality as illustrated in "Resource sheet 6.1 (sexuality, intimacy and relationships, sexual identity, sexual health and reproduction).

Steps

1. Ask the participants what the term sex means to them. Allow them to share their thoughts and record their responses in the "Sex" column on the flipchart.
2. Next, read aloud the following definitions of sex and ask the participants for any comments on the definitions.
   Sex: Sex refers to one's biological characteristics—anatomical (breasts, vagina; penis, testes), physiological (menstrual cycle; spermatogenesis) and genetic (XX; XY)—as male or female. Sex is also a synonym for sexual intercourse, which includes penile-vaginal sex, oral sex and anal sex.
3. Ask the participants what the term sexuality means to them. Allow them to share their thoughts and record their responses in the "Sexuality" column on the flipchart.
4. Next, read aloud the following definition of sexuality and ask the participants for any comments on the definition.

Sexuality: Sexuality is an expression of who we are as human beings—a total sensory experience involving the mind and body. Sexuality includes all of the feelings, thoughts and behaviours of being male or female, being attractive and being in love, as well as being in relationships that include intimacy and physical sexual activity.

Sexual Orientation: Refers to one's sexual attraction. Heterosexual is an erotic or romantic attraction for people of the opposite sex. Homosexuality is an erotic or romantic attraction for people of the same sex. Bisexuality is an erotic or romantic attraction for people of both sexes.

Sexual Rights: The rights of all people to decide freely and responsibly on all aspects of their sexuality, including protecting and promoting their sexual health, be free from discrimination, coercion or violence in their sexual lives and in all sexual decisions, expect and demand equality, full consent, mutual respect and shared responsibility in sexual relationships, including the right to say "NO" to sex if one does not want it.

Sexual Health: The state of well-being in which a person can safely and confidently express their sexuality. It involves physical, emotional, mental, and social well-being related to sex and relationships not just the absence of diseases/disorders or problems

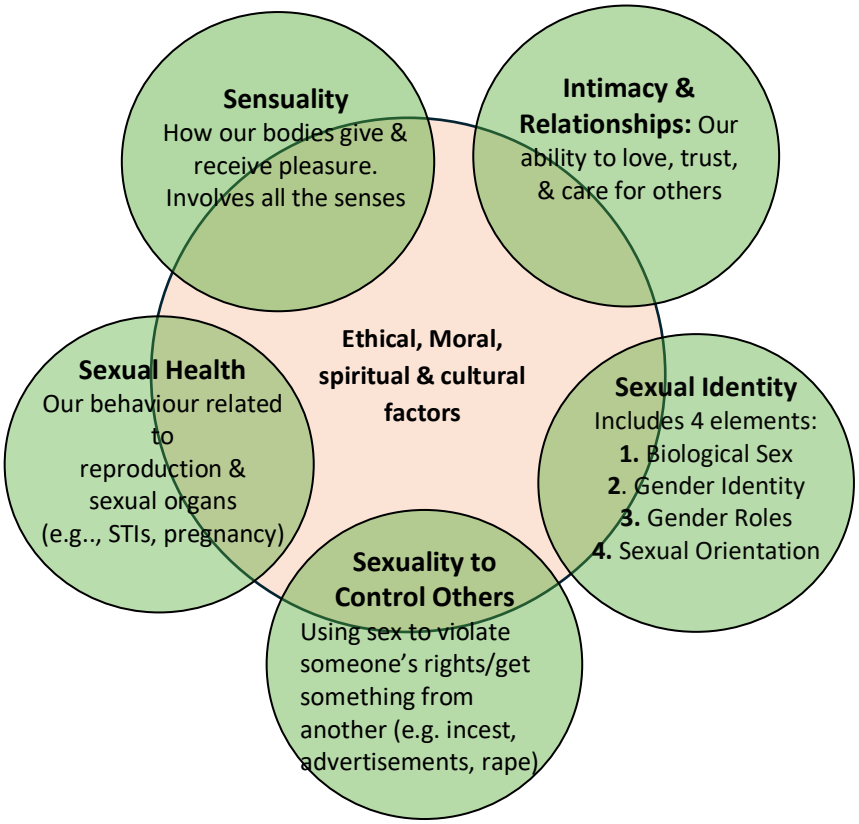
Sexuality begins after birth and lasts throughout the lifespan. A person's sexuality is shaped by his or her values, attitudes, behaviours, physical appearance, beliefs, emotions, personality, likes and dislikes, spiritual selves and all of how he or she has been socialized. Consequently, how individuals express their sexuality is influenced by ethical, spiritual, cultural and moral factors.

5. Explain that while many people often associate the term sexuality with the terms sex or sexual intercourse, it encompasses much more than that. To help the participants understand the complexity of sexuality, discuss four different aspects of sexuality (sensuality, intimacy/relationship, sexual identity and sexual health and reproduction).

Training options for step 5:

The other way to present these four aspects is to use the Four Components of Sexuality in the Resource Sheet 6,1. Explain that each circle in this diagram represents one of the elements of sexuality. When all four circles are placed together, they suggest the total definition of sexuality. In this diagram, there is a space in the middle of the circles where the words "Ethical" "spiritual" "cultural" and "moral factor" are written. These factors may all play a role in how an individual experiences the four components of sexuality. The information can be presented in many ways. The participants can be divided into four groups, and each is assigned a circle to define. Another alternative is to discuss the four aspects in a brief mini lecture. Either way, make sure to cover the points about each element in the "Resource Sheet 6.1 Components of Human Sexuality."

Resource Sheet 6.1: The Components (Circles) of Human Sexuality



6. After presenting this information, ask the participants to provide examples of how a person might enjoy each of the five senses sensually to demonstrate their understanding of each sense.

7. After discussing the four circles of sexuality, draw a fifth circle that is not connected to the other four and label it **Sexuality to control others**. This circle is a negative aspect of sexuality and can prevent an individual from living a sexually healthy life. Explain that this circle can "cast a shadow" on the four other circles of sexuality. Generally, this component is not considered to be an aspect of sexuality but as something that can cast a shadow over a person's healthy sexuality.

8. Close the activity by discussing the following questions
   - Where is "sexual intercourse" included within the definition of sexuality? Does the term play a large or small role in the definition?
   - How does culture influence the various circles of sexuality?
   - Which circles of sexuality are very different between men and women?
   - Do men and women experience sensuality in the same way?
   - Do men and women view relationships in the same way?
   - Do men and women have the same sexual health needs?
   - Do men believe sexual intercourse is a basic need?

Session 6.2: Human Reproductive System

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

Objectives:
By the end of the session participants should be able to:
1. Label different parts of male and female reproductive systems.
2. Explain the function of different parts of the male and female reproductive systems.

Time: 60 Minutes

Materials:
- Small pieces of paper or cards, pens/pencils.
- Enough copies of "Handout 6.1: Male Reproductive System" and "Handout 6. 2: Female Reproductive System (Internal and External)"
- Handout 6.3: Male and Female Reproductive System and Anatomy (Myths and Facts).

Target Audience: Men and Boys

Facilitator's Note
The facilitator will need to determine the level of detail appropriate for the group. For some of the participants, this session will serve as a quick review. However, much of this information may be new to the audience. Also, many of the participants might have a basic understanding of anatomy and physiology, but they might never have had a chance to ask specific questions. If the information is too basic for some, encourage them to share facts

with others who are less familiar with the material. It is important to keep in mind that some participants might not feel comfortable asking questions about men's and women's bodies and genitalia. If this is the case, invite them to write down their questions on small pieces of paper, which can then be collected and read aloud for discussion.

Steps

1. At the beginning of the session, distribute "Handouts 6.1: Male Reproductive System" and "Handouts 6. 2: Female Reproductive System (Internal and External)" to the participants.
2. Instruct the participants to label and describe the function of each part in the diagram.
3. Allow the participants 10 minutes to discuss and label the drawings.
4. Ask the participants to present their pictures and explain their answers in the plenary and use Resource Sheet 6. 2: Male Reproductive System and 6.3: Female Reproductive System to make corrections where necessary.
5. Lead a discussion using the questions below:
   - What were the most difficult genital organs to identify? Why? Do you think it is important for men to know the name and function of the male genital organs? Why?
   - Do men generally have information about these topics? Why or why not?
   - What can you do to ensure that young people in your community have more accurate information about these topics?
6. Distribute "Handout 6.3: Male and Female Reproductive Health Myths and Facts" and ask the participants to answer the questions by stating if the statements are Myths or Facts. Alternatively, read the statements and ask one participant after another to respond. Use "Resource Sheet 6.5: Male and Female Reproductive Health Myths and Facts Answers" to correct or add information to the responses given by the participants.
7. End the discussion by asking participants what they have learnt from this activity and how they are going to use the knowledge.

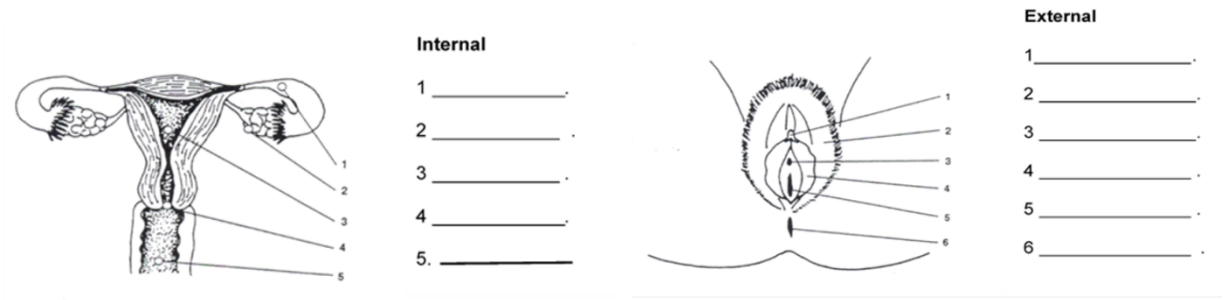
Conclusion

Many men do not know much about their own bodies, nor do they believe it is necessary to devote the time to understanding them. This lack of knowledge about one's own body and how it functions often has adverse effects on hygiene and health. It is also important to have information about women's reproductive systems so that they can be more involved in discussions and decisions about family planning and related matters.

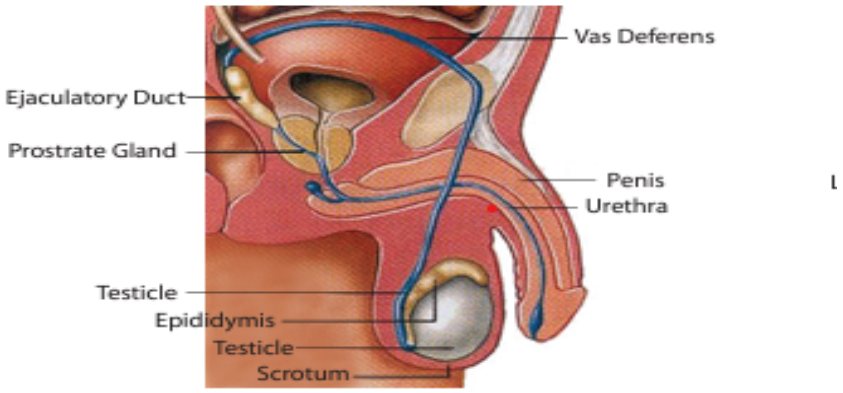
Handout 6.1: Male Reproductive Anatomy

1. ----------
2. ----------
3. ----------
4. ----------
5. ----------
6. ----------
7. ----------

Handout 6.2: The Female Reproductive System (Internal and External)



Resource Sheet 6.2: Male Reproductive System



Male reproductive system - side view

Penis - The male organ for sexual intercourse. Deposits sperm and semen in the female body through urethra, a thin, long tube passing through penis.

Scrotum –The pouch located behind the penis, which contains the testes, provides protection to the testes, controls temperature necessary for sperm production and survival.

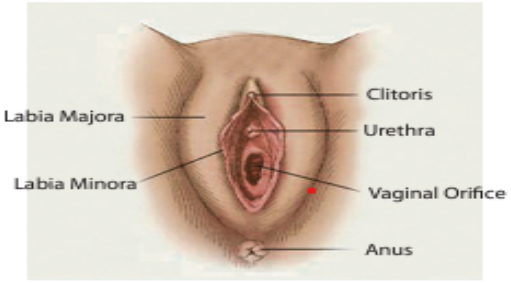
Two Testes - Two round glands lying in the scrotum, which produce and store sperms from puberty onwards. They also produce the male sex hormone responsible for male characteristics and sexual performance.

Two Vas Deferens - From each testis, a thin and long tube arises and is called vas deferens. Sperm is carried from each testis to the urethra by vas deferens.

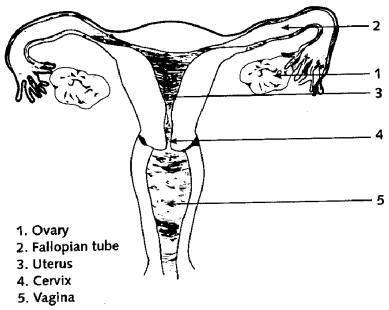
Two Seminal Vesicles - Two sac-like structures lying behind the urinary bladder; secrete a thick milky fluid that forms part of the semen. (Add the pointer on the image)

Prostate Gland - A gland located in the male pelvis, which secretes a thick milky fluid that forms part of the semen.

Resource Sheet 6.3: Female Reproductive System



Female external reproductive system



Vaginal opening/ orifice - Located between the urethral opening and the anus; usually covered by a thin membrane called hymen; outlet for the menstrual flow and childbirth. It is the opening for penetration of penis during intercourse.
Hymen - It is a thin fold of mucous membrane partially covering the opening of the vagina.
Labia Majora and Labia Minora - Two sets of fold on either side of the vaginal opening; provide protection to the clitoris and the urethral and vaginal openings.
Clitoris - A small round and fleshy structure located above the urethral opening at the point where the labia meet; the focal point of sexual stimulation for the female hormones, i.e., estrogen and progesterone; begin maturation and release of eggs puberty onwards. Internal Organs
Vagina - Passageway extending from the outside of the body to the uterus.
Cervix - The narrow lower portion of uterus (with opening into the uterine cavity) that protrudes into the uppermost part of the vagina.
Uterus - A pear-shaped muscular organ located in the pelvic region; beginning at puberty, the lining sheds periodically (usually monthly) during menstruation; the baby develops within it during pregnancy.
Fallopian tubes - Two thin tubular structures arising from the upper part of the uterus and having funnel shaped free ends. Passageway for the egg from the ovary to the uterus; place where fertilization occurs.
Ovaries - Oval-shaped structures located in the female pelvic region; contain many immature egg cells at birth; produce female hormones,
There is no single or "normal" way female genitalia should look; they naturally vary in size, shape, color, and appearance, and all variations are healthy and normal.

Resource Sheet 6.4: Common Questions about the Male Reproductive System and Genitalia[1]
Q. What is masturbation?
A. Masturbation is rubbing, stroking or otherwise stimulating one's sexual organs—penis, vagina, and breasts—to get pleasure or express sexual feelings. Both men and women can relieve sexual feelings and experience sexual pleasure through masturbation. There is no scientific evidence that masturbation causes any harm to the body or mind. Masturbation is only a medical problem when it does not allow a person to function properly or when it is done in public. However, there are many religious and cultural barriers to masturbation. The decision about whether or not to do it is a personal one.
Q. Can semen and urine leave the body at the same time?

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

Q. What is the right length of a penis?

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

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

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

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

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

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

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

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

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

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

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

Q. Do women ejaculate or is it urine?

A. Yes, some women do ejaculate. During sexual stimulation, some women experience the release of fluid from the urethra (the same opening used for urination), usually during intense arousal or orgasm. This experience is sometimes referred to as *"squirting."* The fluid is not urine, although it comes from the bladder area. It is produced by the Skene's glands, often called the female prostate. Only a few girls and women experience ejaculation during intercourse.

Q. Does male circumcision reduce the risk for men to acquire HIV?

A. There is now strong evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. However, male circumcision does not provide 100% protection against HIV infection. Circumcised men can still become infected with the virus and, if HIV-positive, can infect their sexual partners. Male circumcision should never replace other effective prevention methods.

Handout 6.3: Male and Female Reproductive Anatomy and Physiology Myths and Facts

Review the statements below and write the letter *M* (for *myth*) or *F* (for *fact*) in the space provided.

1. _____ It is normal for a man to sometimes be unable to achieve or maintain an erection.

2. _____ A man can urinate and ejaculate at the same time.

3. _____ A longer penis is more likely to satisfy a woman than a shorter one.

4. _____ Even as men get older, they still can have erections.

5. _____ A man always knows whether his female partner has had an orgasm.

6. _____ Just like women, most men are capable of having multiple orgasms.

7. _____ In men, ejaculation and orgasm are the same process.

8. _____ Once a man has an erection, it is physically harmful to him if he does not ejaculate.

9. _____ A man cannot impregnate a woman while she is menstruating (is having her period).

10. _____ You can tell how long a man's penis is by looking at the size of his hands, feet, or nose.

11._____ A man's penis grows longer with frequent use

Resource Sheet 6.5: Male Reproductive Anatomy and Physiology Myths and Facts Answer Sheet

1. It is normal for a man to sometimes be unable to achieve or maintain an erection. – FACT
Sometimes a man can have difficulty achieving or maintaining an erection. This can result from such conditions as fatigue, illness, and nervousness, or it can be a side effect of certain medications. This does not necessarily mean that something is physically or emotionally wrong with him. He will most likely be able to achieve and maintain an erection at another time.
2. A man can urinate and ejaculate at the same time. – MYTH
Although urine and semen are both expelled through the penis, a special muscle controls the flow of urine and semen. The body can expel only one of them at a time.
3. A longer penis is more likely to satisfy a woman than a shorter one. – MYTH
A woman's vagina is most sensitive in the first third of its length. Therefore, many women report that the length of the penis does not affect their sexual stimulation or satisfaction during vaginal penetration.
4. Even as men get older, they still can have erections. – FACT
It may take longer for an older man to achieve an erection, but older men can still achieve and maintain erections.
5. A man always knows whether his female partner has had an orgasm. – MYTH
Although some women ejaculate during orgasm, most women experience muscular contractions without ejaculation. As a result, it may be difficult for a woman's partner to know whether she has had an orgasm.
6. Just like women, most men can have multiple orgasms. – MYTH
Most men can have only one orgasm during an act of sex and must wait through a period after ejaculation before they can have another orgasm.
7. In men, ejaculation and orgasm are the same process. – MYTH
In men, orgasm is the muscular contraction of the pelvic muscles right before ejaculation. Ejaculation is the expulsion of semen through the penis. Although these two processes usually occur in tandem, they are indeed separate functions. It is possible for a man to have an orgasm without ejaculating, as well as for a man to ejaculate without having an orgasm.
8. Once a man has an erection, it is physically harmful to him if he does not ejaculate. – MYTH
While some men may claim this is true, achieving an erection or engaging in sexual activity without ejaculating is not harmful in any way.
9. A man cannot impregnate a woman while she is menstruating (has her period). – MYTH

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

10. You can tell how long a man's penis is by looking at the size of his hands, feet, or nose. – MYTH

The size of a man's hands, feet, or nose or any other body part bears no relation to the length of his penis.

11. A man's penis grows longer with frequent use. – MYTH

Use has nothing to do with how long a penis might or might not become.

Resource Sheet 6.6: Sexual Dysfunction in men and women

Sexual Dysfunction: Sexual dysfunction refers to ongoing problems during any stage of sexual activity that cause distress to an individual or their partner. It can affect desire, arousal, orgasm, or comfort during sex. Sexual dysfunction is common and can affect people of all genders and ages. Having sexual dysfunction does not mean something is "wrong" with you; many factors can contribute, and most conditions are treatable.

Types of Sexual Dysfunction

Sexual dysfunction is commonly grouped into four main types:

1. Desire Disorders
   a) Low or absent sexual interest
   b) Lack of sexual thoughts or motivation: Examples: Low libido, loss of sexual desire
2. Arousal Disorders
   a) Difficulty becoming physically aroused or maintaining arousal. Example: Erectile dysfunction (difficulty getting or keeping an erection)
   b) Difficulty with vaginal lubrication
3. Orgasm Disorders
   a) Delayed, infrequent, or absent orgasm Example: Delayed or premature ejaculation
   b) Anorgasmia (difficulty reaching orgasm)
4. Pain Disorders
   a) Pain during or after sexual activity
   Examples: Dyspareunia (painful intercourse)
   b) Vaginismus (involuntary tightening of vaginal muscles)

Sexual dysfunction often results from a combination of physical (age, fitness, nutrition, health), psychological (mental health), and social factors.

If you suspect you have sexual dysfunction visit a health facility where healthcare providers may:

- Ask about sexual, medical, and mental health history
- Conduct physical exams
- Order blood tests (e.g., hormones)
- Discuss emotional and relationship factors

Key Messages to Remember

- Sexual dysfunction is common and treatable
- It is not a failure or weakness
- Sexual pleasure looks different for everyone
- Seeking help is a sign of self-care, not shame
- Healthy sexuality includes consent, comfort, communication, and choice

Remember that Open and honest communication with a healthcare provider is key to identifying the issue and getting care.

Session 6.3: Sexually Transmitted Infections

Goal: To understand basic information about Sexually Transmitted Infections.

Objectives:

By the end of the session participants should be able to:

1. Explain what an STI is.
2. Describe the common symptoms of STIs.
3. Explain how one can prevent themselves from contracting an STI.

Time: 30 Minutes

Materials Required:

- Flipcharts, markers and masking tape.
- Handout 6.4: Burning Questions about Sexually Transmitted Infections

Target Audience: Both Men and Boys

Steps

1. Ask the participants to explain what an STI is and to provide examples of STIs.
2. Pass out "Handout 6.4: Burning Questions about Sexually Transmitted Infections (STIs)."
3. Tell the group that you are going to discuss eight basic questions about STIs. Go through the list and allow various participants to provide their answers. Correct any misinformation that is shared using the "Resource 6.6: Answers to Burning Questions about Sexually Transmitted Infections (STIs)" to make sure all-important points are covered for each question.
4. Ask the participants if they have any other questions and answer them using the information in Resource Sheet 6.7: Sexually Transmitted Infections Notes.
5. Conclude the Sessions by leading a brief discussion on how champions and service providers can help increase SRH service uptake among boys and men. Use the Facilitators Notes on how to increase SRH service uptake.

Handout 6.4: Burning Questions about Sexually Transmitted Infections (STIs)

1. What are STIs, and how do people get them?
2. What are the most serious STIs?
3. How do I know if I have an STI?
4. How can I protect myself from STIs during sexual activity?
5. Can someone without any symptoms of STIs still be contagious?
6. What should I do if I think I have an STI?
7. If I do have an STI, can it be cured?
8. If I ignore my symptoms, will the STI go away?
9. Do I need to notify my partner if I have an STI

Resource Sheet 6.7: Answers to Burning Questions about Sexually Transmitted Infections (STIs)

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

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

2. What are the most serious STIs?

- HIV infection, which causes AIDS, is fatal.
- Syphilis can be fatal, but it can be cured with drugs.
- Gonorrhea and chlamydia, if left untreated, can cause infertility in both men and women.
- The human papilloma virus (HPV) is an STI that has different strains, some of which produce genital warts, and some of which can lead to cervical cancer in women.
- The presence of any STI increases the risk of contracting HIV.

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

Many people who have STIs have no symptoms. When symptoms appear, they may include: If you have had sexual contact:

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

How can I protect myself from STIs during sexual activity?

- ❖ Go for routine screening of STIs with the sexual partner.
- ❖ Have sex with one uninfected sexual partner.
- ❖ Consistent, correct condom use.
- ❖ Explore safer sexual practices.

5. Can someone without any symptoms of STIs still be contagious?

- ❖ Yes!! Many people who have STIs have no symptoms, but they can still pass the infection on to others. For example, many people infected with chlamydia and gonorrhoea have no symptoms, and individuals infected with HIV may show no signs of infection for many years, but they can still pass the virus on to others.

6. What should I do if I think I have an STI?

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

7. If I do have an STI, can it be cured?

- ❖ Most STIs can be cured with antibiotics. However, those STIs that are caused by viruses - such as HIV, hepatitis B, and genital herpes - cannot be cured. Genital warts can be removed, but they may return.
- ❖ It is important to adhere to the full treatment to improve cure rate and avoid drug resistance v Contact tracing and treatment which will prevent re-infection and community transmission.
- ❖ NB: it is important to continue with preventive measures after treatment to avoid re-infection

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

- ❖ No. The symptoms may go away, but the STI will remain. If the STI is left untreated, it will continue to harm the body, and you can continue to pass the infection on to others.

9. Do I need to notify my partner if I have an STI?

- ❖ It is encouraged to inform your sexual partner if you have an STI so;
  - They can seek care and treatment including testing, and treatment if needed
  - To prevent reinfection during future sexual contact, both for you and your partner
  - To stop further spread of the STI to other partners
  - To protect long-term health, as some STIs can cause serious complications if untreated
  - To support honest communication and trust in sexual relationships

Resource Sheet 6.7: Sexually Transmitted Infections Notes

Facilitators' Notes

Common sexually transmitted infections/ diseases include.

- Chlamydia
- Gonorrhea
- Genital herpes
- Syphilis
- HPV
- Hepatitis
- HIV

Chlamydia

Men get chlamydia through vaginal, oral, or anal sex with an infected partner.

There may be no signs or symptoms of infection. Symptoms may not appear until several weeks after exposure and can include:

- Pain/burning with urination.
- Watery/mucus discharge from penis.
- Redness, swelling or itching at the tip of the penis.
- Hard to start urinating.
- Bloody urine
- Discomfort during sex.
- Testicular and rectal pain, tenderness and swelling

Genital Herpes

The herpes virus is spread by skin-to-skin contact with a person who has it most often, from herpes sores or blisters and during vaginal, anal, or oral sexual contact, or skin-to-skin contact. This may happen even without visible sores.

Men who have the herpes virus may have signs of infection. Many do not know they have the virus. Once you are infected, the virus stays in your nerve cells for life. When the virus is not active, there is no sign of infection. When the virus becomes active, some of the signs and symptoms may be included.

Painful sores, blisters, or ulcers may appear where the virus entered the body. These areas include genital or anal area, the mouth, in the urinary tract and on the buttocks or thighs.

Gonorrhea

Men get gonorrhea from sexual contact with someone who is infected. Gonorrhea can be spread through oral, vaginal, and anal contact.

For men, signs include:

- Painful or burning urination.
- White, yellow or green discharge from penis.
- Testicular/scrotal pain.
- Anal discharge, pain/itching, bleeding or painful anorectal region

Syphilis

Infection develops in stages (primary, secondary, latent, and tertiary). Each stage can have different signs and symptoms.

It may be spread by direct contact with a syphilis sore during vaginal, anal, or oral sex.

Syphilis can spread from a mother with syphilis to her unborn child.

Primary Stage

A single chancre marks the onset of the primary (first) stage of syphilis, but there may be multiple sores. They are painless and resolved with or without treatment. However, without treatment, the infection will progress to the secondary stage.

Secondary Stage

Skin rashes and/or mucous membrane lesions (sores in the mouth, vagina, or anus) mark the second stage of symptoms. This stage typically starts with the development of a rash on one or more areas of the body. Rashes during the secondary stage can appear when the primary chancre is healing or after it's healed. They may appear as rough, red, or reddish-brown spots on the palm of the hands and bottoms of the feet. However, rashes with different appearances may occur on other parts of the body. They may be hard to notice. Condyloma lata which are large, raised, gray or white lesions may develop in warm, moist areas like the mouth, underarm or groin region.

In addition to rashes, signs and symptoms of secondary syphilis may include fever, swollen lymph nodes, sore throat, headaches, weight loss, muscle aches, fatigue.

The symptoms resolve with or without treatment. However, without treatment, the infection will progress to the latent and possibly tertiary stage of disease.

Latent Stage

The latent stage of syphilis is a period when there are no visible signs or symptoms. Without treatment, syphilis will remain in the body even though there are no signs or symptoms. Latent syphilis can last for years.

Tertiary Stage

Tertiary syphilis is rare and develops from untreated syphilis infections. It may occur years later and can be fatal. It affects multiple organs.

N/B: Across the different stages, syphilis can affect the nervous symptoms, the ears and eyes. Signs and symptoms of neurosyphilis can include severe headache; muscle movement problems; muscle weakness or paralysis (not able to move certain parts of the body); numbness; and changes in mental status (trouble focusing, confusion, personality change) and/or dementia (problems with memory, thinking, and/or making decisions).

Signs and symptoms of ocular syphilis can include eye pain or redness; floating spots in the field of vision; sensitivity to light; and changes in vision (blurry vision or even blindness).

Signs and symptoms of otosyphilis may include hearing loss; ringing, buzzing, roaring, or hissing in the ears ("tinnitus"); balance difficulties; and dizziness or vertigo.

Human Papilloma Virus (HPV)

HPV is spread by skin-to-skin contact. Men get HPV from sexual contact with someone who has it. HPV can be spread by vaginal, anal, oral or hand-genital sexual contact. Some may have no signs of HPV but can still spread it to others.

HPV mostly is asymptomatic. However, in some cases e.g. in persons with low immunity HPV infection may cause:

- Genital warts (low-risk HPV)
- Cervical cancer
- Cancer of the penis (more common)
- Cancers of the anus, throat, tongue or tonsils (less common).

Note: HPV vaccine is currently available at health care centers

Risk factors to acquiring sexually transmitted infections

- History of a previous STD.
- Multiple sexual partners.
- Inconsistent and incorrect use of condoms only some of the time.
- Alcohol and substance abuse

How to prevent STDs

1. Abstinence
2. Safer sex:
    - Reduce the number of sexual partners.
    - Always use condoms and use them correctly.
    - Have sex with only one partner who does not have sex with others and does not have an STD.
    - Be faithful to one sexual partner of known status.
    - Minimize drug and substance abuse when engaging in sexual acts.
3. Treatment of infected persons with abstinence until symptoms resolve
4. Tracing and treatment of current and recent sex partners of the infected

1. Summarize by briefly discussing the ways in which champions and service providers can help increase SRH service uptake among boys and men.

Facilitators' Notes on How to Increase Uptake of SRH Services

The uptake of SRH services can be improved through the following strategies.

- Increasing men's awareness and knowledge about SRH through targeted educational campaigns.
- Providing accurate information and addressing the myths and misconceptions on SRH. Highlight the benefits to men's own health and well-being, as well as the well-being of their partners and families.
- Using diverse communication channels, including social media, community outreach, and workplace health programs, to reach men with SRH messages.
- Engaging men as supportive partners in antenatal care, childbirth, and postnatal care, recognizing their roles in reproductive health.
- Peer support groups to provide a safe space for men to discuss SRH issues and share experiences.
- Addressing privacy concerns and offer services at convenient times and locations.
- Promoting open dialogue and community discussions to address misconceptions and beliefs around masculinity, sexuality, and SRH. Engage religious and community leaders in promoting positive attitudes towards men's SRH.
- Collaborating with employers and workplace health programs to provide SRH information, resources, and services to male employees.
- Utilizing male role models, community leaders, and peer networks to promote SRH services

Session 6.4: Sexual Reproductive Health and Rights

Goal: To understand Sexual and Reproductive Health and Rights.

Objectives:
By the end of the session participants should be able to:
1. Describe sexual and reproductive health
2. Identify different reproductive health services and rights

Time: 30 Minutes

Materials Required: Flipcharts and Markers

Target Audience: Both Men and Boys

Steps

1. Start the Session by asking the participants what they understand by the terms "Reproduction" and "Sexual and Reproductive Health"
2. After a few responses, use the information in the Facilitator's Notes to correct reinforce or correct their responses.

Facilitator's Notes

- Reproduction means having offspring or babies. Both man and woman are responsible for reproduction, and they have specific reproductive organs in their bodies to carry out this important function.
- Reproductive health is a state of complete well-being in all matters related to the reproductive system.
- Sexual health involves respect, safety and freedom from discrimination and violence.
- Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system.
- It implies that people can have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when, and how often to do so.

3. Ask the participants what they understand by human rights and what types of rights there are in the country. Note their responses on a Flip Chart paper (Allow not more than 10 minutes for this). Use the Facilitator's Notes below to add or to correct their responses.

Facilitators' Notes

- Examples of rights include the right to speak freely, right to highest attainable health, right to education, right to religion
- As for the reproductive rights, every individual has the basic right to: decide freely and responsibly the number and timing of birth of their children, to have the information to make such decisions (informed choice), to attain the highest standard of sexual and reproductive health and to make decisions by oneself without any coercion or violence.
- SRHR are different human rights related to sexuality and reproduction, such as sexual health, sexual rights, reproductive health, and reproductive rights.

4. Ask the participants to identify the kinds of services and rights that are related to sexual and reproductive health as you list them on a Flip Chart Paper.

5. Use the information in the Facilitators Notes below to add what might have been left out.
6. Conclude the session by highlighting that it is the responsibility of everyone to know the types of Sexual and reproductive health services available for them and to seek them as the need may be. Emphasize that everyone's sexual and reproductive health rights should be respected.

Facilitators Notes: Sexual and reproductive health services include:	
• Antenatal care • Care during and after childbirth • Eliminating unsafe abortion and post-abortal care • Breastfeeding counselling • Family planning • Treatment of infertility	• Treatment of Reproductive Tract Infections (RTIS) and STIs, • Prevention and management of AIDS and cervical cancer, • SRH information and education • SGBV prevention and response

Rights of Clients in SRH services:

- **Dignity** – to be treated with courtesy. Information - to learn about the benefits and availability of services.
- **Safety –** to be able to use methods that are safe and effective.
- **Choice** – to decide freely when to use a family planning method, which method to use, when to change a method, and when to stop using.
- **Confidentiality** – to be assured that any personal information will remain confidential. Access – to avail services at convenient locations.
- **Comfort** – to feel comfortable when receiving services.
- **Continuity** – to receive supplies for as long as needed
- **Opinion** – to express views on services being offered. Privacy – to have a private environment during counselling or services.

Session 6.5: The Role of Men in Family Planning

Goal: To understand the Role of Men in Family Planning

Objectives:
By the end of the session participants should be able to:
1. Define family planning and explain its benefits
2. Explain the role of men in family planning

Time: 60 Minutes

Materials Required:

- Flipcharts and Markers
- Diagrams of male and female reproductive organs visible to the entire group or Models of reproductive organs (You can use the diagrams of Male and Female Reproductive anatomy in Session 6.2)
- Samples or pictures of male and female condoms, pills, IUDs, Depo-Provera Injection
- Handout 6.5: Scenarios for Role Plays of Men Hindering and Supporting FP

Target Audience: Both Men and Boys

Steps

1. Ask participants to pair up and discuss what family planning is, its benefits and barriers to family planning. (Allow 5 minutes for this)
2. Ask the participants to share in the plenary what they have discussed and use the information in the Facilitator's Notes to add what they may have left out.

Facilitators notes

What is family planning-The conscious effort to regulate the number and spacing of births through temporary, long-term, and permanent methods including emergency methods.
Unmet need- Number or % of women (married or in union) who want to postpone or stop having children, but who are not using a FP method.

Benefits of family planning

- FP saves lives – many pregnancies pose risk to mothers and their children when too early or too soon, exposing the mother and newborns to risk
- FP reduces inequity in the community
- FP reduces abortions
- FP reduces adolescent pregnancies, and some methods reduce the risk of sexually transmitted infections
- FP improves children's health and development

Common barriers to family planning include:

- Cultural traditions & norms
- Gender inequality, including intimate partner violence
- Lack of knowledge
- Myths, fears and health concerns
- Lack of contraceptives and / or method of choice
- Method failure
- Quality of services: provider bias and poor counseling
- Poor access to services including integration (e g with HIV services Poor access to services including integration (e.g., with HIV services and post-partum care)
- Poverty
- Fear of side effects

3. Ask the participants to name the types of contraceptives that they know. After a few responses, use the information in the Facilitator's Notes below to correct or add any

information left out and show any Family Planning Samples you may have e.g pills, condoms, IUCD etc.

Facilitators notes

- Barrier methods- Female and male Condoms
- Short acting contraceptive methods such as Pills- Microgeon,
- Natural family planning methods- withdrawal, calendar methods
- Long-acting methods – 3 months injectables- Depo-Provera, Implants- Jadelle, IUDs- Copper T ,
- Permanent contraceptive methods- Vasectomy, Bilateral Tubal Ligation (BTL)
- Emergency contraception- Postinor 2 (P2)

4. Tell the participants that they will develop role play using two scenarios. Divide them into two groups and give them "Handout 6.5: Scenarios for Role Plays". Ask **Group 1** to develop a 5 min role play of Scenario 1 where the man plays a hindering role in the use of Family Planning and **Group 2** to develop a 5 min role play of Scenario 2 where the man plays a supportive role in the use of family planning

Handout 6.5: Scenarios for Role Plays

Scenario 1 – Men as a hindrance to FP

Mary (aged 39) and John (aged 43) are a married couple with four children aged 17, 13, 8 and 5. John and Mary both work in a hardware that they own in Nairobi. Mary is happy with the number of children she has and does not want to have any more children. She knows from her friend that there are several family planning methods that she can use to prevent herself from getting pregnant. She thinks that John wants to have more children, but she really doesn't want to have any more. Before becoming pregnant with their third born, she once talked to him about using condoms, but his response was not so good, and she has been worried to talk about any topic which touches on their sexual life ever since.

Scenario 2 – Men supporting FP.

Andrew and Jenny are a young, married couple with three small children aged 10, 8 and 6. Andrew works in a factory and makes a good salary. Jenny does not want to have any more children any time soon as she feels that it is becoming difficult to provide for their three children with her husband's salary. She is not sure which FP method to use and is not sure about discussing it with Andrew. She also wants to go back to school to finish her education and knows she can't do that if she has a new baby. Her behaviour has been unusual in recent days and Andrew has noted it. So, one day he asks his wife what was really troubling her. This gave her courage to share her concerns with him. He tells her that he has a friend who is a health provider and they would consult him for advice on how to plan their family.

Scenario 1 – Men as a hindrance to FP

Mary (aged 39) and John (aged 43) are a married couple with four children aged 17, 13, 8 and 5. John and Mary both work in a piece of hardware that they own in Nairobi. Mary is happy with the number of children she has and does not want to have any more children. She knows from her friend that there are several family planning methods that she can use to prevent herself from getting pregnant. She thinks that John wants to have more children, but she doesn't want to have any more. Before becoming pregnant with their third born, she once talked to him about using condoms, but his response was not so good, and she has been worried about talking about any topic which touches on their sexual life ever since.

Scenario 2 – Men supporting FP.
Andrew and Jenny are a young, married couple with three small children aged 10, 8 and 6. Andrew works in a factory and earns a good salary. Jenny does not want to have any more children any time soon as she feels that it is becoming difficult to provide their three children with her husband's salary. She is not sure which FP method to use and is not sure about discussing it with Andrew. She also wants to go back to school to finish her education and knows she can't do that if she has a new baby. Her behavior has been unusual in recent days and Andrew has noted it. So one day he asks his wife what was troubling her. This gave her the courage to share her concerns with him. He tells her that he has a friend who is a health provider, and they would consult him for advice on how to plan their family.

5. After 5 minutes, ask the two groups to present their role plays and use the questions below to lead a discussion in a plenary as you use the Facilitator's Notes to add any information left out:
   - What did the man in Scenario 1 do to hinder the use of Family Planning methods? Why do you think he behaved this way?
   - What could he have done instead to be supportive?
   - How did the man in Scenario 2 support his partner?
   - What else could he have done to be supportive?
   - What are some Family Planning methods that these couples can use?

Facilitators' notes

Ways that a man can hinder the use of modern Family Planning methods.

- By not having correct and up-to-date information about modern Family Planning methods. By forbidding his partner from using Family Planning methods, which may lead her to use them secretly.
- By not giving her enough time to use a method before having sexual intercourse (e.g. not giving her enough time to insert spermicide, a diaphragm or a female condom).
- By complaining or criticizing her use of the Family Planning method instead of communicating with her if he has concerns.
- By pressuring her to have sexual intercourse during a time when it is easy for her to get pregnant.

Ways that a man can support the use of modern Family Planning methods:

- By communicating with his partner to choose the Family Planning method that is best for them both.
- By providing financial support (e.g. by paying for or helping to pay for Family Planning methods).
- By providing emotional support (e.g. by going to the clinic with his partner). By supporting his partner's choice of Family Planning method.
- By using a method that, together with his partner's choice of method, will make sure that his partner does not get pregnant.
- By using an additional method when his partner forgets to use or has a problem with her chosen method.

6. Conclude the session by using the information in the Facilitator's Notes to summarize how Champions and Service Providers can help increase the uptake of Family Planning and other SRH services among boys and men.

Facilitators' Notes

The uptake of SRH services can be improved through the following strategies.

- Increasing men's awareness and knowledge about SRH through targeted educational campaigns.
- Providing accurate information and addressing the myths and misconceptions on SRH. Highlight the benefits to men's health and well-being, as well as the well-being of their partners and families.
- Using diverse communication channels, including social media, community outreach, and workplace health programs, to reach men with SRH messages.
- Engaging men as supportive partners in antenatal care, childbirth, and postnatal care, recognizing their roles in reproductive health.
- Peer support groups to provide a safe space for men to discuss SRH issues and share experiences.
- Addressing privacy concerns offering services at convenient times and locations.
- Promoting open dialogue and community discussions to address misconceptions and beliefs around masculinity, sexuality, and SRH. Engage religious and community leaders in promoting positive attitudes towards men's SRH.
- Collaborating with employers and workplace health programs to provide SRH information, resources, and services to male employees.
- Utilizing male role models, community leaders, and peer networks to promote SRH services

Module 7: Non-Communicable Diseases (NCDS)

Session 7.1: Introduction to Non-Communicable Diseases (NCDs)

Goal: To increase knowledge on how to promote awareness on, prevention, and management of NCDs within their communities

Objectives:

By the end of the session participants will be able to:

1. Describe the various types of NCDs prevalent in Kenya.
2. Identify the risk factors contributing to the development of NCDs.
3. Learn how to manage the common NCDs

Time: 30 Minutes

Materials Required:

Presentation materials e.g Flip chart, Markers, Masking Tape ,

Target Audience: Men and Boys

Steps

1. Explain that this session will explore non-communicable diseases (NCDs) and issues related to it
2. Ask the participants in the plenary to provide a definition of the term non-communicable diseases and provide examples of NCDs.
3. After a few responses conclude the activity by adding onto the information they have provided using Resource Sheet 7.1: Non-Communicable Diseases (NCDs) below:

Resource Sheet 7.1: Non-Communicable Diseases (NCDs)

Definition of Non-Communicable Diseases (NCDs)

NCDs are chronic conditions that do not result from an infection and cannot be transmitted from one person to another. Most NCDs are not curable but can be managed through proper diet, lifestyle changes and proper medication.

Majority of the common NCDs affect males more than females. (**Tobacco use**: ~19.9% of men vs ~0.9% of women, **Harmful alcohol use**: ~18.1% of men vs ~2.2% of women and **Elevated blood pressure**: ~25.1% of men vs ~22.6% of women)

Common types of NCDs

- Hypertension
- Cancer
- Diabetes
- Mental health disorders

Risk factors for NCDs

Modifiable Risk Factors - These are Behavioural factors that can be reduced or controlled. They include but not limited to the following: -

- Physical inactivity (Sedentary lifestyle)
- Tobacco use
- Alcohol use

- Poor balanced diets (e.g. increased fat and sodium intake, with low fruit and vegetable)
- Poor health seeking behaviour

Non-Modifiable Risk Factors

These are factors that cannot be reduced or controlled. These include:

- Age
- Sex- Being a female or male
- Race
- Hereditary factors/Genetic predisposition

Hypertension

Is a condition where blood pressure is persistently above 140/90 mmHg for two or more readings of different settings taken on different days using proper measurement techniques in individuals aged 18 years and above. In some situations, children and adolescents under the age of 18 can present with high blood pressure mostly as a result of an underlying cause.

When one has hypertension, the heart pumps blood around the body with greater force than normal.

Signs and Symptoms of Hypertension

Hypertension is **a "silent killer" and can** present with no symptoms for a long time. However, in severe hypertension, the following signs and symptoms may present

- Severe headache
- Fatigue
- Confusion
- Visual problems
- Chest pain
- Difficulty in breathing
- Irregular heartbeat
- Blood in urine
- Nose bleeding.
- Abnormal hear beats (Awareness of heartbeat)
- Erectile disfunction

Men are encouraged to frequently monitor their blood pressure and visit a health facility in case of abnormal reading of blood pressure.

Prevention and Management of Hypertension

It is possible to prevent hypertension through proper diet and lifestyle changes. For those diagnosed with Hypertension it can be managed through proper medication, diet adjustments and lifestyle changes. Adherence to diet and medication is very important

Session 7. 2: Diabetes Signs and Symptoms

Goal: To increase knowledge on signs and symptoms of diabetes

Objectives:

By the end of the session participants will be able to:

1. List the signs and symptoms of diabetes.
2. Learn how to manage diabetes

Time: 30 Minutes

Materials Required:
Flip chart, Markers, Masking Tape
Target Audience: Men and Boys

Steps

1. Ask the participants to brainstorm on what diabetes is and the types of diabetes
2. Record the responses on the flip chart.
3. Clarify the responses given and summarize the activity using the Resource Sheet 7.2: What is Diabetes?

Resource Sheet 7.2: What is Diabetes?
Definition of Diabetes: It is a condition characterized by high blood sugar. There are two types of tests, Fasting blood sugar (3.9 - 5.5 mmol/L) and random blood sugar (7.8mmol/L) This can be due to:

- Inability of the body to produce enough insulin.
- Inability of the body to utilize available insulin.

NB: Insuline is a hormone secreted by the body to regulate blood sugar level
There are 2 main types of diabetes: type 1 and type 2
Type 1 Diabetes - (Juvenile)
It occurs in young children and adolescents. It results from damage to the pancreatic cells which leads to little or failure of insulin production.
Type 2
It is the most common type of diabetes occurring mostly in adults. Majority of people with with type 2 diabetes are women. This type is due to reduced insulin production or resistance of body cells to insulin, or both.
Gestational Diabetes Mellitus
This is the type of diabetes that occurs for the first time during pregnancy. This type of diabetes may or may not resolve after pregnancy.
Pre-diabetes State
This is a state where an individual has abnormally high blood sugar that has not reached levels high enough to be considered type 2 diabetes yet. Without lifestyle changes, adults and children who have prediabetes are at high risk of developing type 2 diabetes.

Activity 2: Signs and Symptoms of Diabetes Mellitus (15 minutes)

Steps

1. Ask the participants to turn to the person sitting next to them and in twos discuss the signs and symptoms of diabetes.
2. Share the pictorial illustration of the signs and symptoms of diabetes (Appendix 1) and summarize the discussions using the Resource Sheet 7.3: What is Diabetes Mellitus? below.

Resource Sheet 7.3: What is Diabetes Mellitus (Type 1 and 2)?
Signs and Symptoms

- Frequent urination
- Excessive thirst
- Extreme hunger

- Unexplained weight loss
- Increased fatigue
- Irritability
- Blurry (unclear) vision
- Impotence- failure to sustain an erection.
- Itching of private parts in women
- Slow healing of cuts and wounds
- Numbness or tingling sensation of the hands and feet

Common Myths and Misconceptions

- If you feel okay, you don't have hypertension
- Hypertension and diabetes are diseases for the elderly people only.
- Hypertension and diabetes can be cured
- Only occurs in overweight and obese
- They are diseases for rich people
- You can't get NCDs if NCDs are not in your family.
- NCDs are hereditary
- NCDs are as a result of a curse.

What do we Need to do to Prevent Diabetes and Hypertension?

Boys and men can take the following steps to prevent high blood pressure or high blood sugar or to control or lower your blood pressure/glucose if it is too high.

- Cook and eat food with less salt (Do not add salt on the table)
- Engage in physical activity for at least 30 minutes every day. E.g. take a brisk walk
- Aim for a healthy weight (achieve the right weight for your height e.g. check your)
- Eat more vegetables and fruits.
- Avoid smoking and tobacco use
- Responsible use of alcohol.
- Seek help for stress
- If one is at high risk of developing the disease, make sure you get regular medical check-ups.

Session 7.3: Prostate Cancer

Goal: To increase knowledge on prostate cancer.
In this section we are going to discuss the most prevalent cancers among men in Kenya

Objectives:
By the end of the session participants will be able to:

1. Identify the common types of Cancers in Men.
2. Identify the risk factors, signs and symptoms of prostate cancer.
3. Learn how to manage cancers

Time: 30 Minutes

Materials Required:
Presentation materials e.g. Flip chart, Markers, Masking Tape,
Target Audience: Men (facilitators to skip this session for adolescent groups)

Plenary Brainstorming Sessions on Cancer: The facilitator will lead a brainstorming session where participants will answer and discuss the following question.

Questions

1. What is Cancer?
2. What Causes Cancer?
3. What are the most common types of Cancers in men?3: What are the Signs and Symptoms of Cancer.?4: What are risk factors of cancers

Resource Sheet 7.4: What is Cancer?

Cancer is a group of diseases where body cells:

- Grow abnormally
- Grow uncontrollably
- Invade adjacent body parts, and
- May spread to organs thereby affecting their functions.

What Causes Cancer?

Cancer is a complex group of diseases with many possible causes. The known causes of cancers include but are not limited to the following:

- **Tobacco and Cancer**- Cigarette, cigar, and smokeless tobacco use affects different groups of people both primary and secondary smokers. Tobacco has many cancer-inducing substances.
- **Genetics and Cancer-** Some types of cancer run in certain families, but most cancers are not linked to the genes we inherit from our parents.
- **Sun and UV Exposure-** There is a link between too much sun exposure and cancer, especially in people with reduced levels of melanin in their skin
- **Radiation Exposure and Cancer Risk-** There are different types of radiation exposure, and they might affect cancer risk. For instance, pregnant women should be careful not to expose the fetus since those exposed are vulnerable to defects and cancer.
- **Other Carcinogens**- The environmental causes of cancer may be there in our homes, at work, in pollution, and even in some medical tests and treatments. Some types of infections are linked to cancer. These abnormal changes are caused by interactions between a person's genetic factors and three categories of external agents which include physical carcinogens (e.g. ionizing radiation), chemical carcinogens (e.g. asbestos, components of tobacco smoke, aflatoxins) and biological carcinogens (certain viruses, bacteria or parasites).
- **Unhealthy diet and Physical Inactivity-** It is factual that unhealthy diet, physical inactivity, and excess body weight, may affect your risk of cancer.

Common types of Cancers in Men in Kenya

- Prostate cancer - 21.9%
- Oesophageal cancer (Cancer of the food pipe) - 9.9%
- Colorectal cancer (Cancer of the large intestines and rectum) - 9.1%
- Stomach cancer - 5.4%

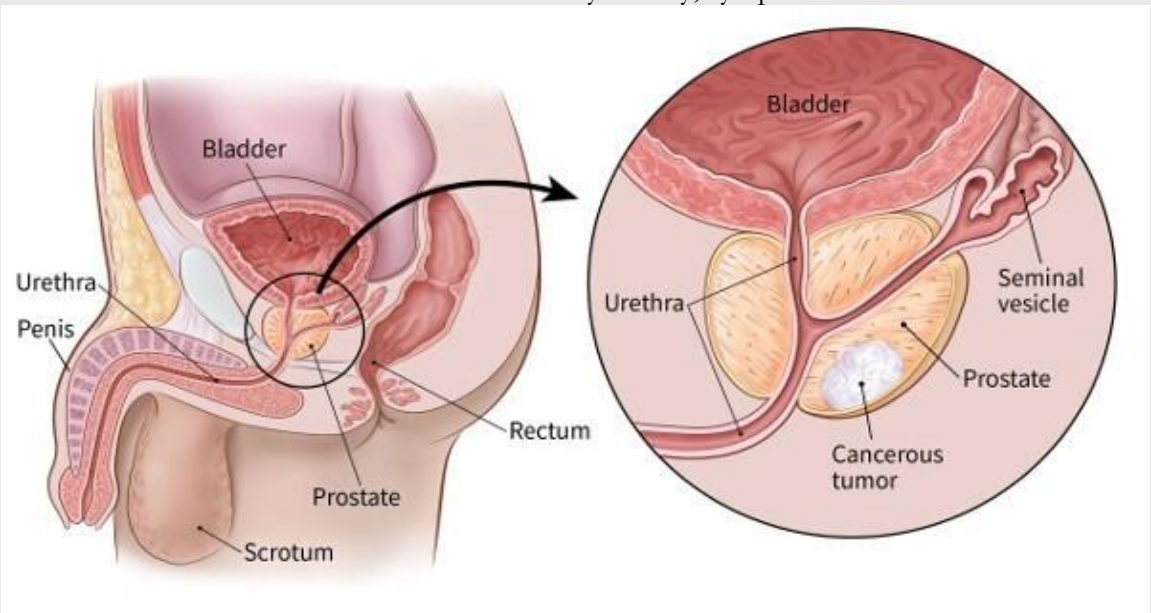
Signs and Symptoms of Cancer

The signs and symptoms of cancer depend on where the cancer is, how widespread it is, and how much it affects the organs or tissues. If a cancer has spread (metastasized), signs or symptoms may appear in different parts of the body.

Resource Sheet 7.5: What is Prostate Cancer?

Prostate cancer is a disease in which abnormal cells grow in the prostate gland (A small gland in men that help make semen) and can spread to other parts of the body if not detected and treated early.

In Kenya, national cancer screening guidance promotes screening from the age of 40. While age is an important consideration, prostate cancer screening should be individualized taking into consideration the risk factors such as family history, symptoms and overall clinical context



Signs and Symptoms of Prostate Cancer

- Most patients are asymptomatic
- Decreased urinary stream
    - A sense of incomplete emptying of the bladder
    - Difficulty in starting or stopping the urinary flow
    - Pain during urination
    - Inability to urinate
    - Urinary frequency (frequent urination; mostly at night)
    - Blood in urine
    - Advanced disease: bone pain, unintentional weight loss, urinary retention, numbness or weakness of the legs, bladder/bowel incontinence

Screening Methods

- Blood test (Serum PSA test)
- Physical examination (Digital Rectal Examination)
- Ultrasound (Trans-Rectal Ultrasonography)

Risk Factors

- Age - Men over 40 years are more at risk
- Family history - Genetic factors
- Diet: Inadequate intake of micronutrients like Zinc, Vitamin E
- Infections e.g. chronic prostatitis (inflammation of the prostate) and
- Sexually Transmitted Infections

Note:

- If one experiences any of the above, he should seek medical attention.
- Early screening and detection are important for successful treatment.

How Can We Prevent Cancers?

- Avoid risky behaviours such as smoking, alcohol use, and multiple sexual partners.
- Promote a healthy lifestyle e.g., healthy eating habits, physical activities.
- Undergo regular health checks ie. Screening, vaccinations, treatment of infections
- Avoid exposure to toxic chemicals, radiation, and excessive sunrays.

Myths and misconceptions about cancer screening, particularly prostate cancer screening, remain a significant barrier to early detection among men. Perceptions related to masculinity, fear of diagnosis, stigma, and misinformation about screening procedures often discourage men from seeking timely screening. Addressing these misconceptions through targeted education and community engagement is essential to improve screening uptake, promote positive health-seeking behavior, and reduce late-stage cancer diagnoses among men.

Breast Cancer

Although breast cancer is common in women, it can also affect men. Men should therefore be aware of signs and symptoms of breast cancer in themselves including lumps, nipple changes or swelling of the chest area. Additionally, men play an important role in supporting early detection in their partners, encouraging breast cancer awareness and promptly seeking medical attention when changes are noticed. This helps dispel the myth that breast cancer only affects women.

Module 8: Mental Health

Session 8.1: Definition of Mental Health and Mental Disorders

Goal: To analyze the causes and consequences of mental health disorders using a problem tree

Objectives:

By the end of the session participants will be able to:

1. Define mental health and mental illness
2. Identify early warning signs of mental health
3. List causes/contributing factors and the consequences of mental health disorders.
4. Identify ways of preventing and responding to mental disorders and promoting mental health wellness

Time: 60 Minutes

Materials Required:
Flip Charts, Marker Pens
Audience: Men and Boys

Steps

1. Start the session by asking the participants to define mental health. After a few responses, define Resource Sheet 8.1: Mental Health
2. Ask the participants to define mental illness. After a few responses, define Resource Sheet 8.1: Mental Health
3. Tell the participants that to better understand the mental health disorders challenge, they will go into groups. Divide the participants into 3 groups.
4. Ask the groups to discuss mental health disorders as a key challenge in the community. Ask each group to consider the following aspects of mental health disorders and list them on a flipchart paper. (allow 15 minutes to do this, as you divide the group and draw the problem three on a flip chart).
   Group 1: Common mental illnesses/disorders
   Group 2: Causes/risk factors of mental illnesses/disorders
   Group 3: Consequences/effects of mental illnesses/disorders
   After the discussion group leaders to populate the problem tree
5. Ask one person from each group to present their discussions in the plenary with a brief explanation. Use Resource Sheet 8.1: Mental Health to add to the group presentations (Allow 5 minutes for each group)
6. Conclude the session by leading a discussion using the following questions and Resource Sheet 8.1: Mental Health.
   - What are some of the warning signs that someone is suffering from a mental disorder?
   - How does the masculine character affect your mental health?
   - How can mental health disorders contribute to the risk of HIV infection and related deaths?
   - How can HIV and TB affect your mental health?
   - What can one especially men do at the personal or community level to prevent and respond to the problem of mental health disorders
   - What are some of the factors that promote mental health wellness and what are the benefits of mental wellness?

End the session by emphasizing that with the right care and treatment, people with mental disorders can manage their illness, get better, and return to normal activities.

Resource Sheet 8.1: Mental Health
What is Mental Health?

Mental health is defined as "a state of well-being whereby individuals recognize and realize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities" (WHO: 2003)

What is Mental Illness?

Mental illnesses are health conditions involving changes in emotion, thinking or behaviour (or a combination of these). Mental illnesses are associated with distress and/or dysfunction in social, occupational, or family set ups. Benefits of mental wellness.

In Kenya, men face a disproportionate burden of mental health issues, with 56.9% of men experiencing mental disorders compared to 43.1% of women. Key issues include high rates of depression, anxiety, and suicide, often driven by stigma, economic pressure, and cultural expectations of stoicism, leading to only 28-50% seeking help; KNBS 2022 - Breaking the silence

Examples of Common Mental Disorders

- Depression
- Anxiety
- Bipolar disorder
- Schizophrenia and Psychotic disorder
- Substance use disorders (Alcohol and Drugs Use)
- Developmental, Emotional, and Behavioural conditions in Children and Adolescent
- Suicidal Behaviour
- Self-Harm
- Dementia
- Epilepsy
- Post-Traumatic Stress Disorder (PTSD)

Early Warning Signs and Symptoms

- Experiencing one or more of the following feelings or behaviours can be an early warning sign of a mental health disorder.
- Eating or sleeping too much or too little
- Keeping away from people and usual activities
- Having low or no energy
- Having a carefree attitude
- Feeling helpless or hopeless
- Smoking, drinking, or using drugs more than usual.
- Feeling unusually confused, forgetful, on edge, angry, upset, worried, or scared.
- Yelling or fighting with family and friends
- Experiencing severe mood swings that cause problems in relationships.
- Having persistent thoughts and memories you can't get out of your head.
- Hearing voices or believing things that are not true.
- Thinking of harming self or others
- Inability to perform daily tasks like maintaining personal hygiene, taking care of your kids or getting to school or work

Causes/Risk Factors Influencing Mental Health

Many factors (social, psychological, and biological factors) are known to affect mental health. Early life development can have huge impacts, both positive and negative on a person's mental health later in life. Factors known to increase the risk of developing mental health conditions include:

Biological Risk Factors

- Infections, such as malaria, meningitis and brain abscess
- Chronic illnesses such as cancer, tertiary syphilis and HIV

- Trauma, especially head injury
- Hereditary factors
- Malnutrition. Biological factors
- Chemical imbalance in the brain
- Genetics
- Brain injury
- Chronic illness
- Drugs and Alcohol Use
- Pregnancy and Childbirth (can be stressful)
- ***Psychological Risk Factors***
- Poor coping skills
- Low self-esteem
- Psycho-trauma
- Violence and abuse
- Poor self-esteem
- Emotional neglect
- Negative thinking

Social Risk Factors

- Poverty
- Life events, such as bereavement or sudden losses
- Stigma and social exclusion and discrimination
- Social instability, e.g. family instability, unemployment and violence.
- Child neglect and child abuse

Economic Risk Factors

- Unemployment
- Underemployment
- Debt

Environmental Risk Factors

- Noise
- Pollution such as Lead, mercury

Facts about Mental Disorders

- Anyone can suffer from a mental disorder.
- Having a mental disorder is not a character weakness or a result of being deliberately lazy or difficult.
- Mental disorders are not the result of curses, witchcraft, or evil spirits.
- People with mental disorders often need help to recover.
- A person with a mental disorder can hold a job and get married.
- Most people with mental disorders are not violent.

Ways of Promoting Mental Health Wellness

- Mental health promotion attempts to encourage and increase protective factors and healthy behaviours that can help prevent the onset of a diagnosable mental disorder and reduce risk factors that can lead to the development of a mental disorder.

- Have good relationships with your family, friends and colleagues to help you to build a sense of belonging and self-worth and provide you with emotional support
- Be physically active by doing exercises which cause chemical changes in your brain which can help to positively change your mood
- Learn new skills which help you to build a sense of purpose
- Give and be kind to others which creates positive feelings, and a sense of reward and helps you connect with other people

Provide support (including treatment support) for people suffering from mental disorders. This may include therapy to help a person identify and change troubling emotions, thoughts, and behaviours

- Promoting Peer support and community networks
- Reducing levels of violence in the community
- Ensuring people are free from stigma and discrimination
- Improving economic opportunities
- **Protect and respect basic civil, political, economic, social, and cultural rights**

Additional resources on Mental Health First Aid are available in the following introductory guide on Psychological First Aid (PFA):
https://pscentre.org/wp-content/uploads/2019/07/PFA-Intro-low.pdf

What not to do to a Person with a Mental Disorder

Common treatments or responses that **DO NOT** help a person with a mental disorder:

- Ignoring/ avoiding the person
- Believing the symptoms will just go away
- Locking the person away
- Being angry with him/her
- Relying exclusively on faith healing
- Relying on traditional healers
- Arranging a marriage if they are unmarried.
- Giving sleeping tablets or appetite stimulants
- Believing that you can cure the person or that you have all the solutions to their problems.
- Restraining them
- Calling names and using derogatory terms
- Do not minimize the issue.

Benefits of Mental Health

Mental health is important in every stage of our lives, which entails emotional, psychological, physical and social well-being which includes:

- Increased self-esteem
- Improved social interactions and relationships
- A greater sense of calm and inner peace
- Improved moods and clearer thinking
- Cope with the stresses of life

Session 8.2: Alcohol, Drug and Substance Abuse

Goal: To describe the alcohol, drugs and substances that are abused widely in Kenya and their effects

Objectives:

By the end of the session participants will be able to:

1. List the types of drugs and substances
2. Illustrate the signs and symptoms of substance abuse
3. Describe the contributing factors to their abuse and the effects of their abuse
4. Describe the prevention and management of alcohol and substance abuse.

Time: 60 Minutes

Audience: Men and Boys

Materials Required:

- Flipcharts
- Markers

Advance Preparation

Prepare a flipchart with the following questions before the session.

1. What is the definition of the terms, Drug use, Drug abuse, Withdrawal, Addiction and Tolerance?
2. Who uses the drugs and are there different levels of use?
3. What are some examples of drugs, what are their street names and where are they available?
4. What are some of the factors contributing to alcohol, drugs and substance abuse for Boys and Men respectively
5. What are some of the signs and symptoms of drug and substance abuse?
6. How do media advertisements on cigarettes and alcohol promote their use of? How do these media advertisements portray the men or women who use their products?
7. What are some of the effects of drug and substance abuse?
8. What are the risks associated with using drugs and substance abuse especially related to health seeking behaviour, sexual decision making, and GBV?
9. How does the use of drug and substance abuse affect relationships? Families? Communities?
10. What is the relationship between HIV/TB and Malaria vs Alcohol, drug and substance abuse?
11. What actions can one take or recommend to a person who would like to recover from alcohol, drugs and substances?

Steps

1. Start the session by informing the participants that we shall be discussing Alcohol, Drug and Substance Abuse as a common mental disorder.
2. Display the flipchart with the questions above Work down the list asking each question in plenary allowing the participants to give their responses. After a few responses, provide more information using Resource Sheet 8.2: Alcohol, Drug and Substance Abuse

3. Conclude the session by giving the participants the key message in the conclusion below.

Conclusion

There are many types of drugs, some legal, some illegal, some more commonly used by women, some more commonly used by men. It is important to think about the personal and social pressures that lead people to use drugs, and to be aware of the consequences of their use on individual lives, relationships, and communities.

It is difficult to generalize what factors lead a person to use drugs. Each person has his or her own reasons and sometimes they're not even clear to the individual. In the majority of cases, there might be a variety of reasons: curiosity, a desire to forget problems, an attempt to overcome shyness or insecurity, dissatisfaction with one's physical appearance, etc.

Family, friends, and peers must offer support, without blame or judgment, to help the individual reflect on the harmful effects of drug use, to identify healthy alternatives, and how to seek competent professional help if needed. National Agency for the Campaign Against Drug Abuse (NACADA) can be contacted on toll-free line 1192 for professional counselling and linkage to accredited treatment and rehabilitation facilities.

Alcohol, drug and substance abuse can be eradicated by awareness creation and education by leveraging community-based education programs and platforms such as religious and cultural spaces targeting boys and men with information, identification and referral of persons with alcohol and drug abuse disorders to the relevant services, offering support for re-integration of persons recovering from alcohol and drug abuse disorders, community-based education programs that destigmatize alcohol and substance abuse and promote mental well-being.

Resource Sheet 8.2: Alcohol, Drug and Substance Abuse

DEFINITIONS

The term drug includes legal and illegal substances such as alcohol, steroids, marijuana etc

Drug use: This term means taking drugs. The term does not necessarily mean that the drug-taking is harmful or ongoing.

Tolerance: Physiological state in which an increased dose is needed to produce a specific effect

Drug abuse: This term is often used to describe drug use that causes harm.

Addiction: Addiction to a drug means that the person: has a strong desire or compulsion to use the drug; finds it difficult to control the drug-using behaviour; is uncomfortable or distressed if the drug taking is prevented or stops (withdrawal symptoms); keeps using the drug, even when it is causing problems.

Withdrawal: It's the symptoms that a person develops when they stop taking the drug.

ALCOHOL ABUSE

What is considered a "drink"?

- 350ml of 5% beer
- 150ml of 12% wine

- 45ml of 40% distilled spirits or liquor e.g., gin, rum, vodka, whiskey

However, to be more accurate, this can be calculated according to the weight of a person.

What is alcohol abuse?

Overconsumption of alcohol - 5 or more drinks within a period of 2 hours on an occasion for men or 4 or more drinks on an occasion for women.

Excessive drinking- ***For*** women, heavy drinking is 8 drinks or more per week. For men, heavy drinking is 15 drinks or more per week.

Underage drinking-Any alcohol use by those under age 18.

SUBSTANCE ABUSE

	DRUG NAME	**STREET DRUG NAME**	**METHOD OF USE**
CANNABIS - is the most widely used illicit drug. It is psychologically addictive.	Marijuana	Weed, pot, grass, joints, Bhangi, ndom, omsala, F, manyaru, ndukulu, ombitho, ngwai	Smoked or ingested
DEPRESSANTS - slow down the central nervous system and all body functions. Depressants cause euphoria and calm, and they decrease inhibitions. Because they are highly addictive, withdrawal is painful.	Alcohol including illicit brews	Beer, wine, distilled spirits, chang'aa, methanol	Ingested
	Benzodiazepines	Xanax, Valium, Halcion, BZD's, benzos, speed	Ingested
	Barbiturates	Luminal, Seconal, Barb, downers	Ingested
	Rohypnol	Roofies, forget-me-pill	Ingested or snorted
	Opioids	Heroine	Injected
STIMULANTS - speed up the brain and the body. They cause temporary excess energy, a false sense of power and erratic behaviour. They are rapidly addicting.	Cocaine	Coke, brown sugar, crack,	Snorted, smoked or injected
		Shisha, Kuber/velo/lift Miraa, muguka	Smoked Sucking Chewing
	Amphetamines	Speed, uppers, cross-tops	Ingested
	Methamphetamines	Meth, crystal, speed, crank, ice	Snorted, smoked or injected
	MDMA (Methylene Dioxy Methamphetamine)	Ecstasy, X, XTC, the club drug, the love drug, Adam, Lovers' speed	Ingested
Legal drugs and substances which are abused	Antidepressants & antipsychotics	Largactil, roche,	Ingested
	Cough syrups		Ingested
	Petroleum products	Glue, fuel	Inhaled

Factors contributing to alcohol, drugs and substance abuse

1. ***Individual factors***
   - Control of Anxiety. (Anxiety is a mental mechanism that compels us to cater for our most basic needs: Food, shelter, and love.
   - Control of emotions
   - Dismiss fear
   - Evade boredom
   - Stress - occurs when there is an imbalance between the demands of life and our inability to cope with them.
   - Too much workload.
   - Low achievement.
   - Overbearing spouses.
   - Sheer Curiosity
   - Lack of Education or information about the effects of drugs
   - Looking forward to your pleasure,
   - Peer/Social Pressure etc
2. ***Relational factors***
   - Marital conflicts
   - Disintegrated families
   - Poor parenting styles etc
3. ***Social economic factors***
   - Information resulting from of media e.g. social media hype
   - Culture-Many cultural activities are associated with drugs e.g. marriage, harvest etc
   - Socio-economic and cultural changes which foster isolation, depression etc
   - Unemployment and unstable occupation/work
   - Poverty
   - High cost of living
4. ***Workplace factors***
   - Work-related stress e.g. toxic work relations
   - Work overload
   - Failure to grow professionally, get recognition or promotion
   - Entropy – Same workstation, same duties, same people, no new challenges
   - Poor work structure and policies

Signs and Symptoms of Drug and Substance Abuse.

Unhealthy appearance, marked deterioration in physical hygiene and grooming, poor physical coordination, slurred or incoherent speech, bloodshot eyes or red eyes, dilated pupils, drooping eyelids, burnt or stained thumbnails or finger tips, burnt holes on clothing, injection marks as evidence of using needles, dark circles under the eyes and a blank facial expression, memory lapses or blackouts, short attention span, difficulty in concentration, insomnia (lack of sleep), moodiness, fatigue, restlessness, shakes, agitation, nausea, vomiting, sweating, hallucinations and convulsions, suicidal tendencies, increased absenteeism or tardiness (slow in arrival), lethargy (lack of energy), inattentiveness, lack of concentration, loss of interest, quarrelsome, chronic dishonesty

Effects of alcohol, drugs and substance abuse

Individual effects

- Poor nutritional habits
- Low immunity and poor health
- Chronic health effects e.g. liver cirrhosis, NCDs

- Risky behaviours including sexual behaviours and effects of that e.g. HIV risk, accidents
- Lack of self-respect
- Poor performance at any task e.g. school, work
- Addiction could lead to suicidal thoughts •
- Mental health problems e.g. high suicide rates, depression, anxiety, low self-esteem etc
- Death

Relational effects

- Poor role model to other family members
- Disintegrated families and marriages
- Caregiver/ spouse/familial stress
- Domestic violence
- Poverty

Societal/community effects

- Poor productivity and poor use of money
- Insecurity e.g. school-related violence, theft etc
- Accidents on the roads, in place of work etc •
- Spread of HIV and AIDS e.g. in PWIDs

Appendices

Appendix1: Dalili za Ugonjwa wa Kisukari (Symtpoms of Diabetes)

Appendix 2: Unhealthy Eating Habits





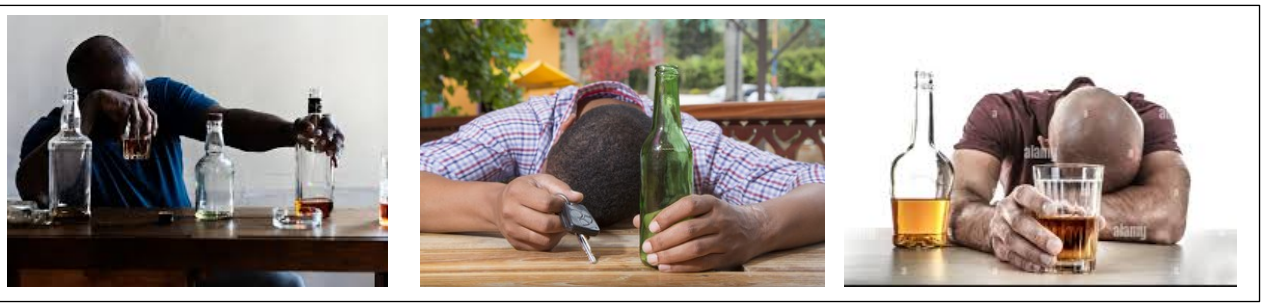

Sedimentary lifestyle




Overweight and Obesity
Waist Circumference: Waist circumference is an indicator of cardiovascular disease risk

Appendix 3: Examples of Alcohol, Drug and Substance Abuse



Excessive alcohol consumption

Appendix 4: Referral Pathways

Gender-based violence (GBV) referral pathways are structured systems designed to ensure that individuals who have experienced or are at risk of experiencing GBV receive the appropriate support and services. These pathways typically involve multiple stakeholders and organizations, including government agencies, non-governmental organizations (NGOs), healthcare providers, law enforcement, legal aid services, and community-based organizations. Here's an outline of the common components and steps in GBV referral pathways:

1. **Identification and Reporting**: The first step in the referral pathway involves identifying cases of GBV. This can occur through various channels, such as individual self-reporting, healthcare providers identifying signs of abuse during medical consultations, social workers, community outreach programs, or reports from concerned family members, friends, or neighbours.
2. **Initial Response and Safety Planning**: Once a case of GBV is identified, the individual is provided with immediate support and safety planning. This may involve removing them from immediate danger, providing emergency shelter if needed, and connecting them with a trained counsellor or advocate who can offer emotional support and guidance.
3. **Referral to Services**: Based on the individual's needs and circumstances, they are referred to appropriate services and resources. These may include:
    - Medical Services: Referral to healthcare providers for medical treatment, including examination, treatment of injuries, sexual and reproductive health services, and access to emergency contraception or STI/HIV testing and treatment.
    - Psychological Support: Referral to mental health professionals, counsellors, or support groups to address trauma, anxiety, depression, or other psychological effects of GBV.
    - Legal Aid and Protection: Referral to legal aid services or organizations that provide legal assistance to survivors of GBV, including support with obtaining

protection orders, navigating the criminal justice system, and accessing legal remedies.

- Shelter and Housing Support: Referral to shelters or safe houses for survivors who need temporary accommodation and protection from their abusers.
- Social Support and Economic Empowerment: Referral to social services, NGOs, or community-based organizations that offer social support programs, economic empowerment initiatives, vocational training, job placement assistance, or financial assistance to survivors to help them rebuild their lives.
- Child Protection Services: Referral to child protection agencies or organizations that provide support and protection to children who have experienced or witnessed GBV.
- Toll-free reporting line: Police (911 and 999), Children (116). Specific to men who have been abused (1198), GBV hotline (1195). ***Facilitators to identify and record specific hotlines within the county.***

4. **Follow-up and Monitoring**: After the initial referral, follow-up and monitoring are essential to ensure that survivors receive ongoing support and assistance. This may involve regular check-ins, counselling sessions, case management, or referrals to additional services as needed.
5. **Coordination and Collaboration**: Effective GBV referral pathways require collaboration and coordination among various stakeholders and service providers. This includes sharing information, coordinating service delivery, and establishing protocols for referral, confidentiality, and data sharing.
6. **Capacity Building and Training**: To strengthen GBV referral pathways, capacity building and training initiatives are essential for frontline workers, service providers, law enforcement officials, healthcare professionals, and community leaders. Training should focus on GBV awareness, trauma-informed care, survivor-centered approaches, legal frameworks, and ethical guidelines.

By establishing comprehensive and coordinated GBV referral pathways, communities can better respond to cases of GBV, provide survivors with the support they need, and work towards preventing future incidents of violence.

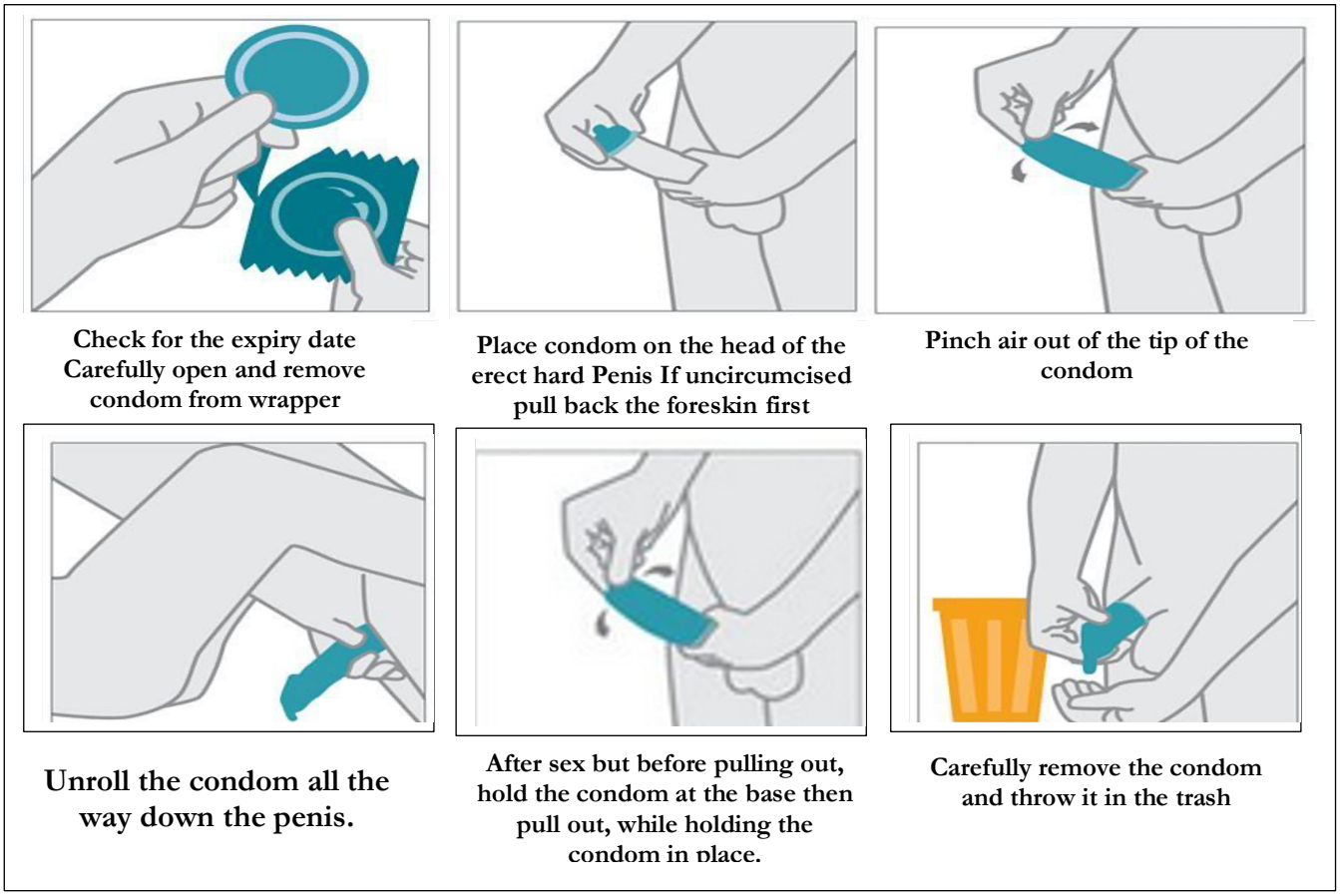
Appendix 5: Standard Operating Procedures for Gender Based Violence

These are the step-by-step procedures to be adopted by police officers in all police stations, police posts, outposts, camps, and patrol bases when handling GBV cases upon receiving a report of a violation. Police officers are expected to:

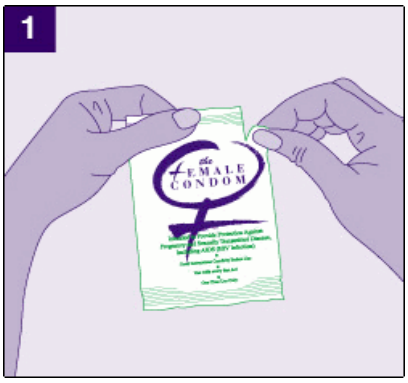
1. Ensure that reports and statements are taken private for confidentiality. No statements should be taken at the front desk in the presence of all and sundry.
2. Record the incidence of violation/abuse in the Occurrence Book and explain to the survivor the process that shall ensue. At this point, the officer may assess whether the survivor needs counselling and may invite a counsellor to attend to the survivor. The officer may also take advice from a medical practitioner in this regard.

3. Issue the survivor with a P3 form free of charge for his/her visit to the health facility. A police officer *must* escort the survivor to the nearest health facility within 72 hours for rape and related cases, or as soon as the violation is reported.
4. Ensure that the medical personnel collect samples/exhibits found either on the clothes or on the body of the victim.
5. Collect all medical exhibits obtained by the medical personnel and the clothes of the survivor in an appropriate container made from appropriate material. They must not under any circumstances be put in a polythene bag.
6. Collect a copy of the duly filled P3 and PRC form from the examining clinician.
7. Ensure that the chain of custody of the exhibits is maintained.
8. Visit the scene of the crime for the collection of more exhibits and to carry out any further investigations that relate to the case.
9. Take the survivor to a calm, private environment where his/her statements will be recorded. As far as possible, the statement should be recorded by an officer trained on handling GBV cases.
10. In case the statement reveals an additional offence or a separate offence from the one initially recorded in the Occurrence Book, the officer should record a new entry, amending the previous entry.
11. Record a comprehensive statement with all the relevant details about the alleged offence.
12. Record statements from witnesses who have accompanied the survivor.
13. Ensure that the suspect is arrested.
14. Record a statement from the suspect.
15. Where necessary, escort the suspect to the nearest health facility for his/her samples to be taken.
16. Draft a charge sheet, with the statement of offence and particulars properly set out.
17. Ensure that the charge sheet is signed by the Officer Commanding the Police Station or Deputy OCS and take the suspect to court within 24 hours.
18. Where it is impossible to charge the suspect within 24 hours, document the activities that took place in the intervening period and the reasons for the inability to charge him/her. An apprehension report form/ affidavit should be prepared/acquired and presented to the court.
19. Where the survivor and the suspect are both under the age of 18, a Social Enquiry Report should be prepared.
20. In cases of incest, or where the survivor is aged 18 and below and is a dependent of the suspect, arrest and charge the suspect; coordinate with the Department of Children's Services to rescue the survivor.
21. Ensure the exhibit memorandum form is filled appropriately.
22. If the suspect denies the charge(s), ensure all witnesses are bonded on time and available to give court evidence.
23. If it is apparent that the survivor is untruthful, an inquiry file should be opened and presented to the ODPP seeking further directions on how to proceed with the case.
24. In the case of complaints filed by an individual with special needs, the case should be referred to an officer specially trained to address their needs. Open a case file and assign it a Serious Crime Register Number.

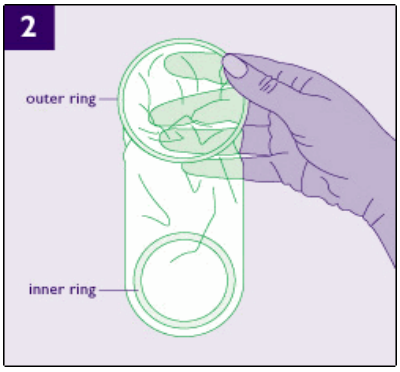
Appendix 6: Illustration on how to put on and Remove a Male Condom



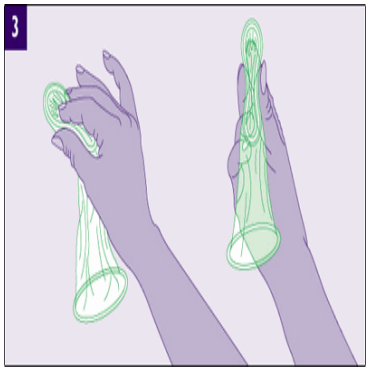
Appendix 7: Steps of using a Female Condom



Open the Female condom package carefully, tear at the notch on the top right of the package. Do not use scissors or a knife to open.

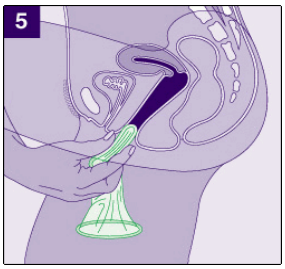


The outer ring covers the area around the opening of the vagina. The inner ring is used for insertion and to help hold the sheath in place during intercourse.

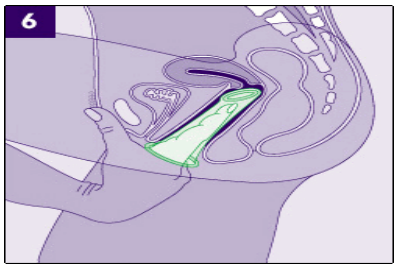


While holding the Female condom at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow

Choose a position that is comfortable for insertion of the Female Condom – squat, raise one leg, sit or lie down



Gently insert the inner ring of the female condom into the vagina. Feel the inner ring go up and move into place.



Place, the index finger on the inside of the Female condom and push the inner ring up as far as it will go. Be sure the sheath is not twisted. The outer ring should remain on the outside of the vagina

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