SIMBA UTANO
PARTICIPANT HANDBOOK

YOUTH ENGAGE
"Promoting Youth Empowerment; Responsibility and Restoring Hope!!"

Katswe Sistahood

With financial support from the Government of Canada
Canada

Simba Utano Adolescent Sexual and Reproductive Health and Rights (ASRHR)

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Contents

Abbreviations

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immuno-Deficiency Syndrome
ART	Antiretroviral Therapy
ASRHR	Adolescent (and young people) Sexual And Reproductive Health and Rights
CATS	Community Adolescent Treatment Supporters
CSE	Comprehensive Sexuality Education
CSOs	Civil Society Organizations
eMTCT	Elimination of Maternal to Child Transmission
ESA	Eastern and Southern Africa
HIV	Human Immuno-deficiency Virus
HPV	Human Papilloma Virus
ICPD	International Conference on Population and Development
IPPF	International Planned Parenting Federation
LFA	Logical Framework Approach
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MoHCC	Ministry of Health and Child Care
MoPSE	Ministry of Primary and Secondary Education
NAC	National AIDS Council
NGO	Non-Governmental Organization
PCC	Parent to Child Communication
PEP	Post Exposure Prophylaxis
PoA	Plan of Action
PrEP	Pre-Exposure Prophylaxis
RMNCH-N	Reproductive, Maternal, Newborn, and Child Health and Nutrition
SADC	Southern African Development Community
SDG	Sustainable Development Goal
SDP	Service Delivery Point

SGBV	Sexual and Gender Based Violence
SMART	Specific, Measurable, Attainable, Realistic and Timebound
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually Transmitted Infection
TOT	Training of Trainers
UN	United Nations
UNICEF	United Nations Children Education Fund
VMMC	Voluntary Male Medical Circumcision
WHO	World Health Organization
YFS	Youth Friendly Services
YFSP	Youth Friendly Services Provision
ZANU PF	Zimbabwe African National Union Patriotic Front
ZDHS	Zimbabwe Demographic Health Survey
ZIMASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZNFPC	Zimbabwe National Family Planning Council

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Background and Purpose of the Guide

Background

Worldwide, young people (10 to 24 years) account for over 30 percent of the population world today. Young people often face barriers in accessing sexual and reproductive health (SRH) information, learning opportunities and services. The resulting lack of knowledge and access to services as well as the stigmatisation of young people's SRH in societies impedes most of them from living a healthy SRH life. These young people face a myriad of challenges, which include gender-based violence, child marriage, HIV infection and other negative reproductive health outcomes. Access to comprehensive information, life skills and friendly services is therefore an indispensable condition for young people to live responsible, healthy and self-determined sexual and reproductive health lives. As such, initiatives that seek to strengthen health service providers' competencies to deliver quality, integrated and friendly health services, including comprehensive information need to be expanded. This guide was developed to help in the process of strengthening such capacity among health service providers.

Purpose of the guide

Zimbabwe, like other Eastern and Southern African (ESA) countries affirmed the 2013 commitment towards strengthening comprehensive sexuality education (both in and out of school) and the provision of quality adolescent sexual and reproductive heath services. Additionally, the National Adolescent and Youth Sexual and Reproductive Health (ASRH) Strategy II: 2016 – 2020, recognises the need for strengthening the capacity of health service providers to provide quality and friendly ASRH information and services, in line with the 2016 World Health Organisation (WHO) global standards on provision of quality adolescent health services. The National ASRH Strategy II defines ASRH service providers from both preventive and curative perspectives, in schools, health facilities, communities and tertiary colleges. The purpose of this handbook is therefore:

- To serve as a reference guide for participants undergoing training or mentorship on Adolescent and Youth Sexual and Reproductive Health (ASRHR), under the Simba Utano Project.

Purpose of the guide

Participants for the ASRHR training *(users of this handbook) can be drawn from schools, health facilities, communities and tertiary colleges (e.g. teachers, clinical health workers, health facility support staff, lecturers, community based distributors, village health workers, counsellors and peer educators/ counsellors).* Below, is a table indicating a mapping of potential participants (users) of this handbook by setting of ASRHR programming in Zimbabwe:

Primary & Secondary School setting	Health facility setting	Tertiary college setting	Community setting
Teachers	Nurses, including mental health	Nurses	Village health workers
Guidance and Counseling teachers	Nurse aids	Nurse aids	Community based distributors
School Health Masters	General hands	General hands	Behaviour Change facilitators
GBV Desk coordinators	Community Adolescent Treatment Supporters (CATS)	Lecturers	Parent-Child Communication mentors
School heads	Doctors	Peer Educators	Community Adolescent Treatment Supporters (CATS)
School inspectors	Pharmacists	Dean of Students	Peer Educators
Heads of departments	Security guards	Chaplin	Sister-Sister Club mentors
	Accounts	Doctors	Young Mother mentors
	Laboratory staff		Community (child) case care workers
	Primary Care counsellors		Community Youth Centre facilitators
	Nutrition coordinators		Pharmacists
	Environmental health officers/ technicians		VMMC mobilisers
	Student nurses and doctors		Police officers (victim friendly unit)
			Health promoters (urban areas)
			Home-based caregivers
			Parents/Guardians
			Religious leaders
			Traditional and faith healers

Duration of training and how to use the handbook

This handbook provides for the ASRHR material that can be delivered in 4-5 days, excluding a one-day for the Training of Trainers (TOT). However, the duration may be adjusted (less or more) depending on the type or cadres being trained. Please note that, this handbook is a just a guide and participants are encouraged to read widely, including the provided references for more information. Some information provided in this handbook may require periodic updating. The following are some of the tips that may help a participant to enjoy and benefit from the training:

1. Have a self-drive and motivation to enhance your knowledge and skills in communicating and engaging with adolescents towards adoption of safe and responsible behaviours.

2. Participate meaningfully.

3. There is no "wrong" answer hence freely participate and contribute during discussions.

4. Be careful not to impose your beliefs and values on the group.

5. Respect and adhere to the norms and ground rules that may be agreed upon by the whole training group members.

6. Have a self-drive to interact and network with other training participants for sharing notes and having fun during the training.

7. Carry out the exercises and assignments given during the training diligently.

8. Even if you have participated a similar or related training, see this training as an opportunity to learn new things and even help enrich learning among other participants through sharing and participating actively during the training.

Training delivery approach

There is currently a global drive to shift away from less effective conventional learning techniques to learning approaches that actively engage participants. It is therefore based on a participatory learning approach that allows for participants to learn through active processes. By means of exercises, participants will explore and share their own experiences and knowledge, critically conceptualise and reflect upon solutions from which they will derive learning contents and ways for behavioural change. Throughout the modules, facilitators will adopt participatory methods, interactive and creative tools to facilitate learning on SRHR topics, other relevant content, and life skills. Several interactive training methodologies will be used, and it is the primary responsibility of the participant to actively participate. During the introductory sessions and towards the closing, participants may be requested to take up pre and post tests, respectively. The results of pre-test serve to benchmark and provide a baseline for measuring against the post test results.

The objectives of the training

- To strengthen, among participants, the understanding of sexual and reproductive health challenges being faced by adolescents.

- To strengthen the skills of participants to effectively advocate, communicate and engage with adolescents on sexual reproductive health and rights issues.

- To strengthen the capacity of participants to design, implement, monitor, evaluate and sustain adolescent friendly sexual and reproductive health services and programmes.

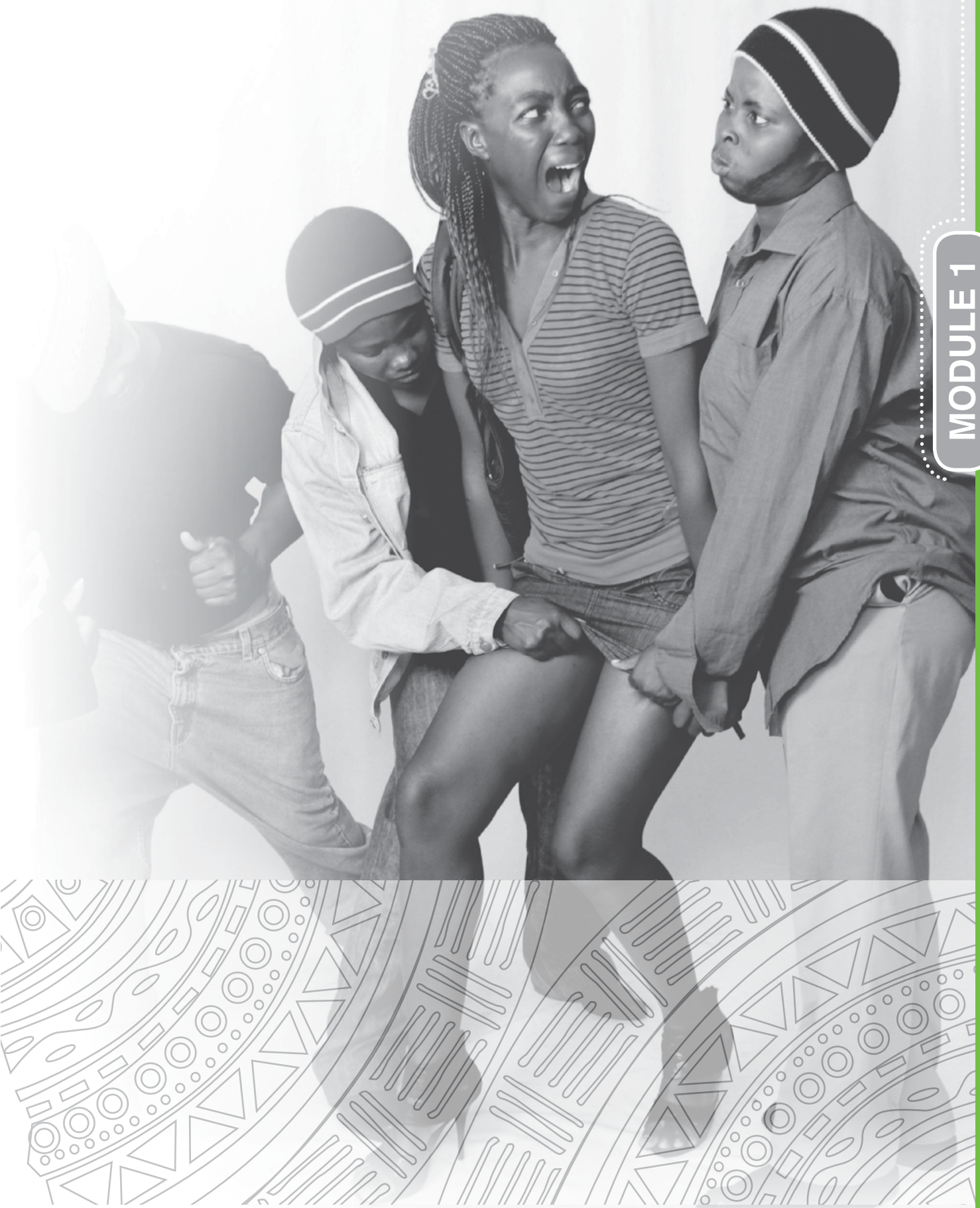
Training program description

Below, is a generic or sample program for the ASRHR training guided by this handbook. Facilitators will conduct an analysis of pre-test exercise on day one and may adjust the flow and time allocations of the program accordingly

Sample training program

Time	Day One	Day Two	Day Three	Day Four
0800	Registration, norms, Welcome, Expectations and Objectives Pre-Test	Laws, Policies, Strategic Frameworks and Advocacy on ASRHR	Quality and friendly SRHR service delivery for adolescents	Post Test
0920	Adolescent Population and subgroups	Principles of ASRHR programming		
1000– 1020	**HEALTH BREAK**			
1020	The SRH challenges being faced by adolescents	Life skills empowerment for adolescents	Self-awareness and empowerment of the service provider	**Action planning**
	Physical development and human sexuality in relation to ASRHR		Values Clarification	**Workshop Evaluation** **Closure**
1300 – 1400	**LUNCH BREAK**			
1400	Adolescents rights and responsibilities in the context of SRHR	Comprehensive sexuality education for adolescents	Educating and counselling adolescents: Practical tools and skills demonstration	
1500 – 1515	**HEALTH BREAK**			
1515	Laws, Policies, Strategic Frameworks and Advocacy on ASRHR	Quality and friendly SRHR service delivery for adolescents	Educating and counselling adolescents: Practical tools and skills demonstration	

The morning sessions from day two to four may need to start with a participatory 5-10-minute recap of the activities of the previous day. The training can end between 1630 - 1700 hours depending on the session delivery methodology. After every session, participants need to be asked to write down at least key three things learnt and at least three things they consider doing differently post training, at both individual and collective team levels.



MODULE 1

ASRHR Situational Analysis

MODULE 1: ASRHR Situational Analysis

The 2002 Zimbabwe Population Census shows that the country has a young population with a third of its population aged between 10-24 years (adolescents and youth). These young people have continued to face various sexual and reproductive health challenges related to their development despite some notable investments in addressing these challenges.

Session 1: Defining the adolescent population and subgroups

1.1.1 Definitions

The World Health Organization (WHO) defines **Adolescent population** as the period between the ages of **10 – 19 years** and young people as the period between the ages of **10 – 24 years.**

The client target population can be broken into the following age categories:

- Early adolescent – 10 to 13 years; Mid adolescent - 14 to 15 years; Late adolescent - 16 to 19 years and Youth – 20 to 24 years.

Young adult refers to anyone aged 15 – 24 years. **Young person** refers to anyone between 10 – 24 years. **Teenager** refers to anyone aged 13 – 19 years and **Child** refers to anyone under 18 years.

In Zimbabwe, the National ASRH Strategy II: 2016 – 2020 and the National Guidelines of Clinical Adolescent and Youth Friendly Services Provision (YFSP) therefore recommend the use of these terms **"adolescents", "young people"** and **"youth"** interchangeably to refer to the 10 – 24-year target age group.

While often viewed as one homogeneous group, in reality adolescents and young people are an enormously diverse group, not only in terms of age and gender, but also in terms of ability, beliefs and the nature of circumstances and vulnerabilities they experience. Furthermore, many approaches that address the vulnerabilities and challenges of adolescent and young people often fail to contextualize sexual reproductive health within a wider framework of young people's lives or involve them in identifying solutions to their challenges. Any working definition of adolescents' sub groups is therefore highly dependent on the socio-economic and cultural context. Below is a list of different sub groups of young people:

- Adolescents 10 - 13 years, 14-15years, 16-19years, and youth 20-24yrs
- Adolescents that are not sexually active
- Sexually active adolescents
- Young people with disabilities
- Young people living with HIV
- Married adolescents
- Pregnant adolescents
- Young parents
- Adolescents in school
- Adolescents out of school
- Young people living on the streets
- Children in conflict with the law
- Orphaned adolescents
- Adolescents selling sex
- Adolescents with different sexual orientations.

1.1.2 Settings for ASRHR programming

Due to their diverse characteristics, young people present and are found in different settings at different times. Zimbabwe has therefore identified and defined four broad settings where young people can be engaged and reached with SRH information and services. These are: the public health facility setting, the primary and secondary school-based setting, the tertiary education institution based setting and the community-based setting. The nature and design of these settings require different approaches, tools and partnership arrangements for effective service delivery. Community settings include family set ups (parents and siblings), community youth centres, private pharmacies, peer groups, recreational centres and religious/faith based groups (e.g. churches). The education setting is divided into primary and secondary and the tertiary levels as a result of the diversity in age group, needs and social experiences of the populations in these institutions. In Zimbabwe, the tertiary settings include universities, colleges, polytechnics, vocational training centres. The public health facility based services are those public institutions that offer a comprehensive range of promotive, preventive, curative and referral, tracking and feedback services. In the educational institution setting, there may or may not be professionally qualified health service providers and therefore the referral mechanisms between and across these settings will ensure effective service provision.

NB: All adolescents' population subgroups require special attention compared to others. Service providers should be able to identify such adolescents and help them accordingly, including referring cases to appropriate health institutions, networks and support organisations.

References

- National Guidelines on Clinical Adolescent and Youth Sexual and Reproductive Health Services Provision (YFSP), 2016 Edition, Ministry of Health and Child Care, Zimbabwe

Session 2: The SRH challenges being faced by adolescents

1.2.1 The SRHR Situation of Adolescents

SRHR situations for adolescents change with times, as laws, policies and strategic frameworks are reviewed and updated. Below is a list of key documents to be reviewed:

- International commitments on ASRHR, including targets (global UN frameworks)
- Regional bodies' strategic frameworks and declarations (e.g. African Union, SADC and ESA commitments)
- National constitution, relevant laws, bills and policies on ASRHR, including any current parliamentary discussions
- Ministerial statements or circulars on ASRHR
- Relevant strategic frameworks

Key sources of data on the SRH status of adolescents include population based surveys (e.g. Zimbabwe Demographic and Health Surveys, the Multiple Indicator Cluster Survey, special surveys and score cards) and management information systems (e.g. Health Management Information System and the Education Information System). The situational analysis need to be comprehensive enough to address the following issues in categorisations, such as by age, sex, residence (e.g. rural/urban & province/district) and literacy levels:

- SRHR and HIV knowledge levels
- Sexual experiences of adolescents (e.g. abstinence and condom use)
- Incidences and prevalence of STIs and HIV
- Sexual and gender based violence
- Pregnancy and childbearing
- Early marriage
- Uptake of various services, e.g. contraception, HIV Testing services, safe delivery and ART
- Maternal morbidity and mortality

NB: ASRHR interventions to adopt individual and targeted approaches, given that adolescents have different vulnerabilities.

Session 3: Physical development and human sexuality in relation to adolescents

1.3.1 Defining Adolescence

Adolescence begins at puberty. It is a period in which an individual undergoes major physical, psychological and emotional changes. It is a period characterised by exceptionally rapid growth and development. During this stage, the body develops in size, strength and reproductive capabilities, and the mind becomes capable of more abstract thinking. It is a phase in an individual's life, rather than a fixed age band, and is perceived differently in different societies. Adolescence is defined by the World Health Organisation (WHO) as the period between the ages of 10 – 19 years. It is broken down into three stages (*which in some literature, overlaps*):

- **Early adolescence:** 10 - 13 years **Mid adolescence:** 14 - 15 years
- **Late adolescence:** 16 - 19 years

During puberty, boys' and girls' bodies grow faster, their reproductive organs start to function and they mature sexually. Boys begin puberty at about 12.5 years to 13 years of age. The process takes about 5 years. Girls begin at 11.5 to 12 years of age, and the process takes about 6 years. Puberty tends to begin earlier in recent years due to nutritional, environmental and social factors. The end of adolescence is difficult to determine because the characteristics are less obvious. It is also determined by various social, legal, psychological, and economic criteria.

1.3.2 The male and female anatomy

The organs of sex and reproduction are similar in origin, they are developed from the same embryonic or erectile tissue (Homologous). They are similar in function (Analogous). In the first six weeks of gestation, male and female foetuses appear identical.

The corresponding organs are:

Male	Female
scrotum	outer lips (labia majora)
lower side of penis	inner lips (labia minora)
glans penis	glans clitoris
testes	ovaries

1.3.3 Changes in Boys/Girls and in Both Boys and Girls

Changes in	Changes in both Boys and Girls
BOYS	
• Spermatogenesis (the production of sperms) • Ejaculation • Growth in body height • Development of pubic hair and facial hair • Body shape beginning to look adult • Voice changes • Skin problems (acne for some) • Sensitivity about personal appearance • Preoccupation with opposite sex • Sensitivity to what others think and say about their wet dreams (nocturnal emissions) • Growth in penis length and thickness • Growth of testes • Gain in muscular strength **GIRLS** • Ovulation (the release of a ripened ovum or egg from the ovary). • Menarche (beginning of menstruation) • Menstruation (the periodic discharge of blood and tissue from the womb). • Development of secondary sexual characteristics e.g., a. Breast enlargement b. Growth of pubic hair c. Enlargement of labia and clitoris	• Growth in body height • Development of pubic hair • Body shape beginning to look adult • Voice changes • Skin problems (acne) for some • Sensitivity about personal appearance • Preoccupation with opposite sex • Sensitivity to what others think and say about them

1.3.4 Hygiene and menstrual health management

1.3.4.1 Hygiene of organs

Frequent Bathing: Regular bathing or showering is important for both male and female adolescents as oil and sweat glands in the genital area of boys' and girls' bodies become active at puberty. Special attention needs to be given to the armpits, feet, and between the buttocks as well as wearing clean clothes.

Using Sanitary Wear: Extra care and hygiene are important during menstruation. Pads and tampons should be changed frequently, and pants should be washed and dried properly. A sanitary pad is an absorbent item worn by a woman while she is menstruating, recovering from vaginal surgery, for post birth bleeding (lochia), abortion or any other situation where it is necessary to absorb a flow of blood from a woman's vagina. They are worn externally between the vulva and a woman's undergarment. Some women use cotton wool in place of pads. Alternatively, some women use washable or reusable cloth. The cloth has to be highly absorbent, such as cotton flannel as the best way to prevent pimples/acne. Washing the skin two or three times a day with regular soap may be enough for some teens, while others need to use a special soap with ingredients that kill bacteria, such as carbolic soap.

Menstrual Discomfort

Menstrual discomfort differs for all girls and women. Some have painful cramps before and during their periods, as the uterus contracts, others do not. Applying a warm compress where the cramps are felt can reduce pain, in many cases. Other possible remedies include: a hot bath, a walk, a hot beverage (such as tea) and pain-relieving medication such as ibuprofen or acetaminophen can be taken if cramps are severe. If very serious cramps occur frequently, a girl may need to consult her health practitioner. Some premenstrual symptoms, such as bloating, tender breasts, headaches, constipation and feeling tired and irritable can be prevented by:

- Cutting down on salt and salty foods to avoid retaining water
- Exercising more frequently to speed up circulation
- Drinking more water to aid digestion and prevent constipation

1.3.5 Pelvic Examination

This is a routine examination of a woman's reproductive and sexual organs to be sure they are healthy and normal and to check for early signs of infection or medical problems. Girls should begin having pelvic examinations by the age of 18 or earlier if they are sexually active in which case they should have an examination every 2 years.

1.3.6 Breast Self-Examination

The self-examination technique is very important to detect early signs of breast cancer. Breast self-examination consists of feeling each breast in a circular motion to search for any lumps or thickening that could signal cancer. Teenagers rarely get breast cancer but getting in the habit of doing self-examination once a month is a good idea. By age 25, all women should examine their breasts once a month.

1.3.7 Douching

Douching is the rinsing of the inside of the vagina. Douching is not usually recommended since it washes away the natural bacteria that keep the vagina clean and free of infection. Some women like to douche, especially after menstruation or intercourse. Douching does not prevent one from getting pregnant or sexually transmitted infections including HIV.

1.3.8 How to keep external female reproductive organs clean

- Use soap and water to wash the external genitalia and under your arms every day, especially during menstruation.
- Use either a disposable pad made of cotton, which has a nylon base, or a clean piece of cotton cloth to absorb blood during menstruation.
- Properly dispose of the pad after each use or, wash and dry the piece of cloth used as menstrual pad before reuse.
- Wash only the external genitalia. Do not try to clean the inside part of the vagina.
- While washing, wash starting from the vagina towards the anus. Do not wash from the anus towards the vagina. This will allow germs to enter the inner genitalia easily and cause infection.
- Be aware of abnormal fluids from your vagina. Do not confuse this with normal vaginal fluids.
- If you see any changes in the vaginal fluid – a change in colour or odour, please visit a health professional.

1.3.9 How to keep the male reproductive organs clean

The penile area releases smegma (a whitish substance) under the folds of the foreskin. The collection of smegma produces an unpleasant odour. Regular bathing is necessary to keep the penis healthy and clean.

- Wash the external genitalia at least daily with soap and water, as you wash the rest of the body.
- Boys who are not circumcised need to pull back the foreskin and gently wash underneath it with clean water.
- Be aware of any abnormal fluids coming from your penis. Do not confuse this with the presence of normal fluids.
- If you see any abnormal fluid or wound, please visit a health professional.

1.3.10 Defining key sexual terms and patterns

Defining sexual terms

Sex: Refers to one's reproductive system as male or female. It has to do with biology, anatomy, and physiology. It is a crucial element in everyone's sexuality.

Gender: Gender refers to socially constructed differences between men and women. These are commonly shared expectations about how men and women should behave in various situations.

Sexuality: Sexuality is an expression of who we are as human beings. Sexuality includes all 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.

Sexuality begins before birth and lasts throughout the course of the life span. 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 the ways in which he or she has been socialized. Consequently, the ways in which individuals express their sexuality are influenced by ethical, spiritual, cultural, and moral factors. Sexuality is much more than sexual feelings or sexual intercourse. It is an important part of who a person is and what she or he will become.

Sexual Health: In broad terms, sexual health is a personal sense of sexual well-being as well as the absence of disease, infections or illness associated with sexual behaviour. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. Sexual health can be described as the positive integration of physical, emotional, intellectual

and social aspects of sexuality. (World Health Organization, 2002).

Reproductive health: Is the state of complete physical, mental and social well-being of an individual in all matters relating to the reproductive system and its processes and functions but not merely the absence of disease or infirmity. It also includes sexual health and suggests that people with adequate reproductive health have a satisfying and safe sexual life, can have children, and can make a choice as to whether they would like to have children and if so, when and how to have them. (International Conference on Population and Development Program of Action, para 7.2).

Gender Roles are the rules set down by society that tell us what is appropriate behaviour for persons of our sex.

Gender Identity a person's inner sense of being male or female, usually developed during early childhood as a result of parental rearing practices and societal influences and strengthened during puberty by hormonal changes.

Sexism is the conscious or unconscious assumption that the members of one sex are on the whole inherently superior to the members of the other in certain attributes by virtue of their sex.

Sexual Orientation refers to a preference for sharing sexual expression with members of the opposite sex, members of one's own sex, or members of both sexes. The sources of sexual learning are all the factors that contribute to our psychosocial development--family values, religious beliefs, parental teachings, societal norms and many others.

1.3.11 Sexual Patterns

Major Sexual Patterns

Heterosexual - Male & female sexual relationships. Individuals who prefer partners of the opposite sex.

Homosexual - Males (gay) or females (lesbian) who prefer partners of the same sex.

Bi-sexual - Individuals who enjoy partners of both sexes. A male or female can be bisexual.

A-sexual - Individuals who have no sex drive. Although psychologically male or female, neither sex stimulates them sexually.

Celibate - Individuals who choose to refrain from sexual activity for personal reasons, such as religion.

Sexual Behaviours

Kissing, touching, hugging, petting, fondling, and penile-vaginal intercourse are often the most commonly thought of sexual behaviours. Oral sex, including cunnilingus (mouth to vulva, vagina, and clitoris) and fellatio (mouth to penis) are acceptable in some cultures.

Masturbation: Manual manipulation of genitals for sexual gratification. It can be a good way for teenagers to release sexual tension without risking pregnancy or disease. Teens who masturbate are normal, and so are those who do not.

Incest: Sexual intercourse between blood-related family members, such as a father and daughter, sister and brother or mother and son.

Sodomy: Anal or other copulation-like act, especially between males.

Voyeurism: Sexual excitement from observing others undressing, making love, kissing, petting, or masturbating. Sometimes voyeurs are called "Peeping Toms".

Exhibitionism: Sexual pleasure from exposing one's genitals.

Satyriasis: Excessive desire for sexual intercourse in men.

Nymphomania: Excessive desire for sexual intercourse in women.

Gerontosexual: Sexual pleasure from elderly by a young person.

Frotteurosexual: Sexual pleasure from rubbing one's genitals against another person.

Paedophilia: Sexual pleasure by having sexual intercourse with children.

Statutory rape: Sexual intercourse by an adult with a person under the age of 16, with or without the young person's consent.

Paedarasty: Sexual pleasure from young boys.

Zoophilia/Beastiality: Sexual pleasure from animals.

Necrophilia: Sexual pleasure from corpses.

Urophilia: Sexual pleasure from urine.

Coprophilia: Sexual pleasure from filth such as faeces, dirt, or soiled underwear.

Sadism: Sexual pleasure from inflicting pain to another person.

Transsexual: Individual of one biological sex (usually a man) who believes he is a woman trapped in a male body. Sometimes these individuals will seek a sex-change operation.

Transvestite: is any person who wears the clothing of the opposite sex so to appear to be a member of that sex. It includes males and females and may or may not be related to sex drive, to gender perception, or to any of a number of things.

Drag Queen: A male homosexual who dresses flamboyantly trying to imitate a woman.

1.3.12 Components of human sexuality in relation to adolescents

a) Sensuality

Is an awareness and feeling about both one's own body and other people's bodies, especially the body of a sexual partner. Sensuality enables a person to feel good about how our bodies look and feel and what they can do. Sensuality also allows people to enjoy the pleasure our bodies can give us and others. This part of our sexuality affects our behaviour in several ways:

Body Image - Whether we feel attractive and proud of our own bodies and the way they function influences many aspects of our lives. Adolescents often choose media personalities or prominent persons as the standard for how they should look, so they are likely to be disappointed by what they see in the mirror. They may be especially dissatisfied with themselves when they recognize that their skin, hair, eyes, body size or other physical characteristics do not match those of the idealised image.

Experiencing pleasure and release from sexual tension - Sexuality allows us to experience pleasure when we or others touch or see certain parts of our bodies.

Satisfying skin hunger - Our need to be touched and held by others in loving, caring ways is referred to as skin hunger. Adolescents typically receive less touch from family members than young children do. Some teens satisfy their skin hunger through close physical contact with a peer. Sexual intercourse may result from a teen's need to be held, rather than from sexual desire. Youth must be able to recognise a good touch and an exploitative touch.

Feeling physical attraction for another person - The centre of sexuality and attraction to others is not in the genitals, but in the brain, the most important "sex organ". The unexplained mechanism responsible for sexual attraction rests here.

Fantasy - The brain also gives us the capacity to have fantasies about sexual behaviours and experiences. Youth often need help understanding that the sexual fantasies they experience are normal, but do not have to be acted upon.

b) Sexual Intimacy

Is the need to be emotionally close to another human being and have that closeness returned. Sharing intimacy is what makes personal relationships rich. While sexuality is about physical closeness, intimacy focuses on emotional closeness. Several aspects of intimacy include:

Liking or loving another person - Having emotional attachments or connections to others is a manifestation of intimacy.

Emotional risk-taking - To have true intimacy with others, a person must open up and share feelings and personal information.

We take a risk when we share our thoughts and emotions with others, but it is not possible to be really close to another person without being honest and open with them. As sexual beings, we can have intimacy with or without having sexual intercourse. In a full and mature romantic relationship between two people, the expression of sexuality often includes both intimacy and intercourse. Unfortunately, intimacy established through caring and good communication is not always a part of adolescents' sexual experiences.

Vulnerability: To have true intimacy means that we share and care, like or love, and take emotional risks. That makes us vulnerable – the person with whom we share, about whom we care, and whom we like or love, has the power to hurt us emotionally.

c) Sexual Identity

Is a person's understanding of who she or he is sexually, including the sense of being male or female. Sexual identity can be thought of as three interlocking pieces that, together, affect how each person sees herself or himself. Each "piece" of sexual identity is important:

Gender identity - Knowing whether you are male or female. Most young children determine their gender by age two.

Gender role - Knowing what it means to be male or female or what a man or woman can or cannot do because of their gender.

Sexual orientation - Whether a person's primary attraction is to people of the same sex (homosexuality), the opposite sex (heterosexuality) or both sexes (bisexuality).

Sexual orientation generally begins to emerge by adolescence.

There are many "rules" about what men and women can and should do that have nothing to do with the way their bodies are built. This aspect of sexuality is especially important for young adolescents to understand, since peer and parent pressures to be "macho" or "feminine" increase at this age. Both boys and girls need help sorting out how perceptions about gender roles affect whether they are encouraged or discouraged to make certain choices regarding relationships, leisure activities, education and careers.

d) Sexual and Reproductive Health (SRH)

Sexual Health: In broad terms, sexual health is a personal sense of sexual well-being as well as the absence of disease, infections or illness associated with sexual behaviour. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. Sexual health can be described as the positive integration of physical, emotional, intellectual and social aspects of sexuality. (World Health Organization, 2002).

Reproductive health: Is the state of complete physical, mental and social well-being of an individual in all matters

relating to the reproductive system and its processes and functions but not merely the absence of disease or infirmity. It also includes sexual health and suggests that people with adequate reproductive health have a satisfying and safe sexual life, can have children, and can make a choice as to whether they would like to have children and if so, when and how to have them. (ICPD Program of Action, para 7.2).

Core SRH activities include providing universal access to voluntary family planning and maternal health services; protection from STIs including HIV, gender violence and harmful traditional practices; and the reduction of gender inequalities.

Adolescents typically have inadequate information about their own or their partners' bodies. They need the information that is essential for making informed decisions about sexual behaviour and health.

Feelings and attitudes are wide-ranging when it comes to sexual behaviour and reproduction, especially health-related topics such as sexually transmitted infections (including HIV) and the use of contraception, abortion and so on. Talking about these issues can increase adolescents' self-awareness and empower them to make healthy decisions about their sexual behaviour.

Sexual intercourse is one of the most common human behaviours, capable of producing sexual pleasure and pregnancy.

Sexual intercourse is mostly for procreation but also provides enjoyment. Youth should be encouraged to be responsible and not abuse it.

e) Sexualisation

Is using sex or sexuality to influence, manipulate or control other people. Often called the "shadow" side of our sexuality, sexualisation spans behaviours that range from harmlessly manipulative to sadistically violent and illegal. Behaviours include flirting, seduction, and withholding sex from a partner to "punish" the partner or to get something you want, sexual harassment (a supervisor demands sex for promotion/salary raises), sexual abuse and rape.

Teens need to know that no one should exploit them sexually. They need to practice skills to avoid or fight against unhealthy sexualisation should it occur in their lives.

1.3.13 Myths and misconceptions on sexual activity and reproduction

Myths and Facts

The following are a mixture of facts and myths surrounding sex and sexuality. Are you able to establish if each of the statements below is correct?

- A girl cannot conceive until she starts menstruating.
- If the penis ejaculates outside the vagina the woman will not get pregnant.
- If a woman jumps up and down after unprotected sexual intercourse she will not get pregnant.
- If a pregnant woman slept where a dead person was washed she will miscarry.
- Having sexual intercourse before marriage will kill one's parents.
- The longer a man's finger the longer his penis.
- If a woman douches right after sex she will not get pregnant.
- A girl cannot use tampons until she has had sex.
- During a woman's period she should stay in bed, avoid exercise and refrain from sex.
- Having sex cures period pains.
- Having a baby cures period pains.
- Girls are always smarter than boys.
- Boys can always run faster than girls can.
- Men make better teachers than women.
- Women make better nurses than men.
- Intelligence is more important for boys than girls.
- All women want to be mothers someday.
- All parents know naturally how to raise children.

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MODULE 2

Unpacking the Environment For ASRHR

MODULE 2: Unpacking the Environment for ASRHR

There is general and global consensus that ASRHR programming requires a life kills and human rights approach. To this end, a strong appreciation of rights, commitments, laws, policies, strategies, and guidelines relating to SRH among health service providers, adolescents and advocates is required if programming is to be effective.

Session 1: Adolescents rights and responsibilities in the context of SRH

2.1.1 Defining key terms

Sexual and Reproductive Health (SRH) is a fundamental human right to human survival and development. It is therefore about rights and choices.

Human Rights: Are basic rights and freedoms that all people are entitled to regardless of nationality, sex age, national or ethnic origin, race, language or other status. They are conceived as universal and egalitarian with all people having equal right by virtue of being human beings. These rights may exist as natural rights or as legal rights both national and international.

Sexual rights: Include the human rights of women and men to have control over and decide freely and responsibly on matters related to their sexuality.

Reproductive rights: Are the basic rights of women and men to decide freely and responsibly on issues of sexuality and family planning, to have access to information to make these decisions and the means to carry them out. Reproductive rights include the right to attain the highest standard of sexual and reproductive health and the right to decide on issues of reproduction free of discrimination, coercion and violence.

(1) "people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so " and (2) "the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant". (International Conference on Population and Development Programme of Action, 1994).

2.1.2 Sexual and Reproductive Health (SRH)

"Reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." The ICPD definition of Reproductive Health (ICPD PoA para. 7.2)

2.1.2.1 Rights relating to sexual and reproductive health (The International Planned Parenthood (IPPF) Charter, 1995)

The right to:

i. Life should be invoked to protect women whose lives are currently endangered by pregnancy (with particular reference to the need to reduce the risk factors for high-risk pregnancies, such as those which are "too early, too late, too close or too many").

ii. Liberty and security of the person should be invoked to protect women currently at risk from genital mutilation, or subject to forced pregnancy, sterilisation or abortion.

iii. Equality and to be free from all forms of discrimination should be invoked to protect the right of all people, regardless of race, colour, sex, sexual orientation, marital status, family position, age, language, religion, political or other opinion, national or social origin, property, birth or other status, to equal access to information, education and services related to development, and to SRH.

iv. Privacy should be invoked to protect the right of all clients of SRH care information, education and services to a degree of privacy, and to confidentiality with regard to personal information given to service providers.

v. Freedom of thought should be invoked to protect the right of all persons to access to education and information related to their SRH free from restrictions on grounds of thought, conscience and religion.

vi. Information and education should be invoked to protect the right of all persons to access to full information on the benefits, risks and effectiveness of all methods of fertility regulation, in order that any decisions they take on such matters are made with full, free and informed consent.

vii. Choose whether or not to marry, and whether or not to found and plan a family should be invoked to protect all persons against any marriage entered into without the full, free and informed consent of both partners. All persons have the right of access to SRH including those who are infertile, or whose fertility is jeopardized by sexually transmitted infections.

viii. Decide whether or when to have children should be invoked to protect the right of all persons to reproductive health care services which offer the widest possible range of safe, effective and acceptable methods of fertility regulation, and are accessible, affordable, acceptable and convenient to all users.

ix. Health care and health protection should be invoked to protect the right of all persons to the highest possible quality of health care, and the right to be free from traditional practices which are harmful to health.

x. the benefits of scientific progress should be invoked to protect the right of all persons to access to available reproductive health care technology which independent studies have shown to have an acceptable risk/benefit profile, and where to withhold such technology would have harmful effects on health and well-being. Some examples of new technology are the provision of emergency contraception, the availability of anti-retrovirals for treating HIV infection, the provision of post-exposure prophylaxis (PEP) kits for treating people who have been accidentally exposed to HIV through rape or a road traffic accident necessitating a possible unsafe blood transfusion, the new vaccine against HPV (the virus that causes cervical cancer), and so on.

xi. Freedom of assembly and political participation should be invoked to protect the right to form an association that aims to promote SRH and rights.

xii. Be free from torture, and ill treatment should be invoked to protect children, women and men from all forms of violence including domestic violence, sexual violence, exploitation and abuse.

NB:

- SRHR are human rights,
- All SRHR are equally important,
- SRHR apply to adolescents as much as they apply to adults,
- Adolescents need to be empowered for them to fully understand and be responsible as well as for them to realise and enjoy their SRH rights.
- Service providers have a role to promote, educate, protect and advocate for the SRHR of adolescents.

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Session 2: Laws, Policies, Strategic Frameworks and Advocacy on ASRHR

2.2.1 Definitions

Public policy can simply be defined as what government chooses to do or not to do about a particular problem . Public policies can be in form or laws, policies, strategies as well as regional and international instruments. Some policies may not even be specifically laid down in writing. Sometimes authorities may choose to say or do nothing about a particular problem; if this stance is applied consistently by government/authorities, that becomes public policy. In terms of ASRHR, much of our legal and policy instruments are informed by regional and international instruments that our government has agreed to. These regional and international instruments are based upon human rights principles. However, the adoption of these regional and international instruments is usually limited on the basis of arguments around cultural sensitivity.

2.2.2 Regional and International Instruments for SRHR

There are a number of regional and international commitments on SRHR, especially targeting the needs of vulnerable groups such as women, children and young people. Although such instruments may not be binding on governments, they do reflect international consensus on issues and provide details on actions that can be taken by governments to meet their commitments. Zimbabwe is a signatory to a number of these commitments. Table 2.1, below provides an overview of some of the major commitments and their key SRHR provisions as well as status of ratification and implementation.

Table 2.1: Key Provisions, Status of Ratification and Implementation of International & Regional Commitments

International Treaties related to SRHR and their Provisions	Signed	Ratified/ Acceded/ Declared	Comments on status of implementation in Zimbabwe
Convention on the Rights of the Child protects children's right to access sexual and reproductive health services and their rights to substantive equality and nondiscrimination.	Yes	(r) 11th September 1990 (no reservations)	Contributed towards the development of the African Charter on the Rights and Welfare of children as well as the Children's Protection and Adoption Act of Zimbabwe. Child protection committees have since been established at local level to protect the SRHR for children as well.
Convention on the Elimination of all forms of discrimination against women: Has the clearest and most specific articulation with respect to family planning information and services. In addition, it also contains the most direct articulation of reproductive autonomy of any human rights treaty through Article 12.	Yes- with reservations	13th May 1991	The Domestic Violence Act and Domestic Violence Council have continued to promote gender mainstreaming in all SRHR planning and implementation processes.
The International Conference on Population and Development (ICPD) Programme of Action: Marked the genesis of expanding SRHR packages beyond family planning.	Yes	1994	Has informed the National Reproductive Health Policy, the ASRH Strategy among other key sector policies.
The Millennium Declaration: The Millennium Development Goals (MDGs) were set at the 2000 Millennium Summit to accelerate global progress in development. Sexual and reproductive health is a prerequisite of all goals, particularly those related to gender and health.	Yes	2000	Provided guidance for the development of interventions that Zimbabwe is implementing to reduce maternal and child mortality rates, whilst recognizing the role of family planning.
Regional treaties on SRHR	**Signed**	**Ratified/ Acceded/ Declared.**	
Africa Youth Charter (Banjul Charter): The Banjul Charter ensures that "…every individual shall have the right to enjoy the best attainable state of physical and mental health… which would and does include sexual and reproductive health.			Informed development of the National Youth Policy.
African Charter on Human and Peoples Rights (ACHPR): Recognizes the right to SRH especially for women.	Yes	(r) 30th May 1986	A human rights approach to SRHR programming has been adopted to a certain extent. Sexual rights remain a thorny issue.
African Charter on the Rights and Welfare of the Child: a holistic view of children's' health and protection and the right to education and information. This holistic view states that every child (below 18 years) has the right to enjoy the best attainable state of physical, mental and spiritual health.	Yes	(a) 19th January 1995	Child-centered approaches on SRHR, through the Child Protection and Adoption Act, have been used.
Convention Governing the Specific Aspects of Refugee Problems to Africa: Recognizes SRHR as a key issue for displaced people and provides guidance on addressing such.	Yes	28th September 1985	Most key SRHR strategic documents have established mechanisms for humanitarian response as well as SRH programming for refugees. Funding remains a constraint.

[1]Thomas Dye, 1972

Cultural Charter for Africa: Calls for cultural sensitivity in addressing SRHR issues.	Yes	5th July 1988	Zimbabwe strives to ensure that SRHR strategies are culturally sensitive and competent. This sometimes creates conflict with the rights discourse.
The Abuja Declaration: 15 percent of the total national budgets should be allocated to health.	Yes	2001	Government yet to meet the target pledging poor economic growth.
Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR): Adopted in January 2006 and endorsed by heads of state. Priority areas of this framework include Sexual & Reproductive Health legislation, Integration of SRH services into Primary Health Care, Budgeting of SRH activities, among others.	Yes	2005	Ongoing incorporation in various strategies and programmes.
The Maputo Plan of Action: Provides a framework to achieve universal access to comprehensive sexual and reproductive health rights (SRHR) and services in Africa.	Yes	2006	Informed the development of the Zimbabwe Maternal and Newborn Health Road Map: 2010 - 2015
Regional Child Survival Strategy	Yes	2006	Informed the development of the 2010 National Child Survival Strategy for Zimbabwe.
Ouagadougou Declaration on Primary Health Care and Health Systems in Africa	Yes	2008	Informed development of the National Health Strategy: 2010 - 2015
SADC Protocol on Gender and Development: Recognizes the gendered nature of SRHR.	Yes	2009	Guide the efforts of the Domestic Violence Council in gender mainstreaming
The African Union initiated Campaign on Accelerated Reduction of Maternal Mortality In Africa (CARMMA)	Yes	2010	Strengthened advocacy work towards SRHR, repositioning of family planning and the need to focus on adolescents and youth
The United Nations Commission on Life-Saving Commodities for Women and Children	Yes	2010	Helped towards development of an SRH Commodity Security strategies
Agenda 2063: The Africa we want: Considers health and SRHR a key issue for the development agenda of Africa.	Yes	2013	Informed the development of the ZimAsset: 2013 – 2018, a government blueprint for development.
Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African (ESA)	Yes	Affirmed 2013	Informed the development of the National ASRH Strategy II, development of the new curriculum framework and the school health policy
Global Strategy for Women's, Children's and Adolescents' Health (2016 – 30)	Yes	2016	Its launch coincided with the development of the RMNCH-N: 2017 – 2021, ASRH Strategy II: 2016 – 2020, Cervical Cancer and Control Strategy and Family Planning Strategy: 2016 – 2020
SADC Model Law on Eradication of Child Marriages	Yes	2016	Informed the development of the Marriage bill

2.2.3 National laws, policies and strategies related to ASRHR

Zimbabwe has made strides to implement the bulk of the international and regional instruments and commitments already reviewed, or at least some of the provisions. The National Reproductive Health Policy is the consolidated policy statement for this sector. The first National Sexual and Reproductive Health Policy, arguably the most important consolidated sector policy, was developed in 2003 and its review was commissioned in 2012. The vision of the policy is to attain the highest possible level of sexual and reproductive

health of all citizens of Zimbabwe and significantly reduce maternal, perinatal and neonatal mortality and morbidity, HIV and STIs and their adverse health impact. The policy seeks to provide, administer, coordinate, promote and advocate for quality, comprehensive, integrated RH services that are equitable, affordable, acceptable and accessible including adequate provision of RH commodities and skilled personnel. Though the policy has no start and end date, it seeks, among other goals, to increase 'availability, access and utilization of adolescent-friendly SRH and reducing the number of unintended pregnancies and unmet need for contraception.' Zimbabwe has many other sub-sector policies, laws or strategies with provisions for SRHR in the country. The table below provides an overview of some of the major policies, laws and strategies in Zimbabwe:

Table 2.2: National Laws, Policies and Strategies related to SRHR

Law/ Policy/ Strategy	Ratified/Acceded/ Declared	Comments
Constitution of Zimbabwe Amendment (No.20), 2013	2013	Currently being used for reviewing various SRHR related policies such as on marriage, public health and termination of pregnancy.
Public Health Act (Act No. 19 of 1924)		Being reviewed for alignment with the 2013 Constitution through Amendment Number 20 – Public Health bill of 2017.
Sexual Offences Act (Acts No. 8 and 22 of 2001	2001	Repealed by section 283 of the Criminal Law (Codification and Reform) Act [Chapter 9:23]. Addresses key aspects of SRHR especially rape and age of consent.
Customary Marriages Act [Chapter 5:07] and the Marriage Act [Chapter 5:11].		Repealed and replaced by Marriages Bill, 2017 which strongly stipulates that No person under the age of eighteen years may contract a marriage or enter into an unregistered customary law marriage or a civil partnership.
Termination of Pregnancy Act	1977	Aligned to section 60 of the Criminal Law and Codification Reform Act Chapter 9:23 of 2004 in terms of managing illegal abortions.
Domestic Violence Act Chapter 5:16	2006	Provides for the establishment of the Domestic Violence Council in 2007 and its functions/role.
National Reproductive Health Policy	No date	Provides for a life cycle and multisectoral approach to SRHR programing. Its review processes began in 2014 and are still in progress
National Population Policy	1998	Recognizes SRHR as a key component of development, the need for population data to inform planning, mainstream gender and address harmful social & gender norms.
National Youth Policy		Seeks to ensure the development and empowerment of the youths (between 15 and 35 years of age). SRHR is integral. Its review processes began in 2017.
National Gender Policy	2004	Reviewed for the period 2013 – 2017. One of the key objectives seeks to improve gender sensitivity in health service delivery and the following are the key policy strategies on health.
National HIV/AIDS Policy in Zimbabwe	1999	Several strategic plans have been developed since then to guide and coordinate the multi-sectoral HIV/ AIDS response.
Zimbabwe School Health Policy	March 2018	Aligned to the Curriculum Framework (2015-2022), the policy seeks to ensure that the Minister of Primary and Secondary Education in consultation with the Minister responsible for Health shall make regulations for the purposes of safeguarding the health of learners.
National Health Strategy For Zimbabwe 2016-2020	2016	The strategy is informed by the review of MDGs progress and the SDG targets.

Reproductive, Maternal, Newborn, Child, Adolescent Health, and Nutrition Strategy (2017 – 2021)	2017	Build on the Maternal and Newborn Health Road Map: 2010 – 2015 to go beyond SRHR and promote integration of nutrition, child survival and eMTCT.
National Adolescent and Youth Sexual and Reproductive Health (ASRH) Strategy II: 2016 – 2020	2016	A multi-sectoral strategy is a step up of efforts towards adolescents and youth, aligned to the SDGs and global standards on provision of quality adolescent health services as well as the 2013 ESA Commitment.
National Family Planning Strategy: 2016 – 2020	2016	The strategy seeks to re-position family planning in all development processes and reduce the unmet need for contraception, with a special focus on adolescents and long-term methods.

Table 2.3: Outstanding legal provisions for SRHR

Constitutional/Legal/Policy Provision	Analysis on Gaps
Age of consent	The Public Health Act (Act No. 19 of 1924) defines an adult as "a person of 16 years of age or over" and implies that anyone under 16 needs the consent of a parent or guardian for medical treatment. Under the Sexual Offences Act (Acts No. 8 and 22 of 2001) the age of consent for sexual intercourse in Zimbabwe is 16. However, Zimbabwe's Children's Act (as amended by Act No.23 of 2001) also fails to specify an age at which children can consent to medical treatment or access health services without parental consent. As such, the age of consent for access to HIV testing services has been set at 16 years. Service provider attitudes and inference from these set ages often results in young people who are sexually active before the age of 16 years being denied access to services. Yet evidence shows that unplanned pregnancies, illegal abortions and STIs are quite high in this area. There are calls to get the Public Health Bill to lower the age of consent to access services to 12 years. However, the dilemma comes at lowering age of consent for services while increasing age at marriage, as this is interpreted by communities to giving permission to adolescents to engage in sex before marriage.
Criminalization of Child Marriages	While the Domestic Violence Act and the ruling by the Constitutional Court invalidated child marriages, Zimbabwe still has no law that criminalizes and punishes offenders.
Gay Rights	The constitution actively prohibits same sex marriages with the country having active laws that criminalize man-to-man sex through the 'The crime of sodomy'. In this case, the law takes a moralistic view. To get reforms in this area, there is need for the constitution to provide for this right.
Sex work	Laws that prohibit soliciting for sex prevent sex workers from accessing services and/or leave them open to abuse and rape as they fear to report perpetrators.
Termination of Pregnancy Act	The new constitution expanded the right to life to cover fetuses thereby further limiting the circumstances under which women and girls can seek legal abortion.
Criminalization of willful transmission of HIV	Calls to repeal the law on willful transmission of HIV are based on difficulties in enforcement. The law promotes stigma and does not have a place in modern society where HIV is no longer a death sentence. Worse, there is no way to prove who was infected first between two parties.

In order to close the policy gaps identified here, advocacy becomes imperative.

2.2.4 Advocacy in ASRHR Contexts

2.2.4.1 Defining Advocacy

The word "advocacy", according to Anush Begloian, comes from the Latin word 'advocare' which literally means 'to call out for support'. Begloian suggests that the origins of advocacy date back to ancient Rome and Greece when well-established orators would perform as advocates or wrote orations specifically for pleading someone's cause. However, although still linked to its origins, the meaning has evolved.

Advocacy in the context of ASRHR can be defined as a **set of organised actions** aimed at **influencing public policies, societal attitudes, and socio-political processes** that enable and empower adolescents to speak for themselves. Another simple but effective way of looking at advocacy is

[2] Sexual Offences Act, 2001, Government Printers, Harare

to consider it as an attempt to cause political action using methods such as civil education and public campaigns to influence decision-makers. Advocacy relies on a set of activities aimed to change public opinion or to get public support for ASRHR.

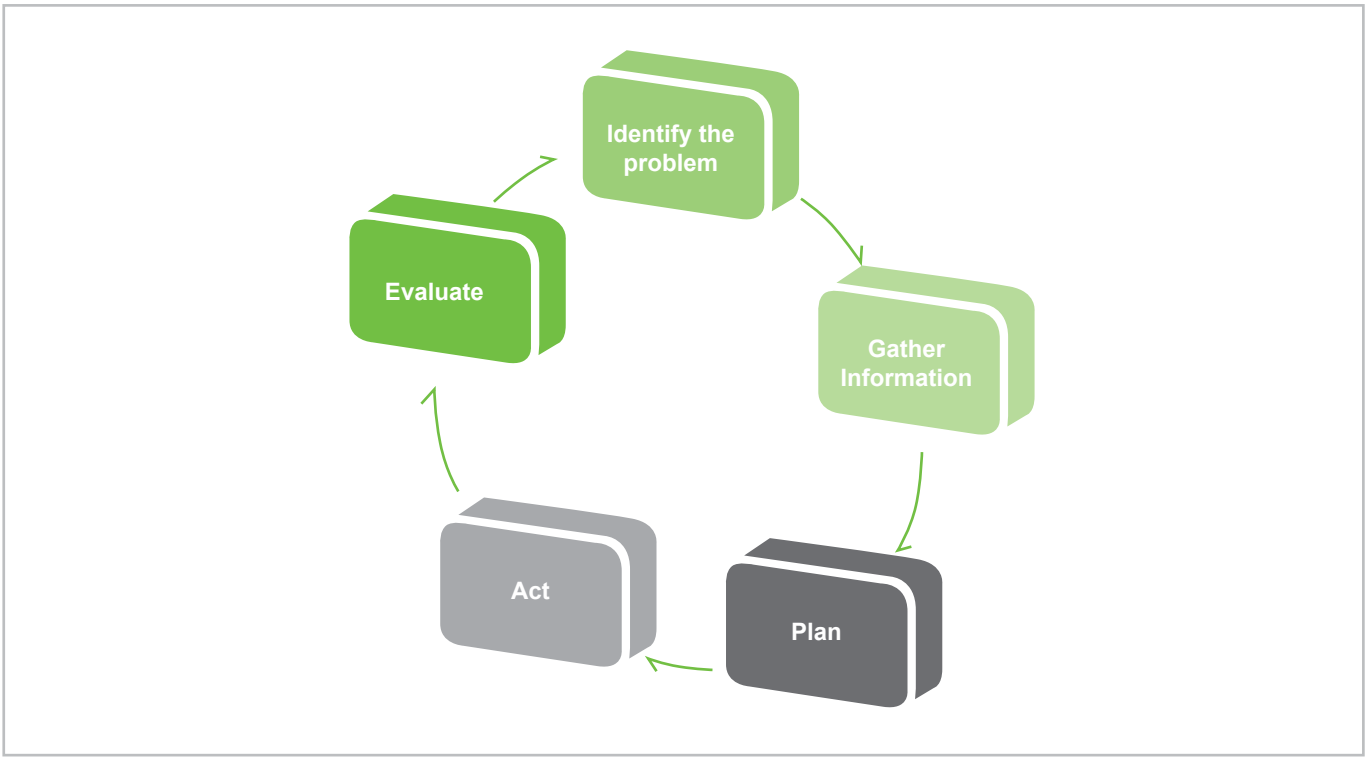
2.2.4.2 The Role of Advocacy in the context of ASRHR

- Ensures that adolescents have a say on the SRHR issues that affect them and contribute to addressing the same
- Helps improve ASRHR policies
- It promotes the safeguarding of ASRHR
- Holds those in public office accountable to the commitments made on ASRHR
- Assists policy makers in meeting the needs of the SRHR of adolescents and young people

2.2.4.3 Key Steps in Advocacy

The advocacy process takes place in a cyclic manner. The advocacy cycle (diagram below) is a useful way of visualizing the steps in advocacy. These steps can also be seen as building blocks for developing an advocacy strategy and its implementation or a step-by-step process of elaborating an advocacy component within a broader program or development project.[3]

Fig 2.1: The Advocacy Cycle



Step 1: Identify the problem

- What are the possible ASRHR problems that could be addressed through your advocacy action?
- What would change look like if the problem/s are addressed?
- Select an issue of focus

Case Study: Sometimes the Advocacy Issue May be Complex

Literature on advocacy often makes it seem as if an advocacy issue is a single easy-to-define issue. However, in reality, the advocacy issue may be linked to many other related issues or could itself be unpacked into many sub-issues. It is possible that the advocacy issue you identify at first is not your advocacy issue (or the only issue) you work with in the end. This is why it is important to have tools that help you reflect on the nature, extent and roots of a selected problem.

Some years back, Katswe Sistahood sought to intervene on one of the biggest contemporary SRHR challenges

[3] Practical Action in Advocacy: An Advocacy Toolkit

affecting adolescent girls and young women (AGYW), the issue of child marriages. A problem analysis revealed that the challenge was not just the lack of laws that protect AGYW from marriage - it was also the lack of robust laws on age of consent to sex that protect girls from adult sexual predators. It turned out that quite a proportion of child marriages were as a result of girls being impregnated by adult men who are then forced to marry these girls. In the end, Katswe Sistahood had to device two separate but mutually reinforcing advocacy campaigns – one to put in place a law that outlaws child marriages and another for a law that sets an optimum age of consent to sex that allows consenting adolescents to engage in safe sex but outlawing adults from having sex with minors.

Step 2: Gather Information

- Undertake research and or analysis to find out more information on the issue. What does statistics and qualitative information say about the nature and extent of the problem? In some cases, this research might simply be desktop review of already existing information on the subject area for the advocacy issue.
- What are the causes and effects of the issue?
- What are the possible solutions?
- What resources will be required to implement the possible solution?

Step 3: Plan

- Develop an advocacy strategy

What is an Advocacy Strategy?

An advocacy strategy spells out your actions, strategies, timelines for action and the sharing of responsibilities for taking action on the identified advocacy issue. An advocacy strategy must also clearly define the results of an advocacy initiative - the outcome in the short term and impact in the long term. Other elements of a good advocacy strategy include:

- Defining outputs
- Formulating SMART Objectives
- Identifying success indicators and means of measurement/verification
- Setting targets
- Identifying allies and opposers
- Defining the activities, methods and approaches for advocacy
- Identification of risks
- Clarification of assumptions.
- Cost the activities

Step 4: Act

- Develop the messages and target them to your various target groups – the messages must define the issue, proposed solutions and describe the actions that need to be taken
- Communicate the message
- Implement the advocacy strategy

Step 5: Evaluate

- Collect and analyze information that determines whether the results are being achieved
- Ongoing monitoring is required throughout the cycle.
- Information gathered through ongoing monitoring or end of process evaluation is important for learning and making necessary adjustments to the advocacy process

Case Study: Funding Implications on Advocacy

When Zimbabwe civil society organizations (CSOs) undertake advocacy targeting government to review laws that limit the rights of LGBTIQ youth, government often pushes back on the grounds of culture. Government often suggests that sexual minority rights are being imposed by Western donor countries and are alien to the local cultures. Imagine, how true this appears in the eyes of the masses when such advocacy initiatives are funded by foreign donors. While there is nothing wrong or illegal with receiving foreign funding, consider the implicit ethical message of using foreign funding to push for such rights .

In such a case, the question of funding becomes an excuse for stalling what, otherwise, is a good campaign representing a *bona fide* constituency. Here are some of the suggestions on ensuring that funding sources do not become a sticking point in advocacy:

- Ensure that you have a critical mass behind you when you do advocacy. Government representatives are under pressure from the moral and religious beliefs of voters not to accept rights of the LGBTIQ community. In order for your advocacy to be successful, you need to demonstrate that you have community buy-in.
- Use public health arguments to indicate that protecting LGBTIQ rights is important to address public health challenges that the nation faces in such areas as HIV/AIDS. Removing legal barriers in this regard will help improve access to ASRHR services by this constituency.
- Base it on the human rights argument. Be clear that SRHR are human rights and government has a responsibility to protect human rights.

Although not included in the steps, the process of fundraising is important when it comes to undertaking successful advocacy. Identify your source of funding and consider the implicit ethical messages hidden in that source of funding. In the case study above, it became clear that your source of funding can become a stumbling block to your advocacy efforts (see case study above).

2.2.4.4 The Zimbabwean Governance System: Having an Influence on Policy Making

At the apex of the country's governance system is an Executive President who is both the head of state and government. The President is elected directly by the people in a harmonized election that also elects members of parliament and local councils. The President, as the leader of the Executive arm of state, has the prerogative to appoint members to the Cabinet from among the elected MPs and a few from outside the Parliament based on their expertise.

The role of the Executive/government is both complemented and checked by the Parliament. Zimbabwe has a bi-cameral system which consists of the National Assembly and the Senate whose primary role is to make laws. Unlike MPs who elected directly, Senators are appointed on basis of proportional representation and do not play a big role in the legislative process. To this end, the Parliament is the more influential of the two.

The Role of Parliament

Although the parliament is considered to have lawmaking functions, in Zimbabwe, Bills are almost always initiated by Ministers. Although there are provisions for MPs to bring to the House private member Bills, it is difficult to get them through without the backing of government[4]. Bills first go through the Cabinet for approval before they are taken to Parliament for scrutiny and debate. This is often done by the Parliamentary Legal Committee, most of whose members are lawyers. The role of this committee is to ensure that Bills are aligned to the constitution. For SRHR-related laws, the Portfolio Committee on Health and Child Care plays a significant role in consulting people through outreaches. Once parliamentarians are satisfied, the pass the Bill which does not become a law until signed by the President. The Parliament has other functions, including most importantly holding the government accountable, especially for policy implementation. These parliamentary processes are subject to political bickering of political parties and political sensitivity is needed in engaging political parties. On legal and policy issues, parliamentarians in Zimbabwe have always voted as a block on partisan lines owing to the 'whipping' system where the parties have leaders in parliament who coordinate how the party votes on issues. This might mean political parties are an opportune, yet to be explored, target for advocacy by champions of SRHR. For neutrals like civil society and non-state actors who want to lobby parliamentarians, targeting individual MPs from one political party, no matter how progressive they may be, has potential to jeopardize policy reform work as the agenda runs the risk of being politicized.

Role of the Local Government

Although the Constitution provides for a devolved provincial government, these provisions are yet to be implemented. However, Zimbabwe has a successful local authorities' system whose responsibility is to manage affairs within local rural and urban jurisdictions. Local authorities or councils are governed by councilors who are elected by the people. These councils are led by Mayors in the case of urban areas and chairpersons in the case of rural areas. Local authorities in Zimbabwe can make own by-laws and regulations as they deem fit for their jurisdictions. They also provide services such as primary health care, for example through council clinics, hence making them key actors in the SRHR sector. Council clinics are usually the entry point for primary health care in most towns and cities in Zimbabwe; they deliver important SRHR services such as maternal and newborn health services, among others. Since they are independent of the central government, they do not always conform to central government policies. For example, it may be difficult to enforce the central government's free maternal health policy in council clinics if government does not provide subsidies. That can be a source of conflict between the two. In Zimbabwe, councils are almost always controlled by a single political party. This does not mean that they are easy to access and influence in terms of policy direction. Central government has been known to meddle in the affairs of local authorities and cases of disagreement between councils and their bureaucracies are not uncommon. Understanding each local authority and its dynamics is always critical for successful SRHR service delivery at the local level. The system of Zimbabwean government, as the analysis above shows, provides multiple entry points for advocacy. Principally, policy reform advocacy can target the Presidency, government ministers, the parliament or local authorities. Who to target, in the end, depends on accessibility and issues at hand. CSOs often find the Parliament more accessible and impactful.

[4] Alex Magaisa – Understanding the System of Government, 2018

2.2.4.5 Stakeholder Analysis

A stakeholder analysis helps participants to understand who the key actors are but also forms an important basis for recommendations on entry points for effective policy change.

The analysis below reveals that, when it comes to ASRHR, power for policy reform resides in the Executive arm of the state but there are also other key formal and non-formal institutions who play an important role in this respect.

Table 2.5: Key Actors, their Role and Level of Influence in SRHR Policy and Programming Discourse in Zimbabwe

Actors	Roles and Responsibilities in SRHR Discourse	Level of Influence
State Actors		
The Presidency and the Executive	• The President and the executive have wide ranging powers to instruct the development and/or execution of laws and policies. They also have political and, to some extent, constitutional power to take key policy decisions or prescriptions. Often, they have been accused of making policies without consultation or even in disregard of the oversight role of cabinet and parliament largely due to different political parties ideologies.	High
Parliament (*esp. Portfolio Committee on Health and Child Care*)	• Policy making function and consulting citizens in the process. • Provide oversight and hold government ministries accountable for implementation of policies related to ASRHR.	High
Ministry of Health and Child Care (*From the position of Permanent Secretary going down* – bureaucrats)	• They are the lead custodians and implementers of SRHR policies in government. • Lead service providers for SRH services in the country reaching out to the majority and marginalized sections of the population. • Responsible for budgeting and final decisions on the use of allocated funds.	High
Ministry of Finance and Economic Development	• Undertaking the national budgeting process and deciding on the allocation of finances from the national treasury to the sector as well as administering the funding from the development partners, e.g. the Zimbabwe United Nations Development Framework and Bilateral Agreement.	Medium
Ministry of Youth, Sport, Arts and Recreation	• Lobbying other government departments to ensure that the SRH issues of young people are addressed by the relevant ministries. • Decision making and policy implementation through the National Youth Policy, promoting children & youth participation and policy tracking.	Medium
Ministry of Primary and Secondary Education (MoPSE)	• With young people, especially learners have unique but urgent SRHR challenges; the MoPSE plays a huge gatekeeper role in terms of in-school health programmes and policies, such as the School Health Policy. Although the MoHCC was amenable to the idea, it is the MoPSE that vetoed the idea of distributing condoms in schools. This Ministry favors an abstinence-only policy.	Medium
Ministry of Women Affairs, Gender and Community Development	• Lobbying other government departments to ensure that the SRH issues of women are addressed by the relevant ministries. • Decision making and policy implementation through the National Gender Policy, promoting women participation and plays an active role in policy tracking.	Medium
Ministry of Justice, Legal and Parliamentary Affairs	• Development of laws and lead drafters of government laws and policies, including those relating to SRHR. • An active implementer of laws and policies considering the role of courts in interpreting the constitution and laws as well as to provide recourse for SRH rights violation.	Medium

Zimbabwe National Family Planning Council (ZNFPC)	• Established by an act of parliament to coordinate provision of family planning and other SRH related services; • Responsible for enforcing the family planning act. However, they work under the direction of the parent MoHCC and, in practice, the minister can override their decisions.	Medium
National AIDS Council (NAC)	• Established by an act of parliament to coordinate provision of the multisectoral response to HIV and AIDS; • The coordinating body also promotes youth participation and integration of SRH issues into the available funding opportunities like Global Fund. Just like any other parastatal, the Executive wields too much power over them.	Medium
Non-State Actors		
Political Parties	• In many instances, the pronouncements done by the leaders of political parties determine the policy direction, especially in the case of the ruling party. In Zimbabwe, the ruling party dictates policy for government through the manifestos, some of which have become Key national policy blueprints (e.g. The ZIMASSET's provisions were guided by the 2013 ruling ruling ZANU PF Manifesto).	High
Development Partners e.g. UN Agencies, Multi-lateral Agencies	• Funding • Technical support • Support in the domestication of international and regional instruments and guidelines	Medium
Private Sector (Service Providers, Pharmaceutical Companies, Other Private Companies)	• Service providers. • Suppliers of commodities for the SRHR sector, through government as well as the private sector model. • Often become active when their business interests are threatened. Do not always speak out on general policy issues in the public interest.	Low
NGOs/INGOs	• Advocacy and lobbying for policy reform and/or implementation. Often, they are only successful where there is antecedent political will and resources for government to introduce or implement a policy. Government accuses NGOs, mostly funded by Western countries, of representing foreign interests which are detrimental to national interests.	Low
Churches (*Faith-Based Coalitions and the Zimbabwe Association of Church Hospitals*)	• Agenda setting and lobbying. • Second largest health service provider in the country through Mission/Church Hospitals. • Zimbabwe is often identified as a Christian country hence policy formulation and dialogues always attract Christian attention, e.g. on prevention and management of abortion and ages of marriage.	High
Media	• Agenda setting and provision of information needed by policy makers to develop and implement policies. • Help to disseminate information on existing policies and their provisions to make citizens aware of their rights. However, in all its roles, the Zimbabwean media is polarized on political lines and seem to the line of their political interests.	Medium
Academia	• Undertake research to inform policy. • Train policy makers and implementers. • Would have been powerful but policy making in the country does not always evidence-based.	Low

Traditional leaders	• Defenders and custodians of cultural and traditional norms and values. • Also administer the traditional courts in settling SRH related matters, such as incest and traditional marriages. • The Council of Chiefs also advises the President and parliament on culture, tradition and SRH. • They are respected and feared by the majority rural population in the country that always decide the national election.	High
Citizens (Parents and the general community)	• Indirectly, detect policy as voters. • Also add voice towards review of laws and policies. They are compromised because they are not always organized *en masse* except through political parties and churches. Organization through politics and religion often leaves them open to manipulation by their leaders to some extent. NGOs, despite all their efforts, seldom match the level of organizing in the political parties and churches.	Medium

Session 3: Adolescents relationships in the context of SRHR

2.3.1 Adolescent Relationships

The family, peers, service providers, teachers and society play a major role in socializing young people. These relationships and the concern on the part of adults for young people may sometimes cause a variety of behaviours including being overprotective especially when they feel society is becoming increasingly permissive. Adolescents' struggle for freedom involves striving for a psychological freedom from parents and adults in order to:

- Gain freedom to be one's own person
- Have one's own thoughts and feelings
- Determine one's own values
- Plan one's own future
- Enjoy one's privacy
- Relate to one's family while maintaining a clear balance between personal and family needs, values and beliefs.

Level 1: Adolescent;

Level 2: Immediate people, e.g. friends/peers, parents/guardians, siblings

Level 3: Community & other support systems e.g. health workers, religious leaders, police, traditional leaders.

2.3.2 Conflict management for Adolescent Relationships

One way to help limit conflict is to decide which relationships and issues are most important and adolescents always need to be responsible and mindful when choosing relationships. For example, the colour of shirt the child is wearing is less important than their choice of a boy or girlfriend, so we may choose to overlook the former and focus on the latter. It is important to always note that "Respect" is the foundation for all stable, non-violent relationships. Open, honest communication around all relationship issues can only promote greater understanding, and thereby reduce conflict. All relationships including sexual relationships should be based on consent as without consent one will be ignoring other people's right to choose and this result in abuse. Young people need to be enabled and more importantly given the skills to choose good and refuse bad influences. While they usually know what is right, they often do not know how to "act right". Counsellors can help young people make decisions that are in their best interest, whilst respective positive social norms and values of their families and society.

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MODULE 3

SRHR Education and Service Delivery

MODULE 3: SRHR Education and Service Delivery

Many service providers find it very difficult to communicate with adolescents about sex and sexuality. They find it especially difficult to use sexual terms or to use the sexual slang many adolescents may be comfortable using. As a result, adolescents may be given inadequate information. Over the past two decades, various models for providing adolescent friendly services have been implemented in Zimbabwe, with little or minimal benefits. This module provides evidence-based models and approaches towards SRHR education and service delivery for adolescents in Zimbabwe.

Session 1: Principles of ASRHR programming

3.1.1 Identifying Key Principles for ASRHR programming

ASRHR programming, globally and Zimbabwe need to recognize that young people occupy a very significant proportion of our current population hence the need to invest in them for harnessing the demographic dividend. Both the National ASRHR Strategy and the 2017 adopted global standards on provision of quality adolescent health services therefore acknowledges the following guiding principles for ASRH programming.

- ASRHR programmes need to contextualize and acknowledge that adolescents and youth are not homogenous hence their health needs vary according to such factors as: gender, religion, traditional beliefs, socialisation, ethnicity, age, life experiences, sexual orientation, social economic situation, disability status, HIV status, level of education and physical or mental disability.
- Health service delivery should be evidence based and adhere to a rights based approach which regards adolescents and youth as important/responsible actors/ decision makers and not just mere recipients of services.
- Meaningful adolescents and youth participation in the planning, development, implementation, monitoring and evaluation of services and programmes will ensure that their needs are addressed in an appropriate manner and also ensure sustainability of interventions.
- Cultural and gender sensitivity & responsiveness is fundamental in ASRHR programmes, to ensure equal access and acceptability of social services and opportunities by adolescents and young people.
- Service provision for adolescents and youth should be based on the understanding that sexual and reproductive health and rights are basic human rights and that every young person deserves to have a full range of sexual reproductive health services and to have their rights upheld.
- The health service delivery should be provided within a framework that ensures a comprehensive, integrated and holistic approach, incorporating different settings for the provision of youth friendly health services.
- Services should provide mechanisms for multi-sectoral implementation with clear referral, tracking and feedback strategies.
- Youth friendly services should include the promotion of healthy development, the prevention of SRH problems, as well as the response to specific SRH needs.
- Service provision should take cognisance of the critical role of community support for effective and sustainable youth health services and programmes.
- Adolescents and youth should be well informed about the availability of good quality health services from the designated service delivery points.
- Integration of life skills and livelihood programmes into SRH programmes is vital for sustainable SRH behaviour change.
- Fostering accountability and transparency at all levels remains critical.

NB: Adolescents are not homogeneous; hence their needs and expectations are diverse. Also re-iterate the right of adolescents to participate in issues affecting their lives.

Session 2: Life skills empowerment for adolescents

3.2.1 Defining Life skills

Life skills are a set of human skills acquired via teaching or direct experience that are used to handle problems and questions commonly encountered in daily human life. In other words, life skills refer to the ability for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life. This term refers to a large group of psycho-social and interpersonal skills which can help people make informed decisions, communicate effectively, and develop coping and self-management skills that may help them lead a healthy and productive life. Health service providers can assist adolescents by teaching them life skills that relate specifically to health issues such as discussing how to delay sexual debut; how to negotiate for safer sex; the importance of using condoms; how to use male and female condoms correctly; and how to live positively with HIV.

3.2.2 Categories of Life Skills

There are three categories of Life Skills:

i. Communication and Interpersonal skills.

ii. Decision making and critical thinking and

iii. Coping and self-management skills.

3.2.2.1 Communication and Interpersonal Skills

Five life skills are identified under communication and interpersonal skills. These are interpersonal communications skills, negotiation/refusal skills, empathy, cooperation and teamwork, and advocacy.

Interpersonal communication skills	Negotiation skills
• Verbal/Nonverbal communication • Active listening • Expressing feelings; giving feedback (without blaming) and receiving feedback	• Negotiation and conflict management • Assertiveness skills • Refusal skills
Empathy	**Cooperation and Teamwork**
• Ability to listen and understand another's needs and circumstances and express that understanding	• Expressing respect for others' contributions and different styles • Assessing one's own abilities and contributing to the group
Advocacy Skills	
• Influencing skills & persuasion • Networking and motivation skills	

3.2.2.2 Decision-Making and Critical Thinking Skills

Two examples of decision making, and critical thinking a given below:

Decision making / problem solving skills	Critical thinking skills
• Information gathering skills • Evaluating future consequences of present actions for self and others • Determining alternative solutions to problems • Analysis skills regarding the influence of values & attitudes of self & others on motivation	• Analysing peer and media influences • Analysing attitudes, values, social norms and beliefs and factors affecting these • Identifying relevant information and information sources

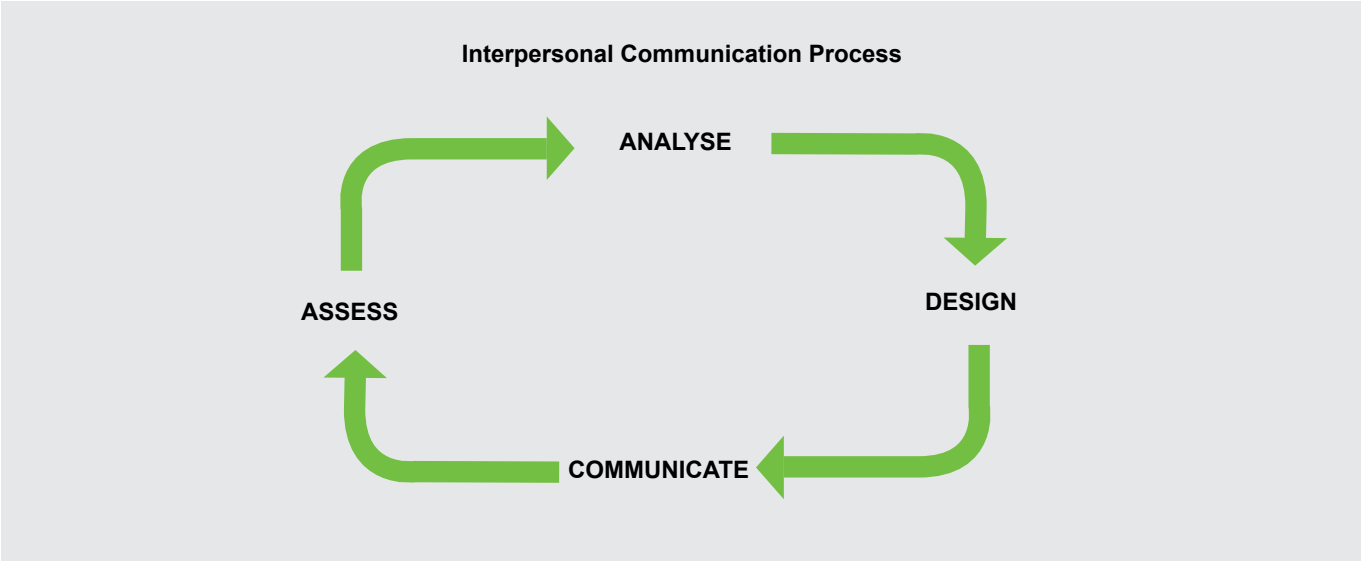
3.2.2.3 Coping and Self-Management Skills

Three broad categories of life skills under coping and self-management are:

Skills for increasing internal locus of control	Skills for managing feelings
• Self-esteem/confidence building skills • Self-awareness skills including awareness of rights, influences, values, attitudes, rights, strengths and weaknesses • Goal setting skills • Self-evaluation / Self-assessment / Self-monitoring skills	• Anger management • Dealing with grief and anxiety • Coping skills for dealing with loss, abuse, trauma
	Skills for managing stress
	• Time management • Positive thinking • Relaxation techniques

3.2.3 Interpersonal Communication

Is a verbal or nonverbal exchange of information between two or more people in each other's physical presence.



The interpersonal communication process is a two-way, interactive cycle in which the communicators exchange messages. All parties involved are both senders and receivers. In this process the receiver interprets previous messages and responds with new messages. The messages communicated are both verbal and nonverbal. There are five steps in the interpersonal communication process.

- **Assess:** The service provider collects information about the adolescent(s), past reproductive health service experience, attitudes toward and knowledge of youth friendly services.
- **Analyse:** The service provider interprets the information gathered about the adolescent to identify information needs.
- **Design:** The provider decides the purpose of communication and the messages. She decides when and where to deliver the messages. She forms a plan.
- **Communicate:** The plan is put into action.
- **Assess/Evaluate:** The service provider assesses the effectiveness of her/his communication (i.e. was the young person interested? Was the message understood? Will the young person act on the information?). Results will assist the service provider to improve communication with others.

Tips in interpersonal skills include:

a) Active Listening/Attending Behaviour

b) Reflecting feelings

c) Asking questions: closed ended, open ended, probing

d) Making Positive Statements – Praise, encouragements and reassurance

Barriers to effective communication, include: Personal barriers (knowledge and attitude), Socio-economic barriers (age, religion and culture, sex, language, economic status) and Logistical barriers (time and venue).

3.2.3.1 Tips for negotiation

The process of negotiation takes at least two parties with two different views on an issue, in this case, sexual behaviour. Each party would then try to persuade the other party to support his/her view, a 'win' situation, or at least to agree on a compromise or middle position, a 'win, win' situation.

- Be a good listener. Let your partner know that you hear, understand, and care about what she/he is saying and feeling.
- Be "ask-able" – let your partner know that you are open to questions and that you won't jump on him/her or be offended by questions.
- Be patient and remain firm in your decision that talking is important.
- Recognize your limits. You do not have to know all the answers.
- Understand that success in talking does not mean one person getting the other person to do something. It does mean that you have both said what you think and feel respectfully and honestly.
- Avoid making assumptions. Ask open-ended questions to discuss.

- Avoid judging, labelling, blaming, threatening, or bribing your partner. Do not let your partner judge, label, threaten, or bribe you.
- Be assertive and not aggressive.

3.2.4 Assertiveness and Self-confidence Methods and Techniques

- Know the facts relating to the situation and have the details on hand.
- Be ready for - anticipate - other people's behaviour and prepare your responses.
- Prepare and use good open questions.
- Re-condition and practice your own new reactions to aggression (posters can help you think and become how you want to be - display positive writings where you will read them often - it's a proven successful technique).
- Have faith that your own abilities and style will ultimately work if you let them.
- Feel sympathy for bullies - they actually need it.
- Read inspirational things that reinforce your faith in proper values and all the good things in your own natural style and self.

3.2.5 Good vs Poor Decision-Making

A good decision rests on an ability to choose the best alternative, based on decision-maker's preferences. Some of the skills required in good decision making include the ability to clarify values and the ability to acquire information. A good decision is based on how it is made - not on how it turns out. **A good decision** is based on the ability to choose the best alternative based on the decision-maker's preferences. **A poor decision** is the inability to choose the best alternative. Two important skills needed to make good decisions are: the ability to clarify values and the ability to acquire information.

Three Cs decision making model:

Step i: In one sentence, write the **Challenge** - The decision that is being made.

Step ii: List at least three options or **"Choices".**

Step iii: For each choice, list several positive and negative outcomes or "Consequences". Being able to predict consequences is a very important skill for young people who often forget the negative aspect of a choice they want to make.

Step iv: Review the choices and consequences and rank them.

Step v: Write down the decision and the reason.

Application Model: Whether or not to have sex is one of the most difficult decisions young people need to make. Failure to make a conscious decision and plan for that decision is one of the most common aspects of teenage pregnancy and infection with STIs including HIV.

NB: Both service providers and adolescents need life skills for effective helping relationships.

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Session 3: Comprehensive sexuality education for adolescents

3.3.1 Defining CSE

Comprehensive Sexuality Education is defined as a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. CSE provides opportunities to explore one's own values and attitudes and to build decision- making, communication and risk reduction skills about many aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to:

- Realize their health, well-being and dignity;
- Develop respectful social and sexual relationships;
- Consider how their choices affect their own wellbeing and that of others and
- Understand and ensure the protection of their rights throughout their lives.

It is therefore a curriculum-based education that approaches sexuality and relationships with information that is:

- Gender and human rights-based
- Age and developmentally appropriate
- Incremental
- Culturally relevant
- Transformative

- Scientifically accurate
- Realistic
- Non-judgmental
- Able to develop life skills needed to support healthy choices

3.3.2 Benefits of CSE

- Gain information about themselves and their sexuality, how to prevent pregnancy and avoid sexuality transmitted infections and HIV and to learn more about preparing for their world of work
- Look at their attitudes and feelings about growing up, gender roles, risk taking, sexual behaviour and relationships; and
- Practise making decisions, setting goals, communicating clearly, negotiating to protect their own health and realistic negative peer pressure

CSE does NOT	FACTS
• Encourage young people to have sex • Undermine parents or the authority of families • Disregard values and morals • Teach young people how to have sex or take away their innocence • Disregard abstinence as an option • Follow an abstinence only until marriage	Extensive evidence shows that effective comprehensive sexuality education programmes paired with availability of services consistently increase adolescents and young people • knowledge of HIV and other health issues, • delay age of sexual debut • decrease number of sexual partners and frequency of sex, increase use of contraception including condoms.

In Zimbabwe, CSE can be delivered through Lessons can be delivered in or out of school using any of the following approaches-:

- In-school guidance and counselling sessions and integration into social and health subjects.
- Peer to peer approaches.
- Clubs (single sex or mixed), and
- Parent to Child Communication (PCC).

Basic tips for communicating on SRHR with adolescents:

- Speak frankly: If service providers do not know the answer, say so and refer where possible or consider assuring to find out the answer for the adolescent.
- Give simple, direct answers you know are accurate.
- Be “approachable”. Service providers do not need to be upset or become agitated when dealing with adolescents.
- Respond in the same way to boys and girls when they ask questions.
- Use words and concepts which they can understand and relate to.
- Always assure and maintain professionalism.
- Use visual aids such as pamphlets, posters, and models (condom demonstration models), as much as possible.

NB:

- Comprehensive sexuality education has positive effects, including young people’s knowledge and improving their attitudes related to sexual and reproductive health and behaviour.
- Sexuality education does not increase sexual activity, sexual risk-taking behaviour or STI/HIV infection rates
- Abstinence-only programmes are not effective in delaying sexual initiation, reducing frequency of sex, or reducing number of sexual partners
- Programmes that are comprehensive and delivered fully as intended are more likely to have the desired positive impact on young people’s health outcomes
- Sexuality education is most impactful when school-based programmes are complemented with non-discriminatory, youth-friendly services and parental engagement.

References

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Session 4: Quality and friendly SRH service delivery for adolescents

3.4.1 Describing Youth Friendly Services

The World Health Organisation describes Youth Friendly Services (YFS) as services that are accessible, acceptable and appropriate for young people. They are in the right place, at the right time, at the right price (free where necessary) and delivered in the right style to be acceptable to young people. It meets the needs of young people and are able to retain their youth clientele for follow up and repeat visits. The following are the key characteristics of YFSP:

Service provider characteristics: Service providers should possess competencies and interpersonal skills that attract adolescents and youth to communicate their concerns with ease and comfort, whist maintaining privacy and confidentiality. All non-clinical staff such as security guards, general hands and receptionists should be trained and oriented to the needs of adolescents and youth and expectations of the systems by the target group.

Service delivery point characteristics: SRH clinical services should be open at times that are convenient for both adolescents and youth to attend and the clinic personnel should be in attendance during after-school hours and weekends where feasible. Providers should avail themselves for emergency services or devise means of ensuring communication mechanisms that support adolescents and youth at all times. Examination rooms and counselling rooms should offer both auditory and visual privacy. Interruptions during client visit sessions should be minimised. Adolescents and youth often prefer environments that are clean, have adequate seating, and are decorated with cheerful colours and appealing IEC materials.

Programme design characteristics: In order to adequately and appropriately address young people's SRH needs, mechanisms need to be put in place to ensure participation of adolescents in the design, implementation, and evaluation of services. Adolescents and youth can also be involved in service-demand-generation as well as in providing feedback on quality of service provision through exit interviews, or through mystery client assessments and/or as members of local SRHR related committees. User fees and long waiting period exemptions are such arrangements that also attract confidence in adolescents. Clear referral pathways for services not available also boast confidence for adolescents to take up services. A wide range of SRHR services also need to be availed all times and limit referrals, whilst providing IEC materials, mainstreaming disability and providing adolescent friendly interactive methodologies for educating them on SRHR.

3.4.2 Settings for YFSP

SRHR can be provided as integrated or stand-alone/vertical/targeted. Integrated services offer a range of services within the same setting at the same time and preferably in the same location. In this approach, adolescents receive various services as part of the general public, but special arrangements may be made to make the services more acceptable to them. Stand-alone services are designed and planned for adolescents alone and are offered in settings that meet only the needs of the youth and do not include other groups. This is possible where space is available to designate a special room/s for serving adolescents and youth. In all approaches each setting MUST put in place a strong and effective referral, tracking and feedback system for services not available. There are four broad settings of youth friendly service delivery that Zimbabwe has adopted. These are, the public health facility setting, the primary and secondary school-based setting, the tertiary education institution based setting and the community-based setting.

Primary and secondary school-based setting: This approach is offered mainly through the provision of life skills and comprehensive sexuality education and counselling for adolescents and youth. Selected health services may be provided at the institution as per national guidelines and policies.

Health facility based setting: This setting offers a comprehensive package of preventive, promotive and curative health services. This setting requires that all clinical and non-clinical support staff in a health facility offer high-quality services to adolescents in a non-judgmental way that ensures privacy and confidentiality.

Tertiary education institution based setting: This setting (which includes tertiary and vocational training institutions) provides comprehensive sexuality education and offer a range of SRH services. Similarly, to the health facility setting, the clinic staff need to be sensitive to the SRHR needs of adolescents and create a strong referral, tracking and feedback mechanisms for services not available at the local clinic.

Community-based setting: This setting uses creative means of reaching out to young people to deliver clinical and other services to locations where young people congregate or are found. This setting accommodates the use community youth centres and can also provide outreach services at non-health settings in strategic locations closer to young people that need the services most. It also reaches out to adolescents through help lines (toll free), mobile phones, community radios and other internet-based-communication technologies as well as through peer education, parent-child communication and single or mixed sex empowerment platforms (e.g. sister to sister clubs).

3.4.3 Standards based adolescent and youth friendly SRH services provision (YFSP)

In 2016, Zimbabwe adapted the WHO global standards on provision of quality health care services for adolescents. These standards have been contextualized to the needs of young people and the health situation in Zimbabwe and are premised on the WHO description of YFS. The standards recognize that provision of friendly adolescent and youth health services,

including in emergency and crisis situations is based on the following guiding principles:

- Adolescents and youths are not homogenous hence their health needs vary according to such factors as: gender, religion, age, life experiences, disability status, HIV status and level of education.
- Adolescents are important actors or decision makers and not just mere recipients of services. This calls for meaningful adolescents and youth participation in issues affecting their lives.
- Community support is critical for effective and sustainable youth health services and programmes.
- Service delivery points should provide the indicated package of health services in conducive environment that adolescents and youth need, at any given time and in all designated facilities, to access services.
- Administrative and management systems and adequate resources should be in place to improve and sustain the quality of youth friendly health services.

3.4.4 Standards on adolescent and youth friendly health service provision

Standard 1. Service Delivery Points (SDPs) need to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services. This include age and culturally appropriate health education and marketing of available services.

Standard 2. SDPs need to ensure that parents, guardians, religious and traditional leaders, community health workers, teachers, community members and community organizations recognize the value of providing friendly health services to adolescents and support such provision and the utilization of services by adolescents through adolescent health committees for quality decision making and coordination of efforts.

Standard 3. SDPs need to avail an integrated package of information, counselling, diagnostic, treatment, and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.

Standard 4. All health-care providers and support staff need to demonstrate the technical competences required to communicate and provide quality health services to adolescents, e.g. without discrimination and judgmental attitudes.

Standard 5. SDPs need to establish and provide convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality to young people. The necessary equipment, medicines, supplies, and technology need to be available.

Standard 6. SDPs need to provide quality services to all young people irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation, or other characteristics.

Standard 7. SDPs need to collect, analyze, and use data on service utilization (disaggregated by age and sex), for quality improvement and decision making.

Standard 8. SDPs need to ensure participation of young people in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision. This include conducting adolescent focused client satisfaction surveys.

Standard 9. SDPs need to have adequate and updated national level policies, strategies, guidelines, and procedures/ protocols for quality service delivery. SDPs also need to devise home grown/institutional based systems/policies and mechanisms to facilitate and sustain friendly service delivery to young people.

3.4.5 Minimum package of SRHR services for adolescents

Service providers must abide by relevant national (and internal) policies in determining whether or not an adolescent is eligible for a particular SRH service. Service providers should use the minimum service delivery package in daily practice and at all levels of youth friendly service provision. In order to provide comprehensive SRH services to adolescents and youth, it is advised that every SDP provides this basic minimum service delivery package with reference to other national policies and guidelines that are specific to each element of care. The minimum package of service delivery consists of promotive, preventive, curative and referral, tracking and feedback services, which should be provided in a complementary and integrated manner. A referral system/pathway should be available and implemented all times, including in emergencies/ humanitarian crisis situations (e.g. COVID or cyclones), complicated cases and procedures and for management of adverse effects. Below is the minimum package of SRHR services for adolescents:

i. Life Skills based counseling and comprehensive sexuality education
ii. HIV Testing Services
iii. Safe Motherhood: family planning, antenatal care, safe delivery (including eMTCT) and post-natal care
iv. Family planning services, including abstinence counselling and emergency contraceptives
v. Abortion Care Services (both termination of pregnancy and post-abortion care)
vi. Prevention and management/treatment of STIs HIV, including condoms, PrEP, PEP, VMMC, ART

vii. Prevention, detection, and management of reproductive health cancers, e.g. HPV vaccinations, cervical and breast cancer examinations

viii. Prevention and management of SGBV

ix. Menstrual hygiene management, e.g. counseling and provision of sanitary ware

x. Nutrition and mental health services

NB: As of November 2020, there is no legislation that specifies the universal age limit below which parental consent is required to receive sexual and reproductive health services in general. However, the public health act of 2018 specifies the need for parental consent in certain circumstances. The following are the specific ages of consent tailored to selected services in Zimbabwe:

- Age of consent for HIV testing services is 16 years (National HIV Testing Services Guidelines).
- Age of consent for medical male circumcision is 18 years (National Medical Male Circumcision Guidelines).
- The age of consent for sex is at 16 years (Sexual Offenses act) whilst marriage is at 18 years (2013 constitution).
- There is no age of consent for contraception or family planning services, hence health workers adopt an individualistic approach towards assessment of clients and making the necessary recommendations, including requesting for parental consent in certain circumstances.

The discrepancies between the ages of majority (18 years), the adult age by the public health act (16 years and above), age of consent for health services ages (e.g. no age of consent for family planning, HTS at 16 years and VMMC at 18 years), age of consent for marriage (18 years) and age of consent for sex (16 years) therefore subject service providers to different interpretations thereby compromising SRH service delivery, especially for adolescents below age of 16. However, the constitutional position on not allowing discrimination on the basis of marital status may complicate the situation whereby service providers have always provided married adolescents with reproductive health services, as they are treated as mature minors.

3.4.6 SRHR and HIV linkages & integration

With the majority of HIV cases being sexually transmitted, the importance of linking HIV as SRHR is abundantly clear. Many illnesses linked to SRHR have the same root causes with those of HIV. For example, the greater proportion of pediatric HIV infections is spread from mother-to-child in the process of pregnancy, childbirth, and breastfeeding.

Linkages: refers to the bi-directional synergies in policy, programs, services and advocacy between HIV and SRH.

Integration: refers to how different kinds of HIV and SRH services or operational programs can be joined together to ensure and perhaps maximize collective improved outcomes. This would include referrals from one service to another. For the clients, integration means health care that is smooth flowing and easy to navigate, sometimes through a reduction in the number of stages in an appointment and the number of visits required to a health facility for a complete or comprehensive service.

Models of integration: There are various models for integrating SRHR and HIV that can be implemented by SDPs. However, the choice and implementation of these models depend on available infrastructure, health care workers' willingness to willingness to provide HIV related services, Patient load in relation to health care worker availability and the Capacity of health care workers to provide all services

a) **Intra-provider integration:** On-site integrated SRH and HIV service delivery- "one-stop shop" where comprehensive services are provided at one location usually by one provider, in the same room and at the same visit.

b) **Intra-facility integration:** This is the "supermarket approach" where SRH and HIV services are offered by several providers in different rooms at the same facility during one visit to the facility

c) **Inter-facility integration:** Off-site integrated SRH and HIV services offered outside the facility with facilitated referral

d) **The mixed-model approach:** Some services are initiated in one facility, but are provided in another or some services are offered in one facility while others are offered in a different facility.

Benefits of integrating SRHR with HIV services:
Integrating services is one key approach for overcoming missed opportunities of meeting the needs of overlapping target populations in HIV prevention and SRH services. Below is a list of important public health, socio-economic, and individual benefits of integration:

- Improved access to and uptake of key HIV and SRH services
- Decreased duplication of efforts and competition for scarce resources
- Better access of people living with HIV to SRH services tailored to their needs
- Reduction in HIV-related stigma and discrimination
- Mutually reinforcing complementarities in legal and policy frameworks
- Enhanced program effectiveness and efficiency
- Improved coverage of underserved/vulnerable/key populations

- Better utilization of scarce human resources for health
- Greater support for dual protection
- Improved quality of care

Client/User Satisfaction Surveys

When it comes to improving access to SRHR services among adolescents, it is important that the services delivered by health workers are youth friendly. In this module, we have already covered the standards in place for youth friendly services. It is important to ensure that young people are involved, not only in evaluating if their needs are met by health workers but also whether this is done in a youth-friendly manner. To this end, it is important to undertake surveys with clients to check if they are satisfied with the services provided. Health services providers can apply the Client Exit Interview Guide (Annex I) to undertake client satisfaction surveys. You can make use of trained peer educators to help conduct these surveys in order to allow free and open feedback. These surveys must be anonymous.

References

- National Guidelines on Clinical Adolescent and Youth Sexual and Reproductive Health Services Provision (YFSP), 2016 Edition, Ministry of Health and Child Care, Zimbabwe
- WHO/UNAIDS (2015). Global standards for quality health-care services for adolescents: a guide to implement a standards-driven approach to improve the quality of health-care services for adolescents. Geneva: World Health Organization. https://www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en/
- http://srhhivlinkages.org/wp/wp-content/uploads/2013/04/linkagesdefinitions_2010_en.pdf
- Linking sexual and reproductive health and rights and HIV in Southern Africa, http://srhhivlinkages.org/wp/wp-content/uploads/Linking-Sexual-and-Reproductive-Health-and-Rights-in-Southern-Africa.pdf

MODULE 4

Self Awareness and Empowerment of the Service Provider

MODULE 4: Self Awareness and Empowerment of the Service Provider

Research[5] has constantly indicated that service provider attitudes are a key barrier for adolescents who seek to access services. Often, these attitudes are informed by the religious and moral values that service providers hold based on their socialisation. This module seeks to empower health service providers by increasing their self awareness of how their socialisation shapes their values and attitudes and how that interferes with their professional roles. Other sessions in this module seek to empower service providers with practical skills for providing information and services, including counselling.

Session 1: Self awareness, values, attitudes, and perceptions of service providers

4.1.1 Definitions

Value: Is a principle, standard or quality regarded worthwhile or desirable. We inherit many of our values from our family, and religion, friends, education, cultural factors, and personal experience influence our values. Values are beliefs, principles and standards to which we assign importance. They are things we prize and give a degree of significance to.

Attitude: Is a state of mind or a feeling. It is the mental stance we take in relation to the world. Attitudes are largely based on our personal values and perceptions. Attitudes are mental views, opinions, dispositions, or postures.

Perception: One's view of the world. The way one regards, understands, or interprets something.

Every perception a person has is based upon their own personal experience. People perceive the world differently because no two people have the same experiences. Experience makes us who we are. It shapes our minds and opinions, our likes and dislikes. Therefore, it is difficult to have one ideal definition of certain concepts, such as justice, virtue, and an ideal society. Our experiences color our opinions of people different than ourselves and even our opinion of the dark. The only way to create one perception of reality would be to systematically force everyone to have the same experiences. This is difficult.

Understanding that we all may view things differently at one point or another is a part of life. Although we may see things differently, this does not necessarily mean that your perception is wrong and mine is right.

4.1.2 Factors that shape individual values, attitudes, and perceptions

Our values as individuals are often drawn from morals, culture and religion.

Moral values are standards/principles of behaviour, which we use to classify behaviour as good or bad (right or wrong). Often, moral values are informed by the culture of a particular community. Culture is the way of life, especially the general customs and beliefs, of a particular group of people at a particular time. Culture is not static; rather it is dynamic.

Religious values define what people expect of themselves and of others based on the beliefs common to the religions they practice. Different religions, just like cultures, have different values. Again, like moral values, what is viewed as good or bad may depend on one's religion.

Examples of common moral values include love, honesty, justice, faithfulness, dignity, responsibility, compassion, and integrity.

Most societies respect certain values for the following reasons:

- ASRHR programmes need to contextualize and acknowledge that adolescents and youth are not homogenous hence their health needs vary according to such factors as: gender, religion, traditional beliefs, socialisation, ethnicity, age, life experiences, sexual orientation, social economic situation, disability status, HIV status, level of education and physical or mental disability.
- They are a part of traditions inherited from elders and generations before (usually traditions are part of a culture).
- Because they are commandments given by a higher power, such as God.
- Moral values set apart human beings from other animals hence humans must be reasonable in their actions.

[5] This was also confirmed by the Simba Utano Project Gender Analysis, 2020

Box 1: Values, Religion, Culture and Gender

Research has shown that religious and moral values are often applied differently to men and women. A gender analysis conducted in 4 districts (Seke, Mazowe, Goromonzi and Umguza), revealed the following interlinkages between religion, culture and the SRHR of women and girls:

- Women and girls are viewed either as non-sexual beings or existing solely to satisfy the sexual needs of men. Women who seek to assert their sexuality and seek to enjoy their sexual and reproductive rights are labelled as 'loose'.
- Religious and cultural beliefs in the communities were cited as sustaining laws that limit women and girls' right to abortion. Such beliefs were said to lead to violence and persecution of the LGBTIQ community thereby driving sexual minorities underground and making it difficult for them to access services.
- Both culture and religion were reported as major drivers of child marriages, a key challenge in all four districts affecting more adolescent girls than boys.
- Female genital mutilation in the form of labia stretching continues to be passed on from generation to generation as a tradition, especially in Mazowe, Goromonzi and Seke districts while virginity testing for AGYW was said to be common in Umguza district.
- The payment of the bride price (*lobola*/*roora*) was also viewed as a cultural practice that commodifies women and exposes them to intimate partner violence. Many men think they have power over the bodies and choices of women just because they paid *lobola.*

Source: The Gender Analysis for the Simba Utano Project

Values and their role in denying adolescents access to SRH services: Worksheet 4.1

Value	How is the Value Applied to Deny Access to ASRH Services?
Abstinence *(Refraining from marriage before marriage)*	*For example:* • *Health services providers pass judgement and treat with negative attitudes unmarried young people who request contraceptives or other services/ sometimes even denying them services* • *Unmarried young people who are sexually active fear/feel embarrassed to come forward to access services*
Virginity *(the state of never having had sexual intercourse at the time of marriage)*	.....
Faithfulness *(Unshakable and exclusive romantic relationship to a person)*	.....
Sin *(Unshakable and exclusive romantic relationship to a person)*	.....
Heterosexuality *(Sexual relations are only sanctioned between males and females)*	.....
Other: *(Please state)*	.....

NB: Although health service providers may not be consciously aware, they do carry values that may interfere with their professional role. It is important that they are self-aware of such values and make an effort not to pass judgement on adolescents who require services.

Session 2: Values Clarification

4.2.1 Understanding Value Clarification

Service providers, regardless of the training they receive and their knowledge of SRHR, are not exempt from applying their own values in their conduct and work. Just like everyone else, they are socialised to esteem those values they hold dear and often, apply them over ethics of the profession. As a result, regardless of the fact that moral values are often the last thing on a person's mind as they act, react to and interact with others, in reality, they inform the assumptions that influence one's attitudes and behaviour. This makes moral values an important factor when we are considering educating and changing human behaviour. To ignore the question of moral values in the process of educating for responsible lifestyles or provision of services is to fail before one has even started. To this end, value clarification is important for health service providers.

Value Clarification is technique that helps an individual, especially a health services provider to increase awareness of any values that may have a bearing on decisions and actions they take in counselling or providing a service to a client. It means sorting out one's own values from the values of the outside world – separating one's personal beliefs from the beliefs of others.

4.2.2 Benefits of Value Clarification

As already suggested, value clarification is important in providing SRHR information and services to adolescents and young people. The following are the key benefits of value clarification:

i. To know oneself more deeply and how one's own values and attitudes and perceptions are formed.

ii. To become more aware of how one's values, attitudes and perceptions can help or hinder the counselling and communication process as well as the provision of services.

In order to change one's attitudes, it is important to become aware of the perceptions and values that lie beneath the surface.

Worksheet 4.2: Value Clarification Statements

Do you agree with these statements? Why/why not? Discuss how your views and perspectives are influenced by your religious and moral values? Are you aware of the professional ethics, rights of adolescents and policies that your religious and moral values may violate in the various scenarios?

- The age of consent to sex should allow consenting adolescents to have sex without legal consequences
- All teenagers should have access to contraception if they want it
- Girls should be virgins when they marry
- LGBTIQ young people must be provided with protection devices for their sexual activities
- Sex workers must be provided with information and contraceptives to protect them from HIV
- Women who refuse to cook for their husbands deserve to be beaten
- Girls who fall pregnant at school must be expelled
- Primary school learners must be taught about sex and sexuality
- Girls should not go to men's houses if they do not want to have sex
- Boys cannot control their sexual behaviour once aroused
- Abortion must be legalised
- An unmarried pregnant girl of 14 years should be allowed to have an abortion
- Adolescent girls who love money and material things expose themselves to rape
- Unmarried teenage girls who carry around contraceptives are promiscuous
- It is a girl's fault if she falls pregnant

Worksheet 4.3: Personal Worksheet on Personal Values, Attitudes and Perceptions

This is a personal exercise. You are supposed to do it own your own and share with others only those things you are comfortable with sharing. However, the goal of the exercise is to use this worksheet as a tool for personal reflection and as the first step towards own behaviour and attitude change.

1. Perceptions, values and attitudes that I hold that help when I counsel adolescents and young people (at least 3):

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2. Perceptions, values, and attitudes that I hold that may hinder when I counsel adolescents and young people (at least 3):

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3. Practical ways through which I can balance or overcome my perceptions, values, attitudes that hinder my effectiveness in counselling adolescents or providing them with services (at least 3):

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Value Clarification Exercise 3

Case Story 4.2.5: Tracey's Dilemma

Tracey is a 15-year-old girl who is still in school. She does not like the life she lives – her parents are poor and can barely afford to send her to school. She thought her life would be better if she falls in love with one of the 'rich' gold panners who practice artisanal mining in the local community. His boyfriend is a married man but she doesn't care; at least he gives her pocket money and even buys her nice things, including expensive mobile phones. She is known in the community as the girl who only dates rich guys. Now Tracey is in trouble – she fell pregnant and her parents tell her they cannot send a 'mother' to school. She is about to drop out of school. Her parents have thrown her out of the family home. The boyfriend won't hear any of it: 'I have a wife,' he says. Tracey is about to commit suicide, but a friend tells her she can easily abort this pregnancy. She follows the advice, but it didn't work out as planned. She presents herself to you with excessive bleeding and narrates her story. She needs urgent help.

Group Discussion Questions

In your group, discuss the following:

1. *What kind of help would you give to Tracey?*
2. *Is it Tracey's fault that she is in this situation?*
3. *What religious and moral values did she breach?*
4. *What would your colleagues and society think if you help this girl? Would they regard you as a good or a bad person?*
5. *What practical steps can you take to ensure that your values, perceptions, attitudes do not hinder your effectiveness in helping Tracey?*

References

- Good therapy, Values clarification, https://www.goodtherapy.org/learn-about-therapy/issues/values-clarification#:~:text=Values%20clarification%20is%20a%20psychotherapy,to%20be%20analyzed%20and%20clarified

Session 3: Educating and counselling adolescents: practical tools and skills demonstration

4.3.1 Understanding and using the adolescent language

Whether one is providing information or services to adolescents, there is a great deal of communication that goes on. However, conversations on sex and sexuality are not easy, especially when it involves adults and young people. To start with, there are taboos surrounding the use of vernacular languages to refer to sexual terms. To get around this problem, young people have their own street lingo/slang for such terms. It is, therefore, important that anyone counselling youth becomes familiar and comfortable with the use of sexual terms as well as the use of slang. It is important to note that young people also use slang to exclude adults from their discussions. To this end, adult service providers may need to invest in building trust with young people if they are to be let in on the slang and have a common language with young people.

Why language is important?

- Having a common language and naming of sexual terms is important to ensure that service providers do not miscommunicate with young clients. Miscommunication can lead to wrong diagnosis, treatment, or failed counselling.
- Young people will be able to communicate about abuse. Sometimes sexual abuse court cases fail because young people do not know the language or are too shy to use proper terms when reporting abuse.
- Yet, the failure by society to acknowledge and utilise proper vernacular sexual terms results in young people who dare to do so being judged.

4.3.2 Do's and Don'ts for communicating with adolescents

DO	DON'T
• Tell the truth always. Accept when you don't know. • Be professional and technically competent • Use words and concepts which adolescents can understand and relate to. Assess, as you go, if they understand. • Use learning aids such as pictures and flip charts (these can also help for people with different forms of disability) • Treat them with respect in terms of how to speak and how you act • Do not prescribe solutions. Empower them to make own decisions by giving all the information/choices and help them decide what to do • Treat all adolescents equally (regardless of sex, sexual orientation, age, social class, educational status etc.) • Be understanding and supportive even if you do not approve of their behaviour • Accept that adolescents may choose to show their individuality in dress or language	• Inaccurate information (to scare them or make them 'behave') • Threaten to break confidentiality 'for their own good' • Giving them only the information you think they will understand • Using medical terms they will not understand • Talking down to them, shouting, getting angry, or blaming them • Telling them what do because you know best as an adult or health service provider • Being judgmental about their behaviour, showing disapproval, or imposing your own values • Being critical of their appearance or behaviour. If their choices endanger their health try to explain to them without being judgmental

4.3.3 Defining Counselling

You may notice from the definitions offered by participants that the practice of "counselling" means many things to different people. However, in general, counselling is a **form of helping individuals (adolescents) with problems through interpersonal communication.** However, ideas on how that is provided, by whom and for whom, may differ widely. Counselling requires extensive knowledge about the subject matter, especially SRHR challenges that young people face (*See Module 1 and Annex on CSE)*. However, much of what is involved in a counselling session is a function of effective communication skills.

4.3.3.1 Introduction to Basic Counselling

In this training we focus on basic or lay counselling as opposed to professional counselling. Lay counsellors must choose their issues carefully and refer complex or difficult cases to professional counsellors.

Counselling does not entail giving adolescents direct solutions to their problems. Rather it entails giving adequate information for them to make informed choices. Part of the counselling process is to reach a mutual understanding of the client's needs, reach agreement on the goals for the counselling process with a particular client, help the client reach those goals, and ultimately achieve a mutually agreeable end to the counselling process. To this end, the following key considerations, summarize what counselling of adolescents on SRHR entails and how to go about it.

Illustration 4.3.3: Basic Counselling Skills

Source: Counselling Tutor

4.3.3.2 Core Counselling Skills

Core listening skills are basic counselling skills, or practiced techniques, that help the counsellor to empathetically listen to the speaker.

Such kills include:

- Active listening
- Being aware of nonverbal communication
- Building rapport

The core counselling skills are described below.

1. Attending: Attending in counselling means being in the company of someone else and giving that person your full attention, to what they are saying or doing, valuing them as worthy individuals. Avoid fidgeting or keep your phone away.

2. Silence: Silence in counselling gives the client control of the content, pace and objectives. This includes the counsellor listening to silences as well as words, sitting with them and recognizing that the silences may facilitate the counselling process. Do not be quick to interject just because the client is silent. It is important to check for cues if the client is finished. It may also be important to ask the client if they are done speaking before interjecting.

3. Reflecting and Paraphrasing: Reflecting in counselling is part of the 'art of listening'. It is making sure that the client knows their story is being listened to.

This is achieved by the counsellor by repeating and feeding a shorter version of their story back to the client. This known as 'paraphrasing'. Use such phrases as 'I hear you are worried about …' or 'You are suggesting that your concern …' etc.

4. Clarifying and the Use of Questions: Questioning in counselling is an important basic skill. The counsellor

uses open questions to clarify his or her understanding of what the client is feeling.

Leading questions are to be avoided as they can impair the counselling relationship. They will also give a client a feeling that they are being judged if they give a certain response. Also, such questions tend to limit the detail you get from a client. Do not ask questions that require a 'Yes' or 'No' answer.

5. Focusing: Focusing in counselling involves making decisions about what issues the client wants to deal with.

The client may have mentioned a range of issues and problems and focusing allows the counsellor and client together to clear away some of the less important surrounding material and concentrate on the central issues of concern. It is not your role to choose which issue to focus on. Rather, you can let the client know that they may need to tackle one issue

at a time, focusing on their capacities and resources. Do not lead them towards what you think is the most important or bigger issue.

6. Building Rapport: Building rapport with clients in counselling is important, whatever model of counselling the counsellor is working with. Rapport means a sense of having a connection with the person. As a counsellor you need to exhibit a friendly demeanor. Look, sit, talk and appear approachable. Smiling needs to be used genuinely and so does showing sympathy. Do not exaggerate friendliness. Clients are able to pick it when you are faking and this can make having a connection difficult.

7. Summarizing: Summaries in counselling are longer paraphrases. They condense or crystallize the essence of what the client is saying and feeling. The summary 'sums up' the main themes that are emerging. Use this technique before you help the client to focus. When you are able to summarize first, the client will not feel like your attempt to focus (see point 5) is because you did not hear or understand their many concerns.

4.3.3.3 Common barriers to communication

- Sometimes, it is things we do not consider, e.g. is your building barrier free and does it allow access by people with disabilities
- A noisy environment where it can be really difficult to hear what is being said can be a barrier to communication.
- Different languages, or not sharing a common language to the same level of competences
- Client has a hearing impairment
- Perhaps one of the biggest barriers to communication is a counsellor who is judgmental or sarcastic.

4.3.3.4 Taboos and language of sexuality

Worksheet 4.4: Taboos and the language of sex

To talk about sex and sexuality with young people, there is need for a common language. Yet, many local cultures have taboos around the use of proper names of sexual activities and organs in their vernacular languages. Adults often use hidden language to refer to sexual terms and organs with young people resorting to slang. To facilitate communication on these issues, therefore, we need to have a common language and, most importantly to overcome taboos. Service providers need to familiarise with the slang terms and language used by adolescents in their respective communities/catchment areas to communicate sexuality issues so that they are able to communicate and engage effectively Below is a list of key sexual terms. In your groups, find vernacular translations as well as alternative terms used by young people and adults in place of the correct vernacular terms.

English Term	Commonly accepted term (adult preferred)	Adolescents' slang term
Buttocks		
Sexual intercourse		
Vagina		
Penis		
Womb		
Menstruation		
Blow job		
Labia		
Testicles		
Sperm		
Breast		
Anus		

4.3.3.5 Communicating with adolescents on SRHR

Box 2: Barriers to communication with adolescents on SRH

The following are some of the barriers that affect communication with adolescents on SRH issues:

- Lack of comprehensive knowledge on ASRHR
- Physical and psychological noise
- Distraction and poor listening skills
- Taboos surrounding sex and sexuality
- Lack of common language or language that is considered appropriate

4.3.3.6 Challenges in counselling adolescents

Counselling adolescents is not easy. The following are some of the key challenges in counselling adolescents with regards to their SRH. Discuss in pairs and provide potential solutions:

Challenge	Possible Solution
Silence: the adolescent won't talk Adolescent won't stop crying Counsellor believes there is no solution to the problem Adolescent threatens suicide Counsellor does not know the answer to a factual question Adolescent refuses help Adolescent not comfortable with the counsellor's age or sex Counsellor and adolescent know each other socially Counsellor is embarrassed by the subject matter Other …… …… ……	

References

- Effective Counselling Skills: https://counsellingtutor.com/basic-counselling-skills/
- Communicating with and Counseling Adolescents, Module 4 http://files.icap.columbia.edu/files/uploads/Module_4_-_PM_Adolescent.pdf
- Kathryn Geldard, David Geldard, Rebecca Yin Foo, Counselling Adolescents, The Proactive approach for Young People, Fourth Edition,

Annex I: Client Exit Interview Guide on Youth Friendly Service Provision in Zimbabwe

This client exit interview can either be self-administered or interviewer administered. Self-administration of the tool reduces bias and should therefore be the most preferred method of assessment where possible. The tool is administered after services have been provided and the client is ready to leave the service delivery point. In the health facility set up, this tool must, ideally, be administered by other young people who sit in the ARSH Committee. Young people are likely to give honest feedback to other young people as opposed to adults or health workers

Self-Administered ☐	**Interviewer Administered** ☐
Name of interviewer (if applicable):	
Name of Service Delivery Point (SDP)/Health Facility :	
Date:	

Introduction before beginning the interview

"We are conducting this interview to assess the quality of care at this clinic/service delivery point and hope to use this information to improve services. We are asking clients about their satisfaction with the services provided. We hope that you can assist by agreeing to be interviewed/complete this form today. Your name is not be required. Your participation or refusal to participate in this interview will not affect the services you receive in any way. The interview will take about 10–15 minutes and will be kept confidential."

General Information

1. **Is this your first time at this clinic?** ☐ **Yes** ☐ **No**
2. **Sex:** **Male** **Female**
3. **How old are you (completed years)?** _____
4. **What is your marital status now?**
   - ☐ Single
   - ☐ Married
   - ☐ Divorced/Separated
   - ☐ Widowed
5. **What type of service did you come for today?**

   [Tick those that apply]
   - ☐ *Information on HIV Prevention*
   - ☐ *Information on STI Prevention*
   - ☐ *Sexuality counselling services*
   - ☐ *Contraceptives*
   - ☐ *HIV counselling and testing*
   - ☐ *Sexually transmitted infection testing and treatment*
   - ☐ *Pregnancy testing*

- ☐ *Maternal care*
- ☐ *Cancer screening*
- ☐ *Treatment for other reproductive health matters*
- ☐ *Services relating to experiences of sexual, physical or emotional violence*
- ☐ *Post-abortion care*
- ☐ *VMMC*
- ☐ *Condoms*
- ☐ *Other – please specify*

_____

6. Could you tell me what (other) services are provided to adolescents in this Service Delivery Point?

- ☐ *Information on HIV Prevention*
- ☐ *Information on STI Prevention*
- ☐ *Sexuality counselling services*
- ☐ *Contraceptives*
- ☐ *HIV counselling and testing*
- ☐ *Sexually transmitted infection testing and treatment*
- ☐ *Pregnancy testing*
- ☐ *Maternal care*
- ☐ *Cancer screening*
- ☐ *Treatment for other reproductive health matters*
- ☐ *Services relating to experiences of sexual, physical or emotional violence*
- ☐ *Post-abortion care*
- ☐ *VMMC*
- ☐ *Condoms*
- ☐ *Other – please specify*

_____

Client's right to information

7. Which of this information did you receive during this visit?

- ☐ *Information on HIV Prevention*
- ☐ *Information on STI Prevention*
- ☐ *HIV testing and Treatment*
- ☐ *Sexually transmitted infection testing and treatment*
- ☐ *On contraception (how it works, side-effects etc.)*
- ☐ *On emergency contraception*
- ☐ *On unintended pregnancy*
- ☐ *Pregnancy testing*
- ☐ *Maternal care*
- ☐ *Cancer screening*
- ☐ *Sexual and gender based violence*
- ☐ *VMMC*
- ☐ *Condoms*
- ☐ *Growing up-body image, , masturbation, wet dreams etc.*
- ☐ *On relationships*
- ☐ *Hygiene and menstruation*
- ☐ *On where to go for services which the SDP does not provide*
- ☐ *Other – please specify*

8. Did you get any written information material such as pamphlets or fliers to read?

☐ **Yes** ☐ **No**

8a. If yes, were they easy to understand ☐ **Yes** ☐ **No**

8b. If no, why not?

9. Did the providers clarify any concerns that you had?

☐ **Yes** ☐ **No** ☐ **Had no concerns**

9a. If yes or no please explain:

10. What did you do while waiting for this consultation?

☐ *Talk to other clients*
☐ *Watch an educational video*
☐ *Listen to health talks*
☐ *Read educational materials*
☐ *Just Sat*
☐ *Other – please specify*

Client's right to access

11. Are the clinic opening hours convenient for you? ☐ **Yes** ☐ **No**

11a. If No, what would be the best day of the week and time for you to come to the clinic?

Day of the week:..... Time:.....

12. Did you pay for the service? ☐ **Yes** ☐ **No**

12a. If yes, how much did you pay?.....

13. Was the cost of the service affordable? ☐ **Yes** ☐ **No**

13a. If no, what would you recommend?

Right to choice

14. Did you get the services you came for? ☐ **Yes** ☐ **No**

14a. If no, why not?

15. Which other services did you want but could not get?

Right to privacy and confidentiality

16. When you were receiving counselling or a physical examination, did you feel that this was private

☐ **Yes** ☐ **No** ☐ **Not Applicable**

16a. If no, describe why and what you observed:

17. Did providers reassure you that any information concerning your personal situation and the service you received will remain confidential

☐ **Yes** ☐ **No** ☐ **Not Applicable**

Client's right to dignity and comfort

18. Do you feel that the time you spent at the clinic was?

☐ **Too long** ☐ **Just right** ☐ **Too short**

19. How long did you wait? _____Minutes _____Hours

20. Do you think that the waiting period was acceptable? ☐ **Yes** ☐ **No**

20a. If no, why not?

21. Did the clinic staff treat you in a friendly manner?

☐ **Yes, all of them** ☐ **Yes, some of them** ☐ **No**

21a. If 'some of them' or 'no', please explain:

Client's right to opinion

22. Were you given an opportunity to express your opinion about the services provided to you?

☐ **Yes** ☐ **No**

22a. If no, please explain:

Right to continuity of care

23. Have you been informed about the following?

23a. When to return for your follow-up visit ☐ **Yes** ☐ **No**

23b. That you can return at any time if you have questions or problems ☐ **Yes** ☐ **No**

24. What suggestions can you make to improve this facility and the services provided?

25. Was there anything in particular that you liked about the facility?

26. Was there anything in particular that you disliked about the facility?

27. Would you recommend the facility to a young friend or relative ☐ **Yes** ☐ **No**

27a. If no, why not?

Thank you for your participation.

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