Standard National Adolescent and Youth Sexual and Reproductive Health (ASRH) Training Manual

Strengthening Designing, Provision, Monitoring, Evaluation and Sustainability of Adolescent Friendly Sexual and Reproductive Health Services in Zimbabwe

2016 Edition
Government of Zimbabwe

Ministry of Health and Child Care

Harare, 2016
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<td>Adolescents Living with HIV</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>AREX</td>
<td>Agricultural Rural Extension</td>
</tr>
<tr>
<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
</tr>
<tr>
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</tr>
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</tr>
<tr>
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</tr>
<tr>
<td>MOHCC</td>
<td>Ministry of Health and Child Care</td>
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<tr>
<td>PCP</td>
<td>Pneumocystis Carini Pneumonia</td>
</tr>
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<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
</tr>
<tr>
<td>PeP</td>
<td>Post Exposure Prophylaxis</td>
</tr>
<tr>
<td>PEP</td>
<td>Parent Education Programme</td>
</tr>
<tr>
<td>PITC</td>
<td>Provider Initiated Testing and Counselling</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living With HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>PNC</td>
<td>Post Natal Care</td>
</tr>
<tr>
<td>POP</td>
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<td>PWD</td>
<td>People with Disabilities</td>
</tr>
<tr>
<td>SAR</td>
<td>Sexual Attitudes Reassessment</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>VCW</td>
<td>Village Community Workers</td>
</tr>
<tr>
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<tr>
<td>VIA</td>
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</tr>
<tr>
<td>ZNFPC</td>
<td>Zimbabwe National Family Planning Council</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS
THE FACILITATORS' GUIDE

INTRODUCTION
In order to improve access to sexual and reproductive health services for adolescents, the Ministry of Health and Child Care (MHCCMOHCC) in collaboration with other line ministries, parastatals, Non Governmental Organisations (NGOs) and young people, with support from UNFPA, UNICEF and WHO and other development partners, developed a National Adolescent Sexual and Reproductive Health (ASRH) Strategy II: 2016 - 2020. The 2016 – 2020 ASRH Strategy II is a follow-up to the 2010-2015 strategy. In the five years leading to this phase many new developments have happened both nationally within the dynamic environment adolescents and young people’s lives and globally influencing trends in the challenges the adolescents and young people face. The National Adolescent Sexual and Reproductive Health (ASRH) Strategy II: 2016 – 2020 refers to the theory of change which identifies: (1) poverty, (2) lack of access to information on ASRH, (3) inadequate and relevant service delivery and (4) inadequate policy, and regulatory framework, as the major drivers for ASRH challenges facing adolescents and young people in Zimbabwe. Addressing these challenges will provide a solution pathway that leads to an environment that is more supportive and cares for ASRH at the family, community and institutional levels. It is this supportive framework that provides an enabling environment for adolescents and young people to change behaviours and begin to seek ASRH services, engage in safer sexual and reproductive practices leading to reduced number of teenage pregnancies and their complications, and HIV and STI infections. Child marriages and sexual abuse of boys and girls are recognised as immediate causes of teenage pregnancies and HIV and STI transmission in localities where such incidences are high.

OVERALL GOAL OF THE TRAINING MANUAL
The overall goal of this training manual is to guide the facilitator in preparing, delivering and evaluating a standard training in youth friendly sexual and reproductive health service provision and programming.

THE FACILITATORS
Ideally the Facilitators who will conduct the training should be familiar with adolescent sexual and reproductive health and rights issues and counselling. The Facilitator must also be experienced in training and should have gone through a Training of Trainers (TOT) Course under this manual. Facilitators are encouraged to seek technical support in areas/sessions which may require technical expertise.

PARTICIPANTS SELECTION CRITERIA
- Participants could be drawn from service providers during pre-service and in-service training, youth-serving organizations, community-based health and development workers (e.g. Teachers, Lecturers, Community Based Distributors, Village Health Workers, Counselors, Prison officers for young offenders, Peer educators, Community leaders, Agricultural Research and Extension Officers) and service providers in religious and traditional organizations
- The selection process also need to identify participants with a special interest and positive attitude towards youth friendly SRHR service provision.

DURATION OF TRAINING
The suggested duration of the training is five (5) days, excluding the Training of Trainers (TOT). However the duration may be adjusted (less or more) depending on the type or cadres being trained.

MATERIALS AND EQUIPMENT NEEDED FOR THE TRAINING
Materials needed for the Facilitator in preparation for training:
- Access to a computer to prepare PowerPoint presentations and an LCD for projection.
- Access to a photocopier to produce handouts for participants.
- Access to information and references identified per session.
- Access to internet facilities may also be required for quick references.

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1 Government of Zimbabwe, National Adolescent Sexual and Reproductive Health (ASRH) Strategy II 2016-2020
• Contact details for all the resource persons for the training.

Materials needed for the Facilitator and participants during the training:
• Name tag and holder or desktop name tags
• Notebook or laptops (for participants who already have them)
• Handouts folder, Ball point pen, Pencil, Eraser

Materials needed for the training:
• Flip charts, Sticky stuff and Markers
• Newsprint
• Extra pens and Extra pencils
• Pencil sharpener
• Extra erasers
• Stapler, staples and Staple remover

ORGANISING THE TRAINING

Before the Training
The following suggestions help the facilitator in organising the training:
1. Choose a time and place that makes it easy for participants to attend. If food and drink are to be provided, the facilitator should ensure that it is organised beforehand.
2. Facilitator should read through this manual a few days before the training, so that s/he becomes familiar and comfortable with the objectives and activities. Activities and discussions can be adapted to suit the needs of training environment.
3. Prepare all power point presentations; identify samples to be used and all materials for the workshop in good time.
4. Liaise with co-Trainers and resource persons in the preparation in order to agree on specific areas of focus and the overall training programme and processes.
5. Use the checklist in Appendix 1 a guide on the preparation of the workshop, during the training and after.

During the workshop
The following points will help a facilitator run a successful workshop:
1. Allow the participants to sit in their most comfortable positions, but avoid classroom-style seating.
2. At the beginning of the workshop, encourage all participants to participate meaningfully and emphasise that their contribution is important.
3. Encourage shy participants, especially women and young females, to talk and participate, even if they feel nervous.
4. As well as encouraging shy participants to speak up, you may need to gently prevent the stronger participants from dominating the training.
5. Listen to all participants and thank them for their contributions. Acknowledge all comments, even if you think they might not be relevant.
6. Your role as a facilitator is to stimulate learning and not just facilitate conversation.
7. Lead the training with passion, excitement and commitment. Make sure you are enthusiastic about everything you say and do, and everything participants say and do. This will make the discussions livelier and encourage full participation.
8. Be careful not to impose your beliefs and values on the group.
9. If the participants request any religious activities (such as opening or closing with prayers), ask them to lead the process. Do not impose your personal views or opinions on the group.
10. Try to use local examples for new ideas so that the participants can relate to what you are saying. Also, explain issues in a simple and clear way, adapting suggestions from the manual that participants can relate to and understand.
11. Respond to the feelings and mood of the group. For example, if they seem tired, introduce a game or energiser.
12. If someone asks you a question, allow the participants to discuss it first before you respond. For example, ask, “Well, what do you think about that?” or “Does anyone else have something they want to say about this?”

13. It is important to encourage questions and discussion at any time during the training as this helps the participants to better understand what they have learned. Do not move to the next activity; participants always need time to debate, discuss and review ideas before putting them into practice.

14. If someone raises an issue that ties into an activity or discussion later in the training, let him or her know that you will address the issue later. Remember to ask for the comments or questions again when you reach the appropriate activity.

15. If there are young people in the group, ensure they get enough opportunities to contribute to the discussions as well.

16. This is a training context and participants should understand that they can only share what they are comfortable sharing.

**STRUCTURE OF THE ASRH TRAINING MANUAL**

<table>
<thead>
<tr>
<th>MODULE</th>
<th>CONTENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MODULE I: Overview of ASRH and Operating Environment</strong></td>
<td>• Training Objectives&lt;br&gt;• Why ASRH?&lt;br&gt;• Mainstreaming gender, disabilities and social media&lt;br&gt;• Adolescent population and sub-groups&lt;br&gt;• SRH rights, Laws, policies and Strategies</td>
</tr>
<tr>
<td><strong>MODULE II: Challenges Adolescents Face Today</strong></td>
<td>• Physical Development and the Body&lt;br&gt;• Human Sexuality&lt;br&gt;• Gender and ASRH&lt;br&gt;• Adolescent Relationships&lt;br&gt;• Sexually Transmitted Infections and HIV&lt;br&gt;• Adolescents and Contraception&lt;br&gt;• Adolescent Fertility&lt;br&gt;• SRHR and HIV linkages and Integration&lt;br&gt;• Stress&lt;br&gt;• Drug and Alcohol Abuse</td>
</tr>
<tr>
<td><strong>MODULE III: Interpersonal Communication with Adolescents</strong></td>
<td>• Moral, Cultural and Religious Values&lt;br&gt;• The Counsellor: Values, Attitudes and Perceptions&lt;br&gt;• Interpersonal Communication Skills&lt;br&gt;• Life Skills&lt;br&gt;• Communicating About Sexuality&lt;br&gt;• <strong>Youth Friendly SRH Services</strong>&lt;br&gt;• Using Learning Aids&lt;br&gt;• Counselling Process&lt;br&gt;• Giving A Group Talk</td>
</tr>
<tr>
<td><strong>MODULE IV: Planning, M &amp; E and Sustaining ASRH Programmes</strong></td>
<td>• Planning, M &amp; E and Sustaining ASRH Programmes</td>
</tr>
</tbody>
</table>

**How Each Module is Organised:** The training manual is divided into three modules. Each module focuses on an aspect of adolescent sexual and reproductive health and consists of several sessions.

**SESSION SUMMARY**
Each session begins with a short summary of the session. It includes the Module number and name, the session number and name, approximate length of time each session will take the objectives of the session, a summary of the session's content, materials that the trainer will need to have on hand to present the session, and a list of references. For example some elements in the session summary for Module I, Session 1 are:

**SESSION 1 SUMMARY**

<table>
<thead>
<tr>
<th>Time: 2 hours, 15 minutes</th>
</tr>
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<tbody>
<tr>
<td><strong>Objectives:</strong></td>
</tr>
<tr>
<td>By the end of the session, participants will be able to:</td>
</tr>
<tr>
<td>• Define adolescence, adolescents, youth and young people</td>
</tr>
<tr>
<td>• Describe the male and female reproductive system</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>5 min</td>
<td>Lecture, Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>2. Definitions</td>
<td>5 min</td>
<td>Lecture, Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>3. Male and Female Reproductive Anatomy</td>
<td>45 min</td>
<td>Lecture, Discussion</td>
<td>Video Charts/diagrams HO 1.1.1 &amp; 1.1.2</td>
</tr>
</tbody>
</table>

**HANDBOUTS**

Some sessions have handouts that facilitators can refer to in preparing their presentations and also copy for the participants. The handouts are marked by a symbol and a reference number. For example Module II, Session 3, Handout 4, is marked as HO 2.3.4.

The handouts are marked for easy reference by this symbol:

![Handout symbol]

**REFERENCES**

Below the session summary, a list of references is provided. These are articles, books or other sources that have more information on the session topic. You are encouraged to read these materials in advance in order to prepare yourself for the session.

**STEPS**

Each session indicates the steps that need to be taken by the Facilitator to deliver the session. For Example in Module 1, Session 1, the Introduction has some instructions under Step presented as follows.

**Step 1:**
- Present the session objectives and discuss.

These are meant to guide facilitation of the session using different participatory methodologies. Some ‘Steps’ are in a text box especially those that explain exercises and role plays. The procedure to follow is still the same in two scenarios. Note that this is just a guide, you may choose a methodology that you feel best suits the topic and learning environment.

**INTERACTIVE TRAINING METHODS**

‘Tell me … I forget, show me … I remember, involve me … I understand’. Ancient Proverb
The Facilitator is expected to utilise a variety of methods to deliver this training. A number of interactive training methodologies are proposed and the Facilitator should choose a methodology that best suits the participants and the skill and knowledge to be learned. Interactive training methods reach a wider range and helps keep participants engaged. The proposed methods include:

**Mini Lectures**
The facilitator will use illustrated/mini lectures to present information on adolescent sexual and reproductive health. These may be in various formats, that include PowerPoint presentations, CDs and DVDs prepared before the training.

**Discussion Triggers**
There are a number of discussion triggers that can be used. These include brainstorming, case studies, questions or statements, problem posing, short videos and readings that are used to prompt spoken or written responses from the participants.

**Creative Play**
Creative plays keep participants motivated as they stimulate new thought processes and ideas. These include games, art projects, role plays, theatre, poetry and creative writing.

**Group discussions**
Group discussions give participants an opportunity to express themselves, to be heard and to hear others. This helps participants develop verbal and listening skills. Through group discussions, everyone has a chance to participate which fosters democratic values and culture. Group discussions include informal dialogue, panel discussions, and debates.

**Participatory reflection and analysis**
Participants are divided into groups to solve problems and to foster group unity and critical thinking. Examples of participatory reflection and analysis include community mapping, problem trees, research projects, and analyzing media messages.

**Personal reflection**
Helps participants gain insight into their own experiences and foster maturity and judgement. They may open the door to new attitudes and behaviours. Some examples include keeping a journal, guided memories, values clarification and creative art projects.

**Other tools for the participatory approach**
The Facilitator can use group and individual goal setting and assign participation roles to help manage the classroom (time keeper, reporter of the day, quote reader, leader of the day), and to review the lesson and what was learned.

**Energizers**
Energizers are fun brief group activities designed to provide participants an opportunity to be physically active, to promote team building and positive feelings about the group. These include icebreakers, name games, songs, and physical exercise. (Refer to “Government of Zimbabwe, 2015, Lets Chat, PCC Facilitator Training Guide, Ministry of Health and Child Care, page 17” for additional icebreakers)

**Participants learn effectively when:**
- They see what they are learning as valuable.
- They have clear goals.
- The experience of all the participants is valued and drawn upon.
- New knowledge and skills are connected to what participants already know.
- They get direct and frequent feedback.
- They share/debate/discuss what they are learning with others.
• They feel respected/listened to.
• They have a say in how the teaching and learning happens.
• Differences in identity and experience are acknowledged and accepted.

YOUR ROLE AS A FACILITATOR
• The Facilitator’s role is to guide and encourage the participants to share ideas, information and experience.
• Participants learn by doing, so if the whole group can participate in the activities and discussions, they will all benefit.
• The Facilitator should bring the discussion to a conclusion.
• The facilitator’s should mainstream gender, disabilities and social media issues throughout the activities.

REFERENCE:


THE TRAINING PROGRAMME

<table>
<thead>
<tr>
<th>TIME</th>
<th>DAY ONE</th>
<th>DAY TWO</th>
<th>DAY THREE</th>
<th>DAY FOUR</th>
<th>DAY FIVE</th>
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<tbody>
<tr>
<td>0800</td>
<td>Registration &amp; Norms</td>
<td>Gender and ASRH</td>
<td>Stress</td>
<td>Youth Friendly SRH Services</td>
<td>Using Learning Aids</td>
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<td></td>
<td>Welcome</td>
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<td>Expectations and Objectives</td>
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<td></td>
<td>Pre-Test</td>
<td>Adolescent Relationships</td>
<td>Drug and alcohol</td>
<td>Interpersonal Communication Skills</td>
<td>Counselling Process</td>
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<td></td>
<td>Why ASRH</td>
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<tr>
<td>1030 – 1050</td>
<td>TEA</td>
<td>TEA</td>
<td>TEA</td>
<td>TEA</td>
<td>TEA</td>
</tr>
<tr>
<td>1030-1050</td>
<td>Mainstreaming gender, disabilities and social media</td>
<td>Adolescent Relationships</td>
<td>Drug and alcohol abuse</td>
<td>Interpersonal Communication Skills</td>
<td>Counselling Process</td>
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<tr>
<td></td>
<td>Adolescent Population and sub groups</td>
<td>STIs and HIV</td>
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<td>1300 – 1400</td>
<td>LUNCH</td>
<td>LUNCH</td>
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Note that this is a generic programme that the Facilitator uses to guide planning of sessions for the 5 day training. The morning sessions from day two to five may start with a 15 minute recap of the activities of the previous day. The training can end at 1700 hours or 1730 hours depending on how you plan your programme and manage your time.

INTRODUCING PARTICIPANTS TO THE TRAINING
- Welcome the participants to the training.
- Self introductions under the following format, name, place of work, responsibilities, likes/ dislikes. (However the facilitator can choose any method of introduction which suits the group)
- Ask participants to spell out ground rules.
- Ask participants to state their expectations and fears.
- Explain the goal, objectives and expected outcomes to the participants.
- Distribute training agenda and adopt it.
- Discuss logistical details about the training.
- Distribute pre-test forms for participants to complete. A pre-test is administered to participants to obtain a baseline level of knowledge, attitudes, and skills (or perceived skills) regarding the issues to be covered in this training. The facilitator should encourage the participants to answer the questions from their own perspectives. A sample pre-test questionnaire is provided in Appendix 4.
- An official opening or welcome remarks can be given where possible.

WORKSHOP OBJECTIVES
The specific objectives of this workshop are to:
- Strengthen the understanding of factors associated with the knowledge, attitudes and behaviours of adolescents in matters related to sexual and reproductive health, among service providers.
- Strengthen the capacity of service providers in effective communication, life skills provision and counselling of adolescents on sexual and reproductive health issues.
- Provide service providers with appropriate information on sexual and reproductive health issues including rights, STIs, HIV, AIDS and the operating environment.
- Provide an opportunity for participants to identify strategies to strengthen networking and coordination in ASRH programming.
- Strengthen the appreciation and capacity of service providers in designing, implementing, monitoring and evaluating and sustaining youth friendly sexual and reproductive health programmes.

EVALUATING THE COURSE
Participant evaluation will be done through:
- Pre- and post-test of participants’ knowledge, attitudes and skills (Appendix 4).
- Daily evaluation of the workshop proceedings (Appendix 2).
- Workshop evaluation at the end of the training (Appendix 3).
These forms are attached as Appendices.

REFERENCES


Standard National Adolescent and Youth Sexual and Reproductive Health (ASRH) Training Manual

MODULE I

Overview of ASRH and operating environment
SESSION 1 SUMMARY
MODULE I: Overview of ASRH and Operating Environment

SESSION 1: Why ASRH?

Time: 40 min

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

- State why ASRH.
- Describe the context of SRHR and HIV for adolescents in Zimbabwe
- Identify the challenges of Comprehensive Sexuality Education (CSE) in Zimbabwe
- Identify barriers or challenges of CSE.
- Discuss about the effects of the challenges to CSE in Zimbabwe
- Identify strategies to minimise their effects

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>5 min</td>
<td>Brainstorming</td>
<td>Flip chart, makers</td>
</tr>
<tr>
<td>2. Definitions</td>
<td>10 min</td>
<td>Power Point presentation</td>
<td>Flip chart, makers</td>
</tr>
<tr>
<td>3. Why ASRH</td>
<td>10 min</td>
<td>Power Point presentation</td>
<td>Flip chart, makers</td>
</tr>
<tr>
<td>4. Challenges of ASRH</td>
<td>10 min</td>
<td>Power Point presentation</td>
<td>Flip chart, makers</td>
</tr>
<tr>
<td>5. Conclusion</td>
<td>5 min</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES:

Adolescents AND YOUNG PEOPLE living with HIV: A training module to complement the National Adolescent Sexual and Reproductive Health (ASRH) Training Manual for Service Providers

Ministry of Health and Child Care, 2015, Zimbabwe National HIV/AIDS Strategic Plan 2016-2020
1. INTRODUCTION: - Presentation (5min)  
**Step 1:**  
- Present the session objectives and discuss.

2. WHY ASRH?- Presentations- (10min)  
**Step 2:**  
- Present power point presentation on, why ASRH including overview of ASRH in Zimbabwe and challenges of CSE.

To set the tone, the Facilitators need to provide an updated/current situational analysis of the SRH and HIV situation on young people, both at local and international level (including statistics on key ASRH indicators). The key sources may include the New ASRH Strategy 2016-2020, Zimbabwe Demographic and Health Surveys, the National Health Management Information System and Operational Studies.

**Step 3: Comprehensive Sexuality Education (Presentation)**  
Comprehensive Sexuality Education is defined as, an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. It can provide young people with the knowledge, skills and efficacy to make informed decisions about their sexuality and lifestyle.

- 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.
- UNESCO identifies the primary goal of sexuality education as that “children and young people become equipped with the knowledge, skills and values to make responsible choices about their sexual and social relationships in a world affected by HIV.

CSE refers to curriculum based education that approaches sexuality and relationships with information that is:
- Gender and rights-based
- Age appropriate
- Culturally relevant
- Scientifically accurate
- Realistic
- Non-judgmental

4. POTENTIAL BARRIERS TO CSE: - Group Discussions- (10min)  
**Step:**

The following are some of the barriers to CSE:
- Implementation challenges
- Service providers not fully trained
- Inadequate support materials
- Funding structure and availability

5. CONCLUSION – Discussion (5 min)  
**Step:**
- Summarize the session by reviewing the objectives and asking questions for clarity.
**What are the myths and facts about CSE?**

**Handout 1.1.1 What is CSE?**

CSE stands for Comprehensive Sexuality Education

Refers to curriculum based education that approaches sexuality and relationships with information that is

- Gender and rights-based
- Age appropriate
- Culturally relevant
- Scientifically accurate
- Realistic
- Non-judgmental

---

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

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**Need for the reference**
SESSION 2 SUMMARY

MODULE I: Overview of ASRH and Operating Environment

SESSION 2: Mainstreaming gender, disabilities and social media

Time: 25 min

Objectives:
By the end of the session, participants will be able to:
- Define mainstreaming.
- Describe the context how gender, disabilities and social media can be mainstreamed in ASRH programming.
- Define social media.
- Identify social media platforms being used by young people.
- State the uses of social media.
- Describe the positive and negative effects of social media.
- Explain what is meant by computer crime and cyber bill.
- Identify the challenges of mainstreaming gender, disabilities and social media.

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>5 min</td>
<td>Brainstorming</td>
<td>LCD Projector, flip chart marker</td>
</tr>
<tr>
<td>2. Definitions</td>
<td>5 min</td>
<td>Power Point presentation</td>
<td>Flip chart Marker, LCD Projector</td>
</tr>
<tr>
<td>3. Mainstreaming Gender</td>
<td>10 min</td>
<td>Power Point presentation</td>
<td>I.E.C Lectures, Audios, Visuals</td>
</tr>
<tr>
<td>4. Mainstreaming Disability</td>
<td>5 min</td>
<td>Power Point presentation</td>
<td>Braille, ICT, Social media platforms</td>
</tr>
<tr>
<td>5. Mainstreaming Social Media</td>
<td></td>
<td>Power Point presentation</td>
<td>Lectures, I.E.C material, Computer crime and cyber bill</td>
</tr>
<tr>
<td>6. Conclusion</td>
<td></td>
<td>Summary</td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES:


1. INTRODUCTION – Brainstorming, Presentation (5 min)

Step 1:
- Present objectives
- Define mainstreaming.

2. DEFINITION OF MAINSTREAMING (PRESENTATION)

Step 2:
- Mainstreaming is a prevailing current or direction of activity or influence.

3. MAINSTREAMING GENDER IN ASRH PROGRAMMING

Step 3:
- Present power point presentation

There are clear differential impacts of the SRH challenges on boys and girls. They face unique challenges based on their gender and reproductive roles. The imbalance in power relations influenced by socially constructed gender roles disempowers girls to negotiate and make decisions concerning their SRH rights free of discrimination and violence. Therefore in this strategy gender considerations are central and mainstreamed as cross cutting in all interventions proposed. In the context of this strategy gender mainstreaming addresses the power imbalances between males and females. This, therefore, requires targeting of both sexes with messages that breakdown the underpinning social constructs. The strategy will build capacity of service providers to address gender issues in ASRH programming. To support gender mainstreaming by service providers, the strategy will develop standard gender mainstreaming guidelines for ASRH.

Definition of mainstreaming gender
Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. The concerns of women and men need to be considered in any planned activities so that women and men benefit equally. This will ensure that inequality on the basis of gender is not perpetuated and therefore gender equality is achieved. At the same time people living with disabilities should not be considered as being disabled with a lack of ability to learn and possible negative stereotyping.

- Gender mainstreaming was established as a major global strategy for the promotion of gender equality in the Beijing Platform for Action from the Fourth United Nations World Conference on Women in Beijing in 1995.

Gender equality is the goal – gender mainstreaming is the strategy
- Gender equality is a goal that has been accepted by governments and international organizations. It is enshrined in international agreements and commitments.
- There are many ongoing discussions about what equality means (and does not mean) in practice and how to achieve it. It is clear that there are global patterns to inequality between women and men.
- For example:
  - Women tend to suffer violence at the hands of their intimate partners more often than men;
- women’s political participation and their representation in decision-making structures lag behind men’s.
- women and men have different economic opportunities.
- women are over-represented among the poor.
- women and girls make up the majority of people trafficked and involved in the sex trade. These issues – and others – need to be addressed in efforts to promote gender equality.

Achieving greater equality between women and men will require changes at many levels, including:
- changes in attitudes and relationships
- changes in institutions and legal frameworks
- changes in economic institutions, and
- changes in political decision-making structures.

4. MAINSTREAMING DISABILITIES IN ASRH PROGRAMMING

Step 4:
Define mainstreaming disability
  - Present powerpoint presentation

Definition of mainstreaming disability
Disability mainstreaming is understood as a process of assessing and addressing the possible impact of any planned action on persons with disabilities. It is a way to promote inclusion and to address the barriers that exclude persons with disabilities from the equal enjoyment of their human rights. Facilitators should therefore ensure that they do not stereotype gender differences and disabilities throughout the training manual.

- It is a way to promote inclusion and to address the barriers that exclude persons with disabilities from the equal enjoyment of their human rights.
- At the same time people living with disabilities should not be considered as being disabled with a lack of ability to learn and possible negative stereotyping.

Papers exploring areas for disability mainstreaming have highlighted a number of possible actions:
- These include, for example:
  - development of disability policy and/or strategy;
  - clear allocation of roles and responsibilities;
  - a department to promote and monitor disability policy;
  - human resources practices that create a disability-friendly and accessible environment;
  - disability awareness raising and training;
  - consultation with organisations working with people with disabilities; approaches to capture shared learning and good practice;
  - appropriate resource allocation.

MAINSTREAMING SOCIAL MEDIA IN ASRH PROGRAMMING

Step 5: Present powerpoint presentation

Distribute Handout 1.2.1 “How wired are you”

Ask participants to respond.

Go through their answers and discuss about how wired they are.
Social media is any form of online publication or presence that allows interactive communication, including social networks, blogs, photo sharing platforms, Internet websites, Internet forums, and wikis.

Examples of social media include, but are not limited to:
- Facebook
- Twitter
- Instagram
- YouTube
- Google+
- Flickr

Uses of Social Media
Some examples of social media uses include:
- Blogging about programmes, projects, movies, sports, or news events;
- Posting updates or activities on your Facebook page;
- Participating in established Whatsapp groups;
- Using a Google Hangout to work on a class project;
- Uploading videos and pictures

Create the digital image you want
- **Align your online image with your goals.**
  - A digital footprint is the reputation you leave online and can include material posted on blogs, and mentions on websites and videos that are uploaded onto sharing sites.
  - Online actions leave a permanent record and remain online, even if you click “delete.”
  - Be thoughtful about what you share online and consider how it would appear to family, friends, colleges, and future employers.
  - Stand behind your words.
  - You should always take responsibility for the content you post in all social media environments.
    - While you may think that using a fake name may prevent posts from becoming part of your footprint, there are still ways to link that information to the person who posted it (e.g. through an Internet IP address or other distinguishing information linking posts).
  - Be your best self online – post accurate information and be accountable for what you say.

Cyber Bullying
Cyber bullying takes many forms. Cyber bullying is the use of electronic technologies to hurt or harm other people. Examples include:
- Sending offensive text messages or emails;
- Posting statements that are not true and create rumors
- Circulating embarrassing photos online

Sometimes, it may be difficult to draw the line between a harmless joke and one which goes too far and becomes hurtful.

6. CONCLUSION (Discussion)
Step 6
- Using Handout 1.2.2 conduct a discussion on “What are the pros and cons of social media?”
- Summarise and end session.
Handout 1.2.1: How Wired Are You?

Do you have a

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1.</td>
<td>cell phone?</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>cell phone with a camera?</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>cell phone with a video camera?</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>cell phone that can access the internet?</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>access to a computer?</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>computer with a video camera?</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>facebook account?</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>twitter account?</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>wifi in your home</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>a gaming system that is hooked up to the internet?</td>
<td></td>
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</table>

Have you ever

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>11.</td>
<td>sent a text message using a cell phone?</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>sent a text message during a meeting?</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>texted while driving?</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>ridden in a vehicle with someone who texts and drives?</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>sent or received a picture using your cell phoner?</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>chatted online?</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>video chatted?</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>used your gaming system to talk with other other people?</td>
<td></td>
</tr>
</tbody>
</table>

Do you know

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<table>
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<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>19.</td>
<td>where in this country can you not get a cell signal?</td>
</tr>
<tr>
<td>20.</td>
<td>Someone who has ever received a nude or semi nude photo via a cell phone?</td>
</tr>
</tbody>
</table>

Adapted from:
### Handout 1.2.2 Social media Pros and Cons

<table>
<thead>
<tr>
<th><strong>CELL PHONES (TALKING)</strong></th>
<th><strong>Pros</strong></th>
<th><strong>Cons</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pros</strong></td>
<td>Easy</td>
<td>Expensive</td>
</tr>
<tr>
<td></td>
<td>Convenient</td>
<td>Run out of minutes</td>
</tr>
<tr>
<td></td>
<td>Can go anywhere</td>
<td>Dropped calls</td>
</tr>
<tr>
<td></td>
<td>Make it easy to find people</td>
<td>Don’t get service everywhere</td>
</tr>
<tr>
<td></td>
<td>Good for emergencies</td>
<td>People can find you</td>
</tr>
<tr>
<td></td>
<td>Can hear person’s voice – you can hear tone and / or know that is the person you are talking to</td>
<td>Can’t use during class</td>
</tr>
<tr>
<td></td>
<td>GPS – if you get into an accident, emergency personnel can find you</td>
<td>Telemarketers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not private – people can overhear what you are talking about</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CELL PHONES (TEXTING)</strong></th>
<th><strong>Pros</strong></th>
<th><strong>Cons</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pros</strong></td>
<td>Easy</td>
<td>Can be expensive</td>
</tr>
<tr>
<td></td>
<td>Convenient</td>
<td>Forwards – you can be forwarded forwarded chain messages, or even viruses to your phone</td>
</tr>
<tr>
<td></td>
<td>Private – people can see you texting, but they don’t know what you are writing</td>
<td>Can’t hear the person’s voice / tone</td>
</tr>
<tr>
<td></td>
<td>Fast</td>
<td>“Sexting”</td>
</tr>
<tr>
<td></td>
<td>Don’t have to talk to the person</td>
<td>The person you think is sending you the text may not really be that person</td>
</tr>
<tr>
<td></td>
<td>Can send pics and videos</td>
<td>Not really private</td>
</tr>
<tr>
<td></td>
<td>Forwarding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Can upload pics and videos to the internet from your phone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Can access the internet</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SOCIAL NETWORKING SITES – FACEBOOK, MY SPACE, TWITTER, ETC</strong></th>
<th><strong>Pros</strong></th>
<th><strong>Cons</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pros</strong></td>
<td>Can keep in touch with your friends</td>
<td>People are not always – a person can say s/he is a teenager and really be an adult; s/he can post a profile pic that is not her or himself; s/he or she can put up a page pretending to</td>
</tr>
<tr>
<td></td>
<td>Can keep up with people who live far away – relatives, people at college</td>
<td></td>
</tr>
</tbody>
</table>

### Notes:

- **Pros**: Easy, Convenient, Can go anywhere, Make it easy to find people, Good for emergencies, Can hear person’s voice – you can hear tone and / or know that is the person you are talking to, GPS – if you get into an accident, emergency personnel can find you.

- **Cons**: Expensive, Run out of minutes, Dropped calls, Don’t get service everywhere, People can find you, Can’t use during class, Telemarketers, Not private – people can overhear what you are talking about.

- **Pros**: Easy, Convenient, Private – people can see you texting, but they don’t know what you are writing, Fast, Don’t have to talk to the person, Can send pics and videos, Forwarding, Can upload pics and videos to the internet from your phone, Can access the internet.

- **Pros**: Can keep in touch with your friends, Can keep up with people who live far away – relatives, people at college.

- **Cons**: People are not always – a person can say s/he is a teenager and really be an adult; s/he can post a profile pic that is not her or himself; s/he or she can put up a page pretending to.
<table>
<thead>
<tr>
<th><strong>MODULE I</strong></th>
<th><strong>ASRH OPERATING ENVIRONMENT</strong></th>
</tr>
</thead>
</table>

- Can meet new people
- Can personalise your page
- Can see pics of people
- Can post pics of your friends
- Can set your profile to private – note that some software can hack privacy settings

be another person, not everything on line is as it appears.

- Bullying – people can post things that are hurtful or not true
- Unwanted contact – people who you don’t know may try to contact you
- People can post pics of you without your permission

### VIDEO CHATTING: SKYPE, FACETIME, ETC

<table>
<thead>
<tr>
<th><strong>Pros</strong></th>
<th><strong>Cons</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy</td>
<td>Could be expensive, depending on which service is used (some are free)</td>
</tr>
<tr>
<td>Can see the person you are talking with</td>
<td>Not all computers and phones are equipped with this technology or with a video camera</td>
</tr>
<tr>
<td>Can talk with, and see someone who can be far away</td>
<td>Videos can be recorded without the person’s knowledge</td>
</tr>
<tr>
<td>Often, you can also text and share links while you talk</td>
<td></td>
</tr>
</tbody>
</table>

### GAMING SYSTEMS

<table>
<thead>
<tr>
<th><strong>Pros</strong></th>
<th><strong>Cons</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fun</td>
<td>Can be time wasters</td>
</tr>
<tr>
<td>Can pass the time easily</td>
<td>Can make you become a couch potato</td>
</tr>
<tr>
<td>Improves hand-eye coordination</td>
<td>Can keep you from spending time with family or friends</td>
</tr>
<tr>
<td>Can access the internet</td>
<td>Expensive</td>
</tr>
<tr>
<td>Can play against family or friends or even against people in other parts of the world</td>
<td>A lot of the games show things that would be unacceptable in real life (e.g violence)</td>
</tr>
<tr>
<td>Can talk over the internet with the game system – headsets, etc</td>
<td></td>
</tr>
</tbody>
</table>

### Discussion Questions:

a. As you look at the lists, what surprises you?

b. Is there anything on the lists that you disagree with? Explain.

### Reference:

SESSION 3 SUMMARY

MODULE I: ASRH Operating Environment

SESSION 3: Adolescent population and sub-groups

Time: 40 minutes

Objectives:
By the end of the session, participants will be able to:
- Define the target populations in relation to ASRH and HIV.
- Define sub groups
- Identify and list at least 5 adolescent sub groups.
- Identify the settings where the young people are.
- Identify the service providers within the local community
- Identify at least 3 situations in which adolescents are said to be in difficult circumstances conflict with the law
- Outline the effects of young people being in difficult circumstances these different sub groups.
- Outline the role of the service provider in management of adolescents in different sub groups

<table>
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<tr>
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<td>5 min</td>
<td>Brainstorming</td>
<td>Flip chart, Markers</td>
</tr>
<tr>
<td>2. Definitions</td>
<td>5 min</td>
<td>Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>3. Adolescents Sub groups</td>
<td>25 min</td>
<td>Role Play</td>
<td>Flip chart, markers</td>
</tr>
<tr>
<td>4. Conclusion and Summary</td>
<td>5 min</td>
<td>Review</td>
<td>Questions</td>
</tr>
</tbody>
</table>

REFERENCES


http://www.ucl.ac.uk/advanced-physiotherapy/paediatric_physio/modules_/cdc

The Social Context of Children in Especially Difficult Circumstances
www.unescap.org/esid/hds/training/se-m1-socialcontext.pdf
1. INTRODUCTION – Brainstorming, Presentation (5 min)

Step 1:
- Pose a question to the participants, “What do we understand by the term adolescent population and sub groups?
- List the main highlighted issues on a flip chart.
- Present session objectives.

2. DEFINITION OF CONCEPT – Presentation, Discussion (5 min)

Step 2:
- Define the term adolescent population
- Define adolescent target population

The World Health Organisation (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.

Adolescent target population:
- Definition - period between the ages of 10 to 19 broken down into three stages:
  - Early adolescent - 10-13 years
  - Mid adolescent - 14 to 15 years
  - Late adolescent - 16 to 19 years

Young adult refers to anyone aged 15 – 24 years.
Youth refers to anyone between 20 – 24 years.
Young person refers to anyone between 10 – 24 years.
Teenager refers to anyone aged 13 – 19 years.
Child refers to anyone under 18 years.

Therefore, for the purposes of ASRH Programming, the terms “adolescents”, “young people” and “youth” are used interchangeably to refer to the 10 – 24 year target age group.

3. ADOLESCENTS AND YOUTH SUB GROUPS – Role Play, Discussion (45 min)

Step 3:
- Ask participants to brainstorm “What are adolescent population sub groups?”
- Present power point presentation on sub groups

Clearly any working definition of adolescents sub groups are highly dependent on the socio-economic and cultural context, but it generally includes certain categories of children: street children, children exploited through labour, children exposed to violence, orphans, children with HIV, disabled children, sexually abused children and trafficked children. There is considerable overlap between these groups.

It is therefore important for the service provider to take into consideration the special needs of young people in different sub groups:
- Adolescents 10 - 13 years, 14-15 years, 16-19 years,
- Youth 20-24 yrs
- Sexually active adolescents
- Adolescents that are not sexually active
- Young People with disabilities
- Young People Living with HIV
- Married adolescent girls
Married adolescent boys
- Pregnant adolescents
- Young mothers
- Young fathers
- Young people living on the streets
- Children in conflict with the law and orphans.
- Adolescents selling sex,
- Adolescents with different sexual orientations.

The difference between adolescents living ON the streets and those living IN the streets is that those ON the streets are like permanent dwellers such as street kids while those living IN the streets do not stay there they go and do whatever they want and then go back to their permanent homes. All the other adolescents might also fit in the two categories of sexually active adolescents and adolescents that are not sexually active.

4. SETTINGS WHERE ADOLESCENTS SUB GROUPS ARE FOUND

4. SETTINGS IN YOUTH FRIENDLY SRH SERVICE PROVISION – Group Work, Discussion, Presentation (15 min)

Step 4:
- Brainstorm the settings where adolescent sub groups are found
- Present the four settings for Youth Friendly SRH Service Provision.
- Use Handout 3.3.3 to prepare your presentation

Zimbabwe has adopted four broad settings of youth friendly service delivery will be used. 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 education institution setting is divided into primary, secondary and tertiary levels as a result of the diversity in age group, needs and social experiences of the populations in these institutions. The public health facility based services are those that offer a comprehensive range of promotive, preventive, curative and referral, tracking and feedback services. On the other hand the other service delivery points are service outlets that may only provide partial and emergency response services due to their separate physical location from the public health facilities which accommodate a comprehensive range of supportive services, e.g. laboratories and x-ray facilities. 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. The public health facility based setting should offer both static and mobile outreach services.

- Health Facility Setting
- Community Based Setting
- Primary & Secondary School-Based Setting
- Tertiary Institution Setting

5. ASRH NEEDS FOR DIFFERENT SUB GROUPS

Step 5

Divide the participants into groups and assign a category of adolescent sub group to each group (e.g. Group 1 – In school,

Ask each group to prepare a role play that will bring out the sexual and reproductive health needs of the adolescents. The role play should bring out strategies of addressing the identified health needs.

Present the role plays in plenary and discuss.
Highlight the ASRH needs.

Share strategies to reach the adolescent sub groups.
Identify the settings where these adolescents will be found

Indicate the community support systems that are critical in each scenario.

Highlight aspects from the presentation that have not been discussed.

Young people continue to have sex. Sex might even increase for several reasons (no rule of law, more free time, coping mechanism for de-stressing, families fall apart, sexual violence).

Some may still be in need of family planning services.

Higher risk of sexual violence leading to unintended pregnancy, unsafe abortions, STIs, HIV, stigmatization, psychosocial problems.

**Family planning:**
- Condoms should be available in places that are accessible to young people, for the prevention of unwanted pregnancies and STIs including HIV

**Gender Based Violence (GBV):**
- Protection of survivor is priority (principles of safety, confidentiality, respect and dignity)
- Multisectoral response:
  - Medical: 24/7 referral available free of charge (no parental consent needed); Treatment of physical injuries; PEP and emergency contraception; Presumptive treatment of STIs, Hepatitis B and tetanus if applicable.
  - Psychosocial support
  - Protection (e.g. shelter)
  - legal/justice support
  - Victim friendly units (Reminder: there is no police report needed for a survivor to receive medical care)
- Awareness raising of GBV risks and available services
- Zero tolerance policy enforced among health workers and all other services providers
- Basic prevention:

**Maternal, Newborn and Child Health (MNNCH):**
- Adolescent friendly antenatal care, obstetric and postnatal care services
- Identify pregnant girls and ensure that they give birth at the health facility
- Post abortion care services

**STI/HIV:**
- Adolescent friendly condom distribution points
- Standard precautions (gloves, waste disposal, etc)
- Treatment of STIs
- Continuation of provision of ART and eMTCT

**YOUNG PEOPLE WITH DISABILITIES**

**Key considerations:**
- Parental/guardian consent
- Breach of human rights
Services that can be offered to the mentally and physically challenged:
- Appropriate IEC materials
- Interpreter
- Counselling
- HIV services-PEP, FP-emergency contraception
- Post Abortion Care (PAC)
- User friendly infrastructure

ADOLESCENTS LIVING ON THE STREETS
Adolescents living on the streets are particularly vulnerable because they don’t have the means and experience to cope with risky and stressful situations like this.

Adolescents will find themselves in risky and stressful situations that they are not prepared to deal with including:
- Breakdown of social norms and rule of law
- Separation from family/community (loss of livelihood, security and protection)
- Might have to take adult roles without support networks or positive adult role models
- Public services discontinued, including education leading to more free time and less structure, boredom and idleness
- Living in crisis may lead to fatalistic views/no positive future perspectives
- The emerging trend of drug and substance abuse especially among adolescent boys living on the streets.

PREGNANT ADOLESCENTS
- Pregnant girls need care and should be able to give birth safely.

ADOLESCENT IN CONFLICT WITH THE LAW

Forms of child abuse: Physical; Emotional; Psychological; Economic and Sexual abuse

These can lead to children going to live on the street. The definition of abused children includes children on the streets.

- Post Exposure Prophylaxis (PEP)
- Emergency contraception
- Continued counselling-Referral to family support
- Psychosocial support (shelter, Victim Friendly Units)

- More and unsafe sex, multiple partners
- Risk of sexual violence and abuse (in community or by fighting parties or even protection forces or humanitarian workers)
- Selling sex to meet basic needs of food or protection

6.0 ASRH STRATEGIES TO REACH DIFFERENT SUB GROUPS:

Step 6:
- Brainstorm the strategies that can be used to reach different sub groups in different settings.
- Present PowerPoint presentation
• Social media and ICT's
• Mass media
• Comprehensive Sexuality education
• Parent to child communication
• Peer education
• Non formal education- edutainment activities like drama, song and dance, sports and livelihood activities
• Ability appropriate IEC material
• Integrating into their networks
• Outreach programs
• Non formal education- edutainment activities like drama, song and dance, sports and livelihood activities

Teachers training (in-service and pre-service)

7. CONCLUSION – Discussion (5 min)

Step 7:
• Summarize the session by reviewing the objectives and asking questions for clarity.

Emphasize that all adolescents population sub groups require special attention compared to others. Service providers should be able to identify such adolescents and help them. Refer cases to appropriate health institutions, networks and support organisations.
### SESSION 4 SUMMARY

**MODULE I: Overview of ASRH and Operating Environment**

**SESSION 4: SRH Rights, Laws, Policies and Strategies**

**Time:** 1 hour, 45 minutes

**Objectives:**
By the end of the session, participants will be able to:
- Define human rights and sexual and reproductive health rights.
- Identify at least 5 sexual and reproductive health rights.
- Describe how at least 2 International and 2 regional conventions and commitments help promote sexual and reproductive health and rights for adolescents.
- Describe at least 3 national laws, policies or/and strategies that promote adolescent sexual and reproductive health and rights.
- Identify gaps within existing policies and strategies and come up with strategies of addressing them.

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>5 min</td>
<td>Brainstorming</td>
<td>Flip chart, markers</td>
</tr>
<tr>
<td>2. Definitions</td>
<td>15 min</td>
<td>Power Point presentation</td>
<td>Flip charts, markers, HO 3.1.1</td>
</tr>
<tr>
<td>3. Rights and Responsibility</td>
<td>15 min</td>
<td>Exercise</td>
<td>Flip charts, markers</td>
</tr>
<tr>
<td>4. ASRH rights</td>
<td>15 min</td>
<td>Lecture/Discussion</td>
<td>Computer, LCD, HO 3.1.2</td>
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<tr>
<td>5. International and regional conventions on ASRH</td>
<td>15 min</td>
<td>Lecture/Discussion</td>
<td>Computer, LCD, HO 3.1.3</td>
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<tr>
<td>6. National policies and strategies on ASRH</td>
<td>10 min</td>
<td>Lecture/Discussion</td>
<td>Computer, LCD, HO 3.1.4</td>
</tr>
<tr>
<td>7. Gap analysis of the legal environment in</td>
<td>15 min</td>
<td>Discussion</td>
<td>Flip Chart, Markers</td>
</tr>
</tbody>
</table>
REFERENCES:
Affirming the Rights of young people: African Regional Agreements and Conferences
UNFPA, 2008. Distance Learning on Population Issues Module 1: Sexual and Reproductive Health Background and key Issue
Zimbabwe National HIV and AIDS Strategic plan (ZNASP) 2015–2018

1. INTRODUCTION – Presentation (5 min)
   Step 1:
   • Present the objective of the session and Discuss

2. DEFINITION OF TERMS – Mini Lecture, Discussion (15 min)
   Step 2:
   • Ask participants to define human rights and sexual and reproductive rights.
   • Ask them to write each definition on a piece of paper and stick them on the wall under the different headings.
   • Read out the different definitions and discuss with the group.
   • Define the terms (HO 3.1.1)

SRH is not just about health care or information about disease – it is also about rights and choices. SRH is a human right and is fundamental to human survival and development.

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 in both national and international contexts.

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 integral parts of human rights. They 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.

The “rights of couples and individuals, to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so” were first recognised as a human rights issue at the

**Note:** Sexual and Reproductive health rights are human rights.

### 3. RIGHTS AND RESPONSIBILITIES

#### DEFINITION OF TERMS – Discussion (15 min)

**Step 3:**
- Ask participants to define human rights and sexual and reproductive rights.
- Ask them to write each definition on a piece of paper and stick them on the wall under the different headings.
- Read out the different definitions and discuss with the group.
- Define the terms (HO 3.1.1)

SRH is not just about health care or information about disease – it is also about rights and choices. SRH is a human right and is fundamental to human survival and development.

#### 4. RIGHTS, RESPONSIBILITIES AND BARRIERS - Exercise (15 min)

**Step 4:**
- Participants will be requested to list rights in one column and identify responsibilities that adolescents should observe.
- Facilitator will also add other rights that might not have been identified by the participants (Refer to Handout 3.1.2)
- Discuss rights and responsibilities for adolescents
- Ask participants to identify barriers that hinder adolescents from enjoying sexual and reproductive health rights.

**Rights:**
- The right to life
- The right to liberty and security
- The right to equality and to be free from all forms of discrimination
- Right to privacy and confidentiality
- Right to freedom of thought or expression
- Right to information and education
- The right to choose whether or not to marry, and whether or not to found and plan a family
- Right to decide whether or not to have children
- Right to health care and health protection
- Right to the benefit of scientific progress
- The right to freedom of assembly & political participation
- The right to be free from torture, and ill treatment
- Right to have safe and satisfying sexual relationship

**Adolescent Responsibilities vis-a-vis Rights**
- Participation in issues that affect their sexual and reproductive rights
- Advocacy for better services
- Taking responsibility for consequences of one’s actions

**Barriers to Rights:**
- Cultural barriers
- Economic barriers
- Legal barriers: Example: although young people have a right to decide when to have a child but abortion is not an option that they can simply choose except in cases of rape, incest or when the pregnancy threatens the health of the mother or the child
- Social barriers
- Lack of harmonisation between some laws and policies

5. INTERNATIONAL AND REGIONAL CONVENTIONS – Group Work, Discussion (15 min)

Step 5:
- Participants should list the international and regional conventions that they know and discuss on what they are about.
- The facilitator will discuss these with the participants and identify their key contributions to sexual and reproductive health for young people.
- Pick two Conventions and highlight their provisions that are in line with adolescents’ sexual and reproductive health.
- Use HO 3.1.3 as a guide

There are a number of international and regional conventions, commitments and agreements that contribute to sexual and reproductive health provision and total well-being of adolescents.

Examples include:
**International Conventions and Commitments**
- Convention on the Elimination of all forms of Discrimination Against Women (CEDAW),
- Programme of Action adopted at the International Conference on Population and Development (ICPD) in Cairo in 1994
- Universal access to treatment
- Sustainable Development Goals

**Regional**
- Sexual and Reproductive Health Strategy for the SADC Region: 2006 – 2015,
- Maputo Plan of Action on Reproductive Health and Rights
- African Charter on the Rights of Children
- African Youth Charter
- ESA Commitment.

6. NATIONAL LAWS, POLICIES AND STRATEGIES – Mini Lecture, Discussion (15 min)

Step 6:
- Brainstorm on 3 laws, national policies and strategies that address sexual and reproductive health and rights, including their provisions.
- Highlight the main provisions that focus on adolescent sexual and reproductive health. (Use Handout 3.1.4 as a guide)
- After presenting the laws, national policies and strategies the facilitator should request participants to discuss the challenges of these
- How do service providers address some of the identified challenges to ensure access and service provision to the adolescent?
- Share practical experiences from your work place and community.

A number of laws, policies and strategies have been put in place for the protection of all the citizens of Zimbabwe.

**Note:** These laws, policies and strategies are reviewed from time to time. As the Facilitator, you need to ensure
that you are referring to the most recent version in your presentations.

Laws:
- Constitution of Zimbabwe 2013
- Termination of Pregnancy Act,
- Sexual Offences Act; 2003,
- Domestic Violence Act,
- The Children’s Protection and Adoption Act,
- The Marriage Act

National Policies and Strategies
- National Reproductive Health Policy,
- National Gender Policy and Strategy,
- National Reproductive Health Service Delivery Guidelines,
- National Reproductive Health Behaviour Change Communication Strategy,
- National Guidelines on Family Planning,
- Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III): 2015-2018
- National Health Strategy: 2015 – 2020,
- Educational Policy, with respect to teenage pregnancy and life skills programmes,
- National Youth Policy
- National ASRH Strategy II: 2016–2020
- National HIV Policy 1999
- ZIMASSET 2013

Sector specific policies
- MOPSE, 2016, School Health Policy

7. GAP ANALYSIS OF THE LEGAL ENVIRONMENT IN ZIMBABWE – Discussion (15 min)

Step 7:
- Ask participants to discuss on the gaps that exist within the laws, policies and strategies on sexual and reproductive health and rights at international, regional and national level.
- Identify areas of contradiction in some of the instruments, (if any).
- Where possible, give practical examples.

- ZINASP III(2015-2018) states that legal barriers to HIV prevention including illegal status of sex work, sex between people of the same sex and prohibition of condom promotion in school settings still exist. Despite the current lack of legal frameworks for prevention activities with sex workers, prisoners and MSM, Zimbabwe has allowed the existence of informal lobby groups for these populations. In the meantime efforts are being made to scale up HIV services to most-at-risk populations using a public health approach.

- The primacy of customary law over the Bill of Rights has affected women's and girls’ constitutional rights on protection and gender equality. While the Constitution includes a clause that promotes gender equality, it nonetheless maintains a “claw back clause” that undercuts the fundamental values by recognizing the primacy of customary law over the Bill of Rights. A study in Zimbabwe demonstrated that married women who experience physical violence only, or both physical and sexual violence, are significantly more likely to be HIV-positive than those who have not experienced any physical or sexual violence.

- The ASRH Strategy II(2016-2020) calls for a strengthened protective environment through implementing policies and ensuring a legal and institutional framework that protects the ASRH rights and prevent stigma.
and discrimination of adolescents and young people infected or affected by HIV. Community leadership, parents and duty bearers are targeted for awareness on ASRH rights and responsibilities and ensuring rights violations are sanctioned. Community leadership are also targeted to champion the underlying causes of ASRH problems that affect youth and protection of ASRH rights. Communities are also mobilised to create awareness about the statutory instruments and laws that deal with issues of child marriages, gender based violence, children’s charter etc. and duty bearers engages in the advocacy and communication to create a protective environment for adolescents and young people.

8. CONCLUSION – Discussion (5 min)

Step 8:

- Summary session using Figure below and highlight the need for all health service providers to familiarise themselves with SRHR.

HANDOUT 1.4.1
Definition of Terms

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.

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).

The ICPD definition of Reproductive Health (ICPD PoA para. 7.2)
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."

**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.

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**HANDOUT 1.4.2**

SRH Rights: IPPF 1995

THE INTERNATIONAL PLANNED PARENTHOOD (IPPF) CHARTER ON SEXUAL AND REPRODUCTIVE RIGHTS, 1995

The right to:

1. 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").

2. 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.

3. Equality and to be free from all forms of discrimination should be invoked to protect the right of all people, regardless of race, 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.

4. 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.

5. 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.

6. 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.

7. 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.
8. 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.

9. 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.

10. 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.

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

12. 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.
State parties should strive to ensure that no child is deprived of his or her right of access to such health care services required and, in particular, to reduce infant and child mortality, develop preventive health care, provide guidance for parents and family planning education and services as well as taking all effective and appropriate measures with a view to abolishing traditional practices detrimental to the health of children.

2. The International Conference on Population and Development (September 1994, Cairo)
The Programme of Action also stresses the following need to:
- Eliminate all forms of discrimination against the girl child
- Eliminate the root causes of son preference; to increase public awareness of the value of the girl child and to strengthen her self-esteem
- Eliminate female genital mutilation, trafficking of girl children and use of girls in prostitution
- Promote gender equality and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles.


4. African Youth Charter: July 2006; Gambia
The African Youth Charter (AYC) is guided by the vision of the African Union; to promote and emphasize the importance of the youth ages 15 to 35 to the development of Africa.

It recognizes the following four major issues that are affecting African youth: education, employment and youth
development; women and girl’s rights; quality sexual reproductive health services and youth participation, involvement and empowerment.

State Parties shall, “secure the full involvement of youth in identifying their reproductive and health needs and designing programs that respond to these needs with special attention to vulnerable and disadvantaged youth...” and that State Parties shall, “provide access to youth friendly reproductive health services including contraceptives, antenatal and post natal services”.


- Launched in 2009, in Addis Ababa, Ethiopia, by the African Union (AU) Ministers of Health, under the theme *Africa Cares: No Woman Should Die While Giving Life!*
- It is enshrined in the 2005 AU Policy Framework for the promotion of sexual and reproductive health and rights in Africa, and in the Maputo Plan of Action on Sexual and Reproductive Health and Rights (2006), which underscores the need for maternal mortality reduction.
- CARMMA recognizes that early sexual encounters and marriages have negative implications on women’s health and increase chances of maternal morbidity and mortality.
- It therefore, recommends the need to ensure availability of appropriate contraceptive services and access to information on sexuality amongst men and women, including adolescents.

**Selected rights from the Zimbabwean Constitution**

**Section 76 Right to health care**
1. Every citizen and permanent resident of Zimbabwe has the right to have access to basic healthcare services, including reproductive health-care services.
2. Every person living with a chronic illness has the right to have access to basic health-care services for the illness.
3. No person may be refused emergency medical treatment in any health-care institution.
4. The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in this section.

**Section 77 Right to food and water**
Every person has the right to—
- safe, clean and potable water; and
- sufficient food; and the State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of this right.

**Section 78 Marriage rights**
1. Every person who has attained the age of eighteen years has the right to found a family.
2. No person may be compelled to enter into marriage against their will.
3. Persons of the same sex are prohibited from marrying each other.

**Section 81 Rights of children**
1. Every child, that is to say every boy and girl under the age of eighteen years, has the right—
   - to equal treatment before the law, including the right to be heard;
   - to be given a name and family name;
   - in the case of a child who is—
     i. born in Zimbabwe; or
     ii. born outside Zimbabwe and is a Zimbabwean citizen by descent; to the prompt provision of a birth certificate;
   - d. to family or parental care, or to appropriate care when removed from the family environment;
   - e. to be protected from economic and sexual exploitation, from child labour, and from maltreatment, neglect or any form of abuse;
f. to education, health care services, nutrition and shelter;
g. not to be recruited into a militia force or take part in armed conflict or hostilities;
h. not to be compelled to take part in any political activity; and
i. not to be detained except as a measure of last resort and, if detained—
j. to be detained for the shortest appropriate period;
k. to be kept separately from detained persons over the age of eighteen years; and
l. to be treated in a manner, and kept in conditions, that take account of the child’s age.

2. A child’s best interests are paramount in every matter concerning the child.

3. Children are entitled to adequate protection by the courts, in particular by the High Court as their upper guardian.

Source: Constitution of Zimbabwe (Final Draft: 1 February 2013)
The Marriage Act:

- The Marriage Act precludes boys under 18 years old and girls under 16 from being “capable of contracting a valid marriage”, except with the written permission of the Minister, which he may grant in any particular case in which he considers such marriage desirable. This age of marriage for boys is in conformity with the legal age of majority. Marriage Act; (revised ed. 1996).
- Married adolescents are considered adults for the purposes of access to services and information on contraception and STI prevention and are no longer subject to parental/guardian consent requirements for medical treatment (The Centre for Reproductive Law and Policy and the Child and Law Foundation, ‘State of Denial: Adolescent Reproductive Rights in Zimbabwe’, 2002).
- However, under the Customary Marriage Act, there is no specification of a minimum age of marriage, only that the girl’s guardian or a deputy appointed by him approves or provides consent.

Domestic Violence Act (Chapter 5:16)

- The Domestic Violence Act was promulgated in 2006. The objective of the Act is to preserve and protect domestic harmony by providing legal channels for dealing with the problem of domestic violence. The Act offers remedies to victims of violence and legal remedies for prevention including protection orders. The two important issues to note with respect to this discussion is that included among the list of complainants is ‘a child of the respondent, whether born in or out of wedlock, and includes an adopted child and a step-child;’ Thus, a child may make a complaint directly to the authorities through a number of individuals outlined in the Act including a police officer, a social welfare officer, an employer of the complainant, a person representing a church or religious organization or a private voluntary organization concerned with the welfare of victims of domestic violence, a relative, neighbour or fellow employee of the complainant or a counsellor.
- Act criminalizes harmful traditional or cultural practices such as forced virginity testing, female genital mutilation, pledging of women or girls for purposes of appeasing spirits and child marriage, forced child marriage, forced wife inheritance and sexual intercourse between fathers-in-law and newly married daughters-in-law.

Sexual Offences Act [Chapter 9.21] (Now repealed by section 283 of the Criminal law (Codification and Reform) Act [Chapter 9:23]):

- The former Sexual Offences Act (2001) has been repealed by section 283 of the Criminal Law (Codification and Reform) Act [Chapter 9:23]. It seeks to protect children, adolescents and women from sexual violence, by criminalizing ‘extramarital sexual intercourse’ with a young person and intellectually handicapped persons.
- The Act condemns any extramarital sexual activity with a boy or girl less than 16 years of age or with a mental disorder or physical handicap.
- It defines statutory rape as a crime where anyone over 15 years of age has extramarital sexual intercourse with anyone under the age of 16 years.
- It also criminalizes the intentional transmission of HIV. The existence of this Act has also led to the development of child or victim friendly courts.

Termination of Pregnancy Act (15:30):

- Permits abortion within limited circumstances.
- Subject to this act, pregnancies may be terminated if: continuation of the pregnancy so endangers the life of the woman concerned or so constitutes a serious threat of permanent impairment of her physical health that the termination of the pregnancy is necessary to ensure her life or physical health, as the case may be; or where there is a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will permanently be seriously handicapped; or where there is a reasonable possibility that the foetus is conceived as a result of unlawful intercourse.
The procedures for obtaining a legal abortion are also outlined and defined by the law:

- For example, in order to effectively carry out the abortion once any of the conditions are met, the medical practitioner requires the permission of the superintendent of the hospital.
- Where the situation involves "unlawful intercourse" permission to terminate is only granted after a certificate has been issued by a magistrate from within the jurisdiction that the crime occurred.
- Section 10 of the Act also specifies that no person, doctor, nurse or otherwise will be "obliged to participate or assist in the termination of a pregnancy".

**Provisions from selected Policies and Strategies**

**National Population Policy (1999):**
The policy specifies that:

- "Individual rights to choose freely and responsibly the number, spacing and timing of children they want will be fully respected," and
- It underlines the need to recognise the aspirations of women and youth in particular.
- The policy stresses the need to address their health, education and other needs as their reproductive choices and decisions would affect the future of the population growth and other related issues.

It proposes the following key strategies for young people:

- Strengthen reproductive health education in and out of school; provide counselling services to minimise problems relating to alcohol and drug abuse and reproductive health issues;
- Advocate for establishment of parent education programmes related to youth problems and parent-child communication and
- Remove obstacles to make reproductive health services easily accessible to all those who are sexually active.

**National Reproductive Health Policy:**

- The only policy which has explicitly attempted to define the term reproductive health and justified the need to provide friendly SRH services to young people and mobile populations, by adopting a life cycle approach
- "To provide the community and young people with information, counselling and user-friendly services in order to attain quality adolescent reproductive health,
- It also recognises the need for a multisectoral approach towards SRH for young people, which also provides an opportunity for meaningful involvement of young people and parents.

**The New National Adolescent Sexual and Reproductive Health Strategy (2016 – 2020):**

- The 2016–2020 ASRH Strategy II represents the second generation results-based strategy to aim to address SRH challenges among adolescents and young people between ages of 10-24 years in Zimbabwe. The strategy incorporates lessons learned in implementing the first generation strategy and changes in the national and global context with regards ASRH. It is a result of extensive review of the challenges facing the adolescent and young people though reviews of operational research, ongoing ASRH programmes, literature review, multi stakeholder consultations both policy makers and implementers and active involvement of the youth themselves.
- The strategy identifies the key challenges facing adolescents and young people as high rates of unplanned pregnancies, early childbearing, adolescent marriages, and gender based violence, maternal mortality and. These were prioritised through problem tree analysis and an assessment of recent evident of the magnitude of the problems, causal factors, underlying causes including policy environment to tackle the challenges.
- The goal is to reduce morbidity and mortality associated with sexual and reproductive activity among adolescents and young people.

**NB:** The realignment of some of these laws might take a while therefore facilitators have to be aware of the disparities regarding such.
What Reproductive Rights is All About
Module II

Challenges adolescents face today
SESSION 1 SUMMARY
MODULE II: Challenges Adolescents Face Today

SESSION 1: Physical Development and the Body

Time: 2 hours, 15 minutes

Objectives:
By the end of the session, participants will be able to:
- Define adolescence, adolescents, youth and young people
- Describe the male and female reproductive system
- Explain how sex hormones affect human development
- State the physical and emotional changes that occur during the adolescent phases
- Understand the physical development challenges of adolescents living with HIV.
- Describe basic hygiene of adolescent sexual and reproductive organs

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>5 min</td>
<td>Lecture, Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>2. Definitions</td>
<td>5 min</td>
<td>Lecture, Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>3. Male and Female Reproductive Anatomy</td>
<td>30 min</td>
<td>Lecture, Discussion</td>
<td>Charts/diagrams</td>
</tr>
<tr>
<td>4. Male and Female Hormones</td>
<td>15 min</td>
<td>Brainstorming</td>
<td>HO 1.1.3</td>
</tr>
<tr>
<td>5. Menstrual Cycle</td>
<td>20 min</td>
<td>Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>6. Adolescents living with HIV</td>
<td>20 min</td>
<td>Lecture, Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>7. Hygiene of Reproductive Organs</td>
<td>20 min</td>
<td>Discussion</td>
<td>Flip chart, markers</td>
</tr>
<tr>
<td>8. Myths and Misconceptions</td>
<td>5 min</td>
<td>Discussion</td>
<td>Flip chart, markers</td>
</tr>
<tr>
<td>9. Conclusion</td>
<td>5 min</td>
<td>Discussion</td>
<td>Flip chart, markers</td>
</tr>
</tbody>
</table>

REFERENCES


http://www.emc.maricopa.edu/faculty/farabee/biobk/BioBookREPROD.html
1. INTRODUCTION - Brainstorming (5 min)

Step 1:
- Ask participants, “At what age did you first learn about male and female physical development?” “As an adolescent were you confused about your own body?” “Why is it important that an adolescent counsellor understand the physical development and the reproductive system?”
- Present session objectives

It is important for a facilitator or counsellor to understand physical development and the reproductive system so that he/she can:
- Give correct information to clients.
- Be aware of the physical changes that are influencing a client’s emotions and behaviour.
- Make recommendations based on a holistic (mental, physical, spiritual) understanding of the client.

2. DEFINITION OF ADOLESCENCE – Presentation (5 min)

Step 2:
- Make a presentation of the definitions below as PowerPoint slides or on a flip chart.

**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

**Young person** refers to anyone between 10 – 24 years (United Nations)

**Youth**: The African Youth Charter describes a youth as anyone between the ages of 15 and 35 years. However, the United Nations define **Youth** as anyone between 20 – 24 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.

3. THE MALE AND FEMALE REPRODUCTIVE ANATOMY – Group Work, Discussion (45 min)

Step 3:
- Divide participants into two groups
- Group one describes the female anatomy while Group two describes the male anatomy
- Groups make presentations in plenary and discuss
- Discuss internal and external male and female reproductive organs using charts, diagrams or Handouts 1.1.1 and 1.1.2.
- Explain both reproductive systems and their functions

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:

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>scrotum</td>
<td>outer lips (labia majora)</td>
</tr>
<tr>
<td>lower side of penis</td>
<td>inner lips (labia minora)</td>
</tr>
<tr>
<td>glans penis</td>
<td>glans clitoris</td>
</tr>
<tr>
<td>testes</td>
<td>ovaries</td>
</tr>
</tbody>
</table>

4. **MALE AND FEMALE HORMONES – Brainstorming, Discussion (20 min)**

**Step 4:**
- Ask participants what kind of male or female changes take place during puberty.
- Facilitate a discussion on male and female hormones.
- Brainstorm on changes that occur in boys and girls due to hormonal development.
- Show and discuss relevant DVDs on male and female puberty, such as “Am I normal?” “Girl Stuff” or others.

Hormones are substances produced by a gland that is carried in the blood and acts as a chemical messenger to another body structure. Hormones regulate body growth and development, control sexual drive and maintain the body’s chemical balance.

**Female Hormones and their Effects**
The principal female hormones are **oestrogen**, secreted by ovaries (female sex glands), which causes the body to develop secondary sexual characteristic, and **progesterone**, which helps maintain pregnancy by keeping the uterus a suitable environment for the embryo.

**Changes in 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

**Male Hormones and their Effect**
The male hormone **testosterone**, produced by the testes, controls the growth of the male reproductive system and stimulates development of secondary sexual characteristics.

The **luteinising hormone** stimulates the synthesis and secretion of testosterone. The **follicle stimulating hormone** is also critical for sperm production. As is the case with girls, the secretion of both luteinising hormone and follicle stimulating hormone is initiated by the releasing factors secreted by the hypothalamus. **Androgens** are other hormones that stimulate male characteristics.

**Changes in Boys and in Both Boys and Girls**

<table>
<thead>
<tr>
<th><strong>CHANGES IN BOYS</strong></th>
<th><strong>CHANGES IN BOTH BOYS AND GIRLS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Spermatogenesis (the production of sperms)</td>
<td>• Growth in body height</td>
</tr>
<tr>
<td>• Ejaculation</td>
<td>• Development of pubic hair</td>
</tr>
<tr>
<td>• Growth in body height</td>
<td>• Body shape beginning to look adult</td>
</tr>
<tr>
<td>• Development of pubic hair and facial hair</td>
<td>• Voice changes</td>
</tr>
<tr>
<td>• Body shape beginning to look adult</td>
<td>• Skin problems (acne) for some</td>
</tr>
<tr>
<td>• Voice changes</td>
<td>• Sensitivity about personal appearance</td>
</tr>
<tr>
<td>• Skin problems (acne for some)</td>
<td>• Preoccupation with opposite sex</td>
</tr>
<tr>
<td>• Sensitivity about personal appearance</td>
<td>• Sensitivity to what others think and say about them</td>
</tr>
<tr>
<td>• Preoccupation with opposite sex</td>
<td></td>
</tr>
</tbody>
</table>
• 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

CONCERNS FACED BY BOYS
Some of the concerns and issues faced by boys include:
• Wet dreams
• Phymosis
• Paraphymosis
• Penile size
• Lack of erection/impotence
• Premature ejaculation
• Un-descended Testes

5. THE MENSTRUAL CYCLE – Brainstorming, Discussion (20 min)

Step 5:
• Discuss ovulation, menstruation and relevant feelings on female puberty
• Show Video on challenges and menstrual cycle.

Menstruation is a blood loss from the uterus through the vagina which occurs when the uterine lining (endometrium) is shed. Menstruation occurs when there is no fertilization of the woman’s ovum and it lasts from 2 – 7 days.

Female fertility is cyclic, unlike male fertility, which is relatively constant. Ovulation occurs only once a month and is regulated by a hormone system that involves the hypothalamus, the pituitary gland, and the ovaries. When a woman understands her menstrual cycle, she can better plan, diagnose, and prevent pregnancies. When providers understand the menstrual cycle, they can better assist the client in planning or preventing pregnancies. A woman’s fertility starts from menarche and lasts until menopause.

Menstrual Cycle Regulation
The menstrual cycle is regulated in the hypothalamus. During puberty, the hypothalamus begins secreting hormones that stimulate the pituitary gland to secrete follicle-stimulating hormone (FSH) and luteinizing hormone (LH). In turn, FSH and LH stimulate production of the ovarian hormones oestrogen and progesterone respectively and interact with them to regulate ovulation and menstruation. Anything that disrupts the balance of these four hormones during the cycle can disrupt reproductive function.

Menstrual Cycle Length
In this session chapter, the menstrual cycle events are described for an average 28 day cycle; but a normal menstrual cycle can last anywhere from 21 to 35 days. The menstrual cycle can be divided into two distinct phases: The first phase begins with the onset of menses and ends at ovulation and the second phase spans the time from ovulation, until the first day of the next menses. The length of the second half of the cycle is very consistent, usually 14 days. For some women, the length of the first half is less consistent and may last anywhere from 12 to 21 days.

The First Phase of the Cycle (FOLLICULAR PHASE)
Days 1 – 2 The menstrual cycle begins with the first day of menstrual bleeding. The lining of the uterus begins to shed, because levels of oestrogen and progesterone have declined from the previous cycle. During the first few days of the cycle, numerous ovarian follicles begin growing. These follicles are balls of cells, each containing an oocyte. During a menstrual cycle a woman may have 10 to 20 follicles growing. The cervical mucus is thick, cloudy and scant.
Days 3 – 5 For most women, bleeding will end sometime during these days. About one-third of the endometrial lining remains after the bleeding ends.

Day 6 – 11 Oestrogen, produced by the ovarian follicles, is primarily responsible for stimulating regrowth of the lining during this time, and thereby ensuring a nutritious home for the potential embryo. This lining will be shed at the end of the cycle if pregnancy is not attained. The hormone levels are generally low during this period, but the pituitary sends increased amounts of FSH to help mature the follicles. Most of the 10 to 20 follicles grow briefly, then recede. One remains to mature. Because it is so receptive to FSH, the remaining follicle continues to grow and produces the oocyte for that cycle. It is also responsible for producing increased amounts of oestrogen.

Day 12 – 13 Oestrogen production accelerates, triggering a sudden increase in LH. As LH reaches its peak, oestrogen production is temporarily inhibited, causing its level to dip. This combination of hormonal surge and dip is thought to cause ovulation. A slow increase in progesterone production also begins here just before mid-cycle. Because of the temporary midcycle dip in oestrogen level, a brief interval of midcycle endometrial bleeding can occur. Ovulation takes place 34 to 36 hours after the LH surge begins (10 to 12 hours after LH peaks).

Ovulation
Day 14 Ovulation may take place earlier or later, but it is normally about 14 days before onset of the next menses. The ovary releases a mature egg (oocyte). As the follicle ruptures it releases 1 cc to 10 cc of follicular fluid, and the barely visible oocyte passes into the fallopian tube. Lower abdominal pain is often associated with ovulation. The cervical mucus at ovulation is copious, thin, and clear. This mucus can be stretched into a strand several inches long (this type of mucus is known as spinnbarkeit) and forms a fern pattern when dried on a microscope slide.

The Second Half of the Cycle (LUTEAL PHASE)
Days 15 – 28 After the follicle ruptures at ovulation, the follicle walls collapse, and follicle cell becomes the corpus luteum. The corpus luteum stays in the ovary and secretes increasing levels of oestrogen and progesterone. The increased progesterone causes a change in cervical mucus, making it scant but thick and sticky.

The endometrial lining is now preparing to support an embryo and allow implantation. Progesterone levels reach their peak in the middle of the luteal phase, and FSH and LH levels fall. If fertilization does not occur, the corpus luteum disintegrates and the levels of hormones drop off, causing the endometrial lining to shed and menstrual bleeding to begin.

Problems Faced by Girls
Some of the problems faced by girls are:

- Premenstrual Syndrome
- Dysmenorrhea
- Amenorrhea
- Lack of control in relationships
- Female Genital Mutilation
- Cancers of the reproductive system e.g. cervical
- Complications of pregnancy

Dysmenorrhea
Menstrual cramping, or dysmenorrhea, may occur with ovulatory cycles. Some women may experience cramping throughout their reproductive lives, some only intermittently, and others experience cramping rarely or never. Uterine cramping is caused by prostaglandins released when the lining of the uterus sheds. These prostaglandins cause uterine muscle to contract and smooth muscle contractions in the digestive tract cause other symptoms such as nausea and diarrhoea.

Many women find their cramping pain is relieved by resting applying gentle heat to the area, or taking common
medications such as aspirin or ibuprofen (a very effective prostaglandin inhibitor). Combined oral contraceptive pills can prevent dysmenorrhoea because they suppress ovulation. In some cases, progestin-only contraceptives may relieve dysmenorrhoea.

When evaluating menstrual cramping, rule out the possibility of infection or early pregnancy because cramping pains may also be caused by disorders that may need treatment:

- Pelvic inflammatory disease (PID)
- Fibroid tumours (leiomyomata)
- Endometriosis or adenomyosis
- Endometrial cancer
- Ectopic pregnancy, spontaneous abortion, or retained products of conception.

Abnormal Bleeding
For most women, the menstrual cycle lasts between 21 and 35 days, with 3 to 7 days of bleeding. The average women will pass about 15 ccs of bloody fluid. Some women will have spotting (light bleeding) at mid-cycle, which is triggered by the temporary drop in oestrogen levels occurring with ovulation. Hormonal contraceptives can alter menstrual bleeding patterns, causing amenorrhea, spotting between periods, or heavier bleeding.

A woman who experiences abnormal bleeding needs to be evaluated to discover the cause. In rare cases, a woman with abnormal bleeding may need emergency care. Heavy blood loss can lead to shock. Early symptoms of shock include severe fatigue, faintness or weakness, dizziness.

6. **THE GROWTH OF ADOLESCENTS LIVING WITH HIV – Brainstorming, Discussion (10 min)**

Step: 7
- **Ask participants to brainstorm the differences in growth that occur in adolescents living with HIV and those not.**
- **List the differences on a flip chart under two headings (adolescents living with HIV and HIV Negative Adolescents)**
- **Introduce participants to the Tanner Scale (Handout 1.1.4)**

Adolescents who acquired HIV perinatally may present with slow skeletal growth and delayed pubertal maturation. This is due to the effect that HIV has on metabolic and endocrine functions. This delay in growth and sexual maturation may also have an impact on the psychosocial development of the adolescent concerned. These delays may cause them feelings of frustration and anger because they look different from their HIV-negative peers.

To assess development in adolescence, the Tanner scale may be used. This scale uses physical measurements of development based on external primary and secondary sexual characteristics. This scale is based on the development of breasts in girls, development of genitalia in boys and the growth of pubic hair in both sexes. In HIV care, the Tanner Scale is used to determine an adolescent’s phase of development, in order to decide whether he or she should receive a paediatric or an adult dose of antiretroviral therapy (ART).

**Sexual Maturity in Adolescence**
Sexual maturity begins from the end of adolescence (about age 20) to age 40 years. During early adolescence people’s physical functioning is usually at its best. The muscular strength and motor skills reach a peak. During late adolescence and early adulthood sexual urges usually become stronger and adults can have a satisfying sex life. Adult relations may be characterized less by the physical aspects and more by emotional intimacy, mutual respect and love.

It is important to note that despite the uncontrolled or involuntary physical development, sexual maturity is not complete until one is fully mentally and emotionally developed, and able to engage in mutually respectful relationships.
7. HYGIENE OF SEXUAL AND REPRODUCTIVE ORGANS – Brainstorming, Presentation
(20 min)

Step 7:
- Brainstorm and discuss on hygiene of sexual and reproductive organs.
- Ask participants on how sexual and reproductive organs are cared for.
- Highlight areas not covered in the discussion.

Frequent Bathing:
Oil and sweat glands in the genital area of boys’ and girls’ bodies become active at puberty, so regular bathing or showering is important for both males and females. This cleanses the genitals and keeps them odour free. Young people should learn to pay special attention to the armpits, feet, and between the buttocks. Regular washing of the face is also important.

Bathing regularly and wearing clean clothes will usually keep a person smelling clean and fresh. Because sweat glands become more active during adolescence some people like to use a deodorant and/or antiperspirant product. Deodorants are designed to cover up natural body odours; antiperspirants are designed to absorb perspiration in the armpits and reduce underarm wetness.

Each person has to decide whether her or his body odour or amount of perspiration requires the use of one of these products.

Extra care and hygiene are important during menstruation. Pads and tampons should be changed frequently, and pants should be washed and dried properly.

Using Sanitary Ware:
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; others do not. Cramps are caused when the uterus contracts during menstruation. This means that muscles around the uterus tighten and relax to help the uterus shed its lining. This may be uncomfortable, but is normal. 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)
- 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
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 age 18 or earlier if they are sexually active, and have an examination every 2 years.

Many girls are nervous about having their first pelvic examination, but the examination need not be painful and is important for maintaining reproductive health, especially for sexually active adolescents.

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.

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.

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 color or odor, please visit a health professional.

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.

REFERENCE:
DSW German Foundation for World Population Sexual and Reproductive Health Training Manual for Young People pg 34; 40

8. MYTHS/CULTURAL PRACTICES - Discussion (5 min)

Step 8:
- Ask participants to share some myths adolescents have on the physical development of the body.
**MYTH:** Extended Labia improves sexual pleasure
**FACT:** There are no scientific studies that have confirmed this

**MYTH:** If you have sex while standing you will not fall pregnant because sperms can be easily flushed out.
**FACT:** As long as a girl has sexual intercourse, there is a possibility of falling pregnant irrespective of the position the sex was performed.

**MYTH:** Circumcision makes masturbation impossible
**FACT:** Masturbation occurs on the shaft and not on the foreskin.

**MYTH:** When you have sex for the first time you don’t fall pregnant
**FACT:** You can fall pregnant at first sexual debut.

9. **CONCLUSION – Discussion (5 min)**

Step 9:
- *Highlight why this training focuses on adolescents (rapid development, hormonal changes, and challenges associated these changes)*
- *Emphasize physical development issues in adolescence living with HIV,*
- *Review objectives and conclude session.*
HANDOUT 2.1.1
Anatomical Pictures of Female Organs

Ovary
Oviduct
Body cavity
Urinary bladder
Urethra
Clitoris
Labium majora
Labium minora
Vagina
Anus
Ureter
Rectum
Uterus
Cervix
Boy and Girl Changes at Puberty

**PUBERTY** is a time of change. During this time many changes occur as girls become women and boys become men. These changes are natural, caused by hormones—oestrogen and progesterone in girls and testosterone in boys. It can be a frustrating time for boys and girls as they begin to look different from their friends.

Puberty in girls begins at about age 10, while in boys it begins a year or two later.

**COMMON CHANGES**
Both boys and girls will experience these changes but at different times and in varying degrees.

1. **Physical**
   - Rapid growth both in height and weight
   - Skin problems such as pimples/acne
   - Hair development in the pubic area and armpits
   - Increased sweating leading to stronger body odour
   - Voice changes

2. **Psychological and emotional**
   - Attraction and preoccupation with the opposite sex
   - Sensitivity to self image
   - Unpredictable moods
   - Rebellious tendencies

These changes are signs that one is sexually maturing.

**Specific Changes in Boys**
- Voice breaks
- Broad shoulders and muscular body
- Proportionate growth in the reproductive organs
- Wet dreams, also called nocturnal emissions

When a boy begins experiencing wet dreams, he is capable of making a girl pregnant. Some boys will have more wet dreams than others.

**Specific Changes in Girls**
- Breast develops
- Hips widen
- Proportionate growth in the reproductive organs
- Menstruation starts – also known as monthly periods

A girl who has undergone these changes can fall pregnant.

Going through puberty means that girls and boys should know how to relate to each other in healthy ways, because irresponsible sexual behaviour may lead to pregnancy, and/or sexually transmitted infections and HIV.
**Tanner Scale: Female Breast**

<table>
<thead>
<tr>
<th>Scale 1:</th>
<th>No breast tissue with flat areola</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale 2:</td>
<td>Breast budding with widening of the areola</td>
</tr>
<tr>
<td>Scale 3:</td>
<td>Larger and more elevated breast extending beyond the areola</td>
</tr>
<tr>
<td>Scale 4:</td>
<td>Larger and even more elevated breast. Areola and nipple projecting from the breast contours</td>
</tr>
<tr>
<td>Scale 5:</td>
<td>Adult size with nipple projecting above areola</td>
</tr>
</tbody>
</table>

**Tanner Scale: Male Genitalia**

[Image of Tanner Scale for Male Genitalia]
Scale 1: Testes small in size (less than 1.5 cc) childlike penis of 3 cm or less

Scale 2: Testes reddened, thinner and larger (1.6-6.0 cc) with childlike penis

Scale 3: Testes larger (6-12 cc); scrotum enlarges further; penis begins to lengthen to about 6 cm

Scale 4: Testes larger (12-20 cc) with greater enlargement and darkening of the scrotum; increase in penis length (10 cm) and circumference

Scale 5: Testes over 20 cc with adult scrotum and penis of 15 cm in length

Tanner Scale: Male and Female Pubic Hair
The Tanner Scale (or Tanner staging) provides a measure of physical development in adolescents. The scale defines physical measurements of development based on external primary and secondary sex characteristics. The scale is based on observing the development of the breasts in girls, the development of the genitalia in boys, and the growth of pubic hair in both sexes.
## Adolescent Psychological and Social Development

### Characteristic Behaviours of Adolescence

<table>
<thead>
<tr>
<th>Developmental Stage</th>
<th>Early Adolescence (10 to 13 years old)</th>
<th>Middle Adolescence (14 to 16 years old)</th>
<th>Late Adolescence (17 to 19 years old)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independence</strong></td>
<td>• Transition to adolescence&lt;br&gt;• Characterized by puberty</td>
<td>• Essence of adolescence&lt;br&gt;• Strong peer-group influence</td>
<td>• Transition to adulthood&lt;br&gt;• Assumption of adult roles</td>
</tr>
<tr>
<td></td>
<td>• Challenges authority, parents, and other family members&lt;br&gt;• Rejects things of childhood&lt;br&gt;• Desires more privacy</td>
<td>• Moves away from parents and toward peers&lt;br&gt;• Begins to develop own value system</td>
<td>• Is emancipated: begins to work or pursue higher education&lt;br&gt;• Enters adult life&lt;br&gt;• Reintegrates into family as emerging adult</td>
</tr>
<tr>
<td><strong>Cognitive Development</strong></td>
<td>• Finds abstract thought difficult&lt;br&gt;• Seeks to make more decisions&lt;br&gt;• Has wide mood swings</td>
<td>• Starts to develop abstract thought&lt;br&gt;• Begins to respond based on analysis of potential consequences&lt;br&gt;• Has feelings that contribute to behaviour but do not control it</td>
<td>• Firmly establishes abstract thought&lt;br&gt;• Demonstrates improved problem solving&lt;br&gt;• Is better able to resolve conflicts</td>
</tr>
<tr>
<td><strong>Peer Group</strong></td>
<td>• Has intense friendships with members of the same sex&lt;br&gt;• Possibly has contact with members of the opposite sex in groups</td>
<td>• Forms strong peer allegiances&lt;br&gt;• Begins to explore ability to attract partners</td>
<td>• Is less influenced by peers regarding decisions and values than before&lt;br&gt;• Relates to individuals more than to peer group</td>
</tr>
<tr>
<td><strong>Body Image</strong></td>
<td>• Is preoccupied with physical changes&lt;br&gt;• Is critical of appearance&lt;br&gt;• Is anxious about menstruation, wet dreams, masturbation, breast or penis size</td>
<td>• Is less concerned about body image than before&lt;br&gt;• Is more interested in looking attractive</td>
<td>• Is usually comfortable with body image&lt;br&gt;• Accepts personal appearance</td>
</tr>
<tr>
<td><strong>Sexuality</strong></td>
<td>• Begins to feel attracted to others&lt;br&gt;• May begin to masturbate&lt;br&gt;• May experiment with sex play&lt;br&gt;• Compares own physical development with that of peers</td>
<td>• Shows an increase in sexual interest&lt;br&gt;• May struggle with sexual identity&lt;br&gt;• May initiate sex inside or outside of marriage</td>
<td>• Begins to develop serious intimate relationships that replace group relationships as primary relationships</td>
</tr>
</tbody>
</table>

Adapted from *Youth-Friendly Services: A Manual for Service Providers* by EngenderHealth 2002
Handout 2.1.6: Menstrual Cycle

SESSION 2 SUMMARY

MODULE II: Challenges Adolescents Face Today

SESSION 2: Human Sexuality

Time: 3 hours

Objectives:
By the end of the session, participants will be able to:
- Define sex, sexuality, sexism and sexual orientation.
- Explain how human sexuality affects adolescent behaviour.
- Identify components of sexuality
- Outline how feelings and relationships change during sexual development.
- Explain human sexuality for adolescents living with HIV
- Describe 5 major sexual patterns.
- List at least 2 ways adolescents are affected by the human sexual behaviours in their community.
- Understand how adolescent’s views on sexuality are affected by Information, Communication and Technology (ICTs)
- Dispel myths about sexual activity and reproduction.

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<th>CONTENT/ACTIVITY</th>
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<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>15 min</td>
<td>Exercise</td>
<td>Paper, pens &amp; pencils</td>
</tr>
<tr>
<td>2. Definitions</td>
<td>20 min</td>
<td>Brainstorm, Lecture</td>
<td>Flipchart, HO 1.2.1</td>
</tr>
<tr>
<td>3. Components of Human Sexuality</td>
<td>30 min</td>
<td>Lecture, discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>4. Feelings and Relationships</td>
<td>40 min</td>
<td>Group work, Discussion</td>
<td>Reference Materials</td>
</tr>
<tr>
<td>5. Sexual Patterns/ Preferences</td>
<td>15 min</td>
<td>Brainstorm</td>
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<td>6. Sexual Behaviours</td>
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<td>Group work, Discussion</td>
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<td>7. Dispelling Myths</td>
<td>10 min</td>
<td>Discussion</td>
<td>HO 1.2.3</td>
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<tr>
<td>8. Conclusion</td>
<td>5 min</td>
<td>Session Summary</td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES

Centre for Disease Control (CDC). Family Planning Methods and Practice: Africa Second Edition 1999, Centre for Disease Control (CDC).


1. **INTRODUCTION - Exercise (15 min)**

   Step 1:
   - Instruct participants to take a paper and pencil and in total privacy and with assurance that they will not be sharing the drawing—draw a picture depicting the word “sexuality”.
   - After a few minutes, ask participants to describe what ideas they had about the word.
   - Ask for volunteers to share their pictures.
   - Present session objectives

2. **DEFINITIONS OF TERMS – Brainstorming, Mini Lecture (20 min)**

   Step 2:
   - Prepare your presentation on definitions using Handout 1.2.1
   - Have participants brainstorm definitions of sex, sexuality, gender role, gender identity, sexism and sexual orientation.
   - Write participants’ responses on a Flipchart and discuss.
   - Present definitions from your prepared PowerPoint slides.

3. **COMPONENTS OF HUMAN SEXUALITY – Lecture, Discussion (30 min)**

   Step 3:
   - Give an illustrated lecture on the effects of human sexuality on adolescent behaviour.
   - Summarize with a group discussion and group work to allow participants to share adolescent experiences.

   a) **Sensuality:**
   Is an awareness and feeling about your own body and other people’s bodies, especially the body of a sexual partner. Sensuality enables us to feel good about how our bodies look and feel and what they can do. Sensuality also allows us 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. 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.

4. CHANGES IN FEELINGS AND RELATIONSHIPS DURING SEXUAL DEVELOPMENT - Group Work, Discussion (40 min)

Step 4:

Divide larger group into five smaller groups and provide reference materials. Assign each group an age group:
- Infants and toddlers
- 3 - 7 years
- 8 - 12 years
- 13 - 19 years
- Adolescents living with HIV

Each group is to help the others learn in some creative way about the sexual development of the group assigned to them.

Reconvene the large group for presentation and discussion. Moderate the discussion and add information or clarify any issues raised.

Write responses on a flip chart. Add any missing information and show film.

Highlight information on adolescents living with HIV and sex

Sexuality in infants and toddlers
Children are sexual even before birth. Males can have erections while still in the uterus, and some boys are born with an erection. Infants touch and rub their genitals because it provides pleasure. Boys and girls experience orgasms from masturbation, but boys do not ejaculate until puberty. By about age two, children know their sex. They are aware of differences between genitals and how boys and girls urinate.

**Sexuality in children ages 3 to 7**

Preschoolers are interested in everything about their world, including sexuality. They may practice urinating in different positions. They are very affectionate and enjoy hugging other children and adults. They begin to be more social and may imitate adult social and sexual behaviours, e.g. holding hands or kissing. Many young children play “father/mother” roles during this stage, looking at each other’s genitals. This is normal curiosity. By age five or six, however, most children become more modest and private about clothing and bathing. Children of this age are aware of marriage or “living together”, based on their family experience. They may role play being married or having a partner while they “play house”.

Most young children talk about marrying or living with a person they love when they get older. School-age children may play sexual games with friends of their same sex, touching each other's genitals or masturbating together. Most sex play at this age happens because of curiosity.

**Sexuality in preadolescent children (ages 8 to 12)**

Puberty is the time when the body matures. It begins between the ages of 9 and 12 for most children. Girls begin to grow breast buds and pubic hair as early as 9 or 10. Boys grow pubic hair and experience penis and testicle development between 10 and 11. Children become more self-conscious about their bodies at this age and often feel uncomfortable undressing in front of others, even a same-sex parent.

Masturbation continues and increases during these years. Preadolescent boys and girls do not usually have much sexual experience, but they often have many questions. They have usually heard about intercourse, petting, oral and anal sex, homosexuality, rape and incest, and they want to know more about these things. The idea of actually having intercourse, however, is unpleasant for most preadolescent girls and boys.

Boys and girls tend to play with friends of the same sex and are likely to explore sexually with them. Looking at or caressing each other is common among boys and girls. Such same-sex behaviour is usually unrelated to a child’s sexual orientation. By age 12 or 13, some young adolescents will pair off and begin dating.

**Sexuality in adolescents (ages 13 to 19)**

Once children reach puberty, their interest in genital sex increases and continue through adolescence. There is no way to predict how a particular teenager will act sexually. As a group, most adolescents explore relationships with one another, fall in and out of “love” and participate in sexual behaviours before the age of 20.

**Adolescents Living with HIV and Sex**

There are two broad categories of adolescents living with HIV which can be considered by their source of infection / mode of transmission - those infected with HIV during pregnancy, labour and delivery and breastfeeding (perinatal/vertical) and those infected during the postnatal period and adolescence, through sexual abuse and consensual sex (horizontal). Children who acquire HIV perinatally, COMMONLY (not necessarily) experience delays in physical development which has a bearing on their sexual maturation.

Regardless of the mode of transmission, people living with HIV do not lose their desire to have sex and bear children. Service providers need to be able to respond to the sexual and reproductive health needs of adolescents living with HIV in a non-judgemental manner. Peer support groups can help adolescents to access practical and appropriate information on living with HIV and provide them with the support that they need to love positively. Service providers have a role in helping to start such groups, and in linking adolescent patients with existing peer support groups.

5. **SEXUAL PATTERNS/ PREFERENCES/ BEHAVIOURS - Brainstorming, Discussion (15 min)**

People have exercised choice on sexual matters for as long as can be remembered.
Unfortunately males practiced most of the choices. Females who tried to exercise them were ridiculed, punished, or even ostracized. Due to the way people are socialised, the choices may be more prominent in some cultures than others making them acceptable or deviant. Let’s start with sexual orientation.

**Step 5:**

Ask participants to list the major sexual patterns and write responses on newsprint and explain each pattern:

**Sexual patterns:** Preference for sharing sexual expression. This can be for partners of the opposite sex from you, same sex with you or both. There are 5 major patterns:

- **Heterosexual:** preferring sexual partners of the opposite sex.
- **Homosexual:** preferring sexual partners of the same sex. (The term gay is commonly used for men who prefer same-sex partners, though it can refer to women as well. The more usual term for women who prefer same-sex partners is lesbian.)
- **Bisexual:** enjoying sexual partners of both sexes.
- **Asexual:** having little or no sex drive. Though asexual persons are physically and psychologically male or female, neither sex stimulates them sexually. They have no desire for sex.
- **Celibate:** deliberately abstaining from sexual activity, a choice people make for a variety of reasons, for example, certain religions.
- **Intersexual:** A person who is physically, emotionally and/or spiritually attracted to persons of the same or opposite sex.
- **Questioning:** Person born with mixed sexual physiology; a sex is often “assigned” at birth, though this practice is under attack as violating one’s well-being. An individual who is currently questioning his or her gender or sexual identity.

6. **SEXUAL BEHAVIOIRS – Group Work, Discussion (40 min)**

Sexual behaviours are acts done by people to gain sexual gratification or derive sexual pleasure. Sexual behaviour includes a wide range of activities, from kissing, touching, hugging, petting, and fondling to penetrative sexual intercourse.

**NB:** Some are approved in almost all cultures. Others may be culturally acceptable in one group or subgroup but not the other. For example incest is unacceptable in Zimbabwe.

**Step 6:**

- Divide group into small groups to list acceptable and unacceptable sexual behaviour in their communities.
- Group reconvenes for presentations.
- Add any missing sexual behaviours from the list.
- Discuss how adolescents views on sexuality are affected by Information, Communication and Technology (ICTs)
- Use Handout 1.2.2 for your presentation

**Sexual Expression**

- The hormonal changes, which trigger sexual maturity also affect a young person’s emotions and feelings
- Some explore sexual feelings through erotic fantasies, masturbation or sexual intercourse
- Adolescents can be taught how to express their energy in constructive and socially accepted ways
- Sexual expression, like gender roles can be shaped by culture, family and one’s personal value system
- Pre-marital sexual intercourse is frowned at in most societies
- Sexual intercourse within marriage among partners of any age is accepted
- Heterosexual expression between consenting adults is accepted in most societies
• Sexual energy can be expressed in friendship, the forging of kinship ties at and devotion to a person.

Some other forms of sexual expression are touching; composing poems; adoring the body; dancing; talking; and working hard to win the affection of a loved one. Sexual intercourse is but one form of sexual expression.

**How Information, Communication and Technology (ICTs) Affect Adolescents Views on Sexuality**

Access to the internet has made access to pornography (pictures, films, cartoons or writing) easy for adolescents, and it also makes pornography difficult to avoid. Some adolescents may find pornography sexually exciting. Pornography only shows sexual images but it does not show how to protect oneself against pregnancy or STIs. Other ICTs that affect sexuality are sexual chat room talk, mobile phone texting—sexting and phone sex.

**Strategies to deal with such Influences include:** Avoiding websites with suspicious web addresses and do not click on pop-ups, not surfing for sites that offer pornography, blocking computers from showing pornography sites, adhering to age restrictions on television and adhering to illegality of pornography in Zimbabwe.

Adolescents may engage in pre-marital sex due to a number of factors that can influence that decision as listed below. However, there are some consequences that may emanate from such behaviours.

<table>
<thead>
<tr>
<th>Adolescents may engage in pre-marital sex due to:</th>
<th>Consequences of Premarital Sex May be:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Peer pressure</td>
<td>• Unintended pregnancies</td>
</tr>
<tr>
<td>• Pressure from a partner</td>
<td>• Sexually transmitted disease</td>
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<tr>
<td>• Sexual attraction</td>
<td>• Loss of self-esteem and self—respect</td>
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<tr>
<td>• Inadequate sex education</td>
<td>• Lack of trust in the opposite sex</td>
</tr>
<tr>
<td>• Drugs and alcohol abuse</td>
<td>• Fear of commitment to a partner</td>
</tr>
<tr>
<td>• Inability to assert themselves</td>
<td>• Difficulties in establishing intimacy in a relationship</td>
</tr>
<tr>
<td>• Loneliness</td>
<td>• Retardation of personal development</td>
</tr>
<tr>
<td>• Coercion or force</td>
<td>• Infidelity in marriage</td>
</tr>
<tr>
<td>• Money or material support curiosity or experimentations</td>
<td></td>
</tr>
<tr>
<td>• Desire to conform to popular images</td>
<td></td>
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<tr>
<td>• Having no good reason to postpone intercourse</td>
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</tbody>
</table>

7. **EFFECTS OF SEXUAL BEHAVIOURS ON ADOLESCENTS:**

**Step 7:**
1. **Ask participants to come up with possible effects of different forms of sexual behaviours on adolescents.**
2. **Discuss how adolescents can delay sexual debut.**
3. **Ask participants to also list the benefits of delayed sexual debut.**

Effects of different forms of sexual behaviours on adolescents include damage to organs; spread of infections; strained relationships; sexual dissatisfaction; stigma; punishment by law and psychological trauma.

Adolescents can delay sexual debut through:
• Socializing in groups
• Planning exciting and public activities
• Involving parents as elders in decision making
• Setting limits on how far they go in expressing romantic affection
• Avoiding sexually stimulating situations
• Not using drugs and alcohol
• Choosing friends who share their values
• Not setting for less than they think they deserve in a relationship
Advantages of delaying sex are:
1. Gaining control over one’s life
2. Developing real friendship based on mutual respect
3. Time to develop one’s skill, talents and interest
4. Exploring a wider range of friendships and relationships
5. Building a firmer foundation for self respect and self control
6. Completion of education and achieving financial independence before marriage or parenting

8. DISPELLING MYTHS ABOUT SEXUAL ACTIVITY AND REPRODUCTION – Group Work, Discussion (10 min)

Step 8:
4. *Divide participants into two groups and give each group a set of facts and myth statements (Use Handout 1.2.3).*
5. *Group 1 asks Group 2 whether the statement is a fact or a myth: Group 2 responds. The groups take turns asking each other, and each correct response scores one point.*
6. *Write scores on the board and clarify any doubts.*

9. CONCLUSION/ LESSONS LEARNED (10 min)

Ask participants to identify at least two things they learned during the session. Have them share this new information with the person next to them. Request volunteers to share with the entire group.
Definition of Terms: SEX AND SEXUALITY

**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).

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**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.
HANDOUT 2.2.2

Sexual Patterns and Behaviours

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 feaces, 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.

**IMPORTANT!** Some of these behaviours are acceptable in some cultures while others are considered as deviant in some cultures. For example, Masturbation is acceptable in some cultures and is encouraged as a means to prevent pregnancy.
HANDOUT 2.2.3

Myths and Facts

- 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 some day.
- All parents know naturally how to raise children.
## SESSION 3 SUMMARY
### MODULE II: Challenges Adolescents Face Today
#### SESSION 3: Gender and ASRH

**Time:** 2 hours

**Objectives:**
By the end of the session, participants will be able to:
1. Define at least six gender terms.
2. Distinguish between gender roles and sex roles.
3. State how gender values, attitudes, stereotypes and behaviour impact on adolescents at personal and societal level.
4. Define Gender-Based Violence (GBV).
5. Outline the impact of socialization on gender based violence (root causes, implications).
6. Identify support systems and legal frameworks for survivors of GBV.

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<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>10 min</td>
<td>Story</td>
<td>HO 1.3.1</td>
</tr>
<tr>
<td>2. Gender Concepts</td>
<td>25 min</td>
<td>Lecture/Group work</td>
<td>Computer, LCD</td>
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<tr>
<td>3. Impact of Socialisation on Gender</td>
<td>15 min</td>
<td>Exercise</td>
<td>Flip chart, marker</td>
</tr>
<tr>
<td>4. Gender Values</td>
<td>20 min</td>
<td>Brainstorm, Discussion</td>
<td>HO 1.3.2</td>
</tr>
<tr>
<td>5. Gender Based Violence</td>
<td>20 min</td>
<td>Role Play</td>
<td>HO 1.3.3</td>
</tr>
<tr>
<td>6. Action to take on GBV</td>
<td>20 min</td>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>7. Conclusion</td>
<td>10 min</td>
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**REFERENCES:**


1. **INTRODUCTION – Exercise (10 min)**

   **Step 1:**
   - Tell the story of a doctor (see HO 2.3.1) or any other relevant story.
   - Post or state session objectives

2. **DEFINITIONS OF TERMS – Brainstorming, Mini Lecture (25 min)**

   **Step 2:**
   - Brainstorm the definition of gender concepts
   - Post and discuss the definitions

   **Gender:** Is a socially constructed concept that carries with it expectations and responsibilities. It identifies social differences i.e. social behaviour roles and activities.

   **Sex:** Is a fact of human biology, it identifies the biological and physical differences between male and female. One is born either male or female.

   **Gender Role:** Set of rules set down by society that tells us how to behave according to our sex and gender. The rules are made by culture—not biology—and are usually assigned to us at the moment of our birth when it is announced, “It is a boy or girl.”

   **Example:** Blue is a colour usually associated with boys and pink with girls. Girls are given dolls to play with and boys are given guns, cars and toy trucks to play with. Men are thought to be stronger both physically and emotionally. Sayings like “big boys do not cry” are good examples of this notion. Women are seen as weak and unable to control their emotions. **NOTE: (Discuss with participants if this is happening in their community).**

   **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.

   **Gender equity:** is a set of actions, attitudes, and assumptions that provide opportunities and create expectations about individuals. It means fairness and justice in the distribution of rights, chances, benefits and responsibilities between women and men.

   **Equality:** Means equal treatment of women and men, in legislation, policies at the workplace and equal access to resources and services within families, communities and society at large. It rests on five different pillars: men and women have the same intrinsic value; men and women are equally valuable to society; men and women should have equal rights and responsibilities; an absence of discrimination (equal opportunities) and realizing that equality does not mean sameness.

   **Gender-based Violence:** Is a behaviour that violates one’s human rights based on ones gender.

   **Socialisation:** Is how society and thinking shapes norms and attributes values, behaviours and identity of an individual.

   **Stereotypes:** Rigidly held and simplified beliefs that men and women, by virtue of their biological make up, possess distinct psychological traits, characteristics and abilities.

   **Discrimination:** Refers to distinction, exclusion or restriction made on the basis of socially constructed gender roles and norms which prevents a person from enjoying full human rights

**Step 3:**
Ask participants to form 2 groups
- Males form their own and females their own
- Ask them to show the distinction between sex and gender, using any format (e.g. on flipchart, a role play)
- Groups make presentations
- Add any missing facts from their lists

<table>
<thead>
<tr>
<th>GENDER</th>
<th>SEX (Male/Female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socially constructed Roles</td>
<td>Biological difference</td>
</tr>
<tr>
<td>Expected Responsibilities</td>
<td>Mutually exclusive categories</td>
</tr>
<tr>
<td>Social attributes on how to act/think</td>
<td>Differences in genitalia</td>
</tr>
<tr>
<td>Dynamic</td>
<td>Anatomical and physiological differences (penis, vagina, sperm, ovary, menses, wet dreams)</td>
</tr>
<tr>
<td>Differs dramatically from culture to culture</td>
<td>Consistent throughout the human race</td>
</tr>
</tbody>
</table>

4. IMPACT OF SOCIALISATION ON GENDER – Brainstorming (15 min)

Step 4:
- Using exercise below, ask participants about impact of socialisation on Gender
- List their contributions on a flip chart
- Summarise by adding missed out points
- Give out Handout 2.3.2

Exploring Gender, Sex & Socialisation
Think as far back as possible in your lives, and write your first experience of realising that you were different from members of the opposite sex, were expected to behave differently and treated differently from members of the opposite sex. Focus on the following:

a) Expected behaviour, sports/games,
b) activities, tasks, responsibilities,
c) actions/responses, where, when, by who, at

d) what age, etc.

For this exercise, NO differences related to Anatomy and physiology should be addressed

Children are socialized into male and female behaviours and sexual identities from infancy, but gender roles take on new meanings at puberty, when girls and boys become highly conscious of their changing bodies, their gendered identities, and their social/cultural environment. Young people are expected to learn a set of gendered social rules about how they should look, think and behave and what forms of social and physical intimacy are encouraged or forbidden – and with whom.

Also the cultural/religious content of gender roles (e.g. influence of the Apostolic church) have clear relevance to what boys and girls are learning about what is permissible or even desirable for males and females to do sexually and in other aspects of their lives (in some cases to endanger the sexual and reproductive health rights of a person) Below are different socialisation processes that further entrench gender roles:

Gender Division of Labour: It often gives males tasks outside the home that also require less time, this gives boys and young men more chances of being exposed to risky situations while potentially being a barrier to girls and young women’s access to health care services and information since their gender roles are time consuming and home bound thus restricting them to stay within the home. Gender division of labour also reflects on the low social status and value of women and girls which underpins the unequal power relations in relationships between men and women.

Dress Code: Boys and girls are socialised to dress differently. In general, there are colours associated with
boys and girls as well the kind of clothes men and women are supposed to wear and how far body parts have to be covered.

**Physical Segregation:** Boys are normally expected to play with boys and girls with girls. Boys are expected to take rough games such as boxing, football whilst girls are encouraged to go for softer/lighter games e.g., netball, volleyball.

**Intellectual Responses:** Girls are generally discouraged from talking back and expressing their opinions. Girls are not encouraged to take Science and Technical subjects whilst boys who take Cookery, Needle Work or Arts are scoffed at as less intelligent. Expectations of submissiveness among women and girls also limit their ability to talk openly in relationships. Men’s receptiveness to dialogue is also affected by this socialization as they are expected to be knowledgeable, especially on sexual matters and take an upper hand. Discrimination based on stereotypes about intellect also affects girls’ access to education and limit their ability to achieve their full potential.

**Emotional Responses:** During sad emotions, girls are supposed to cry while boys should not cry. Crying is considered feminine and weakness on the part of the boys.

**Social Institutions:** These are the mediums for socialisation, from which adolescents learn the messages about gender. They introduce and reinforce the gender roles and identity e.g. as family, religious organisations, schools extended families, education, media and community. They can also be used to unlearn some norms, e.g. harmful traditional practices.

**Gender Roles:** Are a set of rules set down by the society that tell us how to behave according to our sex. Gender roles are not biologically determined. They are socially prescribed and are affected by factors such as class, religion, ethnicity, race and history.

**Step 5:**
- **Make a presentation on the three types of gender roles (10 min)**
- **Discuss the three types of gender roles**
- **Discuss what can be done to address the gender roles that may affect the SRH status of adolescents**

**Productive Roles:** These are activities/tasks, which involve the production of goods and services for consumption or sale on the market e.g., crop, livestock production, formal employment, self-employment, marketing etc. Both males and females are involved in production work but in different positions and are valued and rewarded differently.

**Reproductive Roles:** A reproductive role is giving birth to a child. These are biological functions that are related to one’s reproductive system. For adolescents, they may be often time consuming, repetitive and largely within the home setting. As a result girls who fall pregnant or marry early may or more often retreat into the domestic sphere and fail to access education and health care among other things. They become very vulnerable to GBV and other health concerns for various reasons.

**Community Roles:** These are activities and tasks which involve collective organisation of services and social events e.g., ceremonies, celebrations, community development activities including, self help projects, participation in groups, church services, funerals etc.

**Discussion:** Discuss on strategies and recommendations towards addressing the effects of gender roles on the sexual and reproductive lives of adolescents.

**5. IMPACT OF GENDER VALUES AND STEREOTYPES – Brainstorming, Discussion (20 min)**

**Step 5:**
- **Ask the participants to brainstorm the impact of gender values and stereotypes at personal and societal levels.**
Discuss sexual drive and enjoyment

Record their responses on a Flip chart

Add those which were not mentioned

AT PERSONAL LEVEL

Low Self Esteem
This affects adolescents’ decision making skills resulting in low perceptions of one’s roles, beliefs, capability and behaviour as well as ability to withstand peer pressure of the individual thinks lowly of themselves and need affirmation from their friends in order to feel good about themselves, e.g. girls may not be able to say NO to sexual advances that they are not happy with.

The 3 groups related to low self-esteem are:
- Those who believe and adhere to the norms.
- Those who do not believe but conform in order to avoid conflict.
- Those who do not believe. They do not behave according to the norms. They encounter isolation, stigmatisation and labels. This may result in aggressive behaviour, which may be detrimental to their health.

Susceptibility to STIs Including HIV and unintended pregnancies
- Inability to negotiate safer sex predisposes young people to STIs including HIV and unintended pregnancies.

Discussing sexual issues across sexes is taboo. Therefore, this limits the chance of negotiations with sexual partners and also limits access to information, constructive advice and parental guidance for both sexes.

The concept of risk taking for males predisposes them to STI/HIV as they try to fulfil the expectations of society e.g., multiple sexual partners, unprotected sex, a real man should have several children. The submissive, non-questioning role ascribed to women and girls also places them at risk as unequal partners in relationships. Their economic dependence also makes them vulnerable to exploitation and transactional sex among other things.

The socialization of sexual intercourse is that it must be unprotected and penetrative.

Sex must be initiated by a male to a resisting partner. Males are expected to struggle to get sexual intercourse (thus setting the scene for accepting sexual violence), females are expected to resist. The sexual act leaves no room for healthy communication, negotiated protection and mutual respect. The socialization that females will always resist to seem acceptable, especially in relationships. This leaves no room for communication, negotiated protection and mutual respect.

Sexual Drive and Enjoyment
Males are expected to have a high sexual drive which is uncontrollable. Adolescents may be put under the social “pressure” and engage in risky sexual behaviours to “prove” that they are men enough.

Sexual gratification is perceived as only important for males, e.g. dry sex, harmful herbs and ointments are introduced in the sexual activity. Dry penetration (which reduces prospects of condom use and effectiveness) may cause bruises which may further increase the chances of STI transmission and cancers of the reproductive system.

AT SOCIETAL LEVEL
- Denial of women to access and control of their own lives, bodies and economic resources (discrimination against women)
- Relegation of women to the domestic sphere, subordination to men, marginalisation and resistance to change
- Lack of participation of women in development

**Violation of Women's Sexual and Reproductive Rights** some of which are:
- Right to life
- Right to bodily integration and security of the person
- Right to privacy
- Right to benefits of scientific progress
- Right to seek, receive & impart information
- Right to education
- Right to health
- Right to equality in marriage and divorce

6. **GENDER BASED VIOLENCE – Role Play, Discussion (20 min)**

**Step 6:**
- *Refresh the definition of GBV and ask the group to share what they know about gender-based violence.*
- *Divide participants into three groups:*
  - **Group 1:** Role Play - physical violence
  - **Group 2:** Role play - sexual harassment/violence
  - **Group 3:** Discuss - emotional and psychological abuse. Write answers on a flip chart
  - *Present in plenary and discuss.*

**Types of Violence**

<table>
<thead>
<tr>
<th>Sexual Harassment/Violence</th>
<th>Emotional and Psychological Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Beating a person to force him/her to have sex</td>
<td>• Telling someone she/he is ugly</td>
</tr>
<tr>
<td>• Touching a person's sexual parts against his/her will</td>
<td>• Denial of love/affection/sex</td>
</tr>
<tr>
<td>• Using vulgar language and abusive language to coerce someone into having sex</td>
<td>• Humiliation</td>
</tr>
<tr>
<td>• Putting drugs into a person's drink so that it is easier to have sex with him or her</td>
<td>• Refusing to help</td>
</tr>
<tr>
<td>• Refusing to use contraceptives or condoms</td>
<td><strong>Physical Violence</strong></td>
</tr>
<tr>
<td>• A woman forced by her husband to have sex when she is feeling unwell or when she doesn't want to as the husband has STI</td>
<td>• Peer pressure to join gang to prove manhood by physically attacking other men</td>
</tr>
<tr>
<td>• Early/forced marriage with a minor</td>
<td>• Slapping, beating, pinching, hair pulling, burning, strangling</td>
</tr>
<tr>
<td>• Female genital mutilation</td>
<td>• Threatening or attacking with a weapon or object</td>
</tr>
<tr>
<td>• Incest with young boys and girls</td>
<td>• Throwing objects at a person</td>
</tr>
<tr>
<td>• Forced marriage</td>
<td>• Physically confining (locking in a room or tying up)</td>
</tr>
<tr>
<td>• Rape/sexual coercion</td>
<td>• Ripping off clothes</td>
</tr>
<tr>
<td>• Pornographic displays</td>
<td>• Bullying</td>
</tr>
<tr>
<td>• Suggestive languages/gestures</td>
<td>• Kidnapping</td>
</tr>
<tr>
<td>• Forced sexual attention</td>
<td><strong>Economic Abuse</strong></td>
</tr>
<tr>
<td>• Indecent exposure</td>
<td>• Denying to pay children’s school fees</td>
</tr>
<tr>
<td></td>
<td>• Refusing women to work</td>
</tr>
<tr>
<td></td>
<td>• Not leaving money or resources for the family’s upkeep</td>
</tr>
</tbody>
</table>

**Step 7:**
- *At the end of the role play, discuss possible outcomes of gender-based violence*
· List them on a flip chart
· Share and discuss Handout 2.3.3 on possible outcomes of GBV.

8. ACTION TO TAKE WHEN ONE IDENTIFIES ANY TYPE OF VIOLENCE – Brainstorming. Discussion (20 min)

Step 8:
- Discuss the action to take when you identify any type of violence (personal level and community support systems).
- Ask one of the participants to write down the responses on a flip chart.
- Trainer summarizes by adding missed information.

1. Communicate to the aggressor 'You don't want it'. One has to be assertive.
2. Report persistent harassment to relevant authorities e.g. police, parents, relatives, teacher, church elders' etc. If the authority does not act on your report, take it to higher authority or report it elsewhere. You report must be taken seriously.
3. Never keep or postpone secrets about any type of gender-based violence.
4. If abused by someone in authority, seek audience with a higher authority.
5. In a case of rape, timeous reporting is critical for the young person to receive Post Exposure Prophylaxis to prevent HIV infection (within 3 days of event) and emergency contraception for the prevention of pregnancy (within 5 days of event). Refer to the Protocol on the management of survivors of sexual violence.
6. Find out about shelters within the community so as to move away from the aggressor.
7. Seek counselling services if necessary.

NB: The Government is committed to protecting all against gender-based violence. It has ratified, enacted and is implementing several laws and policies such as: Human Rights, Children's Rights (1990), Reproductive Health Rights (1996), Child Protection Act, Sexual Offenders Act, Gender Act, Legal Age Of Consent, Legal Age of Majority Act (LAMA), Matrimonial Causes Act, Labour Relations Act, Immovable Property Act and Deceased Persons Family Maintenance Act, Domestic Violence Act and the Convention to Eliminate all forms of Discrimination Against Women (CEDAW).

9. CONCLUSION – Personal Reflections/Summary (10 min)

Step 9:
- Ask participants to volunteer sharing any important personal lessons learnt in the session.
- Summarise the experiences gained from the individual exercise
- Review the session objectives and summarise the main points on each objective.
A man and a son are driving down the high way in a yellow car. The man who is driving is a doctor - they have a terrible accident in which the man is killed and the son is badly injured. The son is rushed to the nearest hospital where he is taken to surgery. As he is lying there, the doctor is called to attend to him. The doctor takes one look at the boy and says NO, NO I CAN'T OPERATE. HE IS MY SON and walks out of the room.

Participants answer this question.

How can the injured boy be the doctor's son.
Handout 2.3.2
Gender Game

STATEMENTS ON GENDER and SEX

- In a study of 224 cultures, there were five in which men did all the cooking and 36 in which women did all the house building
- Men are naturally prone to violent behaviour
- ‘Real’ men must have wider sexual experience
- Boys must not cry even when they are hurt emotionally or physically
- Women are more vulnerable to sexually transmitted infections than men
- Men must have a male child in order to carry on with the family name
- Men are custodians of sexual decision making; women are not
Possible Outcomes of Gender Based Violence

VIOLENCE

FATAL OUTCOME
- Death/murder
- Suicide
- AIDS

Mental Health
- Low Self esteem
- Sexual risk taking
- Substance/alcohol abuse
- Anxiety/depression

Physical Health
- Injury
- Blindness
- Disability etc.

NON-FATAL OUTCOME

Sexual Reproductive Health
- STIs/HIV
- Unintended Pregnancy
- Pelvic Inflammatory Disease
- Abortion

STIs/HIV
- Unintended Pregnancy
- Pelvic Inflammatory Disease
- Abortion
SESSION 4 SUMMARY

MODULE II: Challenges Adolescents Face Today

SESSION 4: Adolescent Relationships

Time: 1 hour, 20 minutes

Objectives:
By the end of the session, participants will be able to:
- Identify the types of relationships that adolescents engage in
- Identify at least 4 circumstances that can lead to conflict between adolescents and their families, and cite ways to overcome or deal with them.
- Describe at least 3 ways in which adolescents can be helped to identify and refuse negative peer influences.
- Outline at least 3 strategies adolescents can employ to handle difficult situations and problems that may arise from dating.

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>5 min</td>
<td>Drawing</td>
<td>Paper, pens &amp; pencils</td>
</tr>
<tr>
<td>2. Introduction</td>
<td>10 min</td>
<td>Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>3. Kinds of Relationships</td>
<td>15 min</td>
<td>Brainstorm</td>
<td>Newsprint, markers</td>
</tr>
<tr>
<td>4. Families and Resolving Conflicts</td>
<td>15 min</td>
<td>Role Play</td>
<td>Flipcharts, markers</td>
</tr>
<tr>
<td>5. Dealing with Influences</td>
<td>15 min</td>
<td>Brainstorm</td>
<td>Flipcharts, markers</td>
</tr>
<tr>
<td>6. Stigma and discrimination</td>
<td>10 min</td>
<td>Role Play</td>
<td>Discussion</td>
</tr>
<tr>
<td>7. Conclusion and Summary</td>
<td>5 min</td>
<td>Drawing</td>
<td>Markers, paper</td>
</tr>
</tbody>
</table>

REFERENCES:


1. INTRODUCTION – Drawing, Discussion (5 min)

Step 1:

Tell participants that they will each draw 3 circles. One circle will represent them, another their friends and another their family. Tell them to think about how these 3 circles influence one another and their relative importance. Show them the following examples of how the circles might be drawn and tell them to label the circles they draw.

Ask why they think they were asked to do this exercise? Do participants’ drawings differ from one another? Do the differences or similarities among participants’ drawings surprise you? Ask them to keep their drawings for further discussion at the end of the session.

2. ADOLESCENT RELATIONSHIPS – Presentation and Discussion (10 min)

Step 2:

- Present the session objectives and introduce the topic of adolescent relationships within their immediate and extended family.
- Discuss how relationships within and between these circles work for each participant. Note that adults and young people may place and define the relationships between the circles differently and that this is to be expected, as is the conflict that sometimes arises.

The family, peers 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. It is natural for parents to want to protect their children from making poor decisions.

However, young people will eventually move out of the safe family orbit and strike out to find their own place in the world. What they need most from adults is to be helped and empowered -- not judged, as individuals to build healthy relationships. This is an important part of enabling growth and attaining a healthy sense of independence.

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.

3. KINDS OF RELATIONSHIPS – Brainstorming, Discussion (15 min)

Step 3:

- Brainstorm on the different kinds of relationships that adolescents have. Define these relationships and list important characteristics of these relationships. Note both positive and negative motivating factors.
- Discuss differences that might exist between adolescents’ and adults’ views. Develop short strategies to minimize these differences.
Next, ask the participants to list different activities that may occur within each kind of relationship.

Encourage the participants to cite all possible consequences and/or outcomes from the above cited activity, both negative and positive. Record responses.

Lastly, have the participants work in groups to develop various strategies that could be used to avoid each of the negative consequences cited above.

Kinds of Relationships

There are many different relationships that young people may explore. Dating is one type of relationship. It is different from courtship in that dating involves a couple socializing while in courtship the couple is preparing for marriage.

Family: Relationships amongst relatives and family members.

Friendships: Relationships with the same or opposite sex.

Dating: Socializing (either in groups, or as couples) with members of the opposite sex or same sex.

Courtship: To win affections or love of the opposite sex in preparation for marriage.

Activities within these Relationships

Different kinds of activities take place in different types of relationships.

Relationship: Dating

Activity: Engaging in sexual intercourse

Possible Consequences:

- Pregnancy or contracting a sexually transmitted infection
- Being chased away from home
- Losing respect; being mistrusted

Possible Strategies:

- Going to open, as opposed to private, places
- Playing games and other activities as groups
- Developing life-skills
- Respecting each other’s feelings
- Use of condoms and other contraceptives (dual protection)

Note: 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.

4. CONFLICTS WITHIN FAMILIES – Brainstorming, Role Play, Discussion (15 min)

Step 4:

- Brainstorm on various approaches to help young people, as well as adults (teachers, counsellors and parents) eliminate or lessen these causes. Emphasize that while there are dangers in granting too much freedom to youth, conflicts may also arise from not granting any, or enough, freedom. Adults (counsellors, teachers and parents) need to give young people both the responsibility and the opportunity to explore and make decisions, and live with the consequences, as well as to formulate family rules.
- Role play a situation where an adolescent wants to spend a night with friends who are unknown to his/her parents.
- Discuss how the conflict can be resolved.
In Zimbabwe there are different types of families. The nuclear family consists of father, mother and children. The extended family consists of a nuclear family and a relative or relatives.

The one parent family has a father or mother with children. There are also child headed families.

“The best thing you can learn from family members is how to make each other feel valued.”

In many families conflict between adults and young people arises from issues related to:

- Choices of friends (especially boy/girl)
- Coming home late
- Type of or level of music
- Clothing and appearance
- Activities (that they are forbidden to engage in)
- Choosing a future path and career in life

One way to help limit conflict is to decide which issues are most important. 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.

Family: Advice, support, counselling, primary socialisation

5. **DEALING WITH INFLUENCES – Role Play, Discussion (15 min)**

Step 5:

- Divide participants into three groups
- Ask Group 1 participants to list on a flip chart positive and negative influences that can affect adolescents from a family setting.
- Ask Group 2 to do a role play on positive and negative influences from peers that can affect adolescents.
- Ask Group 3 to brainstorm and list on a flip chart positive and negatives influences that can affect adolescents from information, communication and technology (ICTs).
- Groups present and have a discussion on the influences.
- List the identified influences on a flip chart. Add some from content below.

Emphasize the dilemmas that young people experience, as they grow up, especially in choosing and maintaining friendships. They are often torn between loyalties to their families and to their friends or peers.

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. Some adolescents experience teenage pregnancies, drug and alcohol abuse and involvement with gangs because of peer influences.

**Family Influences**

The family environment can be a strong source of support for developing adolescents, providing close relationships, strong parenting skills, good communication, and modelling positive behaviours. It can also be a problematic environment when those supports are lacking, or when negative adult behaviours like smoking and heavy drinking are present. Where adolescent health is concerned, clearly the family matters, and parents matter.

**Positive Influence**

*Family meals* serve as an important time for adolescents to communicate with and spend time with their parents, and have been associated with less drug and alcohol use, alcohol luse, delinquency, depressive
symptoms, and suicide attempts, and with better grades and academic performance. Adolescents who eat meals regularly with their parents are also more likely to eat fruits, vegetables, and dairy foods and less likely to skip breakfast.

Parents’ health-related behaviours can affect adolescent well-being in several ways including providing positive (or negative) role models and by contributing to healthy or unhealthy physical and social environments. Parental habits can also shape adolescent health behaviours by increasing easy access to cigarettes or alcohol in the home, or, on the positive side, increasing access to healthy foods.

Exercise - Adolescents whose parents exercise are themselves more likely to do so.

Parental monitoring includes knowing children’s whereabouts after school, as well as knowing children’s friends and activities, when combined with parental support, have been shown to be positively related to higher adolescent self-esteem and greater academic success.

Negative

Smoking - Children who live with someone who smokes are likely to inhale second-hand smoke, which increases their risk of developing health problems such as pneumonia, bronchitis, and other lung diseases, as well as increased asthma attacks and ear infections. In addition, living in a family with smokers places adolescents at a higher risk of developing the habit themselves, further increasing their chances of developing serious health problems.

Alcohol - Children who can easily access alcohol or who have alcoholic parents have a greater risk of developing their own problems with alcohol abuse, although other factors such as one’s peers also play a large role in determining whether an adolescent will abuse alcohol.

Some peer influences cause negative consequences, while many others are positive.

<table>
<thead>
<tr>
<th>Positive Peer Influences</th>
<th>Negative Peer Influences</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Reading</td>
<td>- Cheating on parents and/or teachers</td>
</tr>
<tr>
<td>- Physical exercise (athletics, soccer and other games)</td>
<td>- Stealing</td>
</tr>
<tr>
<td>- Arts and music</td>
<td>- Lying</td>
</tr>
<tr>
<td>- Fashion</td>
<td>- Taking health risks including:</td>
</tr>
<tr>
<td>- Prayer</td>
<td>- smoking</td>
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<td></td>
<td>- drinking</td>
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<tr>
<td></td>
<td>- early debut of sexual intercourse</td>
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<td></td>
<td>- drugs</td>
</tr>
</tbody>
</table>

7. STIGMA AND DISCRIMINATION- PRESENTATION/ DISCUSSIONS (10MIN)

Step 7:
- Display the words STIGMA and DISCRIMINATION
- Ask participants in groups to role play how one can be affected by stigma and discrimination
- Ask participants to brainstorm definition of stigma and discrimination.
- Present definitions from your prepared presentation.
- Discuss stigma and discrimination in relationships

Stigma is an ‘act of identifying, labeling or attributing undesirable qualities targeted towards those who are perceived as being “shamefully different” and deviant from the social ideal.’

Discrimination occurs when a distinction is made against a person that results in his/her being treated unjustly on the basis of their belonging or being perceived to belong, to a particular group.
Due to the stigma associated with HIV and AIDS and the discrimination that may follow the rights of the people living with HIV and AIDS and their families are frequently violated.

Stigma and discrimination in adolescent relationships
- Present a case of stigma and discrimination in adolescent relationship.
- Discuss the questions often asked by ALHIV – Kudzi’s story Adolescents Living with HIV. Handout 17 (Government of Zimbabwe, 2015, Lets Chat, PCC Community Level Training Manual on Parent to Child Communication on SRH for Zimbabwe, Ministry of Health and Child Care, Harare page 68)

8. CONCLUSION – Drawing Discussion (5 min)
Return to circle diagrams. Ask participants how they would change the diagram in order to construct any best relationship among the three circles for an adolescent. Ask for volunteers to share their ideas. Share the relationship circle below and discuss.

Relationships Circles
SESSION 5 SUMMARY

MODULE II: Challenges Adolescents Face Today

SESSION 5: Sexually Transmitted Infections and HIV

Time: 1hr 40 minutes

Objectives:
By the end of the session, participants will be able to:
• Define sexually transmitted infections, PPTCT, PMTCT, EMTCT, and HTS
• Describe 6 signs and symptoms of sexually transmitted infections (STIs).
• List at least 3 advantages of seeking early treatment for STIs.
• Explain 3 strategies for preventing STIs
• Describe at least 2 ways of preventing HIV.
• Explain the importance of adhering to treatment.
• Identify at least 2 types of disclosure
• Describe the relationship between HIV and other STIs.
• Identify the prevention priorities and support that service providers can offer adolescents living with HIV.

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>5 min</td>
<td>Presentation</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>2. Definitions</td>
<td>5 min</td>
<td>Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>3. Common STIs</td>
<td>30 min</td>
<td>Discussion/Role play</td>
<td>HO 1.4.1</td>
</tr>
<tr>
<td>4. HIV &amp; AIDS</td>
<td>35 min</td>
<td>Discussion/Role play</td>
<td>HO 1.4.2; HO 1.1.4 HO 1.4.3</td>
</tr>
<tr>
<td>5. Prevention Strategies</td>
<td>30min</td>
<td>Group work</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>6. Disclosing Status</td>
<td>30min</td>
<td>Plenary Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>7. ART</td>
<td>30 min</td>
<td>Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>8. Myths</td>
<td>10 min</td>
<td>Group work</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plenary Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>9. Conclusion</td>
<td>5 min</td>
<td>Discussion</td>
<td>Flip Chart and markers</td>
</tr>
</tbody>
</table>

REFERENCES

Government of Zimbabwe, 2015, Lets Chat, PCC Community Level Training Manual on Parent to Child Communication on SRH for Zimbabwe, Ministry of Health and Child Care, Harare

Government of Zimbabwe, 2016, Adolescents and young people living with HIV: a training module to complement the National Adolescent Sexual and Reproductive Health (ASRH) Training Manual for Service Providers


National HIV/AIDS Policy for Republic of Zimbabwe, 1999

SAFAIDS, WHO and IFRCRC, 2008. HIV Prevention, Treatment, Care and Support: A Training Package for Community Volunteers. International Federation of Red Cross and Red Crescent Societies.

The Population Council. 2009. It’s All One Curriculum: Guidelines and Activities for a Unified Approach to....
Sexuality, Gender, HIV and Human Rights Education. The Population Council, New York.


WHO 2015, Guidelines
1. **INTRODUCTION – Presentation (5 min)**

Step 1:
- Make a PowerPoint Presentation of session objectives.

2. **DEFINITIONS – Brainstorming, Discussion (5 min)**

Step 2:
- Brainstorm and discuss meaning of STIs.
- Define sexually transmitted diseases

Sexually Transmitted Infections (STIs) are diseases that are usually transmitted from an infected person to a partner during sexual intercourse.

This session is important as evidence has shown that adolescents (especially younger ones) are unaware of the existence of STIs apart from HIV, attribute their symptoms to other causes, experience only mild symptoms or none at all (more common among girls). Although younger adolescents are less likely to be infected with STIs/HIV than their older counterparts, because of their lower average levels of sexual activity (aside from those who were born HIV positive), some groups are at high risk, including girls and boys living on the streets or in situations of conflict, violence, young migrants and refugees and sexually trafficked youngsters. Cross-generational sex and early child marriage is also a risk.

3. **COMMON SEXUALLY TRANSMITTED INFECTIONS – Mini Lecture, Discussion (30 min)**

Step 3:
- Make a mini lecture on signs and symptoms of some sexually transmitted diseases
- Brainstorm and discuss the signs and symptoms of the different STIs
- Brainstorm vernacular and slang names for common STIs.
- Discuss some of the consequences of STIs for adolescents.

There are many STIs but we shall discuss a few which can easily be noticed. The period from the day when a person is infected to the day the signs and symptoms occur differs according to the type of STI. This period is referred to as Incubation Period.

<table>
<thead>
<tr>
<th>Types of STIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genital Ulcer</td>
</tr>
<tr>
<td>Syphilis</td>
</tr>
<tr>
<td>Chancroid</td>
</tr>
<tr>
<td>Herpes</td>
</tr>
<tr>
<td>Granuloma inguinale</td>
</tr>
<tr>
<td>Lymphogranuloma Venereum</td>
</tr>
</tbody>
</table>

**Signs and Symptoms**

The different STIs present different signs and symptoms. Some of these signs and symptoms are:
- Urethral Discharge
- Burning when passing urine
- Ulcers on genitals
- Pain in genitals
- Vaginal discharge that might be offensive
- Vaginal or vulval itches
- Lower abdominal pain in women
- Swelling and pain in the inguinal region
- Baby aged less than one month has discharging eyes
Management of STIs
For management of all these STIs, refer to the National Protocol and Guidelines or the Reproductive Health Manual.
- Encourage young people to seek STI treatment early
- Encourage adolescents to bring their partners for treatment
- Refer young people for treatment.

4. **HIV AND AIDS – Mini Lecture, Role Play and Discussion (2 hours)**

**Step 4:**
- Ask participants to brainstorm ways in which HIV is transmitted.
- Record responses and lead discussion on HIV and AIDS; what it is, the window period, and the signs and symptoms.
- Select participants to role play modes of transmission.
- Help participants identify behaviours that do not spread HIV.

HIV (Human Immunodeficiency Virus) is the virus that causes AIDS. It attacks the immune system – the body’s defence against disease. HIV is found in blood, breast milk, semen and vaginal fluids.

AIDS (Acquired Immuno Deficiency Syndrome) is the name given to a group of illnesses in HIV positive people. These are illnesses that arise when People Living with HIV are no longer able to fight off infection because of lowered immunity.

**Window Period**
It can take 3 months or longer for HIV to be detected in a person. During this period an infected person can infect any sexual partners before realizing that he or she has the HIV. The virus will continue to attack the body’s disease-fighting power. Without treatment, it can take 5 to 10 years for a person to develop symptoms of AIDS. During this period of time the infected person does not show any sign of a disease and looks healthy. There is a high risk of passing the infection to a sexual partner.

**Modes of Transmission of HIV**
- Through unprotected sexual intercourse with an infected person.
- Mother-to-Child Transmission - From an HIV infected mother to the unborn baby during pregnancy, labour and delivery, and breastfeeding.
- By use of infected needles, razor blades and other skin-piercing instruments which are not cleaned properly or sterilised.
- Through a blood transfusion from infected blood. However in Zimbabwe blood is screened for HIV and the risk is minimal.

**Myths of Transmission**
HIV cannot be transmitted through the following acts:
- Kissing and hugging
- Sharing cutlery
- Sharing the same toilet and baths
- Sitting together
- Working together
- Living in the same house
- Shaking hands
- Talking, sneezing or coughing
- Mosquito and other insect bites

However, persons caring for people living with HIV and AIDS at home need information to protect themselves.
Universal precautions should always be observed when dealing with blood.

**Opportunistic Infections/Conditions Associated with HIV and AIDS**

- **Tuberculosis** – is an opportunistic infection among people living with HIV and AIDS and is a major cause of death in this group.

- **Gullian Bar’s Syndrome** – This is paralysis of both lower limbs as a nervous disorder. The condition starts from feet and spreads upwards, resulting on the individual patient being unable to walk and finally completely paralysed.

- **Diarrhoea** – Diarrhoea that is chronic and persistent or intermittent. This condition results in loss of 10% or more of total body weight.

- **Herpes Zoster** – This is a nervous disorder. The same virus that causes chicken pox is the one that causes herpes zoster. The virus attacks a nerve and produces very painful shingles which may reoccur after healing.

- **Kaposi Sarcoma** – This is a cancer of the skin. It produces nodules and progresses fast and has no specific treatment.

- **Cryptococcal Meningitis** – This is a viral type of meningitis that usually infects the brain structures of an HIV positive person. It presents with severe headaches, neck stiffness and confusion and in severe cases with convulsions and unconsciousness.

- **Pneumonias** – Including Pneumosist Carini Pneumonia (PCP) – This is a lung infection and is usually fatal in People living with HIV.

- **Thrush** – This can be vaginal or oral thrush and is caused by fungal infection called candida abicans. It causes painful white patches inside the mouth and throat or in women it causes mild vaginal discharge.

**Factors Affecting Adolescent Exposure**

STIs present a major threat to the health of sexually active adolescents.

- Experimentation is a normal part of adolescent development, but it exposes them to risk
- Adolescent boys often feel they have to prove themselves sexually active.
- Adolescents’ sexual reactions are often unplanned, and sometimes, a result of coercion or force

Young girls are more vulnerable than young men because of biological factors, as well as social, cultural and economic factors. These sexual relations often occur typically before they have adequate information about STIs and lack experience and skills on how to protect themselves. Some of the consequences of STIs in adolescents include:

- Pelvic inflammatory disease
- Infertility
- Cancer of the cervix
- Stigma and discrimination

**Adolescents living with HIV**

In our communities, there are a number of adolescents living with HIV. There are two groups of adolescents living with HIV (defined by mode of transmission), whose needs may differ significantly. Some may be taking ARVs unknowingly, while others do not even know they are HIV positive. These adolescents require special attention when providing health services to address their special needs. These two groups of adolescents are:

- **Adolescents who acquired HIV perinatally**, during pregnancy, labour and delivery or post partum through breastfeeding. These adolescents may have been attending paediatric services since infancy, may be familiar with health services and have known their HIV diagnosis for many years. It is increasingly recognised that a large number of perinatally infected adolescents progress slowly, known as ‘slow progressors’. As they are
asymptomatic for many years, they may only come to the attention of health services when they are adolescents.

**Adolescents who acquired HIV during postnatal period and adolescence**, usually through sexual abuse, unprotected sexual intercourse or injecting drug use, or less frequently through an HIV positive blood transfusion, sharing instruments used for tattooing or skin piercing. These adolescents may have only recently learnt of their HIV status and generally have not had long contact with health services. Most adolescents come to health services because they feel unwell.

Many adolescents who acquired HIV during postnatal period and adolescence would be in WHO clinical staging 1 or 2 of the disease and may not yet feel unwell or need treatment. Many of them may not even know that they are infected with HIV. However, it is important that these adolescents make contact with health services so that they can receive prevention, care, treatment and support.

**Differences between two groups of adolescents living with HIV based on transmission period (perinatal and adolescence)**

<table>
<thead>
<tr>
<th>Differences Relating to:</th>
<th>Period When Acquired HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Perinatal</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>Younger: early adolescence</td>
</tr>
<tr>
<td><strong>Physical development</strong></td>
<td>Delayed: Shorter Stature</td>
</tr>
<tr>
<td><strong>Sexual and reproductive health</strong></td>
<td>Not yet sexually active</td>
</tr>
<tr>
<td></td>
<td>Thinking about sex</td>
</tr>
<tr>
<td></td>
<td>Sexual debut</td>
</tr>
<tr>
<td><strong>Relationships/Married</strong></td>
<td>No/May be</td>
</tr>
<tr>
<td></td>
<td>Wanting Intimate</td>
</tr>
<tr>
<td></td>
<td>Relationship</td>
</tr>
<tr>
<td><strong>Disclosure</strong></td>
<td>To adolescent, if he/she does not yet know the diagnosis</td>
</tr>
<tr>
<td></td>
<td>Peers</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family Support</strong></td>
<td>Orphan</td>
</tr>
<tr>
<td></td>
<td>Living with Caregivers</td>
</tr>
<tr>
<td><strong>Antiretroviral Therapy</strong></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Adherence may be a problem as an adolescent, not as a child</td>
</tr>
<tr>
<td><strong>Stigma/&quot;Blame&quot; for HIV</strong></td>
<td>Less likely – generally viewed as &quot;victims&quot;</td>
</tr>
</tbody>
</table>

**Note:** The purpose of this table is to highlight some of the most common differences between the two transmission groups and their needs. These are generalisations and may not refer to all adolescents.

**ASRH Needs for Adolescent living with HIV (Refer to Handout 1.4.3)**
- HIV testing and counselling
- Issues of parents/guardian consent and confidentiality.
- Beneficial disclosure and continued counselling
- ART – use of the Tanner Scale to determine whether adolescent receives paediatric dose of ARVs or adult dose. Adolescents who are at Tanner Scale 1, 2 and 3 are pre-pubertal and should be treated with paediatric doses of ARVs, while those in 4 and 5 should be treated with an adult dose (refer to Tanner Scale HO 1.1.4)
- Monitoring and management of side effects
- Drug adherence
- Relationships and disclosure
- Pregnancy, antenatal care, labour and delivery, postnatal care and infant feeding – (EMTCT).
- Post abortion care
- Contraception especially dual contraception
- Psychosocial support – siblings, parent/guardians, peers, treatment buddy and support groups
- Referral to support systems (e.g. support groups especially those led by peers who have successfully implemented and adhered to ART themselves)
- Access to information

It is anticipated that an increasing number of adolescents living with HIV will seek health services in the future. This can be attributed to the following factors:
- With successful ART and care, more children with perinatally acquired HIV are surviving to adolescence.
- More adolescents are being tested for HIV, as a result of factors such as provider initiated testing and counselling, increased awareness, voluntary testing, and increasing availability of antiretroviral therapy (ART) providing a reason to be tested.
- More adolescents who are pregnant are being tested as services for preventing mother to child transmission (EMTCT) become more widely available.

As the stigma of living with HIV lessens and the understanding of HIV increases, more adolescents will come forward for testing, treatment and care.

The Relationship between STIs and HIV
Concentrating on the prevention and treatment of STIs, rather than just focusing on HIV infection and AIDS, has a number of advantages:
- Infection with other STIs, in particular those that cause sores in or around the sexual parts, makes it easier for a person to get HIV.
- HIV affects the response to treatment of STIs (making them difficult to treat and slow to heal).
- HIV changes the signs of some STIs making it difficult to identify them.

Controlling the spread of HIV infection includes preventing and controlling STIs.

HIV TESTING SERVICES (HTS)

Step 6:
- Discuss HIV testing services (HTS) and its approaches
- Discuss PMTCT

HIV testing services is an entry point to prevention, treatment, care and support. It allows clients to make informed decisions.

All HIV testing services should be provided within WHO's essential 5Cs: Consent, Confidentiality, Counselling, Correct test results and Connection (linkage to prevention, care and treatment).

This includes pre-test information, post-test counselling, linkage to appropriate HIV prevention, care and treatment services and other clinical and support services, quality HIV testing, accurate test results and diagnosis, and coordination with laboratory services to support quality assurance.

HTS approaches include:
- Voluntary Counselling and Testing (VCT) - initiated by the client at his own free will
- Provider Initiated Testing and Counselling (PITC) - Provider initiated testing, but clients have to give their consent before testing.

Indications of HTS
Anyone who wants to know his/her HIV status.
Anyone with a chronic condition not responding to treatment.
Anyone with repeated infections.
Those referred by their doctors or relatives.
As a requirement for insurance or employment in other countries.
Compulsorily for sexual offenders.
Following accidental needle prick for health providers, etc
PITC – target all people visiting health institutions empowering the health workers with information to make informed decision on HIV testing and counselling. It is a population based strategy (Refer to PITC module).
It is mandatory in rape cases and organ transplants

Prevention of Mother-to-Child Transmission
HIV can be passed on from an infected mother to her child before birth, during delivery or while breastfeeding. Prevention of mother to child transmission of HIV (PMTCT) is an intervention aimed at reducing the risk of baby/child getting the infection from the mother.

In all the provinces in Zimbabwe, there are some hospitals and clinics offering PMTCT services to pregnant women on a voluntary basis. To reduce the chances of men resisting PMTCT, social mobilisation campaigns have been launched leading to the intervention being renamed - prevention of parent to child transmission of HIV (EMTCT).

5. STRATEGIES OF PREVENTING STIs and HIV – Group Work, Discussion (10 min)

Step 7:  
- Brainstorm the high-risk behaviours that may lead adolescents into contracting STIs/HIV
- Discuss the magnitude of the problem with participants sharing their experiences from their community.
- Explain the relationship between STIs and HIV, emphasizing that there is no cure for HIV and AIDS.
- Discuss prevention strategies of HIV for adolescents.

A number of strategies can be employed in order to achieve ‘Zero’ new STI/HIV infections.
- A - abstinence
- B - be faithful to one mutual partner
- C - correct and consistent use of condoms
- D - delay early sexual debut
- E - early treatment of STIs
- F - frank discussions about sex /HIV and AIDS
- G - get real by getting tested
- M - Male Circumcision
- P - Prevention of Mother to Child Transmission
- T – Treatment as prevention: ARVs lower the amount of HIV in the body, reducing the chances of transmitting to an uninfected partner

AIDS has no cure.

Prevention
The spread of HIV infection can be prevented by:
- Abstaining from sex.
- Having one mutually faithful uninfected partner.
- Correct and consistent use of condoms
- Avoiding the use of or sharing of unsterilized needles and syringes.
- Avoiding sharing razor blades and ear-piercing instruments that cut the skin.

6. **VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC), PEP AND PREP – Video, Discussion (30 min)**

**Step 6:**
- Define VMMC, PEP and PrEP as prevention methods
- Show video on VMMC
- Discuss benefits of VMMC, PEP and PrEP as HIV prevention methods
- Use handout 1.4.3

Male circumcision is the surgical removal of some or the entire foreskin (prepuce) from the penis. The WHO currently recommends circumcision as part of a comprehensive program for prevention of HIV transmission in areas with high endemic rates of HIV. Male circumcision reduces HIV transmission from HIV infected females to males by 60%.

**Benefits of VMMC**

- Easier hygiene. Circumcision makes it simpler to wash the penis
- Decreased risk of urinary tract infections
- Decreased risk of sexually transmitted infections including HIV
- Prevention of penile problems
- Decreased risk of penile cancer.

Male circumcision provides only partial protection, and therefore should be only one element of a comprehensive HIV prevention package which includes:

- The provision of HIV testing and counselling services;
- Treatment for sexually transmitted infections;
- The promotion of safer sex practices; e.g. promotion of male and female condoms use.

Refer adolescents who want to know more about circumcision to the following centres:

- Spilhaus, at the Zimbabwe National Family Planning Council Centre in Harare
- The Eye Clinic situated at the Old Memorial Hospital, Bulawayo
- Mutare Provincial Hospital
- Karanda Hospital in Mt Darwin
- All Provincial and District Hospitals
- And any other identified centres in different provinces and districts at the time of training.

**Post Exposure Prophylaxis (PEP) - Brainstorming**

Post-exposure prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. Within the health sector, PEP should be provided as part of a comprehensive universal precautions package that reduces staff exposure to infectious hazards at work.

Please note that PEP is a specialized prevention service which is used only under certain conditions. Adolescents and youth have to be educated about its side effects before use.

**Pre-exposure Prophylaxis (PrP) - Brainstorming**

PrEP means - Pre-Exposure Prophylaxis, and it’s the use of anti-HIV medication that keeps HIV negative people from becoming infected. PrEP is approved by the FDA and has been shown to be safe and effective. A single pill taken once daily, it is highly effective against HIV when taken every day. The medication interferes with HIV's
ability to copy itself in your body after you've been exposed. This prevents it from establishing an infection and making you sick.

It's usually administered to people who are mostly at risk.

7. DISCLOSING HIV STATUS – DEMONSTRATION/ VIDEO (30MIN)

Step: 7
- Identify at least 2 types of disclosure.
- Understand that disclosure is a process and its therapeutic
- Comprehend key considerations when providing pre-disclosure support for adolescents and young people living with HIV
- List the key considerations when providing post-disclosure support for adolescents and young people living with HIV
- Use Kudzi’s story Handout 17 (Government of Zimbabwe, 2015, Lets Chat, PCC Community Level Training Manual on Parent to Child Communication on SRH for Zimbabwe, Ministry of Health and Child Care, Harare page 68)

Health care providers may find themselves facing personal, ethical and legal dilemmas when counselling young people with HIV in relation to disclosure. However, an approach that respects the experiences, wishes and confidentiality of that young person is essential. Young people require support for both the pre and post disclosure process in a range of ways.

8. ANTI-RETROVIRAL THERAPY (ART) - Role Play, Posters and discussion(10min)

Step 8:
- Define ART
- Identify the steps for initiating ART
- State the key points on ART
- Discuss Antiretroviral Medications and Hormonal Contraceptive Agents

IMAI states that for all patients living with HIV, there are seven requirements for initiating ART at the health centre.

1. HIV infection confirmed by written documentation
2. Medical eligibility
3. Patient fits criteria to be started on ART at the first-level facility
4. Any opportunistic infection has been treated/stabilized
5. Patient is ready for ART
6. Supportive clinical team prepared for chronic care
7. Reliable drug supply.

Treatment and care for adolescents living with HIV
These same seven requirements also apply to adolescent patients.
- readiness for ART
- adherence preparation
- mental health (more information in IMAI-IMCI Basic HIV care with ART and prevention guideline module, page H28)
- Need for support

It is also important to review previous prescriptions and the adolescent’s adherence record as a way of identifying personal strengths or weaknesses. The health worker needs to become aware of the circumstances of
an adolescent’s life and discuss which regimen could provide the “best fit”, based on dosage requirements and the side effects profile.

When the health worker and the adolescent have decided to start therapy, a period of actual drug-taking skills-building begins. The adolescent can try tasting the agents in the proposed regimen first and be advised on how to mask the flavour. Some adolescents may need training to learn how to swallow the larger pill sizes.

Key points on Antiretroviral Therapy (ART)

- There are seven requirements in IMAI to initiate ART at the health centre for all patients living with HIV. The same requirements apply equally to adolescents.
- The choice of regimen and dosing (adult or paediatric) of ART should be based on the adolescent’s sexual maturity rating using the Tanner scale. Those who are at Tanner scales 1, 2 and should be given a paediatric regimen and those who are at Tanner scales 4 and 5 should be prescribed an adult regimen.
- In choosing an appropriate regimen, there is a need to think beyond the Tanner scale. Simplification and anticipated long-term adherence are further important criteria for selecting an appropriate first-line regimen for adolescents.

With adolescents, the health worker should be especially attentive to:
- readiness for ART
- adherence preparation
- mental health
- family and other support.

Antiretroviral Medications and Hormonal Contraceptive Agents

The clinical significance of these drug interactions has not been evaluated thoroughly, but may cause oral contraceptive failure, ARV failure, or medication toxicity, depending on whether drug levels are lowered or raised by the interacting drug. The consequences of decreased hormone levels may include an increased risk of pregnancy, so an alternative or additional method of contraception is commonly recommended. The consequences of decreased ARV levels may include virologic failure and development of resistance mutations. The consequences of a higher level of hormones may include risk of thromboembolism, breast tenderness, headache, nausea, and acne.

REFERENCE:
IMAI One-day Orientation on Adolescents Living with HIV 2010
IMAI-IMCI Basic HIV care with ART and prevention, 8.1, pages H25-26).

9. MYTHS ABOUT STIs - Discussion (5 min)

Step 9:
- Ask participants to discuss myths on STIs in their community.

Some of the myths include:
- A man cannot transmit a sexually transmitted infection (STI) if he withdraws before ejaculation.
- A monogamous person cannot contract an STI.
- If you have an STI once, you become immune to it and cannot get it again.
- Herbal treatments are effective in curing STIs.
- Special medicines can cure HIV infection.
- HIV is a disease that affects only sex workers and homosexuals.
• A man can be cured of HIV by having sex with a girl who is a virgin

10. **CONCLUSION - Discussion (5 min)**

Step 10:
• Summarize the session by emphasizing the need to promote abstinence among adolescents, delayed sexual debut, safer sex for those sexually active and early treatment and partner notification in case of an STI.
• Review objectives of the session. Ask the group to share how they would utilise this information.
Common Sexually Transmitted Infections (STIs)

Sexually Transmitted Infections (STIs) are usually spread from an infected person to a partner during sexual intercourse. While some are spread only through sexual intercourse, others can be spread in other ways. These infections mainly affect the reproductive organs, and with the culture of silence on reproductive matters STIs can be difficult to talk about.

Some common infections are:
- Gonorrhoea
- Chancroid
- Syphilis
- Genital Herpes
- Genital Warts
- HIV
- Trichomonas Vaginalis
- Thrush/Candidiasis
- Pubic Lice

Signs and Symptoms: Any abnormality in the genital area should be treated. Most signs are easily noticed in men due to the position of their organs, but signs may be absent or difficult to detect in women.

Major signs include:
- Ulcers, sores, bruises, wounds or rash on the genitalia.
- Discharge from the vagina or penis (women have a normal discharge from the vagina which is colourless, odourless, non-itchy and not heavy. Any deviation should be investigated).
- Pain in urinating.
- Pain in the reproductive organs.
- Growth on or around the reproductive organs.
- Lower abdominal pain.
- Lower backache.

Treatment Compliance: If those with STIs seek treatment early, most STIs can be treated and cured. Delaying makes the infection more difficult to treat and allows time for infecting partners. Be open with the health care provider, as misinformation can result in your getting the wrong treatment. Finish all the medication even when signs and symptoms disappear. Use condoms with all sexual partners until you are completely cured. Advise all sexual partners to seek treatment. Go for review even if you feel very well.

Prevention: All STIs are preventable, and it is your duty to protect yourself and the ones you love.
- Abstain from sexual intercourse.
- Stick to one uninfected, mutually faithful partner.

Condoms for males or females greatly reduce the risk of getting STIs if they are used correctly and consistently.

REMEMBER!
Some STIs are curable, but all STIs are preventable.

Preventing the spread of sexually transmitted infections is everyone’s responsibility.
AIDS means Acquired Immuno Deficiency Syndrome. It is a condition where the power in the body to fight against infection (immunity) is weakened. The germ (virus) which causes AIDS is called HIV (Human Immunodeficiency Virus). AIDS has no cure.

Window Period: It can take 3 months or longer for the AIDS virus to be detected in a person. During this period an infected person can infect any sexual partners before realizing that he or she has the HIV. The virus will continue to attack the body’s disease-fighting power. It can take 5 to 10 years for a person to develop symptoms of AIDS. During this period the infected person looks completely healthy but is continuously infectious.

Modes of Transmission of HIV
- Through sexual intercourse with an infected person.
- Through a blood transfusion from infected blood. However in Zimbabwe blood is screened for HIV.
- From infected mother to her child during pregnancy, labour and delivery and breast feeding.
- By use of infected and not properly cleaned needles, razor blades and other skin-piercing instruments.

What happens when a person has developed AIDS
- HIV has no obvious signs or symptoms.
- Weight loss.
- Chronic diarrhoea.
- Fever for long durations
- Hair becomes thin, scanty and shiny.
- May get TB which is difficult to cure.
- Skin diseases and rashes.
- Other opportunistic infections.

Prevention: The spread of HIV infection can be prevented by:
- Abstaining from sex.
- Having one mutually faithful uninfected partner.
- Correct and consistent use of condoms all the time during sexual intercourse
- Avoiding the use of or sharing of unsterilized needles and syringes.
- Avoiding sharing razor blades and ear-piercing instruments that cut the skin.

The HIV virus CANNOT be spread through kissing and hugging; sharing cutlery; sharing the same toilet and baths; sitting together; working together; living in the same house; shaking hands; talking, sneezing or coughing nor mosquito and other insect bites. However, persons caring for people living with HIV at home need information to protect themselves.

THE RELATIONSHIPS BETWEEN STIs AND HIV: Concentrating on the prevention and treatment of STIs, rather than just focusing on HIV infection and AIDS, has a number of advantages:
- Infection with other STIs, in particular those that cause sores in or around the sexual parts, makes it easier for a person to get HIV.
- HIV affects the response to treatment of STIs (making them difficult to treat and slow to heal).

HIV changes the signs of some STIs making it difficult to identify them. Controlling the spread of HIV infection is linked to preventing and controlling STIs.

HIV TESTING SERVICES (HTS)
An HIV prevention intervention normally initiated by the client and entered by the client’s free will. It is the opportunity for the client to confidentially expose and understand his or her HIV risks and to learn his or her HIV status. HTS helps clients to make informed decisions.

**Indications of HTS**
- Anyone who wants to know their HIV status.
- Anyone with a chronic condition not responding to Post Test Counselling
- Anyone with repeated infections.
- Those referred by their doctors or relatives.
- As a requirement for insurance or employment.
- Compulsory for sexual offenders.
- Following accidental needle prick for health providers, etc.

**PMTCT:** HIV can be passed on from an infected mother to her child before birth, during delivery or while breastfeeding. Prevention of mother to child transmission of HIV (PMTCT) is an intervention aimed at reducing the risk of baby/child getting the infection from the mother.

In all the provinces in Zimbabwe, there are some hospitals and clinics offering EMTCT services to pregnant women on a voluntary basis. To reduce the chances of men resisting PMTCT, social mobilisation campaigns have been launched leading to the intervention being renamed - prevention of parent to child transmission of HIV (PPTCT)

**Opportunistic Infections/Conditions**
- Tuberculosis; Gullian Bar's Syndrome; Diarrhoea;
- Herpes Zoster; Karposi Sarcoma; Cryptococcal Meningitis
- Pneumonias including PCP; Thrush;

**Creating a Referral Network**
- The client should be informed about other services in the community which offer further counselling.
- If the client is positive, should be referred to AIDS support groups for further counselling and support.
- Trainers to be knowledgeable on AIDS policy and home based care policy and discharge policy.

**Accepting and Coping with HIV Status**
- Support – should come from family, social groups, fellowshipping, peer – HIV Positive
- Living positively – clients should get adequate nutrition, clean water, counselling to reduce stress.
- Risk education – clients should be educated on behaviour change, disclosure of status, HTS, use of condoms.
- Create awareness on the programme.
- Counsel pregnant mothers on HTS to help them have options of breastfeeding.
- Creating awareness on availability of anti-retroviral drugs and their significance on the prevention of parent to child transmission of HIV/AIDS.
- Promotion of safe motherhood i.e. pregnant youths to attend antenatal care at health institutions.
Adolescents Living with HIV

Special challenges in providing Prevention, Treatment, Care and Support for Adolescents living with HIV

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Adolescents who acquired HIV perinatally</th>
<th>Adolescents who acquired HIV during adolescence</th>
</tr>
</thead>
</table>
| Beneficial disclosure      | • If not yet discussed, disclosure to adolescent  
• Peers                                                                                   | • Need support to tell chosen family members and friends  
• Will benefit from others knowing so they can get support  
• Fear of stigma/blame                                                                 |
| Positive prevention        | • Not yet sexually active  
• Preparing for sexual activity  
• Wanting sexual relations and pregnancy in the future                                          | • Already sexually active  
• Changes in health risk behaviour(s)  
• Wanting marriage and children  
• Need life skills, peer support                                                                 |
| Consent & confidentiality  | • Living with family/guardian  
• No longer a compliant child  
• Needs to start taking responsibility for own treatment                                            | • Legal position on age of consent  
• Concern about confidentiality  
• Desire for independence and need for support                                                                 |
| Transition of care         | • Paediatric to adolescent                                                                                | • Adolescent to adult                                                                                       |
| ART and adherence          | • Choice of regimens  
• Adherence: no longer a child                                                                    | • When to begin ART  
• Choice of regimen  
• Adherence                                                                                     |
| Antiretroviral therapy     | • Yes  
• Adherence may be a problem as an adolescent, not as a child                                        | • Probably not yet needed  
• When taking ARVs: adherence may be a problem                                                             |
SESSION 6 SUMMARY
MODULE II: Challenges Adolescents Face Today

SESSION 6: Adolescents and Contraception

Time: 1 hour, 20 minutes

Objectives:
By the end of the session, participants will be able to:
- Define contraception.
- State at least 2 reasons why it may be necessary for adolescents to use contraceptives.
- List at least 8 methods of contraception that adolescents can use.
- Discuss contraceptive options for Adolescents Living with HIV
- State at least 3 advantages and 3 disadvantages of each method of contraception for adolescents.
- List at least 5 sources where adolescents can obtain contraceptives.

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>5 min</td>
<td>Role play</td>
<td>Rehearsed role play</td>
</tr>
<tr>
<td>2. Definitions</td>
<td>5 min</td>
<td>Presentation</td>
<td></td>
</tr>
<tr>
<td>3. Why Adolescents may need Contraceptives</td>
<td>15 min</td>
<td>Group work Discussion</td>
<td>Flipchart, markers</td>
</tr>
<tr>
<td>4. Methods of Family Planning</td>
<td>30 min</td>
<td>Group Work Demonstration</td>
<td>HO 1.5.1; HO 1.5.2 HO 1.5.3, Condoms, Models for condom demonstration</td>
</tr>
<tr>
<td>5. Sources of Contraception</td>
<td>10 min</td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>6. Myths</td>
<td>10 min</td>
<td>Exercise, Discussion</td>
<td>Survey</td>
</tr>
<tr>
<td>7. Conclusion</td>
<td>5 min</td>
<td>Review Questions</td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES


1. **INTRODUCTION – Role Play, Discussion (5 min)**

**Step 1:**
- Have 2 participants already prepared to enact a brief role play.
- An adolescent girl shyly approaches a provider for contraceptives. The provider is rude to her, and she leaves without a method.
- Lead participants into the next discussion and present session objectives

2. **DEFINING CONTRACEPTION – Brainstorming, Discussions (5 min)**

**Step 2:** Define contraception

**Definition on Contraception:**
The intentional prevention of conception through the use of various devices, sexual practices, chemicals, drugs, or surgical procedures. This means that something (or some behaviour) becomes a contraceptive if its purpose is to prevent a woman from becoming pregnant. There are several types of contraceptives that have been officially labelled as such because they have shown reliability in preventing conception from occurring.

3. **REASONS ADOLESCENTS MAY FIND CONTRACEPTIVES NECESSARY – Group Work, Discussion (30 min)**

Adolescents can be categorized into 3 groups:

1. Those who are still virgins, not yet begun sexual activity.
2. Those who have had sexual intercourse but have not yet experienced any problems.
3. Those who have engaged in sex and have experienced problems e.g. unintended pregnancy, STI, HIV and AIDS, school dropouts.

**Step 3:**
- Divide participants into 3 groups (to represent virgins, sexually active sex but no problems and sexually active and have experienced problems).
- Discuss which of the 3 groups would need contraception and why.
- Ask participants to discuss some of the reasons why it may be necessary for young people to use contraceptive methods.
- Record responses on flip chart and discuss.
- Ask participants to discuss when adolescents should receive contraceptives.

Based on discussions from the group, highlight that adolescents who are sexually active may require contraception to:
- avoid unintended pregnancies
- avoid unsafe abortion.
- avoid sexually transmitted infections (STIs) including HIV.
- emergency contraception

Emergency contraception, which is also called the “morning-after pill,” is a birth control measure that, if taken after sexual intercourse, may prevent pregnancy. If a woman has unprotected sexual intercourse or a condom failure, she can take a regimen of pills within 120 hours that will prevent pregnancy. **NB:** Service providers need to emphasise that this is not a form of contraception to be used on a regular basis and should be kept only for emergency situations.

4. **METHODS OF FAMILY PLANNING – Presentation, Demonstrations and Discussion (30 min)**

**Step 4:**
- Ask participants to name the different methods of contraception and list them on a flip chart. If
any contraceptive methods are not named, add them to the list.

- Ask participants to help tick the methods most suitable for adolescents (including those living with HIV) and discuss why.
- Lead a discussion on the methods. Definition of the method; mode of action and effectiveness; advantages and disadvantages and side effects to adolescents, including those living with HIV: Refer to HO 1.5.1.
- Conduct condom demonstration exercises for both male and female on models – also give an opportunity for participants to demonstrate

Family Planning Methods
- Abstinence
- Condom (male & female)
- Combined pill
- Progestogen only pill
- Intra-uterine device (IUD)
- Implants
- Injectables
- Diaphragm
- Voluntary surgical contraception such as tubal ligation and vasectomy.
- Spermicides - foams, creams, pessaries,

Highlight the methods that can be combined for dual protection and emphasize the importance of dual protection in protecting against pregnancy and the transmission of HIV and other STIs.

5. SOURCES OF CONTRACEPTION – Discussion (10 min)

Step 5:
- Ask participants to list different places where adolescents can obtain methods of contraception. List the sources on a flip chart.
- Lead discussion on sources of contraceptives for adolescents.

Sources for Contraception
- Health Facilities (Clinics/hospitals)
- Pharmacies (only condoms)
- Private doctors/nurses/midwives
- Family planning centres
- Youth corners and centres
- Community Based Health Workers, e.g. CBDs
- Supermarkets (only condoms)

Highlight that all contraceptive methods except condoms are to be initiated by a health personnel. Trained non-medical personnel such as Community Based Distributors (CBDs) can also initiate young people on contraceptives like pills, and spermicides. Encourage young people to obtain contraceptives from reputable sources.

6. MYTHS – Discussion (10 min)

Step 6:
- Discuss myths adolescents have about how to prevent pregnancy that may stop them from seeking contraception.

Young people believe that pregnancy can be prevented by:
- douching with Coca Cola after sex.
- having sex while standing.
- taking strong black tea.
- jumping up and down after sex to push sperms out.

However, these are myths and not facts, and unprotected sex (without a real contraceptive) can cause pregnancy.

7. CONCLUSION – Review Objectives (5 min)

Step 7:
- Ask participants to share a few cases from their communities.
- Summarize the session by discussing the importance of counselling adolescents for contraception.

Emphasize that only abstinence protects the user from contracting sexually transmitted infections (STIs) including HIV. Condoms reduce the risk of contracting STIs/HIV and unintended pregnancies. Adolescents need to be adequately counselled to make an informed decision about using contraceptives. Also emphasise that dual contraception for adolescents living with HIV is vital for prevention of both unintended pregnancies and STIs.
**Contraceptive Options for Adolescents**

Adolescents who choose to be sexually active need dual protection:
- Protection against STIs/HIV
- Protection against unintended pregnancy

Contraceptive Options for Adolescents:
- Promote abstinence
- Fertility Awareness Methods
  - Difficult for adolescents if cycle is irregular
  - **Unreliable method for adolescents**
- Coitus interruptus - usually ends up as coitus ‘almostus’ interruptus.
  - Adolescents may find it difficult to practice interruptus.
  - **Unreliable method for adolescents**

**Condoms**
- Ideal for all who are sexually active
- Proper use should be taught using models
- Requires adolescent to predict acts of intercourse and have condoms available
- **Recommended for adolescents**

**Diaphragm**: Prone to cause pain during intercourse and it requires adolescent to predict acts of sexual intercourse and have it ready. **May suit adolescents**

**Oral Contraceptives (Pills)**: Safe to use after menarche and tends to regulate irregular periods
- COCs cause withdrawal bleeding if not taken properly
- POPs may cause spotting
- Failure increased among adolescents due to missed pills
- Conditions requiring precautions are rare in adolescents
- **Recommended for adolescents**

**Injectables**: Delayed return to fertility is common; more than half the youth will become amenorrhoeic (have no periods); experience irregular menses, weight gain and acne. **Recommended for adolescents**

**Implants**: Cause amenorrhoea common, irregular menses and weight gain and acne are common and may not be acceptable to adolescents. **Recommended for adolescents**

**Intra Uterine Devices (IUDs)**: Only recommended if there is no risk of STIs/HIV. Insertion must be done by trained health personnel. **Recommended for adolescents**

**Voluntary Sterilisation**: Not recommended for adolescents

**Emergency Contraception**: This is the use of high doses of oral contraceptives to prevent pregnancy after unprotected sexual intercourse. **Recommended for adolescents in emergency situations only**.

**NB**: Although these methods or the recommended methods for adolescents have been named above, the need for dual protection should be emphasized.

**WHO Technical Statement Hormonal contraception and HIV:**

16 February 2012; WHO/RHR/12.08
[http://whqlibdoc.who.int/hq/2012/WHO_RHR_12.08_eng.pdf](http://whqlibdoc.who.int/hq/2012/WHO_RHR_12.08_eng.pdf)
Following new findings from recently published epidemiological studies, the World Health Organization (WHO) convened a technical consultation regarding hormonal contraception and HIV acquisition, progression and transmission. The meeting was held in Geneva between 31 January and 1 February 2012, and involved 75 individuals representing a wide range of stakeholders.

**General Recommendations:**

All evidence was reviewed carefully, and there was extensive discussion of the interpretation and implications of the results. The group considered the strength of the epidemiological and biological data, possible implications for country programmes, taking into account the need for HIV prevention, and the risk of unintended pregnancy on maternal mortality and pregnancy-related morbidity. Most concern focused on the relationship between progestogen-only injectable contraception and risk of HIV acquisition in women. In considering the totality of available evidence, the group determined that currently available data neither establish a clear causal association with injectables and HIV acquisition, nor definitively rule out the possibility of an effect. The group agreed that use of hormonal contraceptives should remain unrestricted if a strong clarification was added to the Medical Eligibility Criteria (MEC), which reflected the difficulties the group had with the data, the need for an enhanced message about condom use, for both male and female condoms, and other HIV prevention measures, and the need for couples to have access to as wide a range of contraceptive methods as possible. A clear recommendation was also made on the need for further research on this issue and an undertaking to keep emerging evidence under close review.

Thus, the expert group determined that women at high risk of HIV or living with HIV, can continue to use all existing hormonal contraceptive methods (Category 1) (oral contraceptive pills, contraceptive injectables, patches, rings, and implants), but that a strong clarification (as detailed above) relating to the use of progestogen-only injectables be added for women at high risk of HIV. Overall, women should receive correct and full information from their health-care providers so that they are in a position to make informed choices.

**Recommendations for women at high risk of HIV infection:**

- Women at high risk of HIV can continue to use all existing hormonal contraceptive methods without restriction.
- It is critically important that women at risk of HIV infection have access to and use condoms, male or female, and where appropriate, other measures to prevent and reduce their risk of HIV infection and sexually transmitted infections (STIs).
- Because of the inconclusive nature of the body of evidence on progestogen-only injectable contraception and risk of HIV acquisition, women using progestogen-only injectable contraception should be strongly advised to also always use condoms, male or female, and other preventive measures. Condoms must be used consistently and correctly to prevent infection.

**Recommendations for women living with HIV infection:**

- Women living with HIV can continue to use all existing hormonal contraceptive methods without restriction. (Make reference to Session 7 on Anti Retroviral Treatment: on page
- Consistent and correct use of condoms, male or female, is critical for prevention of HIV transmission to non-infected sexual partners.
- Voluntary use of contraception by HIV-positive women who wish to prevent pregnancy continues to be an important strategy for the reduction of mother-to-child HIV transmission.
# Contraceptive Chart

<table>
<thead>
<tr>
<th>GROUP</th>
<th>TYPE</th>
<th>DEFINITION</th>
<th>HOW IT WORKS</th>
<th>EFFECTIVENESS RATE</th>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
<th>SIDE EFFECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural Methods</td>
<td>Abstinence</td>
<td>A state of not having sexual intercourse.</td>
<td>No sexual intercourse occurs</td>
<td>100%</td>
<td>No cost, Natural, Morally acceptable, Avoids STIs/HIV, Avoids unwanted pregnancy</td>
<td>NIL</td>
<td>NIL</td>
</tr>
<tr>
<td>Barriers</td>
<td>Male Condom</td>
<td>A thin rubber sheath that covers the erect penis</td>
<td>Prevents sperm from entering the vagina during the sexual intercourse</td>
<td>98%</td>
<td>No examination required before use, Cheap and easily available, Allows male responsibility for contraception, Prevents spread of STI/HIV</td>
<td>Can tear or slip off if not worn properly, Some may feel it will interfere with sex act</td>
<td>Allergy to rubber</td>
</tr>
<tr>
<td></td>
<td>Female Condom</td>
<td>A strong soft plastic sheath inserted into the vagina</td>
<td>Same as male condom</td>
<td>98%</td>
<td>Non-irritating, Non-hormonal, Does not interfere with a woman’s monthly cycle, Protects against STIs/HIV and pregnancy</td>
<td>May be oily, May be noisy</td>
<td>Allergy to poly-urethane (plastic)</td>
</tr>
<tr>
<td></td>
<td>Diaphragm</td>
<td>A shallow rubber cap that is put in the vagina to cover the cervix</td>
<td>Prevents sperms from entering the vagina</td>
<td>97%</td>
<td>Protects against some STIs, Decreases risk of cervical cancer, Effective when used properly, No systemic medication involved</td>
<td>High failure rate, Needs sustained motivation, May interfere with sexual act, Requires trained provider for measurement</td>
<td>Allergies to rubber, Can promote urinary tract infections</td>
</tr>
<tr>
<td></td>
<td>Spermicides</td>
<td>Foams, creams, pessaries or jellies inserted into the vagina before intercourse</td>
<td>Kill sperms in the vagina</td>
<td>97%</td>
<td>Easy to insert, Can be used by anyone, No prescription needed, Can be inserted just before intercourse, No systemic effect, May protect against cervical cancer</td>
<td>May interfere with sexual act, May be messy, Must be used before each act, Needs sustained motivation, High failure rate</td>
<td>Allergies to spermicides, May cause sensation of heat to woman or partner</td>
</tr>
<tr>
<td>GROU P</td>
<td>TYPE</td>
<td>DEFINITION</td>
<td>HOW IT WORKS</td>
<td>EFFECTIVENESS RATE</td>
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<td>DISADVANTAGES</td>
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<td>------------------------------------------------</td>
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<td>---------------------------------------------</td>
</tr>
<tr>
<td>Oral Contraceptives</td>
<td>Pills</td>
<td>These are hormonal pills women take daily by mouth</td>
<td>Prevent the release of the ripe egg from the ovary.</td>
<td>99.9% (COC)</td>
<td>Decrease amount of bleeding during a period</td>
<td>COC decreases milk supply in breast-feeding mothers</td>
<td>Weight gain, Headache, Nausea and vomiting, Irregular bleeding patterns, Missed periods</td>
</tr>
<tr>
<td></td>
<td>Combined Oral Contraceptives (COC)</td>
<td></td>
<td>Blackens the cervical mucus.</td>
<td>99.5% (POP)</td>
<td>Cheap, easily available</td>
<td>Needs sustained motivation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Progestogen Only Pill (POP)</td>
<td></td>
<td>Prevent the inner lining of the womb from thickening in preparation for pregnancy</td>
<td></td>
<td>Easy to take</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Does not interfere with sex act</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Reversible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable</td>
<td>Depo-Provera® Noristerate®</td>
<td>Injectable contraceptive that contains hormone similar to that in the woman's body</td>
<td>Prevent the release of the ripe egg from the ovary.</td>
<td>99.7%</td>
<td>Very effective</td>
<td>Requires qualified persons for injection</td>
<td>Weight gain, Headache, Irregular periods, Loss of libido</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Blackens the cervical mucus.</td>
<td></td>
<td>Long-acting</td>
<td>Needs medical supervision</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Prevent the inner lining of the womb from thickening in preparation for pregnancy</td>
<td></td>
<td>Private</td>
<td>Delays return to fertility</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Easy to use</td>
<td>Lack of period</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Reversible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implants</td>
<td>Jadelle®</td>
<td>Two thin capsules filled with a hormone inserted under the skin of the woman's upper arm</td>
<td>Prevent the release of the ripe egg from the ovary.</td>
<td>99.8%</td>
<td>Immediate effectiveness</td>
<td>Needs to be inserted and removed by a trained person</td>
<td>Irregular bleeding patterns, Weight gain</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Blackens the cervical mucus.</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td>Highly effective</td>
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<td></td>
<td></td>
<td>Private</td>
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</tr>
<tr>
<td></td>
<td>Implanon</td>
<td>Implanon is a one (1) rod implant which is inserted under the skin in the inner aspect of the upper arm. It lasts over 3 years.</td>
<td>Prevent the release of the ripe egg from the ovary.</td>
<td>99.8%</td>
<td>Immediate effectiveness</td>
<td>Implanon</td>
<td>Irregular bleeding patterns, Weight gain</td>
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</tr>
<tr>
<td>Intra Uterine Device</td>
<td>Copper T® Multi-load®</td>
<td>Plastic device with copper which is inserted in the woman’s uterus</td>
<td>Prevents sperms and egg from meeting and implanting Copper ions on IUD weaken the sperm</td>
<td>99.9%</td>
<td>Very effective Last long Reversible Fewer check-ups Used for woman who cannot use hormones</td>
<td>Needs to be inserted by a trained person Not good for people at risk of STIs/HIV</td>
<td>Heavy bleeding for first 3 months Cramps Spotting Backache</td>
</tr>
<tr>
<td>Permanent Methods</td>
<td>Tubal ligation (Females) Vasectomy (Males)</td>
<td>Tying and cutting of tubes of a woman or man to prevent pregnancy.</td>
<td>Prevents sperm from meeting the women egg (ovum).</td>
<td>100%</td>
<td>Very effective Permanent One lifetime procedures</td>
<td>Irreversible Small operation required Required trained personnel. Men do not become sterile immediately.</td>
<td>Bleeding from site Infection Pain</td>
</tr>
</tbody>
</table>
TIPS ON CONDOM USE

CONDOM USE
• Use a condom every time you have intercourse to ensure that the female adolescent does not get pregnant and you do not infect each other with an STI.

PRECAUTIONS
• Use each condom only once. For repeated sexual intercourse, you must use a fresh condom.
• Do not use petroleum jelly as it might cause the rubber to tear.
• Store condoms in a cool dry place.
• Do not expose condoms to sunlight or heat as these can damage the rubber.
• Examine the plastic condom packet for tears or holes expiry date before use:
  i. if the packet is broken
  ii. if the colour is uneven or changed.
  iii. if the condom is unusually sticky.
• Discard the condom and obtain a new one.
• Wash hands after using condoms.

Dual Protection
• Using spermicides in addition to condoms increases the effectiveness of condoms.

IF PROBLEMS ARISE
• If you have problems, return to the health centre, CBD, or Peer Educator, even if you still have your supply of condoms.
• Return to the clinic if you or your partner is dissatisfied with the method.
SESSION 7 SUMMARY

MODULE II: Challenges Adolescents Face Today

SESSION 7: Adolescent Fertility

Time: 1 hour

Objectives:
By the end of the session, participants will be able to:
- define ANC
- identify signs and symptoms of pregnancy
- list the benefits of early booking and services offered during ANC.
- Describe the components of and list the advantages of institutional delivery
- Define postnatal period and postnatal care.
- List the benefit of postnatal care
- define the term abortion
- outline pre-disposing factors that lead to abortion
- list complications and consequences of abortions and preventive methods
- identify post abortion care services
- Explore myths and misconceptions around abortions
- Identify the legal statutes/instruments on abortion

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<tbody>
<tr>
<td>1. Introduction</td>
<td>5 min</td>
<td>Lecture</td>
<td>Computer, LCD</td>
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<tr>
<td></td>
<td>5 min</td>
<td>Discussion</td>
<td>Flip charts, markers</td>
</tr>
<tr>
<td>2. Antenatal Care</td>
<td>10 min</td>
<td>Presentation and Discussion</td>
<td>Flip charts, markers</td>
</tr>
<tr>
<td>3. Labour and delivery</td>
<td>10 min</td>
<td>Presentation and Discussion</td>
<td>Flip charts, markers</td>
</tr>
<tr>
<td>4. Post Natal Care</td>
<td>10 min</td>
<td>Presentation and Discussion</td>
<td>Flip charts, markers</td>
</tr>
<tr>
<td>5. Abortion</td>
<td>20 min</td>
<td>Presentation and Discussion</td>
<td>Flip charts, markers</td>
</tr>
<tr>
<td>6. Conclusion</td>
<td>5 min</td>
<td>Group Work</td>
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</tbody>
</table>

REFERENCES:
Government of Zimbabwe, Ministry of Health and Child Care – Reproductive Health Unit, September 2012 Basic Emergency Obstetric and Newborn Care

Government of Zimbabwe, Ministry of Health and Child Care – Reproductive Health Unit, Focused Antenatal care

Government of Zimbabwe, Ministry of Health and Child Care – National Guidelines for Comprehensive Abortion Care in Zimbabwe second edition

Government of Zimbabwe, Ministry of Health and Child Care – Reproductive Health Unit, National Post natal care guidelines Caring for the mother and newborns

1 ANTENATAL CARE

Step 1
- define ANC
- identify signs and symptoms of pregnancy
- list the benefits of early booking.
- list the services offered during ANC.

What is Antenatal Care (ANC?)
Antenatal care is the care given to a pregnant woman from the time conception is confirmed until the beginning of labour.

Aim of Antenatal care
The aim of antenatal care is to monitor the progress of pregnancy to optimize maternal and fetal health. Therefore the midwife or health service provider critically evaluates the physical, psychological and sociological effects of pregnancy on the woman and her family.

Signs and symptoms of pregnancy/ Change and adaptation which occur during pregnancy
Anatomical and physiological adaptations occurring throughout pregnancy affect virtually every body system

a) Physiological changes in the reproductive system
- Menses stops / amenorrhea.
- Uterus start to increase in shape and size
- The cervix
- The vagina - increase in blood flow to the vagina results in a bluish purple coloration of the vagina, there is increase in volume of vaginal secretions, there is also increase in vaginal acidity.

b) Changes in the cardiovascular system.
- The heart - increase in size shifted upwards and to the left.
- Cardiac output increases
- Arteries – dramatic systemic and pulmonary vasodilation to increase blood flow.
- Capillaries – increased permeability.
- Veins – vasodilation and impeded venous return in lower extremities.
- Blood – Haemodilution, increased capacity for clot formation.

c) Changes in the respiratory system.
- The respiratory changes can be extremely uncomfortable and may lead to dysnoea, dizziness and altered exercise tolerance.

d) Changes in the central nervous system
- Various hormonal and mechanical influences promote insomnia leading to disturbed sleep during pregnancy.

e) Changes in the urinary system
- Urinary incontinence.
- Asymptomatic bacteriuria

f) Changes in the gastrointestinal system.
- Ptyalism.
- Nausea and vomiting
- Pica
- Heartburn
- Abdominal distension
- Constipation and haemorrhoids.

g) Changes in metabolism.

h) Maternal weight
- Weight gain

i) Musculoskeletal changes
• Back pain.

j) Skin changes

• Hair growth

k) Changes in the endocrine system

**Benefits of early booking**

Pregnant women are supported to access antenatal care ideally by 12 weeks gestation. The first booking is defined as the initial assessment.

**Objectives or benefits of early booking**

- To build the foundation for trusting relationship in which the woman and midwife/health care worker are partners in care.
- To assess health by taking a detailed history and offering appropriate screening test.
- To ascertain baseline recordings of blood pressure, urinalysis, blood values, uterine growth and fetal development to be used as a standard for comparison as the pregnancy progress.
- To identify risk factors by taking accurate details of past and present midwifery, obstetric, medical, family and personal progresses.
- To provide an opportunity for the woman and her family to express and discuss any concerns they might have about the current pregnancy and previous pregnancy loss, labour, birth and puerperium.
- To give public health advice pertaining to pregnancy in order to maintain the health of the mother and fetus.
- To make appropriate referral where additional healthcare or support needs have been identified.

Tampons are thin rolls of cotton and/or other fibres that are placed in the vagina to absorb menstrual flow. Attached to one end of the tampon is a string that extends through the vagina and hangs outside the vulva. The string is gently pulled to remove the tampon after use. Toxic shock syndrome is a rare occurrence that can result if a tampon is left in place for too long.

**Facial Care:**

Blackheads occur when the adolescents’ glands produce extra oil that clogs pores in the skin. If blackheads are not removed, oil continues to back up in the oil gland below the pore, causing pressure and inflammation. If germs get into the pore, pimples can develop. Teens who have blackheads often find help from using a mild soap. Keeping the skin clean and free of excess oil is the

2. **LABOUR AND DELIVERY**

**Step2:**

- *Describe the components of institutional delivery.*
- *List the advantages of institutional delivery*

Approximately 85% of women sustain some degree of perineal trauma following vaginal birth. Morbidity in the short and long term following trauma and repair can lead to major physical, psychological, sexual and social problems affecting the woman’s ability to care for her newborn baby and other members of the family hence the importance for institutional delivery were there will be skilled attendance.

**Aims of institutional delivery**

- Protect the life of the mother and newborn
- Support normal labour and detect and treat complications in a timely fashion
- Support and respond to needs of the woman, her partner and family during labour and childbirth

3. **POSTNATAL CARE (PNC)**

**Step 3**
• Define postnatal period and post natal care.
• List the number of Post natal care
• List the benefit of post natal care

Definition of postnatal period/puerperium/postpartum

• It is a period which starts immediately after birth of the placenta and membranes and continues for 6 weeks. These three terms (Post natal period, puerperium and postpartum) are used interchangeably.

Definition of postnatal care

It is the care offered to a woman and her infant during the postnatal period.

A large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery. Therefore, prompt postnatal care (PNC) is important for both the mother and the neonate to treat complications arising from the delivery as well as provide the mother with important information on how to care for herself and her child.

Timing of postnatal care.

• First hour
• Day One
• Day three
• Day seven
• Six weeks

What does postnatal care involve?

➢ PNC is likely to include the routine and specific clinical examination and observation of the mother and her baby.
➢ Education and empowerment of mother and her immediate family.
➢ Assist mother and family to establish infant feeding.
➢ Do investigations such as HIV, RPR if these were not done especially for unbooked mothers who presents in advanced labour or those who deliver at home.
➢ Dealing with specific postnatal conditions or complications like post-partum hemorrhage (PPH), Post-partum eclampsia,
➢ Early identification and treatment of infant postnatal conditions like neonatal jaundice,
➢ Assist mother commence on contraceptive method of choice.
➢ Offering cervical cancer screening.

4 ABORTION

Step 4:

• define the term abortion
• outline pre-disposing factors that lead to abortion
• list complications and consequences of abortions and preventive methods
• identify post abortion care services
• Explore myths and misconceptions around abortions
• Identify the legal statutes/instruments on abortion

Definitions of abortion

Abortion is the termination of pregnancy before the foetus can have independent existence (viability)

There are 2 broad types:

• Spontaneous abortion [miscarriage] which follows some pathological condition in either the woman or the conceptus.
• Induced abortion: intentional termination of the pregnancy by the woman or another person. May be either “safe” or “unsafe”.

Trimester

- 1st trimester – up to 12 weeks gestation (weeks of pregnancy)
- 2nd trimester – from 13 to 28 weeks
- 3rd trimester – from 29 to 40 weeks

Illegal versus unsafe abortion - Handout 2.7.1

- Unsafe abortion is defined by WHO as "a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both"
- Abortion can be illegal, but safely provided

5. CONCLUSION (5mins)
Step 5:
Summarise and conclude.
HANDOUT 2.7.1

ABORTION AND POST ABORTION CARE

Conditions under which abortions may occur

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<tr>
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<th>LEGAL ABORTION</th>
<th>ILLEGAL ABORTION</th>
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<tbody>
<tr>
<td>SAFE</td>
<td>Performed by trained and skilled persons in an environment not lacking minimal medical standards</td>
<td>Performed by trained and skilled persons in an environment not lacking minimal medical standards</td>
</tr>
<tr>
<td>LESS SAFE</td>
<td>Performed by trained and skilled persons in an environment lacking minimal standards</td>
<td>Performed by persons lacking necessary skills in an environment not lacking minimal medical standards</td>
</tr>
<tr>
<td>UNSAFE</td>
<td>Performed by persons lacking necessary skills in an environment lacking minimal medical standards</td>
<td>Performed by persons lacking necessary skills in an environment not lacking minimal medical standards</td>
</tr>
<tr>
<td>VERY UNSAFE</td>
<td>Performed by persons lacking necessary skills in an environment lacking minimal medical standards</td>
<td>Performed by persons lacking the necessary skills in an environment lacking minimal medical standards</td>
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</table>

Abortion methods
- Manual vacuum aspiration (MVA)
- Electric vacuum aspiration (EVA)
- Dilation & Evacuation (D&E)
- Dilation & Curettage (D&C)
- Medical Abortion (MA)

Second trimester abortions
- Second trimester abortions (after the 12th week of gestation) are harder for women’s bodies to tolerate.
- They usually require a 2 day stay at a facility because the cervix must be dilated before the abortion can be performed.
- Doctors may use misoprostol to soften the cervix before the surgical intervention; in this case, the misoprostol is not the abortion method

Post abortion complication
- Complications from an abortion (spontaneous or induced) that are severe enough to need treatment in a health facility
  - Include not only extreme cases such as those with sepsis or perforated uterus, but also cases termed “incomplete abortions,” usually identified by heavy bleeding
  - Does not include threatened abortions

Post abortion complication (PAC) care
Post abortion complications (PAC) care may include the following five elements:

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<tbody>
<tr>
<td><strong>1.</strong></td>
<td><strong>Treatment</strong> of incomplete and unsafe abortion and complications</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td><strong>Counselling</strong> to identify and respond to women’s emotional and physical health needs</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td><strong>Contraceptive and family-planning services</strong> to help women prevent future unwanted pregnancies and abortions</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td><strong>Reproductive and other health services</strong> that are preferably provided on-site or via referrals to other accessible facilities</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td><strong>Community and service-provider partnerships</strong> to prevent unwanted pregnancies and unsafe abortions, to mobilize resources to ensure timely care for abortion complications, and to make sure health services meet community expectations and needs</td>
</tr>
</tbody>
</table>

Post Abortion Care- Who and where?
- Post abortion complications care can be provided at any facility with the necessary equipment and staffed with a PAC-trained provider
- Providers trained in PAC are those who:
  - Can administer D&C, EVA, MVA or misoprostol
  - Can recognize abortion complications, diagnose and treat
  - May also provide antibiotics of IV fluids if other treatment not necessary
- Complete necessary investigations (e.g. FBC/x match blood)

Abortion and contraception in Zimbabwe

Abortion is only legal under limited circumstances in Zimbabwe under the Termination of Pregnancy Act of 1977:
- When the life or physical health of the woman is endangered
- When the child may suffer a permanent physical or mental defect
- When the fetus was conceived as a result of rape or incest.
SESSION 8 SUMMARY

MODULE II: Challenges Adolescents Face Today

SESSION 8: SRHR and HIV Linkages and Integration

Time: 1 hour, 10 minutes

Objectives:
By the end of the session, participants will be able to:
- discussing why it is necessary to link SRHR and HIV
- describe the benefits of linkages and integration
- describe the factors that promote linkages and integration
- describe the factors that hinder linkages and integration
- brainstorming session on Linkages and Integration at service delivery level.

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<td>5 min</td>
<td>Lecture</td>
<td>Computer, LCD</td>
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<tr>
<td>2. Key Definitions</td>
<td>5 min</td>
<td>Brainstorming</td>
<td>Flip charts, markers</td>
</tr>
<tr>
<td>3. Historical perspective in relation to SRHR and HIV linkages</td>
<td>5 min</td>
<td>Lecture</td>
<td>Flip charts, markers</td>
</tr>
<tr>
<td>4. The benefits of linking SRHR and HIV</td>
<td>10 min</td>
<td>Groupwork</td>
<td>Flip charts, markers</td>
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<tr>
<td>5.</td>
<td>20 min</td>
<td>Discussion</td>
<td>Flip charts, markers</td>
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<tr>
<td>7. Integrated SRH and HIV services available for young people</td>
<td>5 min</td>
<td>Discussion</td>
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</tr>
<tr>
<td>6. Conclusion</td>
<td>5 min</td>
<td>Discussion</td>
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REFERENCE:
Adolescents AND YOUNG PEOPLE living with HIV: A training module to complement the National Adolescent Sexual and Reproductive Health (ASRH) Training Manual for Service Providers
1. INTRODUCTION - Lecture (5min)

Step 1:
- Introduce the session by discussing why it is necessary to link SRHR and HIV

The importance of linking HIV and AIDS as a part of sexual and reproductive health and rights (SRHR) is abundantly clear: the majority of HIV cases in Zimbabwe about 92% are sexually transmitted and both HIV and AIDS and many illnesses linked to SRHR have the same root causes. The greater proportion of pediatric HIV infections is spread from mother-to-child in the process of pregnancy, childbirth, and breastfeeding. In Sub-Saharan Africa, the majority of new HIV cases are among women and girls, a major target of SRH services. Despite these overlaps, HIV and SRH services have been historically separate and uncoordinated. The parallel financing and health service infrastructure for HIV and AIDS was developed in response to the urgent call to address the AIDS crisis and the global health community’s understanding of the disease over three decades ago.

2. KEY DEFINITIONS - Brainstorming and Discussion (5min)

Step 2:
- Ask participants to brainstorm the meaning of Bi-directionality, Linkages and integration.
- Record responses that best describe integration on a flip chart and discuss
- Present session objectives

Bi-directionality: Refers to linking both SR with HIV-related policies and programs and HIV with SRH-related policies and programs.

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 example. It is based on the need to offer comprehensive health services. For the clients, integration means health care that is seamless, smooth flowing and easy to navigate. Users want a coordinated service that minimizes both the number of stages in an appointment and the number of visits required to a health facility.

3. HISTORICAL PERSPECTIVE IN RELATION TO SRHR AND HIV LINKAGES – Lecture (5 min)

Step 3:
- Briefly discuss key events (global, Regional and Sub-regional) that led to SRHR and HIV Linkages

The international community has evolved considerably in its understanding of HIV and AIDS in the last three decades. A number of events took place globally, regionally and sub-regionally which led have led to the
- In September 1994, the International Conference on Population and Development (ICPD) established that the effective prevention and treatment of sexually transmitted diseases, including HIV, is an integral part of reproductive health services.
- Numerous meetings have been held since that landmark conference that has issued important position statements that appeal for international action.
- All confirm the international community’s commitment to intensify the linkages between SRH and HIV and recognize the need to consider the sexual and reproductive health and rights (SRHR), needs, and desires of people living with HIV/AIDS (PLWHA).
- Pioneered by both the May 2004 Glion Call to Action on Family Planning and HIV & AIDS in Women and Children and the New York Call to Commitment: Linking HIV and AIDS and Sexual and Reproductive Health, June 2004. The fundamental linkages were articulated and human rights were enshrined as the corner stone of this joint response.
In 2006, African Union adopted the 'Maputo Plan of Action', calling on countries to “strengthen commitment to achieving universal access to Sexual and Reproductive Health Services, including Family Planning.”

- **Key strategy:** Integrating STI/HIV/AIDS and Sexual and Reproductive programs and services including reproductive health cancers to maximize the effectiveness of resource utilization and attain a synergetic complementary of the two strategies.

- During the 2008 International AIDS Conference in Mexico City, in the absence of a vaccine, a case was made to put prevention at the forefront of HIV and AIDS. Experts recognized that the pandemic cannot be defeated without effective prevention.
  - The international community agreed that the health related Millennium Development Goals (MDGs) would not be achieved without ensuring access to SRH services and an effective global response to the HIV epidemic.
  - Reinforcing and scaling up linkages between HIV and SRH was viewed critical for the achievement of the health related Millennium Development Goals namely: 4 (Reducing child mortality); 5 (Improving maternal health) and 6 (Reducing new HIV infection)
  - Since no single strategy was sufficient, a portfolio of all possible biomedical, behavioral, and structural interventions, including those from the field of SRH, were needed to combat the epidemic in what is currently being termed “combination prevention”.

- In 2011, UNGASS High-level Meeting: target # 10 - Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts.

### 4 THE BENEFITS OF LINKING SRHR AND HIV - Group work and plenary (15 min)

**Step 4:**
- Ask participants to do the following group work. Divide participants into three groups and instruct them to work on the following topics:
  
  **Group I:** Describe the benefits of linkages and integration
  **Group II:** Describe the factors that promote linkages and integration
  **Group III:** Describe the factors that hinder linkages and integration

- Ask each group to assign chairperson who moderates the discussion and a rapporteur who report on their group findings. Provide each group with flip chart and Markers to present their responses.
- Allow 5 minutes for the groups to finalize the group work.
- Allow each group to present their responses in plenary in 5 minutes
- Summarize the discussion after each presentation

The Benefits of SRH and HIV Linkages and Integration

Integrating services are now seen as a key strategy for overcoming missed opportunities of meeting the needs of overlapping target populations in HIV prevention and SRH services. Moreover, there is widespread recognition that strengthening linkages between HIV and SRH programs could lead to a number of important public health, socio-economic, and individual benefits:

<table>
<thead>
<tr>
<th>Benefits of Linkages</th>
<th>HIV and SRH Integration</th>
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<tr>
<td>Improved access to and uptake of key HIV and SRH services</td>
<td>Decreased duplication of efforts and competition for scarce resources</td>
</tr>
<tr>
<td>Better access of people living with HIV to SRH services tailored to their needs</td>
<td>Mutually reinforcing complementarities in legal and policy frameworks</td>
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<tr>
<td>Reduction in HIV-related stigma and discrimination</td>
<td>Enhanced program effectiveness and efficiency</td>
</tr>
<tr>
<td>Improved coverage</td>
<td>Better utilization of scarce human resources</td>
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</table>
Upholding human rights is intrinsic to the linkages agenda, in particular the human rights of people living with HIV, key populations, and young women and girls. SRHR and HIV related stigma and discrimination against vulnerable people such as young person – in particular young women and girls, and marginalized groups prevent them from attaining basic rights.

Factors Promoting or Inhibiting Effective Provision of Integrated ASRH Services

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<tr>
<th>Promoting Factors</th>
<th>Inhibiting Factors</th>
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<tbody>
<tr>
<td>Positive attitudes and good practices among providers and staff</td>
<td>Lack of commitment from stakeholders</td>
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<tr>
<td>Ongoing capacity building</td>
<td>Non-sustainable funding</td>
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<td>Involvement of the community and government during planning and implementation</td>
<td>Understaffed facilities, low morale and high turnover of staff., inadequate training,</td>
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<tr>
<td>Simple, easily applied additional services which add no costs to existing services</td>
<td>Inadequate infrastructure, equipment, and commodities</td>
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<td>Non-stigmatizing services</td>
<td>Lack of male partner participation</td>
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<tr>
<td>Male partner inclusion</td>
<td>Women not sufficiently empowered to make SRH decisions</td>
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<tr>
<td>Engagement of key population</td>
<td>Cultural and literacy issues</td>
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<td>Adverse social events/ gender based violence incidence</td>
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<td>Poor programme management and supervision</td>
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<td>Stigma preventing clients from utilizing services</td>
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Tell participants that the purpose of the role play is to ensure that participants are able to demonstrate that they are able to link the services.

Tell the participants that they will role play for 5 minutes and they will get feedback from colleagues on whether they were able to link SRH and HIV and any other observations.

5. INTEGRATED SRH AND HIV SERVICES AVAILABLE FOR YOUNG PEOPLE Discussion – (15 min)

Step 5:

- Lead a brainstorming session on Linkages and Integration at service delivery level. To guide the discussion, ask the following questions:
  - Which SRHR and HIV services for youth are you currently integrating at service delivery level?
  - What lessons did you learn from the provision of these integrated SRHR and HIV services to the young people?
  - Note the responses for the two questions on the flipchart.
  - Discuss with the participants any areas that need noting.
  - Show the slide (below) with the SRH and HIV services that are available for the youth at the various health facilities. Allow the participants to comment on availability of these methods at their facilities.
- Ask participants to add other services which they think have been left out.

6. MODELS OF PROVIDING INTEGRATED SRH AND HIV SERVICES- Brainstorming and discussion (15 Min)

Step 6.1:
- Introduce the session so that participants understand what is being referred to as models or approaches of offering integrated SRHR and HIV services for young people

Determining the optimal model for integrating services depends on a variety of factors. To date, successful methods of service integration have captured the ground realities faced by a variety of service providers. From delivering all SRHR and HIV services by one provider to providing selected high quality health and other services through innovative partnerships. The success of many integrated SRHR and HIV services rests on the quality and effectiveness of referrals. Facilitated referrals need to be strengthened to ensure that many of the opportunistic illnesses related to HIV are addressed, including tuberculosis, malaria and SRHR concerns such as infertility and cervical cancer are made priorities in HIV services.

Step 6.2:
- Ask participants to brainstorm on the different approaches or models of offering integrated SRHR and HIV services for young people that they know.
- Define the models and list the characteristics of each of the models.
- Ask participants to identify models that they think are applicable at the various facilities eg. Rural Clinic, Urban primary care clinic, Rural Hospital, Mission hospital, District hospital, Provincial hospital and Central hospital.
- Ask participants on the factors that determine service delivery approach within a model and discuss
- Ask participants to discuss some of the missed opportunities in the provision of ASRH

Models of providing integrated SRH and HIV for youth

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.

What determines service delivery approach within a model?
- Infrastructure – multiple and well equipped consultation rooms
- Health care worker attitudes – willingness to provide HIV related services, and the quality of the interpersonal communication
- Change of mindset and willingness to change practices towards provision of linked and integrated services.
- Patient load in relation to health care worker availability
- Capacity of health care workers to provide all services

Missed Opportunities:
- Integration of SRHR and HIV services for key populations
- Cervical cancer screening for young women in HIV care and treatment clinics
- Family planning in HIV care and treatment clinics
- Lifelong ART for pregnant women
- Gender based violence prevention and Counselling in HIV care and treatment clinics
Meeting the sexual and reproductive health needs of a diverse group of young people. For example - the varied SRH desires of young people living with HIV; issues facing young people living with HIV as they embark on new relationships (disclosure; potential sexual rejection because of HIV status, etc.) and sexual health priorities of young sex workers.

7. ROLE PLAYS (25 Min)

Step 7.1:
- Ask participants to work in their groups and prepare role plays
- Group 1: A girl aged 17 years is seeking some contraceptives
- Group II: A boy aged 19 years wants VMMC
- Group III: Young Couple (the lady aged 18 is living with HIV). The gentleman is 22 and they have come for Counselling on what to do since they are in a serious relationship and are considering marriage

Step 7.2
- Ask if there are any last questions or comments on SRH and HIV linkages and Integration
- Ask participants to indicate what they plan to do at their health facility to manage patient flow in order to enhance provision of integrated SRHR and HIV services for adolescents
- Ask participants to indicate how they plan to meet the SRHR and HIV service needs of vulnerable and key populations e.g adolescents living with HIV, young sex workers, adolescents living with disability etc.
- Review session objectives
SESSION 8 SUMMARY

MODULE II: Challenges Adolescents Face Today

SESSION 9: Stress

Time: 1 hour, 10 minutes

Objectives:
By the end of the session, participants will be able to:
- Define stress.
- List at least 5 factors that may cause stress.
- Identify the signs and symptoms of stress.
- Identify ways of helping adolescents to prevent and reduce stress.
- List 5 complications of stress

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</tr>
<tr>
<td>3. Stressful Experiences</td>
<td>10 min</td>
<td>Brainstorm</td>
<td>Flip charts, markers</td>
</tr>
<tr>
<td>4. Predisposing Factors</td>
<td>10 min</td>
<td>Discussion</td>
<td>Flip charts, markers</td>
</tr>
<tr>
<td>5. Signs and symptoms</td>
<td>10 min</td>
<td>Brainstorm and discussion</td>
<td>Flip charts, markers</td>
</tr>
<tr>
<td>6. Stress Management</td>
<td>20 min</td>
<td>Brainstorm</td>
<td>Flip charts, markers</td>
</tr>
<tr>
<td>7. Complications of Stress</td>
<td>5 min</td>
<td>Group Work</td>
<td></td>
</tr>
<tr>
<td>6. Conclusion</td>
<td>5 min</td>
<td>Discussion</td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES


http://dying.about.com/od/glossary/g/stress.htm

1. **INTRODUCTION – Presentation (5 min)**

   **Step 1:**
   - *Introduce the session objectives and ask participants if they would like to add any to the list.* (Be prepared, as trainers, to respond to these additions)

2. **DEFINITION OF STRESS – Presentation, Discussion (5 min)**

   **Step 2:**
   - *Present through PowerPoint or writing on a flip chart the definition of stress.*
   - *Discuss the definition of stress.*
   - *Ask participants if they agree with the definition.*

   Stress is the body’s reaction to a change that requires a physical, mental or emotional adjustment or response. Simply put, stress is any outside force or event that has an effect on our body or mind. Stress can come from any situation or thought that makes you feel frustrated, angry, nervous, or anxious.

3. **STRESSFUL EXPERIENCES - Brainstorming, Discussion (10 min)**

   **Step 3:**
   - *Ask the participants to think of the last few times they felt stressed and make a list of the situations.* (Note: Participants should imagine they are adolescents and narrate stressful experiences that relate to adolescents.)
   - *Brainstorm and add to this list stressful situations specific to adolescents.*
   - *Group these situations according to different types of stress (i.e. physical, emotional, mental etc.).*

   Explain that an event that may be stressful to one person may not necessarily be so to another. People react differently to various situations. What is important is that we identify potentially stressful situations and help young people identify and develop ways to deal with these situations so that they can be stronger, not weaker individuals because of them.

4. **PREDESPOSING FACTORS THAT CAN LEAD TO STRESS - Brainstorming, Discussion (10 min)**

   **Step 4:**
   - *Brainstorm and discuss predisposing factors that cause of stress.*
   - *Emphasize the differences between wants and needs—particularly as they relate to stressful conditions the participants have listed.*

   There are pre-disposing factors that may lead to stress, such as:
   - Emotional/personal problems
   - Traumatic experiences (violence, rape, abuse)
   - Death of a family member or friend
   - Economic hardships e.g. lack of money
   - New environments or situations, changes in places of work, living situation, family situation
   - Unemployment

5. **SIGNS AND SYMPTOMS – Brainstorming, Discussion (5 min)**

   Stress may manifest itself in either or both physical and emotional signs.
<table>
<thead>
<tr>
<th>Physical:</th>
<th>Emotional:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Excessive drug and alcohol abuse</td>
<td>• Mood swing</td>
</tr>
<tr>
<td>• Fatigue</td>
<td>• Isolation or loneliness</td>
</tr>
<tr>
<td>• Weight loss/gain</td>
<td>• Depression</td>
</tr>
<tr>
<td>• Sleeplessness/insomnia</td>
<td>• Change in normal patterns of behaviour</td>
</tr>
<tr>
<td>• Change in appetite</td>
<td>• Anger or aggressiveness</td>
</tr>
<tr>
<td>• Skin problems (rash, pimples, acne)</td>
<td>• Irritability</td>
</tr>
<tr>
<td>• Loss of libido</td>
<td>• Sudden poor school performance</td>
</tr>
<tr>
<td>• Impotence</td>
<td></td>
</tr>
</tbody>
</table>

6. **STRESS MANAGEMENT – Discussion (20 min)**

**Step 5:**
- **Brainstorm with the participants and list healthy and unhealthy strategies that they have used to overcome stressful situations.**
- **Discuss which healthy ones would be most helpful for adolescents and why.**
- **Work in groups to first briefly describe a stressful situation of an adolescent. Then have each group give their situation to another group which will explore techniques and develop a specific strategy to help the young person overcome stress. Discuss with the larger group.**
- **Briefly review all the different strategies for coping with stress.**
- **Ask what one new strategy they would like to try for themselves to reduce stress in their own lives.**

**Strategies and techniques to help reduce stress:**

<table>
<thead>
<tr>
<th>Psychotherapy</th>
<th>Diversional Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provision for sharing stress inducing situation.</td>
<td>• Engaging the mind away from stressful situations.</td>
</tr>
<tr>
<td>• Communication (i.e. sharing problems with someone you trust—a relative, counsellor or friend)</td>
<td>• Sports (i.e. jogging)</td>
</tr>
<tr>
<td>• Recognizing those things that are really important and those that are not</td>
<td>• Hobbies</td>
</tr>
<tr>
<td>• Child/parent counselling</td>
<td>• Change of environment</td>
</tr>
<tr>
<td>• Praying and meditation</td>
<td></td>
</tr>
<tr>
<td>• Religious singing</td>
<td></td>
</tr>
<tr>
<td>• Positive self-talk</td>
<td></td>
</tr>
<tr>
<td>• Accepting reality</td>
<td></td>
</tr>
<tr>
<td>• Recognizing what you can control and what is not in your control</td>
<td></td>
</tr>
<tr>
<td>• Positive socialization (i.e. joining a youth club)</td>
<td></td>
</tr>
</tbody>
</table>

| Others                                                                                                                                 |
|---|---|
| • Proper rest                                                              |                                           |
| • Deep breathing                                                          |                                           |
| • Relaxation exercises                                                     |                                           |
| • Being more organized                                                    |                                           |
| • Sports (i.e. jogging)                                                    |                                           |
| • Hobbies                                                                  |                                           |
| • Positive socialization (i.e. joining a youth club)                       |                                           |
| • Change of environment                                                    |                                           |
| • Communication (i.e. sharing problems with someone you trust—a relative, counsellor or friend) |                                           |

7. **COMPLICATIONS OF STRESS – Discussion (5 min)**

**Step 6:**
- **Brainstorm on complications**
- **Role Play (Optional)**

**Complications of stress include:** High Blood Pressure; stroke; death; suicide; disposition to violent behaviour; depression; psychosis; neurosis and strained relationships.

The role of the service provider is to:
- educate youth on dangers of stress
• counsel and refer youth appropriately
• help youth cope with stressful situations
• manage personal stress and ensure it does not come in the way of service provision, particularly to young people

8. **CONCLUSION – Discussion (5 min)**

People are individuals and have limitations to what they can do and individuals must know the difference. Emphasize the importance of meeting one’s needs, as opposed to fulfilling all of one’s wants and desires, as important in overcoming stress.
SESSION 10 SUMMARY

MODULE II: Challenges Adolescents Face Today

SESSION 10: Drug and Alcohol Abuse

Time: 1 hour, 40 minutes

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

- Define drug and alcohol abuse.
- List at least 5 drugs and types of alcohol commonly abused by adolescents.
- Identify at least 4 reasons for drug and alcohol abuse by adolescents.
- Identify at least 10 signs and symptoms of drug and alcohol abuse
- List at least 5 consequences of drug and alcohol abuse.
- Describe how adolescents can avoid drug and alcohol abuse.

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>5 min</td>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>2. Definitions</td>
<td>5 min</td>
<td>Exercise/Discussion</td>
<td>Newsprint, markers</td>
</tr>
<tr>
<td>3. Types of Drug and</td>
<td>20 min</td>
<td>Video and Discussion</td>
<td></td>
</tr>
<tr>
<td>alcohol Normally</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abused</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Predisposing Factors</td>
<td>5 min</td>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>5. Signs and Symptoms</td>
<td>10 min</td>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>6. Consequences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Ways to help Adolescents</td>
<td>10 min</td>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>8. Making Proper Decisions</td>
<td>30 min</td>
<td>Role Play or Guest Speaker</td>
<td></td>
</tr>
<tr>
<td>9. Conclusion</td>
<td>5 min</td>
<td>Brainstorm</td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES

Anheuser-Busch Inc. and the USA Department of Consumer Awareness and Education. *How to Talk to Your Kids About Drinking: A Parents’ Guide*.


1. **INTRODUCTION – Discussion (5 min)**

**Step 1:**
- Talk about the magnitude of the problem
- Note: A guest speaker from Ministry of Home Affairs (police) could be asked to give this talk

2. **DEFINITIONS - Exercise, Discussion (5 min)**

**Step 2:**
- Ask participants to define drug and alcohol abuse and record responses, and then explore the difference between abuse and dependency.
- Present the definitions of drug and alcohol abuse and dependency.

**Drug and alcohol abuse** is the intake of chemicals to create an artificial mood with or without knowledge or concern of the possible harmful effects on the individuals, family and society at large.

**Dependency** is a state where the individual can no longer do without the drugs and alcohol.

**Addiction** is a state where the individual is unable to stop intake.

3. **TYPES OF DRUGS AND ALCOHOL COMMONLY ABUSED – Brainstorming, Discussion (20 min)**

**Step 3:**
- Brainstorm on types of drugs and alcohol adolescents in the participants' areas are commonly using and how they use them.

Some of the drugs and alcohol commonly abused by adolescents are: tobacco; alcohol; analgesic syrups; cocaine; cannabis (mbanje); glue; mandrax; cough mixture and injectables such as heroin.

4. **PREDEPOSING FACTORS – Discussion (5 min)**

**Step 4:**
- Discuss the appeal and attraction of drugs and alcohol to adolescents

The drugs and alcohol are used in order to:
- cope with different stressful situations
- feel good/get high
- be like the others (peer pressure)
- be “macho”
- show social status
- show that one is grown up
- experiment

5. **SIGNS AND SYMPTOMS OF DRUG AND ALCOHOL ABUSE AMONG ADOLESCENTS – Discussion (10 min)**

**Step 5:**
- Discuss behaviour usually linked with substance abuse.
- Ask participants to discuss signs and effects of substance abuse and how to identify them.
- Refer to handout on substance specific signs.

The following symptoms may indicate that a young person is involved in or abusing drugs:
- Unusual patterns of behaviour
• Mood swings or attitude changes
• Euphoria
• Hallucinations
• Alteration in personal appearance
• Withdrawal from responsibilities and family contacts

6. CONSEQUENCES OF SUBSTANCE ABUSE – Discussion (10 min)

Step 6:
• Brainstorm and discuss consequences of drug and alcohol abuse.

<table>
<thead>
<tr>
<th>Health risks</th>
<th>Social risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Engaging in unprotected sex</td>
<td>- Being ostracized by family &amp; friends</td>
</tr>
<tr>
<td>- Unintended pregnancies</td>
<td>- Loss of social acceptance</td>
</tr>
<tr>
<td>- Susceptibility to STI/HIV</td>
<td>- Stigmatization</td>
</tr>
<tr>
<td>- Mental illness</td>
<td>- Dependence on substance</td>
</tr>
<tr>
<td>- Disability</td>
<td>- Loss of self esteem</td>
</tr>
<tr>
<td>- Suicide</td>
<td>- Changes in appearance</td>
</tr>
<tr>
<td>- Death</td>
<td>- dependency</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Criminal tendencies</th>
<th>Economic risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Violence</td>
<td>- Loss of income or employment</td>
</tr>
<tr>
<td>- Rape</td>
<td>- Dependence on others</td>
</tr>
<tr>
<td>- Theft</td>
<td></td>
</tr>
</tbody>
</table>

7. WAYS TO HELP ADOLESCENTS AVOID DRUG AND ALCOHOL ABUSE – Brainstorming (10 min)

Step 7:
• Brainstorm ways to help adolescents avoid using drug and alcohol and how to help young people who already are.
• Record responses and summarize.
• Discuss centres where adolescents with problems of drug and alcohol abuse can be referred for help.

Keeping one-self busy through:
1. Recreational activities e.g. sports, hobbies, clubs and reading
2. Income-generating projects
3. Self empowerment
4. Making adolescents aware of the need to have self esteem (avoid negative peer pressure; remain in control; and set life goals and work towards achieving them).

Support systems for Adolescents who have abused drugs and alcohol:
Youth friendly centre/ corners; Alcoholic Anonymous; Bread of Life;
Good Samaritans; Religious Organisations; Victim friendly Unit;
Health Centres; Family; Social Services.

8. MAKING PROPER DECISIONS – Group Work (30 min)

Step 8:
9. CONCLUSION – Summary (5 min)

Review session objectives and highlight the consequences of drug and alcohol abuse.

Adolescents are better equipped to make proper decisions about substance abuse, including drinking, if they are given the facts. Trying to scare them about drinking, or presenting alcohol or drinking as evil, has not proven to be effective in reducing drug and alcohol abuse. That is partly because adolescents have many sources of information, and exaggeration or telling unfounded scare stories does not work.

In discussing drinking with adolescents, it is always best to stress immediate consequences or effects, since young people have the tendency to believe that they are indestructible and will live forever.

Have the participants role play situations in which youths who are believed to be “at risk” for drug and alcohol abuse or who are already abusing drug and alcohol are counselled. Use examples of both alcohol and drug abusers. OR

Invite guest speakers (including young people who have experimented with drugs, or adults who experimented as youth). Enable them to share their stories to help other youth make better decision and prevent other youth from getting involved with drugs. OR

Draw a line on a piece of newsprint. Label one end “death from drug and alcohol abuse” and the other end “never uses”. Ask participants to describe different levels of drug or alcohol use and where people they know would place on a continuum. However, remind them NOT to use real names. For example, “Joseph (not his real name) drinks four beers a day but holds down a job although he loses his temper often”.

## Effects and Consequences of Drug and Alcohol Abuse

<table>
<thead>
<tr>
<th>Name of Drug and/or Alcohol</th>
<th>Effects</th>
<th>What can be Observed</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inhalants:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Petrol</td>
<td>Nausea</td>
<td>Odour of substance/</td>
<td>Unconsciousness and suffocation</td>
</tr>
<tr>
<td>• Glue</td>
<td>Dizziness</td>
<td>on clothing and breathing</td>
<td>Nausea and vomiting</td>
</tr>
<tr>
<td>• Paints</td>
<td>Headaches</td>
<td>Intoxication</td>
<td>Damage to brain and central nervous system</td>
</tr>
<tr>
<td>• Spirit</td>
<td>Lack of coordination and control</td>
<td>Drowsiness</td>
<td>Sudden death</td>
</tr>
<tr>
<td>• Spirit</td>
<td></td>
<td>Poor muscular control</td>
<td></td>
</tr>
<tr>
<td>• Spirit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Narcotics:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Codeine</td>
<td>Euphoria</td>
<td>Needle marks and syringes</td>
<td>Addiction, lethargy</td>
</tr>
<tr>
<td>• Pethidine</td>
<td>Nausea and vomiting</td>
<td>Moist skin</td>
<td>Weight loss</td>
</tr>
<tr>
<td>• Mbanje</td>
<td>Insensitivity to pain</td>
<td></td>
<td>Contamination from unclean needles</td>
</tr>
<tr>
<td>• Tobacco</td>
<td>Watery eyes and runny nose</td>
<td></td>
<td>Risk of HIV infection</td>
</tr>
<tr>
<td>• Tobacco</td>
<td></td>
<td></td>
<td>Accidental overdose</td>
</tr>
<tr>
<td>• Tobacco</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stimulants:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Speed</td>
<td>Alertness</td>
<td>Pills and capsules</td>
<td>Fatigue leading to exhaustion</td>
</tr>
<tr>
<td>• Cocaine</td>
<td>Talkativeness</td>
<td>Loss of sleep and appetite</td>
<td>Addiction</td>
</tr>
<tr>
<td>• Amphetamines</td>
<td>Mood elevation</td>
<td>Irritability and anxiety</td>
<td>paranoia</td>
</tr>
<tr>
<td>• Mudzepete</td>
<td>Wakedness</td>
<td>Weight loss</td>
<td>Depression</td>
</tr>
<tr>
<td>• Mudzepete</td>
<td>Increased blood pressure</td>
<td>Hyperactivity</td>
<td>Confusion</td>
</tr>
<tr>
<td>• Mudzepete</td>
<td>Loss of appetite</td>
<td></td>
<td>Hallucinations</td>
</tr>
<tr>
<td>• Mudzepete</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Injectables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Heroin</td>
<td>Euphoria</td>
<td>Needle marks and syringes</td>
<td>Addiction, lethargy</td>
</tr>
<tr>
<td>• Morphine</td>
<td>Nausea and vomiting</td>
<td>Moist skin</td>
<td>Weight loss</td>
</tr>
<tr>
<td>• Morphine</td>
<td>Insensitivity to pain</td>
<td></td>
<td>Contamination from unclean needles</td>
</tr>
<tr>
<td>• Morphine</td>
<td>Watery eyes and runny nose</td>
<td></td>
<td>Risk of HIV infection</td>
</tr>
<tr>
<td>• Morphine</td>
<td></td>
<td></td>
<td>Accidental overdose</td>
</tr>
<tr>
<td>• Morphine</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Handout 2.9.2: The Story of Nawala and Jonathan

**Nawala is 17 years old. She says:** Here in Greenwood, we have a lot of small bars. Every weekend we just go and hang around there and drink. And of course, guys will come and buy alcohol for us and then entertain us. They always expect sex from us because they are spending their money on us. Okay, we feel obligated. We have to go and have sex with them because they are spending their money on us. When we don’t want sex, they sometimes get violent with us. One time, a guy got really violent. He was really angry, telling me --- what did I expect after drinking all of his money? He ended up beating me. My face was really messed up. It was blue and my eye was swollen. I use condoms, but it was only with some of them that I did not use a condom. I think that I was too drunk. I really cannot remember.

**Jonathan is 19 years old.** He says: I met this beautiful girl in a bar and we started chatting and drinking together. She was getting drunk and she sat on my lap. I went with her just because I was drunk. After that, we had sex and there was no condom used. It all happened so fast. I only realized what I had done when I was sober but it was already too late. I am scared of HIV, but it is only alcohol. If I am drunk, then I cannot even think of using a condom.

**Discussion Questions**

- What is Jonathan doing that is putting him at risk?
- What is he at risk for?
- What is Nawala doing that is putting her at risk?
- What is she at risk for?
- Are these situations common in your community? Why or why not? What do others think?
- What about using drugs?

**Source:** UNFPA, 2016, *Comprehensive Sexuality Education for out of school young people in Eastern and Southern Africa Facilitator’s Manual*
Not drinking at all is the healthiest choice. However, some people will decide to drink. For those people who do drink, here are some ways to drink responsibly and to reduce the risks that can come with drinking:

- **Know your limits**: If you are going to drink, moderation is the key. Don’t get very drunk. If you use, DON’T ABUSE!
- **Drink smarter**: If you choose to drink alcohol, drink water or soft drinks in between. This will keep you hydrated and help you not to drink too much alcohol.
- **Eat before and during drinking**: Food slows down the absorption of alcohol, so the level of alcohol in your blood stays lower and this helps stop the feeling of being out of control.
- **Carry condoms with you**: Whether you drink alcohol or not, a condom is the best way to protect against HIV, STIs and unintended pregnancy.
- **Plan ahead**: If you’re off to a party or going into town, plan how you’re going to get home later. If you have a cell phone, make sure it is charged, so that you can call home if you need to.
- **Look out for friends**: Make sure your friends are safe. Be sure that they get home safely; talk them out of arguments; and make sure they’re not getting sick.
- **Don’t drink and drive and check that your ride is safe or walk**: If you have been drinking, don’t drive. If you have a ride home, make sure the driver has not been drinking. If you are walking home, make sure you have a friend to walk with.

**Source**: UNFPA, 2016, *Comprehensive Sexuality Education for out of school young people in Eastern and Southern Africa Facilitator’s Manual*
SESSION 1 SUMMARY

MODULE III: Interpersonal Communication with Adolescents

SESSION 1: Moral, Cultural and Religious Values

Time: 1 hour, 35 minutes

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

- Define moral, cultural and religious values.
- Describe at least 5 moral values.
- Define religious and cultural practices
- Identify at least 3 foundations from which moral values are derived.
- List at least 5 disadvantages resulting from not emphasizing moral values.
- Identify at least 3 cases when moral values appear to be in conflict.
- List at least 5 ways through which moral values are reinforced.
- List at least 5 ways through which moral values are eroded.
- Identify the different cultural and religious practices that affect Adolescents Sexual and Reproductive Health

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction definition of Moral Values, Culture Religion Values</td>
<td>5 min</td>
<td>Discussion</td>
<td>Computer, LCD Flip chart and pens</td>
</tr>
<tr>
<td>2. Description of Key Moral Values</td>
<td>5 min</td>
<td>Brainstorming and Discussion</td>
<td>Newsprint and markers</td>
</tr>
<tr>
<td>3. Foundation of Moral Values</td>
<td>20 min</td>
<td>Discussion</td>
<td>Flip chart, markers</td>
</tr>
<tr>
<td>4. Culture and religious Values</td>
<td>10 min</td>
<td>Exercise and Discussion</td>
<td>HO 2.1.1</td>
</tr>
<tr>
<td>5. Moral Values in Conflict</td>
<td>10 min</td>
<td>Brainstorming, Exercise, Discussion</td>
<td>Flip chart, markers</td>
</tr>
<tr>
<td>6. Reinforcing</td>
<td>10 min</td>
<td>Brainstorming</td>
<td>Flip Chart, markers</td>
</tr>
<tr>
<td>7. Erosion</td>
<td>10 min</td>
<td>Exercise, Discussion</td>
<td>HO 2.1.1</td>
</tr>
<tr>
<td>8. Conclusion</td>
<td>5 min</td>
<td>Brainstorming</td>
<td>Flip chart, markers</td>
</tr>
</tbody>
</table>

REFERENCE:
DSW German Foundation for World Population Sexual and Reproductive Health Training Manual for Young People
1. **INTRODUCTION – Presentation (5 min)**

   **Step 1:** Make a PowerPoint Presentation of session objectives.

2. **DEFINING MORAL, RELIGIOUS AND CULTURAL VALUES – Brainstorming, Discussion (5 min)**

   **Step 2:** Brainstorm and discuss meaning of moral values.

   Moral values are standards (principles) of behaviour, which we use to classify behaviour as good or bad (right or wrong).

   Culture is the way of life, especially the general customs and beliefs, of a particular group of people at a particular time. Culture is the the ideas, customs, and social behaviour of a particular people or society. Culture is not static as it is dynamic. Culture is the the ideas, customs, and social behaviour of a particular people or society.

   Religious values define what people expect of themselves and of others based on the beliefs common to the religions they practice.

   Different religions and cultures have different values. Just like moral values, what is viewed as good or bad also depends on one’s religion and culture. Culture evolves but tradition remain stagnant.

3. **DESCRIPTION OF KEY MORAL VALUES – Exercise, Discussion (30 min)**

   **Step 3:** Distribute HO 2.1.1 with the moral values in the left column and ask participants to fill in their descriptions in the spaces provided and compare answers.

   **Key Moral Values**

   Love - commitment to treat others well.
   Honesty - commitment not to lie, cheat, steal, or deceive.
   Justice - to be without prejudice, discrimination or dishonesty.
   Faithfulness - undeviating allegiance to a person, contract or oath.
   Dignity - according appropriate worth to self and to others.
   Responsibility - thinking rationally and being accountable for one’s behaviour.
   Compassion - caring for those smaller and weaker than ourselves and not abusing or taking advantage of anyone.
   Integrity - consistency in what one says and does and the commitment to be honest and conscientious in what one does or says.

4. **FOUNDATIONS OF MORAL VALUES – Brainstorming, Exercise, Discussion (10 min)**

   **Step 4:**
   - Brainstorm and discuss why moral values should be upheld.
   - **Exercise 1:** Ask participants which of the foundations for moral values a, b, and c is the best one and why? (Optional- 3 groups can debate a, b, and c)
   - Encourage them to discuss their choice.

   a) Tradition
   To some people moral values must be upheld because they are part of the traditions inherited from ancestors. To such people, to do justice is to uphold an important tradition thereby pleasing the ancestors.

   b) Religion
To some people moral values must be upheld because they are commandments given by a higher power, such as God.

**c) Reason**
To some people moral values must be upheld because humans must do what is reasonable in order to be different from lower animals that are not reasonable.

### 5. Culture and Religious Values

**STEP 5:**

- Discuss how different religions and cultural practices affect Adolescents.

Young people are subjected to cultural and religious as well as traditional practices. The effect of these practices to a large extent affects women more than men. Based on the different parts of the country, discuss how these practices affect the young people. (refer to hand out on harmful practices)

- **Moral Values in Conflict – Exercise, Discussion (10 min)**

**Step 5:**

Ask participants to discuss the moral values and attitudes reflected in statements 1 through 4. Ask participants to suggest moral values in conflict found in each of these case studies.

**Case #1:**
A medical doctor has diagnosed Sheila’s blood sample as HIV positive. If the doctor tells Sheila’s fiancée (who has been diagnosed negative), the fiancée may react insecurely and dump Sheila. If the doctor does not tell Sheila’s fiancée, chances are they will engage in unprotected sex, thus putting the fiancée at risk.

**Case #2:**
Reverse the gender of case #1. The man is HIV positive. His fiancée is not. Are the same issues present? Do they differ? Should they differ?

**Case #3:**
Tendayi engaged in an extramarital relationship soon after he married Nyasha. In fact it was a resuscitation of a close friendship he had had with Thandi before he met and eventually married Nyasha. Thandi informs Tendayi she is 8 weeks pregnant and does not mind Tendayi buying her a flat where they would both raise their baby without Nyasha knowing.

**Suggested moral values in conflict:**

**a) Justice:** Sheila’s fiancée has the right to know. **AND**
**Love:** Love for Sheila means treating her well. Telling her fiancée may destroy her future.

**b) Love:** for Sheila’s fiancée who is at risk. **AND**
**Honesty:** the doctor should not lie, cheat or deceive.

**Case 3:**

**a) Faithfulness:** Tendayi, having been unfaithful to Nyasha, now wants to restore his faithfulness to her. **AND**
**Responsibility:** Tendayi must be responsible for his behaviour and support and provide for Thandi and the baby.

**b) Love:** Tendayi loves Nyasha so much he would not tell her about the affair and pregnancy. **AND**
**Justice:** Nyasha’s dignity has been violated and she has the right to know.
6. **REINFORCING MORAL VALUES – Brainstorming, Discussion (10 min)**

**Step 6:**
- List some of the ways in which moral values are reinforced. Ask participants to indicate whether or not they agree with this list.
- Ask participants to highlight other ways.

**Reinforcement:** There are a number of ways through which moral values are reinforced in the hearts and minds of people. Here are some of them:

- Parents can make it their responsibility to set the example before their children. Children learn more by imitating than listening.
- High-profile public figures can make it their responsibility to set the moral example before the public. People respect and emulate their public figures.
- Friends can choose to associate with people who value and inspire moral values.
- A person can adhere to a religion (such as Christianity or Islam) that upholds and reinforces moral values.
- The print and electronic media can highlight events, activities and personalities that encourage and foster moral values and not just the sensational.

7. **EROSION OF MORAL VALUES – Brainstorming, Exercise, Discussion (20 min)**

**Step 7:**

Mention some of the ways through which moral values can be eroded. Ask participants to indicate whether they agree with this list or not.

Ask participants to highlight other ways through which moral values may be eroded.

Use HO 2.1.1 and ask participants to write the negatives of these moral values in the spaces adjacent and then compare with the suggested negatives in the left column.

**Exercise 2:** Ask participants to match the following statements with matching negatives above and discuss.

A married man who engages in extra-marital sexual affairs and risks infecting his wife with HIV.

An adult who seduces adolescents into sexual activities.

An individual who chooses not to disclose to his or her spouse that he or she is HIV positive.

8. **CONCLUSION – Brainstorming (5 min)**

**Step 8:**
- Ask participants to identify at least 3 values they have learnt from the session.

Moral values are often the last thing on “our minds” as we act, react to and interact with others, yet they are, in reality, the assumptions that influence our attitudes and behaviour. This fact 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 life-styles is to fail before we have even started.
HANOUT 3.1.1
Moral Values Worksheet

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HARMFUL PRACTICES AFFECTING YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH

Harmful practices
Culture and tradition play a significant role in shaping the way young people and adolescents behave and lead their lives. However, young people have become victims of some harmful tradition of these practices, which affect their human and reproductive rights. These practices differ from place to place but primarily affect women. Among the most widely practiced are:
- female genital mutilation/cutting;
- early marriage; marriages
- wife (widow) inheritance; and sexual violence.

Female Genital Mutilation (FGM)/Female Genital Cutting (FGC)
Increasingly, FGM/FGC is seen as a violation of basic rights and a form of sexual discrimination. FGM/FGC refers to the removal of all or part of the female external genitalia. It is practiced in more than 30 African, 7 Middle Eastern and 4 Asian countries and even in Western Europe, the UK and the US where certain ethnic groups from these countries have migrated.

Types of FGM/FGC
FGM/FGC is practiced in many forms; the most common ones are:
- Sunna: in which the tip of the clitoris and/or its covering (prepuce) are removed.
- Clitorodectomy: where the entire clitoris, the prepuce and adjacent labia are removed.
- Infibulation: also known as Pharonic Circumcision, which is the clitorodectomy followed by sewing up of the vulva. A small opening is left to allow urine and menstrual blood to pass. In some cultures the woman is cut open by her husband or elderly women on her wedding night. She may be sewn up again if her husband leaves on long trip.

Consequences of FGM/FGC
FGM/FGC doubles the risk of women’s death in childbirth and increases the risk of a child being stillborn (dead before delivery from the uterus) by up to four times. There are also more immediate consequences for women or girls who undergo the practice and these can include,
- Hemorrhage
- Chronic urinary and pelvic infections
- Keloid formation
- Labial adherences
- Clitoral cysts
- Pain-induced shock (since no anaesthetics is used)
- Urine and menstrual blood retention
- Damage to urethra and anus
- Painful scars resulting in painful sexual intercourse
- Sexual dysfunction
- Risk of STIs including HIV/AIDS
- Obstructed labour
- Psychological trauma
- Sterility, and
- Different gynaecological and obstetric problems

Early marriage
Despite national and international laws relating to minimum ages of marriage, marriage of girls below these legal limits (generally set at around 18 years of age for girls – the age is usually higher for boys) is still common in many countries, particularly in rural areas, and among poor or poorly educated communities. The greatest risks
associated with early marriage are that the girl will be forced to leave school and end her education, and that an early marriage also means early pregnancy. Early pregnancies, as we have seen in previous sessions, carry risks for both the young mothers and their children. Children born to adolescent mothers are more likely to die during their first year of life than those born to women in their twenties, and are at even greater risk during their second year.

**Wife (widow) inheritance**
This practice is most common in cultures where men pay a “bride-price” for their wives. If the man dies, several factors converge. Women are more likely to be seen as possessions, something which has been “purchased” by the man and his family and therefore another (male) family member simply “inherits” the wife, just as he might a house or cattle. The second is that in cultures where a woman, once married, may not return to her father’s home, there is little choice for the woman (and her children) but to accept whatever security (social, financial) is offered by remaining within her husband’s family. The practice not only devalues women, but is now widely contributing to the spread of STIs, including HIV/AIDS.

**Sexual violence**
There are several forms of sexual violence. Three of the most common ones are described below.

**Sexual abuse**
Sexual abuse is defined as “Violation perpetrated by a person who holds, or is perceived to hold, power over someone who is vulnerable” (Shanler 1998:1). The abuse may have physical, verbal and emotional components. It includes such sexual violations as rape, sexual assault, sexual harassment, incest, and sexual molestation.

**Sexual harassment**
Sexual pressuring of someone in a vulnerable or dependent position - a youth, employee, or student for example - is termed as sexual harassment. Employers, teachers, or other people in authority may use their ability to control or influence jobs or grades to coerce people into sexual relations or punish them if they refuse. In extreme cases, a person may be threatened with being fired or being given bad grades if she or he will not submit to the demand. Sexual harassment can take a variety of forms, including verbal sexual remarks about clothing or appearance, unnecessary touching or pinching, and demands for sexual favours.

**Sexual assault: Rape**
Sexual coercion that relies on the threat or use of physical force or takes advantage of circumstances that render a person incapable of giving consent to sexual intercourse (such as when drunk) constitute sexual assault or rape.

When the victim is younger than the legally defined “age of consent,” the age at which a young person is said to be capable of fully understanding and consenting/agreeing to sexual intercourse, the act constitutes statutory rape (often referred to as “defilement”), whether or not coercion is involved. Many countries set 16 as the legal age of consent.

Rape victims suffer both physical and psychological injury. For most, physical wounds are not severe and heal within a few weeks. Psychological pain lasts longer and is often considered to be worse than the physical suffering.

**REFERENCE:**
DSW German Foundation for World Population Sexual and Reproductive Health Training Manual for Young People pg 72 -74
MERI'S STORY

Meri is 19 years old. She comes from a poor family that has strong Christian faith. She grew up believing that you should wait until you are married to have sex. She also believes that it is important that people who have sex use protection so that they don't have an unplanned pregnancy or get an STI or HIV.

A month ago she met Peter. They started talking and really liked each other. Since then, they hang out together all the time and they have become very close. Meri feels like she is falling in love with him. Last night, he came over to her house when her parents and other family were away. He started touching her and told her that he loved her and wanted to have sex with her. She wasn’t sure what to do. Then she started thinking about how she thought she loved him and how some of her friends have sex with their boyfriends. Finally, she agreed to have sex with him, but only if he used a condom.

1. What are Meri’s values about sex and protection?
2. Which value did Meri follow?
3. Which value did she not follow? Why did she ignore her own value?
4. If she followed her own value, what should she have done?
### Session 2 Summary

#### Module III: Interpersonal Communication with Adolescents

**SESSION 2: The Counselor: Values, Attitudes and Perceptions**

**Time:** 3 hours

**Objectives:**
By the end of the session, participants will be able to:
- Define each of the following: values, attitudes, and perceptions.
- Identify at least 3 personal values, attitudes, and perceptions that are held about young people.
- Explain 2 ways that values, attitudes and perceptions can help the counsellor-youth relationship.
- Explain 2 ways that values, attitudes and perceptions can hinder the counsellor-youth relationship.

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<td>4. Perceptions</td>
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<td>5. Attitudes</td>
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<td>Conclusion</td>
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**REFERENCES**


Bender D and Bean C. *Counselling Skills in Family Planning: Trainers Handbook*, Carolina Population Centre, USA, 1982
1. **INTRODUCTION – Values Clarification Worksheet (15 min)**

   **Step 1:**

   Exercise (a):
   Ask participants to complete in writing the following sentence 10 times: I am... Pair them and ask them to share their lists and identify categories such as gender, age group, professional role or ethnic group. OR

   Exercise (b):
   Post the Values Clarification Worksheet (HO 2.2.1). Read statements from the Values Clarification worksheet. Ask participants to move to the area of the room with the sign “Agree or Disagree” that reflects their opinion.

   Ask a few participants from each sign area to explain the reasons behind their choices. Repeat the process as much as time permits. Wrap up the exercise by asking the following questions:

   What was most striking to you when you did this exercise with regards to:
   - a) Yourself?
   - b) Others?

   Were you surprised by the responses of your peers?
   How did you feel when others disagreed with you?

   Explain the objective of the session to the participants. Ask how exploring these subjects could be helpful to you.

   The benefits of discussing values, attitudes and perceptions are twofold:
   1. We will come to know ourselves more deeply and how our own values, attitudes and perceptions are formed.
   2. We will become more aware of how our values, attitudes and perceptions can help or hinder the counselling and communication process.

   2. **DEFINITION OF TERMS – Discussion (15 min)**

   **Step 2:**

   - *Ask participants what they understand about these three words: values, attitudes and perceptions.*
   - *Record responses on a flip chart and Give correct definitions*

   **Value:** is a principle, standard or quality regarded as 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:** State of awareness achieved directly through the senses, to achieve understanding. Thus, perceptions lead to insight, intuition, or knowledge.

   3. **SOURCES OF VALUES, ATTITUDES AND PERCEPTIONS – Discussion (20 min)**
Step 3:
- Lead discussion on what shapes our values and attitudes.
- Ask participants how values, attitudes and perceptions are related to one another.
- Display the drawing of a Hippo and explain that values, attitudes and perceptions can be imagined as a hippopotamus in the water.

Where do we get our values and attitudes?
From parents, society, culture, traditions, religion, peer groups, media (TV, music, videos, magazines, advertisements), school, cinemas, climate, environment, information communication technology, politics, friends, personal needs, economics, family, and personal experiences.

Values clarification means sorting out one’s own “real” (intrinsic) values from the (extrinsic) values of the outside world—separating one’s personal beliefs from the beliefs of others. It means saying what we really mean.

Although one may only see the small ears and eyes sticking out of the water, beneath the water lies a very large hippo on which the eyes and ears are based.

The same is true of values, attitudes and perceptions. We present our attitudes to the world, and they may appear to stand on their own. Yet they are based on a large set of often unspoken underlying values and perceptions.

If those underlying values and perceptions were different, it is most likely that our attitudes, our stance toward the world, would be different. Just as if the hippo’s body was, in fact, a giraffe, the eyes and ears shown to the world would be different. And perhaps, less frightening! Therefore, in order to change one’s attitudes, it is important to become aware of the perceptions and values that lie beneath the surface.

Each person is a unique mix of values, attitudes and perceptions that makes up a personal cultural identity.

Most of us only see the obvious “attitudes” but these are based on values and perceptions that are below awareness - often even our own awareness.

4. PERCEPTIONS – Exercise (20 min)

Step 4:

**Exercise: Seeing the Woman** (10 min)
Display image of Old/Young Woman to the group. Ask them to silently and individually, without talking or sharing, write down how old they think the woman is. Ask the participants to each say out loud the age they wrote down.

Ask the group, “How is it that some people think she was old and others young? What led to such a variety of answers?”

**Exercise: Sitting Quietly** (5 min)
Ask participants to sit quietly for one minute and pay attention to what they perceive through their senses. Ask them to write down exactly what they see, hear and feel. For example, I see a red shirt, I hear a buzzing sound, and I feel my foot on the floor. Ask the group for comments on their experience.
Exploring Perceptions: Our age, gender, social class, tribal background and other personal factors affect our perceptions. We may think that we see somebody clearly but these influences colour our vision as though we were wearing coloured eyeglasses. As a result, no two people perceive something or somebody exactly the same.

Exploring perceptions is known as direct perceiving, unencumbered by values and judgements. To spend a few minutes a day sitting quietly and paying attention to our direct perceptions can be very useful to us in experiencing the world more clearly. In many cultures, this practice is known as meditation.

5. VALUE CLARIFICATION – Exercise (25 min)

Step 5:

Exercise: (15 min) Using the answers on the newsprint, explain how our values, attitudes and perceptions greatly influence counselling of young people. Ask each participant to write down a list of five common basic Zimbabwean values. In small groups, members should compare lists, select a recorder and reporter, and decide on one list of five. The reporter will present the list to the larger group. Each small group should be prepared to explain and defend their choices.

Discuss this exercise. Ask “Was it difficult to agree? Why, since we are all from Zimbabwe? Were there any values that we’ve heard that could be in conflict with one another? Were there any values that we all agreed on easily? If so why were they so easy to agree on”?

Ask participants why it is important to discuss values, attitudes and perceptions to such an extent in a youth counselling training. Record answers on newsprint.

Ask participants to give examples of which would influence the counselling relationship: values or attitudes.

Present the following example for discussion: I may hold a value which believes that prostitution is wrong. I may then regard a prostitute as an immoral and dirty person. This is my attitude based on my value about prostitution. Therefore, when I am counselling a girl who is a prostitute, I might communicate this value in the following way....
If we allow our own attitudes and value to impose themselves on the counselling and communicating relationship, it is unlikely that we will attain our primary goal of helping adolescents.

We cannot “get rid of” our own values and attitudes or act like we think they are wrong. The point is to become as aware as possible of the underlying assumptions we have and to learn skills that will help us to perceive the young client in as objective a light as possible.

6. **ATTITUDES – Exercise (60 min)**

**Step 6:**

**Exercise: (30 minutes)**
Tell the story of Crocodile River. Following the story, the participants are asked to privately rank the five characters from the one they like most (#1 - least offensive) to the one they dislike most (#5 – most objectionable). Distribute the Handout 2.2.2. *(Note: You can use any other relevant story).*

After the participants have made their own ranking, discuss the rankings in the large group. How many felt Abigail was the best character? How many felt she was the worst character? Who was the best character?

Divide participants into groups according to the character they liked best. Ask each group to select an “advocate” and develop a persuasive argument for why that person is the best character. Each advocate should present to the group, trying to persuade them to change their minds. Manage this process carefully, making comments that relate the topic to this session’s goals and major learning points.

7. **APPLICATION AND CONCLUSION – Exercise (25 min)**

**Step 7:**
- **Ask participants what are some attitudes that the counsellor could hold which would hinder the counsellor-adolescent relationship? Record on newsprint.**
- **Exercise: (15 min) Ask participants to complete the handout “Personal values, attitudes and perceptions,” individually.**
- **After a few minutes ask volunteers to share their hindrances and strategies. Ask for additional suggestions from the participants.**

It takes a lifetime to form values, attitudes and perceptions and it is not an easy or quick process to change them. It is, however, important to examine them in order to make conscious decisions about which values and attitudes we want to keep and which we think may no longer be useful to hold.

People are a complex mix of unique characteristics, which includes physical characteristics but also various values, attitudes and perceptions. This session focused on how one’s internal world can help or hinder one’s ability to help young people.
HANDOUT 3.2.1
Values Clarification

- The age of majority should be reduced from 18 years to 16 years.
- All teenagers should have access to contraception if they want it.
- Girls should be virgins when they marry.
- Most of the youth today are promiscuous.
- Sex and sexuality should be taught in primary school level.
- It is the girl's responsibility not to be raped.
- An unmarried pregnant school girl should be expelled from school.
- Abortion is murder.
- An unmarried pregnant girl of 14 should be able to have an abortion.
- Any teenager caught abusing drugs should be locked away in prison.
- Men can enjoy sex without love.
- Women can enjoy sex without love.
- Information on contraception should be introduced at primary schools.
- Love is not necessary for marriage.
- Polygamy is a family planning method.
- Family planning increases a woman's promiscuity.
- Boys cannot control their sexual behaviour when aroused.
- Disabled persons should not have children.
- Girls who swear, go around half-naked, are promiscuous.
- It is a girl's fault if she gets pregnant.
Once upon a time there was a woman named Abigail who was in love with a man named Gregory. Gregory lived on the shore of a river. Abigail lived on the opposite shore of the river. The river which separated the two lovers was teeming with man-eating Crocodiles. Abigail wanted to cross the river to be with Gregory.

Unfortunately, the bridge had been washed away. So she went to ask Sinbad, a riverboat captain, to take her across. He said he would be glad to if she would consent to go to bed with him preceding the voyage. She promptly refused and went to a friend named Ivan to explain her plight. Ivan did not want to be involved at all in the situation. Abigail felt her only alternative was to accept Sinbad’s terms. Sinbad fulfilled his promise to Abigail and delivered her into the arms of Gregory.

When she told Gregory about her amorous escapade in order to cross the river, Gregory cast her aside with disdain. Heartsick and dejected, Abigail turned to Slug with her tale of woe. Slug, feeling compassion for Abigail sought out Gregory and beat him brutally. Abigail was overjoyed at the sight of Gregory getting his due. As the sun sets on the horizon, we hear Abigail laughing at Gregory.
Personal Values, Attitudes and Perceptions

1. Perceptions, values and attitudes that I hold that help when I counsel youth:

________________________________________________________________________________________
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2. Perceptions, values and attitudes that I hold that may hinder when I counsel youth:

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3. Ways I can balance the perceptions, values, attitudes that hinder my effectiveness:

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### Module III: Interpersonal Communication with Adolescents

#### Session 3: Interpersonal Communication Skills

**Time:** 2 hours, 5 minutes

**Objectives:**

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

- Define communication
- Define interpersonal communication
- Outline the interpersonal communication process
- Define at least five interpersonal communication skills
- Identify at least three examples of clinical situations where interpersonal skills can be used
- List at least three barriers to effective communication and strategies to overcome them
- Demonstrate interpersonal communication skills in at least two classroom activities

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<td>2. Definitions</td>
<td>5 min</td>
<td>Presentation</td>
<td>Computer, LCD</td>
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<td>3. Interpersonal Communication Process</td>
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<td>Presentation</td>
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<td>4. Interpersonal Communication Skills</td>
<td>45 min</td>
<td>Role Play, Exercise</td>
<td>HO 2.3.1; HO 2.3.3;</td>
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<td>5. Barriers to effective communication and strategies to overcome them</td>
<td>45 min</td>
<td>Discussion</td>
<td>HO 2.3.4</td>
</tr>
<tr>
<td>6. Conclusion</td>
<td>5 min</td>
<td>Discussion</td>
<td></td>
</tr>
</tbody>
</table>

**REFERENCES**

- *Counselling Makes a Difference*. Population Reports.
1. INTRODUCTION – Discussion (5 min)

Step 1:
- Post session objectives and review them
- Lead a discussion on session objectives.

2. DEFINITIONS – Brainstorming, Discussion (5 min)

Step 2:
- Ask the participants to define communication and record their responses on Flip charts
- Show definitions on PowerPoint, and point out similarities with their own.
- Ask the group to define interpersonal communication and record their answers.
- Define interpersonal communication and point out the differences between communication and interpersonal communication, and emphasise that this session will cover interpersonal communication.

Communication: a process of transmitting information or thoughts on a particular topic through words, actions, or signs.

Interpersonal Communication: is a verbal or nonverbal exchange of information between two or more people in each other's physical or virtual presence.

3. INTERPERSONAL COMMUNICATION PROCESS – Presentation, Discussion (20 min)

Step 3:
- Ask group members to list different ways in which they communicate with adolescents. Write their responses on a Flip Chart. Their answers might include: one – to – one, group talks, leaflets, posters, and videos.
- Show the PowerPoint slide with the diagram of the Interpersonal Communication Process.

Interpersonal Communication Process

Many people are familiar with the communication process of sender, channel, message and receiver. This is different from the interpersonal communication process. 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.

**Step 4:**

- Ask participants what they think is the importance of each step.
- Record their answers on a Flip Chart. As you do this, explain each step to the participants.

Point out that:

- The process is a cycle and therefore continuous
- The assessment and analysis steps are essential to the communication process but are often forgotten, and
- Because of the cyclical nature of the process, assessment is ongoing and occurs throughout communication.

Summarise the cycle using the example of an adolescent who comes to the clinic with a malnourished baby. The provider first assesses the child’s nutritional status and then analyses the mother’s information and counselling needs (information on providing better nutrition for her child).

Next, the provider designs messages to meet those needs (information on breastfeeding and foods) and delivers the messages.

Finally, the provider asks questions to evaluate the adolescent’s understanding and to determine whether there are other reasons for the child’s nutritional status.

**Note:** The Facilitator can use any other relevant example that would be ideal to the target group

4. **INTERPERSONAL COMMUNICATION SKILLS – Presentation, Role Play, Exercise, Discussion (45 min)**

There are a number of communication skills and not all are discussed in this session. Depending on availability of time, the Facilitator may choose one or two activities and not necessarily all.

**Step 5:**

- Ask the participants to name some interpersonal communication skills and give examples of each.
- Record their responses on a Flip Chart. Add any that they have missed.
- Distribute Handout 2.3.1 on ‘Interpersonal Communication Skills’
- Have participants practice some skills through exercises.

There are a number of techniques the provider can use to facilitate good communication with adolescents.
a) Active Listening/Attending Behaviour

Providers let the youth know through verbal and nonverbal expressions that they are listening. Facial expressions and posture should show the youth that he/she is interested and paying attention. Some examples are maintaining eye contact, nodding as client speaks, saying ‘um hmm’.

b) Summarizing and Paraphrasing – Exercise HO 3.3.2 (about 5 min)

**Step 6:**

<table>
<thead>
<tr>
<th>The purpose of this exercise is to practice active listening skills as well as paraphrasing and summarizing techniques.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare a list of controversial topics (e.g. abortion, prostitution, condoms and marriage and teens and family planning). Ask participants to pair off, select a topic, and then take turns making statements about the selected topic. <strong>Before each new statement,</strong> however, each participant must paraphrase or summarise what the other person just said.</td>
</tr>
<tr>
<td>After 5 minutes, stop the exercise and ask the following questions:</td>
</tr>
<tr>
<td>1. How did you feel doing this exercise? 2. Was anything difficult? Why? 3. What was useful about it?</td>
</tr>
</tbody>
</table>

**Possible Responses:**
- It forces you to really listen.
- Helps practice non-judgemental communication.
- Helps identify biases on controversial topics.

Following the discussion questions for this and other exercises, the facilitator can give feedback on non-verbal communication and attending behaviours observed during the practice sessions.

The provider restates what the adolescent has said in his/her own words. Summarizing usually restates many thoughts in a shorter form. This assures the adolescent that s/he has heard and understood what the adolescent has said. For example:

**Adolescent:** ‘I don’t know what the matter is. I just don’t feel well today.’

**Provider:** ‘You are not sure what the matter is, can you tell me where you are feeling unwell.’

c) Reflecting Feelings

By observing and listening, providers imagine how adolescents feel. Then they tell the adolescent what they think those emotions are. For example, when a young person sounds and acts confused, the provider can point this out saying, ‘You seem confused’. This serves three purposes:

1. It makes the adolescent think about how s/he feels and why,
2. The provider finds out whether or not the adolescent is confused, and if there is confusion, the adolescent and provider can clear it up through discussion.

d) Questioning – Exercise # 2: Open-ended Questions (about 5 min)

**Step 7:**
The provider encourages adolescents to talk about themselves by asking questions. Questions can be open or closed-ended.

**Open-ended questions** gives a provider a wide range of information from the adolescent without influencing his/her responses. Open-ended questions usually begin with the words ‘how’, ‘what’ or ‘why’. For example, ‘how have you been?’

**Closed-ended questions** are leading and limit possible responses. They may cause the adolescent to give answers he/she thinks the provider wants to hear. For example, ‘have you been well?’

Closed-ended questions can be used to shorten a discussion. But, if used too often, the provider might miss important information.

**Probing questions or statements** are used to elicit further details from the adolescent. They can be open or closed-ended, but are usually open-ended.

‘Tell me more about…’
‘And?’
‘Um hmm,’ followed by silence.
‘Is there anything you left out?’

When probing get information the adolescent might feel is personal or private, probes should be worded carefully.

e) Making Positive Statements - Exercise: HO: 3.3.3 (about 5 min) (Praise/Encouragement/Reassurance)

**Step 8:**

Ask for volunteers to make positive responses to the following statements.
Ask participants:

- Was it difficult to think of something positive to say?
- How does it feel to have someone give a positive response in a situation where you are worried?
- When is praise appropriate?
- When is encouragement appropriate?
Making positive statements can help adolescents feel good about themselves. When an adolescent is in a crisis, it can help him/her get control of his/her own situation. Avoid giving false praise. Some examples are:

Praise: ‘You are looking well today’.

Encouragement: ‘You did the right thing by coming here’.

Reassurance: *Being HIV positive does not mean that you will die.*

Some examples of Positive Responses follow:

- I lost my treatment clinic card.
  Sample Response: ‘But it’s good that you still remembered to come’.

- I forgot to take my treatment for two days
  Sample Response: ‘You were smart to come back so that we could discuss what the problem might be’.

- The condom we were using broke, but it’s okay because it was right in the middle of the month.
  Sample Response: ‘I am glad you came to discuss this. We need to discuss how you are using the condoms and how your monthly cycle works’.

Note: The Facilitator may do a five-minute demonstration of a counselling session for a returning adolescent who has a number of concerns, illustrating the interpersonal communication skills covered in this session.

f) Giving Information

When giving information, explanations should be simple, clear, and in language the adolescent understands. Use Learning aids whenever possible. Part of giving information is assessing whether they have understood the message. Do this by asking questions, having adolescents repeat instructions, and having them demonstrate what has been taught.

Note: Qualities of a good communicator such as remaining non-judgemental and being empathetic will be covered later in the training session.

5. **BARRIERS TO EFFECTIVE COMMUNICATION AND HOW TO OVERCOME THEM** – *Presentation, Role Play, Discussion (45min)*

**Step 9:**

- Give participants a copy of the checklist on communication skills and ask them to mark the right box every time they observe one of the communication skills listed.

- Ask participants to comment on the skills displayed. Point out that good communication does not always require a lot of time.

- Introduce the topic by asking participants what gets in the way of understanding and being understood. Record their answers, on a flip chart, in two columns. List barriers in the left column. Make sure that all the barriers described in these notes are included on the list. Then ask the group to identify strategies to overcome them, and record them on the right-hand side next to each of the barriers.

- Distribute the handout on ‘Barriers to Communication and Strategies to Overcome Them’.

- Choose one of the following two role plays for this session.

**Role Play # 1 (Group Talk or Fishbowl):**

Select a participant to lead a group talk on any topic (see the handout for suggested topics and for more details on the role play). Select five participants to be ‘adolescents’ and give each of them a piece of paper describing their character. Tell them not to reveal who their character is. Ask the rest of the participants to be observers and to write down any barriers to communication that they see. Arrange the seating so that the observers sit in circle surrounding the ‘youth’ and the ‘speaker’. After five minutes, stop the role-play and ask the following questions. Record the group’s responses.
- Ask everyone what barriers to communication occurred during the role play.
- Ask each 'adolescent' how the character they played felt in this situation.
- Ask everyone what the speaker could have done to overcome each barrier.

**Role Play # 2:** The trainer and co-trainer role play a counselling session that demonstrates some communication barriers. Tell participants to write down the barriers as they identify them. The trainer should act out as many barriers as possible.

**Role Play HO: 3.3.2**

Trainer and co-trainer role play a counselling session that demonstrates some communication barriers. Tell participants to write down the barriers as they identify them. The trainer acts out as many barriers to effective communication as possible.

Afterwards, ask the following questions:

1. What barriers to communication did you observe?
2. What could the counsellor have done to overcome them?

### a) Personal Barriers

**Knowledge** – Service providers cannot communicate effectively if their knowledge of the subject is inadequate.

**Strategies:** Make sure your knowledge is up-to-date. If you do not know something, tell the young person that you do not know at present, but that you can find out for them.

**Attitude** – A service provider’s negative attitudes can affect the impact of the message. Good communication must be non-judgemental.

**Strategies:** Be aware of your attitudes and biases, and keep them out of your communication. Never impose your opinions on controversial topics.

### b) Socio-Economic Barriers

**Age** – Some adolescent do not feel comfortable with people either younger or older than themselves.

**Strategies:** Show proper respect. Identify yourself as a health professional who deals with sensitive topics, explain that when there are serious health consequences, there is a need to discuss issues that are sometimes personal. Involve senior members of the group in discussions.

**Religion and Culture** – sometimes religious and cultural backgrounds may interfere with communication.

**Strategies:** It helps to have background information on the religious and cultural beliefs of young people. Try to acknowledge when religious and cultural values might interfere with communication and work with them (do not ignore them).

Always refer to health issues in culturally sensitive ways. Respect people’s values, even when you do not agree with them.

**Sex** – Some prefer to communicate with people of the same sex, especially on sensitive subjects.

**Strategies:** Again, acknowledge that the discussion might be embarrassing but explain that, because of health consequences, it is necessary to discuss sensitive topics. Acknowledging embarrassment usually helps adolescents to overcome it.

**Language** – Adolescents may misunderstand technical language. It is important to speak in terms that they understand and to use acceptable terminology. Also keep in mind that adolescents might speak another
language.

**Strategies:** Keep language simple. Confirm whether terms are familiar and understood by adolescents. If they are not, explain them or use other, more familiar words. If adolescent speaks a different language, find a reliable person who can translate (confidentially, when necessary).

**Economic Status** – Adolescents might find it hard to relate to a person who appears to be of another economic status.

**Strategies:** Show respect no matter how poor the adolescent may be. Avoid fancy dress. Sit among group members, instead of standing over them or sitting apart from them. Wearing traditional dress in community settings can help break barriers.

**Note:** To minimise social and economic barriers, whenever possible involve a provider or person who can relate to the adolescents. You must know your audience, however, to determine who can relate to them most effectively.

c) Logistical Barriers - Discussion/Role Play

**Step 10:**
- Ask participants to give examples of situations where interpersonal communication skills can be used.
- Use the 'Role Play Worksheet' to conduct a role play.
- Divide participants into groups of three or four.
- Distribute a role play work sheet to each group and ask them to practice using their interpersonal communication skills in the situations outlined on the worksheet.
- For each situation, one person will be the ‘counsellor’, one will be the ‘adolescent’, and the third will be the ‘observer’. The observer will watch for use of the different skills and record them on the sheet. Allow 3 – 5 minutes for ‘counselling’ on each topic. Immediately afterwards, the observer should give feedback to the ‘counsellor’, then the group members will switch roles until everyone has had a chance to act as a ‘counsellor’.

After 30 minutes, stop the sessions and ask if anyone has any questions or comments. Ask the participants the following questions:
- Which skills were used most frequently?
- Which skills were harder to use?
- Do you feel you need more practice with any of the skills.

Some of the logistical barriers include:

**Time** – The meeting time may not be suitable for the young people.

**Strategy:** When possible, let the adolescents choose the time. Remember, good communication can occur even when little time is available.

**Venue** – Noise, excessive temperatures, and inadequate seating facilities can interfere with effective communication.

**Strategy:** Make sure the venue is private, comfortable and in an accessible location.

**Use of Interpersonal Communication Skills in Youth Service Situations**

**Possible Situations**
- Counselling
- Health Education
• Group Talks

6. CONCLUSION – Review of Objectives (5 min)

Review the session objectives and summarise the main points of the session. Interpersonal communication can be an effective way of communicating with adolescents.
**Active Listening/ Attending Behaviour**

Providers let youth know through verbal and non-verbal expressions that they are listening. Facial expressions and posture should show the youth that they are interested and paying attention. Some examples are:

- Maintaining eye contact,
- Nodding as the youth speaks, and
- Saying ‘um hmm’.

**Summarising and Paraphrasing**

The provider restates what the youth has said in her own words. This assures the youth that the provider has heard and understood what the youth has said. For example:

Adolescent: ‘I don’t know what is the matter. I just don’t feel well today’.
Service Provider: ‘You are feeling sick today?’

OR

Adolescent: ‘I was supposed to take these pills for a week, but I stopped after two days when I felt better’.
Service Provider: ‘You decided to stop when you felt better’.

**Questioning**

The provider encourages youth to talk about themselves by asking questions. Questions can be open or closed ended. Open-ended questions give the youth a wide range of options for a response and can be used to get information from the youth without influencing their responses. Some examples are: ‘how have you been?’, and ‘how do you feel about taking modern medication?’

Closed-ended questions are more leading, and limit possible youth responses. They may cause youth to give the provider answers they think the provider wants to hear, instead of what they are really thinking. Some examples are, ‘have you been well?’ and ‘do you take medication?’ Closed questions can be used to focus the youth on a particular issue. However, if used too often, the provider might miss important information.

Probing questions or statements are used to pursue further details from the youth. They can be open or closed-ended, but are usually open-ended. For example:

‘Tell me more about…’
‘And?’
‘Um hmm,’ followed by silence.
‘Is there anything you left out?’
‘How does that make you feel?’

When probing to get information the youth might feel personal or private, probes should be worded carefully.

**Making Positive Statements (Praise/Encouragement/Reassurance)**

Making positive statements can help youth to feel good about themselves. When a youth is in a crisis, it can help him/her get control of the situation. Avoid giving false praise or false reassurance. Some examples are:

Praise: ‘You are looking well today’ (if true), or ‘You took the packet of pills perfectly’.
Encouragement: ‘You did the right thing by coming here’.

Reassurance: ‘A lot of people have that concern. The IUD does not leave the uterus and travel around the body’, or ‘It is normal to experience a little weight gain in the first few cycles, but it is usually only temporary’.

**Giving Information**

When giving information, explanations should be simple, clear, and in a language youth understand. Use learning aids whenever possible. Part of giving information is assessing whether youth have understood the message. To do this, ask questions, have youth repeat instructions, and ask youth to demonstrate what has been taught.
### Communication Skills Checklist

**For Use with Video**

#### Personal Barriers

<table>
<thead>
<tr>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open-Ended Questions</td>
</tr>
<tr>
<td>Probing</td>
</tr>
<tr>
<td>Summarizing/Paraphrasing</td>
</tr>
<tr>
<td>Reflecting Feelings</td>
</tr>
<tr>
<td>Giving Information Clearly And Assessing Adolescent Understanding</td>
</tr>
<tr>
<td>Praise/Encouragement/Reassurance</td>
</tr>
<tr>
<td>Active Listening/Attending Behaviour</td>
</tr>
</tbody>
</table>
Barriers to Communication and Strategies to Overcome Them

Barriers Created by Service Providers

Sometimes service providers can create barriers to communication. Here are a few examples, including strategies to overcome them.

- **Knowledge** – This may be important if you are speaking on a topic you do not know a lot about.
  
  **Strategies:** Make sure your knowledge is up-to-date. If you do not know something, it is okay to tell youth that you do not know at present, but that you can find out for them.

- **Attitude** – Negative attitudes can affect the impact of the message. Good communication must be non-judgemental.
  
  **Strategies:** Be aware of your attitudes and biases, and keep them out of your communication. Never impose your opinions on controversial topics.

**Socio-Economic Barriers**

1. **Age** – Some youth do not feel comfortable with people either younger or older than themselves.

   **Strategies:** Show proper respect. Identify yourself as a health worker who deals with sensitive topics. Explain that when there are serious health consequences, there is a need to discuss issues that are sometimes personal.

2. **Religion and Culture** – Sometimes youth may feel uncomfortable sharing their thoughts and feelings with a person from another culture or religion.

   **Strategies:** It helps to have background information on the religious and cultural beliefs of youth. Try to identify times when religious and cultural values might interfere with communication, and work with them (do not ignore them). Respect people’s values, even when you do not agree with them.

3. **Sex** – Some prefer to communicate with people of the same sex (especially about personal subjects)

   **Strategies:** Again, acknowledge that the discussion might be embarrassing but explain that it is necessary to discuss personal topics for health reasons. Acknowledging embarrassment usually helps youth to overcome it.

4. **Language** – Technical words can be too difficult to understand. It is important to speak in terms that people understand and to use acceptable names for things.

   **Strategies:** Keep language simple. Confirm whether terms are familiar and understood by youth. If not, explain the terms or use more familiar words.

5. **Economic Status** – Youth might find it hard to relate to a person who appears to be of another economic status.

   **Strategies:** Show respect no matter how poor the adolescent might appear. Avoid fancy dress. Sit among group members, instead of standing over them or sitting apart from them.

**Note:** For all social and economic barriers, it is important to know your audience to determine who can work well with them. Whenever possible, involve providers who can relate to the youth.

**Logistical Barriers**
6. **Time** – Adolescent might not be interested in talking with providers if they are busy doing something else. **Strategy:** When possible, let the adolescent choose the time for discussion. Remember, good communication can occur even when little time is available.

7. **Venue** – Noise, excessive temperatures, and poor seating facilities can make good communication difficult. **Strategy:** Make sure the venue is suitable and in a location that is accessible.
HANDOUT 3.3.4
Role Play Worksheet: Use of Interpersonal Communication Skills

Each group member chooses a situation from the following list. For each situation selected, one person is the ‘counsellor’, one is the ‘youth’ and the third is the observer. Each participant should have a chance to play each role.

Situation 1: A woman wants to discuss how to talk to her husband about HIV and AIDS.

Situation 2: A husband and wife are having a conflict over school fees. The husband wants to use the money to buy car parts and the woman wants to use the money for her daughter’s education.

Situation 3: A friend is having problems getting along with her co-worker. She wants to talk to you about it.

Situation 4: A young person comes in with a variety of non-specific complaints. You explain that there is an underlying issue to talk about.

COMMUNICATION SKILLS RECORD

Every time you hear or see the person you are observing use a communication technique discussed in class, make a mark in the correct box.

<table>
<thead>
<tr>
<th>Question or Probing</th>
<th>Participant 1</th>
<th>Participant 2</th>
<th>Participant 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summarizing or</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Paraphrasing</td>
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<tr>
<td>Praise or Encouragement</td>
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<td>Reflecting Feelings</td>
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<tr>
<td>Active Listening or Attending Behaviour</td>
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</table>
HANDOUT 3.3.5
Character Description for Fishbowl Role Play

(Trainer: Copy this page before the session, and cut the copy into pieces. Give each participant who is playing a role a description of their character)

Speaker. Select a theme on which to lead a discussion. It can be anything, such as how to make sadza, how to grow mealies, how children are born in your area, why people go traditional healers. It should be something about which you are knowledgeable, so that you can speak comfortably. Encourage the group members to participate in the discussion.

Character 1. You are someone who is very shy and does not say anything. You are also concerned because you don’t have any money to pay for the services you need today.

Character 2. You are someone who is in a lot of pain. You are having difficulty paying attention.

Character 3. You come from a culture very different from the speaker’s culture. You do not agree with anything the speaker says because she is not from your culture.

Character 4. You can’t speak the language being used to give the talk. You ask the person next to you to translate.

Character 5. You are someone who thinks he knows more than the speaker and the other group members. You interrupt a lot and argue when you disagree with people.
SESSION 4 SUMMARY

MODULE III: Interpersonal Communication with Adolescents

SESSION 4: Life Skills

Time: 2 hours, 40 minutes

Objectives:
By the end of the session, participants will be able to:
- Identify at least 3 life skills.
- Identify at least 5 tips for negotiation.
- State 2 reasons why it is important for adolescents to make decisions in an organized manner.
- Describe conditions that build a sense of high self-esteem.

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>5 min</td>
<td>Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>2. Definition of terms</td>
<td>15 min</td>
<td>Exercise, Discussion</td>
<td>HO 2.4.1</td>
</tr>
<tr>
<td>3. Negotiation Skills</td>
<td>20 min</td>
<td>Role Play, Discussion</td>
<td></td>
</tr>
<tr>
<td>4. Importance of decision making</td>
<td>10 min</td>
<td>Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>5. Types of Decisions</td>
<td>10 min</td>
<td>Brainstorm</td>
<td></td>
</tr>
<tr>
<td>6. Decision-Making Model</td>
<td>30 min</td>
<td>Presentation, Exercise</td>
<td>HO 2.4.2</td>
</tr>
<tr>
<td>7. Factors Influencing Decisions</td>
<td>10 min</td>
<td>Brainstorm</td>
<td>HO 2.4.3</td>
</tr>
<tr>
<td>8. Self Esteem</td>
<td>50 min (all sections)</td>
<td>Brainstorming, Group Work, Discussion</td>
<td></td>
</tr>
<tr>
<td>9. Conclusion</td>
<td>10 min</td>
<td>Discussion</td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES


en.wikipedia.org/wiki/Life_skills and [schoolsanitation.org/Resources/Glossary.html](http://schoolsanitation.org/Resources/Glossary.html).


Module 7: Life Skills

The English dictionary


1. INTRODUCTION - Discussion (5 min)

Step 1:
- Ask the group to think back on an important decision they have made recently. How did they make it? Ask for comments, without charting them.
- Verbally note the level and type of decisions reflected in the participants’ comments.
- Explain the goals for the session and how they will be achieved.

2. DEFINING LIFE SKILLS – Exercise, Mini Lecture (15 min)

Step 2:
- Define life skills
- Give each participant a card or newsprint and a marker, and ask them to write down the most important life skill that they have.
- Allow 5 minutes for the exercise.
- Collect the cards and group them according to similarities and display them. Ask participants if the listed life skills can lead to a healthy and productive life. Add in further identified life skills.
- Refer to Session 11- Interpersonal Communication is one of the Life Skills. Use Handout 2.4.1
- Present the Life skills under the three categories and explain how they differ (i.e. communication, decision making and coping mechanisms).

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.

Which Skills are Life Skills?

There are three categories of Life Skills, namely Communication and Interpersonal Skills; Decision Making and critical thinking and Coping and Self Management skills. Examples under each category are listed below:

a) Communication and Interpersonal Skills

Interpersonal communication skills
- Verbal/Nonverbal communication
- Active listening
- Expressing feelings; giving feedback (without blaming) and receiving feedback

Negotiation
- Negotiation and conflict management
- Assertiveness skills
- Refusal skills

b) Decision-Making and Critical Thinking Skills

Decision making / problem solving 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 and attitudes of self and others on motivation

**Critical thinking skills**
• Analyzing peer and media influences
• Analyzing attitudes, values, social norms and beliefs and factors affecting these
• Identifying relevant information and information sources

**Coping and Self-Management Skills**

**Skills for increasing internal locus of control**
• Self esteem/confidence building skills
• Self awareness skills including awareness of rights, influences, values, attitudes, strengths and weaknesses
• Goal setting skills
• Self evaluation / Self-assessment / Self-monitoring skills

**Skills for managing feelings**
• Anger management
• Dealing with grief and anxiety
• Coping skills for dealing with loss, abuse, trauma

3. **NEGOTIATION SKILLS - Role Play, Discussion, Mini Lecture (20 min)**

**Step 3:**
- **Ask participants to do a role play on an adolescent relationship, for example a male adolescent negotiating for sex with his adolescent girlfriend.**
- **Lead discussion by asking some questions such as ‘What skills were used in the negotiation?’ ‘What skills decided the outcome of this negotiation?’ ‘What tips can you suggest to the two for a positive outcome in another negotiation?’**
- **Add information missed out from the discussion.**

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.

**Negotiation Skills:**
• Persuasion
• Ability to assess the situation
• Good listening skills
• Knowledge to express one self
• Appropriate timing
• Observation of non verbal skills

**Tips for Negotiation**
• 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 don’t 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. Don’t let your partner judge, label, threaten, or bribe you.
- Be assertive and not aggressive.

**Step 4:**

- **Follow-up this discussion, define assertiveness and highlight its importance in negotiation.**
- **Which specific areas in sexual and reproductive health do adolescents have to be assertive? Why?**
- **Bring out the differences in assertiveness, passiveness and aggressiveness.**

**ASSERTIVENESS**

Being assertive is standing up for your personal rights without putting down the rights of others. If you can do this you will be able to:

- Say ‘No’ without feeling guilty
- Disagree without becoming angry
- Ask for help when you need it
- As a result you will feel better about yourself

As a result you will feel better about yourself and have more honest friends and relationships. As assertive will respect themselves as well as others, listen and talk, express positive and negative feelings.

There are two other extreme behaviours to being assertive, these are aggressiveness and passiveness.

**Passiveness** - This is giving in to the will of others and hoping to get what you want without actually having to say it. It is also includes leaving others to guess or letting them decide for themselves. A passive person usually has a very submissive character.

**Aggressiveness** - This is expressing your feelings, opinions or desires in a way that threatens or punishes the other person. It includes insisting on your rights whilst denying the rights of others. An aggressive person on the other hand can be very dominating.

**Step 5:**

- **Present and discuss the methods and techniques that can be used to enhance assertiveness and self-confidence.**

**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.

**4. IMPORTANCE OF DECISION-MAKING PROCESS – Discussion (10 min)**
Step 6:
- Ask participants to consider a poor decision that they made recently. Why did they think it was a poor decision? What is a poor decision? What is a good decision?
- Emphasize the importance of the process of decision-making as opposed to the outcome.

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.

Good decision-making will minimize the possibility of getting an unfavourable outcome, but it cannot eliminate the possibility. The best protection you have against an undesired outcome is a good decision.

An outcome is the result, consequence, or aftermath of that person’s act or decision. Often, the outcomes are not in our total control.

Two important skills needed to make good decisions are:
1. The ability to clarify values; and
2. The ability to acquire information.

When most people say a decision is poor, they mean the result was not what they would have wanted. For example, “It didn’t turn out the way I thought it would. The outcome was not good. Things did not happen right”. However, their decision may have been a good decision at the time. One of the first lessons in decision-making is to learn to make the distinction between a poor decision and a poor outcome, a good decision and a good outcome—or the distinction between a decision and an outcome.

5. TYPES OF DECISIONS – Brainstorming, Discussion (10 min)

Step 7:
- Brainstorm a list of decisions that youth might have to make. Discuss the difficulties that a young person might have in making these decisions.
- Ask, what are some of the most risky decisions youth make? Place a '*' by these decisions, or add to the list.
- Reinforce the idea that young people are making important, life-changing decisions all the time and need the skills to make good choices.

Areas that adolescents make decisions include appearance; friends; activities; school work; career; sexual activity; having unprotected sex; breaking the law; mixing driving and alcohol; and using drugs.

6. DECISION-MAKING MODEL/Critical Thinking – Mini Lecture, Exercise (30 min)

Step 8:

Present the “3-C” decision-making model, using a decision that most participants need to make or recently made.

Divide the participants into small groups and ask them to put themselves in a young person’s place and use the model to decide whether or not they should have sex as young persons.

Each group should be given the means to present the results of their decision-making to the rest of the group.

Ask the group: What are the best arguments for waiting? Can someone who decided to wait change his or her mind? Why? What is the worst thing that can happen to a teen who says yes? Who says no?
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.

7. FACTORS INFLUENCING DECISIONS – Brainstorming, Discussion (10 min)

Step 9:

Brainstorm and discuss influences on decisions.

Ask participants what influences are the most difficult for teens to resist? Why?

Tell the group to imagine the same young person they had in mind during the small group exercise. Using deciding about sex as an example, brainstorm what influences might change this person’s mind. After a few minutes, ask each participant to use Handout 2.4.2 to complete the exercise. Ask volunteers to share.

Adults sometimes accuse adolescents of making poor decisions, but often making the decision is the easier part. Staying with the decision can be much more difficult.

Influences
- Peer pressure
- Media messages
- Pressure from romantic partners
- Parents’ wishes
- Influence of alcohol or drugs
- Self–feelings and values

8. SELF ESTEEM - Brainstorming, Discussion (5 min) (Note: 50 minutes for all Sections)

Step 10:
- Brainstorm with the participants a definition of self-esteem.
- Ask the participants to write down what their sense of self esteem was when they were 18 years old. Then ask them to write down what an adolescent they know might have written and how theirs is similar to or different from the adolescent’s.
- Define self esteem
Different people define self-esteem in different ways. Self-Esteem is the way we put value on ourselves. It encompasses the way we perceive, the way we feel, the way we think and act.

Characteristics of High and Low Self Esteem – Group Work (20 min)

Step 11:
- Discuss characteristics of high and low self-esteem. How can we identify these characteristics in the behaviour of adolescents?
- Compare the participants' lists and add or discuss differences with these short, prepared lists below.
- Ask participants to come up with some conditions that contribute to low self-esteem. Record responses and discuss.
- Discuss possible consequences of low self esteem. List them on a Flip chart.

<table>
<thead>
<tr>
<th>High Self-Esteem</th>
<th>Low Self-Esteem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enthusiasm</td>
<td>Pessimism</td>
</tr>
<tr>
<td>Optimism</td>
<td>Aggressiveness</td>
</tr>
<tr>
<td>Ambition</td>
<td>Withdrawal</td>
</tr>
<tr>
<td>Cooperation</td>
<td>Depression</td>
</tr>
<tr>
<td>Respect of self and others</td>
<td>Uncaring</td>
</tr>
<tr>
<td>Kindness</td>
<td>Passive</td>
</tr>
<tr>
<td>Accepting responsibility</td>
<td>Negative attitude</td>
</tr>
<tr>
<td>Voluntarism</td>
<td>Irresponsibility</td>
</tr>
<tr>
<td>Confident</td>
<td>Volunteering others</td>
</tr>
<tr>
<td>Proactive</td>
<td></td>
</tr>
</tbody>
</table>

The following conditions can result in adolescents having a low self-esteem:

Conditions that contribute to low self esteem
- Negative role models in early childhood
- Expectations from parents (high and low)
- Absence of conditions outlined under high self-esteem.

Consequences of low self esteem
- This can lead to suicide if one faces challenges and chooses not to seek help from available support systems
- Vulnerability to abuse
- Exposure to negative peer pressure

Conditions for the Development of High Self Esteem – Group Work, Discussion (15 min)

Step 11:
Go back to the definition of self-esteem that the participants shared previously. Ask them to work in small groups and discuss what the primary influences were that shaped their sense of self-esteem when they were growing up. If it changed as they became adults, ask them to describe what influenced, or brought about this change.

Have the groups continue to brainstorm and then develop concrete strategies for building young people’s sense of self-esteem, as well as the places or institutions where they think this could ideally and realistically take place.

Have each group share what strongly influenced their sense of self-esteem as a young person and based on that – the strategy they developed to increase a young person’s sense of self-esteem.

Discuss conditions that facilitate a high sense of self-esteem.
We learn to value ourselves as others value us. Children with high self-esteem know that they are loved. They tend to come from families in which their achievements are valued and praised, and where they are encouraged to make decisions and are given some responsibility for their own actions.

Self-esteem usually develops throughout adolescence. At first it depends very much on being liked and accepted by family and friends, with maturity, it comes more and more from a combination of personal achievement along with family and social support. The following conditions can help adolescents to have a high sense of self-esteem:

- Sense of connection and relationship to others that is a feeling of belonging either to a family, friends, a group, country or locality.
- A sense of one’s own uniqueness and value (such as your talents, looks, or abilities).
- A sense that one has power to stand up for oneself and family and make choices about what happens to self and family.
- Positive role models to identify with in society.
- Exposure to incidences that call for decision-making.

Tips for Building Self Esteem – Brainstorming (10 min)

Step 12:
- Brainstorm with the participants and come up with a list of tips for building self-esteem.
- Add any tips the participants may not have thought about to their list.

We see that it takes more self-esteem than most teens have to be able to rely on who they ARE rather than what they LOOK like to make an impression on others. What can we do to help them?

- when you criticize, try to be positive rather than hurtful (be objective)
- praise their achievements and give credit
- if you dislike their behaviour, make it clear that you don’t dislike them
- don’t “label” children
- show that you’re interested in what they do
- show them that you accept and value them as they are
- trust them to make the right choices for themselves and reinforce their choices when you can
- encourage them to have opinions and values of their own
- show that you love them even when they make bad choices

9. CONCLUSION – Discussion (10 min)

Step 12:
- Review objectives.
- Ask the group how life skills help adolescents make better choices concerning their sexual and reproductive health.
- Ask for volunteers to share.

Highlight these factors. Life skills assist adolescents in:
- Translating knowledge, attitudes and values into healthy behaviour.
- Making informed decisions about their health.
- Empowering girls to avoid pregnancy until they reach physical and emotional maturity.
- Developing in both boys and girls responsible and safe sexual behaviour, sensitivity and equity in gender relations.
- Preparing boys and young men to be responsible fathers and friends.
- Encouraging adults, especially parents, to listen and respond to young people.
**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.

<table>
<thead>
<tr>
<th>Interpersonal communication skills</th>
<th>Negotiation skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Verbal/Nonverbal communication</td>
<td>• Negotiation and conflict management</td>
</tr>
<tr>
<td>• Active listening</td>
<td>• Assertiveness skills</td>
</tr>
<tr>
<td>• Expressing feelings; giving feedback (without blaming) and receiving feedback</td>
<td>• Refusal skills</td>
</tr>
</tbody>
</table>

**Empathy**

<table>
<thead>
<tr>
<th>Cooperation and Teamwork</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ability to listen and understand another’s needs and circumstances and express that understanding</td>
</tr>
</tbody>
</table>

**Advocacy Skills**

<table>
<thead>
<tr>
<th>Advocacy Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Influencing skills &amp; persuasion</td>
</tr>
<tr>
<td>• Networking and motivation skills</td>
</tr>
</tbody>
</table>

**Decision-Making and Critical Thinking Skills**: Two examples of decision making and critical thinking are given below.

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

**Coping and Self-Management Skills**: Three broad categories of life skills under coping and self management are:

<table>
<thead>
<tr>
<th>Skills for increasing internal locus of control</th>
<th>Skills for managing feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Self esteem/confidence building skills</td>
<td>• Anger management</td>
</tr>
<tr>
<td>• Self awareness skills including awareness of rights, influences, values, attitudes, rights, strengths and weaknesses</td>
<td>• Dealing with grief and anxiety</td>
</tr>
<tr>
<td>• Goal setting skills</td>
<td>• Coping skills for dealing with loss, abuse, trauma</td>
</tr>
<tr>
<td>• Self evaluation / Self assessment / Self-monitoring skills</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skills for managing stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Time management</td>
</tr>
<tr>
<td>• Positive thinking</td>
</tr>
<tr>
<td>• Relaxation techniques</td>
</tr>
</tbody>
</table>
The 3 C’s DECISION-MAKING MODEL

1. **Challenge** (or decision) being faced:

2. **Choices:**

   1. 
   2. 
   3. 

3. **Consequences** of each choice:

   - Consequence of Choice #1:
     - Positive
     - Negative

   - Consequence of Choice #2:
     - Positive
     - Negative

   - Consequence of Choice #3:
     - Positive
     - Negative

   The decision is:

   The reason is:

3 C’S TO GOOD DECISION-MAKING (THE PROCESS)

1. **Challenge** (or decision being faced): Should I have sex?

2. **Choices:**

   a. To have sex.
   b. Not to have sex.
   c. To seek advice.
   d. To have protected sex.

3. **Consequences** of each choice:
CHOICE A (to have sex)

<table>
<thead>
<tr>
<th>Positive Consequences</th>
<th>Negative Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual gratification</td>
<td>STI/HIV</td>
</tr>
<tr>
<td>Prove one is an adult</td>
<td>Remorse</td>
</tr>
<tr>
<td>Prove manhood/boast (boys)</td>
<td>Unwanted pregnancy</td>
</tr>
<tr>
<td>Acceptance by peers</td>
<td>Lose trust with your parents</td>
</tr>
<tr>
<td>Gain experience</td>
<td>Expulsion/drop out of school</td>
</tr>
<tr>
<td>Satisfy curiosity</td>
<td>Early parenthood</td>
</tr>
<tr>
<td>Recreation</td>
<td>Lose friends</td>
</tr>
<tr>
<td>Stop pressure from friends/partner</td>
<td>Lose partner</td>
</tr>
<tr>
<td>Communicate loving feelings in a relationship</td>
<td>Lost virginity</td>
</tr>
<tr>
<td>Get affection</td>
<td>Lose reputation</td>
</tr>
<tr>
<td>Avoid loneliness</td>
<td>Early/forced marriage</td>
</tr>
<tr>
<td>Hold on to a partner</td>
<td>Abortion</td>
</tr>
<tr>
<td>Become a parent</td>
<td>Baby-dumping</td>
</tr>
<tr>
<td>Get material rewards (girls?)</td>
<td>Destitution/prostitution</td>
</tr>
</tbody>
</table>

CHOICE B (not to have sex)

<table>
<thead>
<tr>
<th>Positive Consequences</th>
<th>Negative Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow religious beliefs or personal/family values</td>
<td>Lack experience</td>
</tr>
<tr>
<td>Wait until ready for intercourse</td>
<td>Can’t boast</td>
</tr>
<tr>
<td>Keep a romantic relationship from changing</td>
<td>No material gains</td>
</tr>
<tr>
<td>Avoid pregnancy</td>
<td>Contempt of peers</td>
</tr>
<tr>
<td>Avoid STIs and HIV infection</td>
<td>Boredom</td>
</tr>
<tr>
<td>Avoid hurting parents</td>
<td>Lose partner</td>
</tr>
<tr>
<td>Avoid hurting reputation</td>
<td>Feel guilty/develop stress</td>
</tr>
<tr>
<td>Avoid feeling guilty</td>
<td></td>
</tr>
<tr>
<td>Reach future goals/career mobility</td>
<td></td>
</tr>
<tr>
<td>Find the right partner</td>
<td></td>
</tr>
<tr>
<td>Wait for marriage</td>
<td></td>
</tr>
<tr>
<td>Keep virginity</td>
<td></td>
</tr>
<tr>
<td>Keep real friends</td>
<td></td>
</tr>
<tr>
<td>Feel empowered</td>
<td></td>
</tr>
<tr>
<td>Positive self-esteem</td>
<td></td>
</tr>
<tr>
<td>Maintain trust</td>
<td></td>
</tr>
<tr>
<td>Avoid responsibilities of early parenthood</td>
<td></td>
</tr>
</tbody>
</table>

CHOICE C (seek advice)

<table>
<thead>
<tr>
<th>Positive Consequences</th>
<th>Negative Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get informed</td>
<td>Influence of others (may not be true to oneself)</td>
</tr>
<tr>
<td>Make good decisions</td>
<td>Not responsible for own decision</td>
</tr>
<tr>
<td>Physical and mental maturity</td>
<td>Incorrect information from others</td>
</tr>
<tr>
<td>Safe sex</td>
<td>Loss of confidentiality</td>
</tr>
</tbody>
</table>

The reason is: _____________________________________________________________
INFLUENCES ON YOUNG PEOPLE REGARDING SEXUAL ACTIVITY AND WAYS A YOUNG PERSON COULD COMBAT THESE INFLUENCES

1. Peer pressure
2. Media messages
3. Social media
4. Pressure from a romantic partner
5. Parents' wishes
6. Influence of drugs or alcohol
7. Self (feelings and values)

YOUR DECISION + OTHER INFLUENCES = YOUR BEHAVIOUR
SESSION 5 SUMMARY
MODULE III: Interpersonal Communication with Adolescents

SESSION 5: Youth Friendly SRH Services

Time: 2 hours

Objectives:
By the end of the session, participants will be able to:
- Define Youth Friendly SRH Services (YFS)
- Describe the guiding principles of Youth Friendly SRH Service (YFS) provision.
- Outline 4 characteristics of Youth Friendly SRH services.
- Identify at least 4 existing support systems in the community.
- List at least 3 benefits of community support systems in ASRH provision.
- Identify the importance of working with adolescents, parents and communities.
- Describe strategies / approaches in Youth Friendly SRH Service provision.

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>10 min</td>
<td>Role Play</td>
<td>Flip chart, markers</td>
</tr>
<tr>
<td>2. Definitions</td>
<td>25 min</td>
<td>Lecture/Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>3. Standards for YFS</td>
<td>10 min</td>
<td>Presentation/ Discussion</td>
<td>Flip charts, markers</td>
</tr>
<tr>
<td>4. Characteristics of YFS</td>
<td>15 min</td>
<td>Presentation</td>
<td>Computer, HO 3.3.1</td>
</tr>
<tr>
<td>5. Settings in YF SRH Service provision</td>
<td>15 min</td>
<td>Group exercise</td>
<td>HO 3.3.2</td>
</tr>
<tr>
<td>6. Meaningful involvement of Adolescents and parents in ASRH Service provision</td>
<td>20 min</td>
<td>Brainstorming/ Discussion</td>
<td>HO 3.3.3</td>
</tr>
<tr>
<td>7. Minimum package of integrated SRH and HIV services for young people</td>
<td>20 min</td>
<td>Lecture/Discussion</td>
<td>HO 3.3.4 Computer,</td>
</tr>
<tr>
<td>8. Community support systems</td>
<td>20 min</td>
<td>Presentation</td>
<td>LCD, Flip charts, markers</td>
</tr>
<tr>
<td>9. Conclusion</td>
<td>5 min</td>
<td>Review lessons learnt</td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES:
Adapted from PHN Centre focus on young adults project 2000
Government of Zimbabwe, 2016 National Guidelines on Clinical Youth Friendly Sexual and Reproductive Health Service Provision (YFSP)

WHO (2002). *Adolescent Friendly Health Services – An Agenda for Health.*


1. **INTRODUCTION – Role Play (10 min)**

**Step 1:**
- *Introduce the session*
- *Role Play: Have an ‘adolescent’ seek health services from a clinic in their area where the service provider is an adult of the age of his/her mother/guardian and Discuss.*

According to UN agreements and recommendations, adolescents have a right to receive accurate sexual and reproductive health information and confidential services without discrimination (UN Committee on the Rights of the Child).

**The Importance of Focussing on Adolescents:**

a) **To reduce death and diseases in adolescents now:** A number of adolescents die each year mainly from accidents, violence, pregnancy related problems or illnesses that are either preventable or treatable.

b) **To reduce burden of disease and make decisions for later life:** This is the age when sexual habits and decisions about risk and protection are formed. Some of the highest infection rates for STIs are in adolescents. The HIV and AIDS pandemic alone is sufficient reason to look anew at how health services address the needs of adolescents.

c) **To invest in health today and tomorrow:** Today’s adolescents are tomorrow’s parents, teachers, and community leaders. Adolescence is a period of curiosity when young people are receptive to information about themselves and their bodies and when they begin to take an active part in decision making.

d) **To deliver on human rights:** Convention on the rights of the child (CRC) says that young people have a right to life, development and (article 24) “the highest attainable standard of health and facilities for the treatment of illness and rehabilitation of health.”

2. **DEFINITION OF TERMS – Mini Lecture, Discussion (20 min)**

**Step 2:**
- *Define Youth Friendly SRH Services*
- *Discuss the guiding principles of Youth Friendly SRH Service provision.*

Youth Friendly Services (YFS) are 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.

**Guiding principles of Youth Friendly SRH Services**
- Provide integrated SRH services, information and management of STIs including HIV, and general primary health care for young people from a human rights, continuum of care and developmental approach.
- Integration of life skills and livelihood programmes into SRH programmes is vital for sustainable SRH behaviour change.
- Gender and cultural sensitivity is fundamental in ASRH programmes, to ensure equal access and acceptability of social services and opportunities by young people.

“…..promote programmes directed to the education of parents, with the objective of improving the interaction of parents and children to enable parents to comply better with their educational duties to support the process of maturation of their children, particularly in the areas of sexual behaviour and reproductive health.” (ICPD POA, Paragraph 7.48)
- Adopt an evidence-based, participatory and multi-sectoral approach to ASRH programming, ensuring meaningful and active participation of young people, parents and community at all levels.
- Foster accountability and transparency at all levels.

3. **STANDARDS FOR YOUTH FRIENDLY SERVICE PROVISION (YFSP)**

   **Step 3:**
   - **identify with the 9 standards for quality health care services for adolescents refer to Handout 5.5.1.**
   - **explain the 9 standards for quality health care services**

   The World Health Organization (WHO) describes Youth Friendly Services (YFS) as;

   “Service that is accessible, acceptable and appropriate for adolescents. They are in the right place at the right price (free where necessary) and delivered in the right style to be acceptable to young people. They are effective, safe and affordable. They meet the individual needs of young people who return when they need to and recommend these services to friends.”

   Zimbabwe developed youth friendly service guidelines by initially reviewing the WHO global standards for quality health care services for adolescents. These were adapted and contextualized to the needs of young people and the health situation in Zimbabwe. Subsequently the guidelines were developed from the contextualized standards and from the experiences of stakeholders involved in programming for youth and by young people themselves.

   The standards and guidelines presented below define the elements necessary for providing quality and efficient youth friendly care. The guidelines are based on identified components of ASRH clinical care and support and grounded on other existing complementary guidelines and standards that are relevant to SRH within the Zimbabwe context.

   **Adapted from the National Guidelines on Clinical Youth Friendly Sexual and Reproductive Health Service Provision (YFSP)**

1. **CHARACTERISTICS OF YOUTH FRIENDLY SRH SERVICES – Mini Lecture, Discussion (25 min)**

   **Step 4:**
   - **Make a presentation on characteristics of Youth Friendly SRH Services.**
   - **Discuss the characteristics and ask participants to share information on ASRH services provided at their institution.**
   - **Use Handout 3.3.1 to discuss minimum conditions for friendly ASRH Service Provision in Zimbabwe.**

   The following key characteristics are associated with youth friendly SRH services and they will be referred to in the standards and guidelines in the next sections. These basic fundamentals differ based on factors such as geographical area, culture and various characteristics of the target group such as age, gender, sexual diversity, HIV status, marital status and sexual experience. What is important for one group may not necessarily be as important for another group. Some aspects appear universal and are critical to the majority of young people.

   **Provider Characteristics**
   a) **Trained staff:** Trained providers are the foundation for establishing youth friendly services. Skills must include familiarity with the physiology and development of adolescents as well as appropriate medical options based on the age, needs and concerns of young people.
   - Service providers should possess competencies and interpersonal skills that attract young people to communicate their concerns with ease and comfort.
   - Providers should be carefully selected for YFS, based on their interest and willingness to transform and adopt positive attitudes towards young people.
All non-medical staff such as security guards, janitors and receptionists should be trained and oriented to the needs of the young people and expectations of the systems by young people.

b) **Respect:** Providers must be free of prejudices and biases against adolescent sexual activity and be able to relate to adolescents in a respectful way. Importantly, selection of youth service providers should be carried out carefully and with caution to avoid recruiting and engaging providers with negative attributes to work with young people.

c) **Privacy and confidentiality:** Many young people fail to seek health care due to fear and anxiety that providers will disclose their reasons for seeking services and other private information with relatives and those close to them. Privacy must therefore be arranged for counselling sessions and physical examinations; young people must feel confident that their important and sensitive concerns are not disclosed to other persons. Similarly, registration procedures should be simple and allow for confidentiality. Access to client’s registers and other records must be restricted to ensure confidentiality. A youth friendly SDP policy on confidentiality should be displayed and clearly expressed to the client and accompanying persons especially parents/guardians at the first visit/interaction.

a) **Age Barrier:** Many young people report that they feel more comfortable talking to people their own age about sensitive issues although for more technical issues, they tend to prefer adult providers. However, the age difference between a service provider and a young person seeking health care should not be a barrier to interaction if the older person realises the potential constraint and adopts an open and flexible attitude. It is therefore critical, to have peer counsellors available as complements for some aspects of service provision such as information provision and counselling.

**Service Delivery Point Characteristics**

a) **Special Times Set Aside:** This strategy may apply to young adolescents, first-time clinic users, non-sexually active clients, and marginalised young people, with high unmet needs for health care. Providers should capitalise on less busy periods to cater for “separate time” so that they can allocate more time for young people and help increase privacy. Local needs assessments should be conducted before adopting such a strategy.

b) **Convenient Opening Hours:** SRH clinic services should be open at times that are convenient for both young people to attend and the clinic personnel to be in attendance during after-school hours and weekends. Providers should avail themselves for emergency services or devise means of ensuring communication mechanisms that support young people at all times.

c) **Separate and Private Space:** Examination rooms and counselling rooms should offer both auditory and visual privacy. Interruptions during client visit sessions should also be minimised. A provider-youth client study in Zimbabwe showed that, although counselling occurred in a separate room in most clinics (92%), other people could overhear 23% of the sessions and also see what was happening during 32% of the sessions. More than one-third (36%) of the sessions were interrupted by other staff members².

d) **Comfortable Surroundings:** Young people often prefer environments that are clean, have adequate seating, and are decorated with cheerful colours and IEC materials.

**Programme Design Characteristics**

- **Youth Participation and Continuing Feedback:** To adequately address young people’s SRH needs, youth should be involved in the design, implementation, and evaluation of services. There are various strategies that can be used to meaningfully involve young people in their treatment and care services. Deliberate efforts should involve them in carrying out needs assessments for improving services offered at youth-friendly SRH facilities, training them as peer educators to provide counselling services to youth in the community before referral for treatment. Young people should also be involved in service-demand creation

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as well as in providing feedback on quality of service provision through exit interviews, or through mystery 
client assessments and as members of the ASRH Community Committees.

- **Open Access to Services**: Young people may have constraints of scheduling access to health services. They are more likely to access services if they can be seen without an appointment. If an adolescent is turned away and told to return at another time, or if are given an appointment that is several weeks way, their chances of returning for the new appointment are limited.

- **Overcrowding and Waiting Period**: Having to wait a long time to be served in a clinic is often cited as a barrier by young people. Young people are often unwilling to wait for services; and if the SDP is crowded, they are particularly concerned that someone they know will see them while they are waiting.

- **User fees**: Youth friendly services should be free or affordable in view of the fact that most youth are unemployed and may not want their parents or guardians to know that they are seeking SRH services.

- **Demand Creation/Service Branding**: Demand creation for YFS access and utilisation can be achieved through community mobilisation in order to alert adolescent about the existence of SRH services, the SDP location, and operating hours. The services should be advertised by youth themselves through fliers, word of mouth or through community outreach presentations including at schools. Appropriated branding should make it clear that boys and young men are welcomed and served. The accompanying of a girl by a boyfriend to the clinic can be an important element especially in the decision to seek contraceptive services. Such opportunities foster shared responsibility for decision-making and offer young men to access SRH information, counselling, and other services such as VMMC. It may be necessary to develop clinic programmes designed especially for young males that are sensitive to their values, motivation, feelings, and cultural influences.

- **Wide Range of Services Offered**: Youth friendly services that are attractive to young people offer a wide range of integrated services including contraceptive methods. Attempts should be made to identify and provide the most needed ASRH services as a “one-stop shopping exercise.” Age alone should not constitute the sole reason for denying medical service to adolescents. Although the legal age of consent to sexual activity in Zimbabwe is 16 years, all adolescents who are sexually active should be offered a contraceptive method of their choice. Adolescents, married or unmarried, have also been shown to have higher contraceptive discontinuation rates mainly because they tend to be less tolerant of side effects. Expanding the number of method choices offered, as well as proper education and counselling can lead to improved satisfaction, increased acceptance and increased prevalence on contraceptive use.

- **Referral Services**: It may be necessary to refer some types of specialised health care and related social services to those able to provide them. Cognisant of the broad range of determinants of health (especially relating to SRH) it is critical that health service providers are oriented and knowledgeable on what to refer outside their scope of operation and where to. Health services should have readily available records kept for such external service as, recreational facilities or livelihoods-supporting NGOs. Effective working arrangements should be established to ensure that youth receive the identified referral services and that referral sites provide appropriate, youth-friendly treatment.

**Other Characteristics**

- **Information, Communication and Educational Material**: Since some young people prefer to learn about sensitive issues, such as STIs, on their own, (using written or audio visual materials) and such information should be easily accessible and available to take home. The material can also be made available for use while clients are waiting to be attended to.

- **Opportunity for Group Discussions**: This type of information exchange can be very productive for young people who are comfortable sharing and learning in groups. This communication strategy should be explored where feasible and without any coercion.
• **Delayed pelvic examination and blood tests:** Although not documented as policy in Zimbabwe, youth friendly services should consider delaying procedures feared by young people, especially pelvic examination and blood tests except in emergency situations. This fear can deter young women from going to clinics and obtaining the necessary services such as contraceptives, pap smears or STI treatment.

5. **MEANINGFUL INVOLVEMENT OF ADOLESCENTS, PARENTS AND COMMUNITIES IN ASRH SERVICE PROVISION – Brainstorming (10 min)**

**Step 5:**
- **Brainstorm the importance of working with adolescents, parents/guardians and community members**
- **Ask participants to brainstorm in pairs how adolescents can be involved meaningfully in ASRH service provision**
- **Each group to share with the participants the main factors identified and discuss**
- **Refer to HO 3.3.4**

Meaningful and active participation of young people in addressing SRH issues affecting their lives is a key prerequisite for the success of ASRH programmes. This reaffirms young people’s participation as a right enshrined in the Convention on the rights and welfare of children, article 12: “right to be listened to and to be taken seriously”. The International Conference on Population and Development paragraph 7.48 seeks to “…..promote programmes directed to the education of parents, with the objective of improving the interaction of parents and children to enable parents to comply better with their educational duties to support the process of maturation of their children, particularly in the areas of sexual behaviour and reproductive health.”

7. **MINIMUM PACKAGE OF INTEGRATED SRH AND HIV SERVICES FOR YOUNG PEOPLE - Discussion- (15 min)**

When young people visit a health facility it is assumed that they usually are seeking help for a specific SRHR or HIV related care. The reason for the visit is taken as an entry point for other SRH and HIV services and information.

**Step 7**
- **Distribute the handout on “Minimum Level of SRHR & HIV Integrated Youth Friendly Services” to the participants**
- **Go through the handout and describe to the participants the minimum package table.**
- **Make sure they understand the three columns of the handout on what they stand for.**
- **Ask participants to read allowed the services that can be incorporated**
- **Lead a discussion on the package**

The adolescent and youth friendly minimum package of service delivery will consist of promotive, preventive, curative and referral services, which shall be provided in a complementary and integrated manner. A system of referrals should be implemented for emergencies, complicated cases and procedures and for adverse effects. In line with the priority health challenges of young people identified in the National Adolescents Sexual Reproductive Health Strategy the clinical YFSP will address the following elements (Refer to Handout 3.3.3)

8. **COMMUNITY SUPPORT SYSTEMS IN YFS PROVISION - Discussion (20 min)**

**Step 8:**
- **Break participants into groups. Put participants coming from the same locality into one group.**
- **Ask participants to map support systems available in the community to support the provision of**
Youth Friendly Services to adolescents.
- Use Handout 3.3.5
- Each group to make a presentation, highlighting the benefits of working with community support systems. List the benefits on a flip chart.
- Discuss.

A community is a group of people who share the same norms, values and culture and live in the same geographical area. A support system is a network of personal or professional contacts available to a person or organization for practical, social and moral support.

In every community, there are government departments, non-governmental organisations, community based organisations, religious groupings and support groups that health institutions can collaborate with in supporting sexual and health provision to adolescents. Examples are:

Government: Ministry of education (Youth Friendly Corners); Ministry of Social Welfare (social welfare); Ministry of Home Affairs (Victim Friendly Units); ZNFPC (counselling)

NGOs: Red Cross, Care, (humanitarian support)

CBOs: Musasa Project (support for survivors of violence)

Support Groups: HIV treatment support.

Identify the benefits of community support systems
- Provision of resources (Shelter, food, recreation)
- Social integration is enhanced
- Prevention of delinquency
- Fosters communication
- Reduces social ills (prostitution, substance abuse
- Empowerment through life skills.

9. CONCLUSION – Discussion (5 min)

Review the objectives of the session and highlight the key areas of the presentation. Emphasize the importance of community support networks in service provision.
### Theme | Standard
--- | ---
1. Adolescents’ health literacy | **Standard 1.** The SDP facilitates and implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.

2. Community support | **Standard 2.** The SDP facilitates and implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.

3. Appropriate package of services | **Standard 3.** The SDP provides a 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.

4. Providers’ competencies | **Standard 4.** Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both healthcare providers and support staff respect, protect and fulfill adolescents’ rights to information, privacy, confidentiality, non-discrimination, non-judgmental attitude and respect.

5. Facility characteristics | **Standard 5.** The SDP has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.

6. Equity and non-discrimination | **Standard 6.** The SDP quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.

7. Data and quality improvement | **Standard 7.** The SDP collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. SDP staff is supported to participate in continuous quality improvement.

8. Adolescents’ participation | **Standard 8.** Adolescents are involved 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.

9. Policies, Procedures and Institutional Support | **Standard 9.** Appropriate national level policies, procedures, and institutional support to improve and
scale up quality adolescent and youth friendly health services that protect adolescents and youth’ rights are in place and being implemented.

**HANDOUT 5.5.2**

**Minimum Conditions for Friendly ASRH Service Provision in Zimbabwe** *(adapted from the ASRH New ASRH Strategy 2016 to 2020)*

The New National Adolescent Sexual and Reproductive Health Strategy seeks to instil a common sense of understanding on defining ASRH services among all ASRH stakeholders. Currently, there is no standard definition of friendly ASRH services in Zimbabwe. However, the World Health Organisation (WHO) describes them as:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Minimum level of Services to be incorporated</th>
<th>Basic Health Systems Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adolescent Sexual and Reproductive Health Services</strong></td>
<td>• Information on abstinence, delaying sexual activity, and safer sex</td>
<td><strong>Service delivery:</strong> Develop/adapt job aids that guide integrated SRHR and HIV services.</td>
</tr>
<tr>
<td></td>
<td>• Promotion of dual protection for prevention of unintended pregnancy, HIV and STIs. Information on condom use and provision of condoms</td>
<td>Service guidelines and protocols on Family Planning, RH, STI syndromic management, HTS, ART, ANC, PNC PMTCT, EDLIZ</td>
</tr>
<tr>
<td></td>
<td>• FP information and provision of services</td>
<td><strong>Health workforce:</strong> Review curriculum to include minimum levels of HIV and SRHR services for young people</td>
</tr>
<tr>
<td></td>
<td>• Emergency contraception information and services</td>
<td>Train health service providers on provision of integrated youth friendly SRHR and HIV services</td>
</tr>
<tr>
<td></td>
<td>• STIs/RTIs information and services</td>
<td><strong>Medical products and technologies:</strong> HIV test kits; Condoms demonstration models; Condoms; STIs drugs, contraceptive methods,</td>
</tr>
<tr>
<td></td>
<td>• HIV Testing Services</td>
<td>Adolescent Sexual and Reproductive Health Strategy</td>
</tr>
<tr>
<td></td>
<td>• Information on voluntary medical male circumcision</td>
<td></td>
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<tr>
<td></td>
<td>• Psychosocial support, including adherence support for adolescents living with HIV on opportunistic infection/ART</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pregnancy testing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Antenatal and Post-natal Care</td>
<td></td>
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<td></td>
<td>• PMTCT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Post abortion care services</td>
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<tr>
<td></td>
<td>• Information and counselling on SGBV and referral for comprehensive post rape care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Information on cervical cancer screening and</td>
<td></td>
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</tbody>
</table>
referral if needed

- Information on adolescent developmental milestones and sexual development
- Information on hygiene of sexual and reproductive organs
- Information and counselling on sexuality for adolescence living with HIV
- Information on gender relations and SRH rights
- Information on healthy lifestyles
- Counselling on Life skills (assertiveness, decision making, standing one's ground and not succumbing to peer pressure on sexual relations and substance abuse)
### HANDOUT 5.5.3

#### Basket of SRH and HIV Services

<table>
<thead>
<tr>
<th>Category</th>
<th>SRH SERVICES</th>
<th>HIV SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIV Prevention</strong></td>
<td>Family Planning / Reproductive Health</td>
<td>• HIV testing and counselling&lt;br&gt; • Prevention of mother to child transmission (At a minimum, PMTCT Prong 3: Access to antiretroviral drugs to prevent vertical transmission and for ongoing treatment for mothers)&lt;br&gt; • Early Infant diagnosis&lt;br&gt; • Voluntary Medical Male circumcision (VMMC)&lt;br&gt; • Condom provision&lt;br&gt; • Post-exposure prophylaxis</td>
</tr>
<tr>
<td><strong>HIV care</strong></td>
<td>Maternal &amp; Child Health</td>
<td>• TB screening&lt;br&gt; • Other OI screening&lt;br&gt; • OI prophylaxis&lt;br&gt; • Psychosocial support&lt;br&gt; • Clinical staging&lt;br&gt; • Clinical monitoring and restaging</td>
</tr>
<tr>
<td><strong>Antiretroviral Therapy (ART)</strong></td>
<td>Sexual health</td>
<td>• ART&lt;br&gt; • ART adherence counselling&lt;br&gt; • Psychosocial support&lt;br&gt; • Treatment as prevention</td>
</tr>
<tr>
<td></td>
<td>• Family planning (counselling on and provision of modern contraceptive methods)&lt;br&gt; • Pregnancy testing&lt;br&gt; • Emergency contraception&lt;br&gt; • Prevention of unsafe abortion&lt;br&gt; • Management and post-abortion care</td>
<td>• Prevention of mother to child transmission (At a minimum, PMTCT Prong 3: Access to antiretroviral drugs to prevent vertical transmission and for ongoing treatment for mothers)&lt;br&gt; • Early Infant diagnosis&lt;br&gt; • Voluntary Medical Male circumcision (VMMC)&lt;br&gt; • Condom provision&lt;br&gt; • Post-exposure prophylaxis</td>
</tr>
<tr>
<td></td>
<td>• Antenatal care&lt;br&gt; • Labour and delivery&lt;br&gt; • Postnatal care&lt;br&gt; • Newborn and child health</td>
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</tr>
<tr>
<td></td>
<td>• Sexual health counselling&lt;br&gt; • STI/RTI screening, diagnosis and treatment&lt;br&gt; • Condom provision&lt;br&gt; • Cervical cancer screening&lt;br&gt; • Post-exposure prophylaxis for survivors of gender-based violence</td>
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</tbody>
</table>
HANDOUT 5.5.4
Settings in Youth Friendly Service Provision and Minimum Package of Services

Zimbabwe, under the New National ASRH Strategy (2016 – 2020) adopted four broad settings of youth friendly service delivery. 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. However, a strong and effective referral system among the settings needs to be established and maintained.

Service packages offered by service providers should meet the following criteria:
The service package should be accessible, appropriate, and affordable and meet the needs of the adolescent and young person seeking the services. All relevant commodities and internal tools (e.g. forms, referral databases) that form part of the service package should be available in adequate quantities.

Basic Elements of ASRH Services
- Life Skills and Comprehensive Sexuality Education
- Counselling and Testing Services Service around Safe Motherhood
- Contraceptive and Family Planning Services
- Post abortion care services
- Service related to the prevention, screening, management, and/or treatment of HIV/AIDS and STIs
- Services related to the prevention, detection, and management of reproductive health cancers
- Services related to SGBV.

The adolescent and youth friendly minimum package of service delivery should consist of promotive, preventive, curative and referral, tracking and feedback services, which shall be provided in a complementary and integrated manner. A system of referrals should be implemented for emergencies, complicated cases and procedures and for adverse effects. In line with the priority health challenges of young people identified in the National Adolescents Sexual Reproductive Health Strategy the clinical YFSP will address the following elements:

Minimum Package of SRH Services for Young People

<table>
<thead>
<tr>
<th>Basic Element</th>
<th>Health Facility Setting</th>
<th>Community Based Setting</th>
<th>Primary &amp; Secondary School-Based Setting</th>
<th>Tertiary Institution Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life skills and Comprehensive Sexuality Education and General Counselling</td>
<td>Provide Counselling and information on: - Prevention of pregnancy and consequences of early pregnancy - Prevention of HIV and STI - Nutrition and Balanced Diet - Menstrual Health and Hygiene - Emotional and Mental Health - Accessing Health Information</td>
<td>Provide Counselling and information on: - Life skills: Interpersonal, communication skills, decision making, goal setting and problem solving skills. - Sexuality and how bodies function and dealing with sexual and reproductive changes, feelings, and sexual behaviours - Attitudes and feelings about growing up, gender roles, risk taking, - How to prevent pregnancy and avoid STIs and HIV, and learn about preparing for the world of work</td>
<td>Provide Counselling and information on: - Life skills: Interpersonal, communication skills, decision making, goal setting and problem solving skills. - Sexuality and how bodies function and dealing with sexual and reproductive changes, feelings, and sexual behaviours - Attitudes and feelings about growing up, gender roles, risk taking, - How to prevent pregnancy and avoid STIs and HIV, and learn about preparing for the world of work - Negotiation to protect their own health</td>
<td>Provide Counselling and information on: - Life skills: Interpersonal, communication skills, decision making, goal setting and problem solving skills. - Sexual relations - How to prevent pregnancy and avoid STIs and HIV, and learn about preparing for the world of work; - gender roles, risk taking, - Negotiation to protect their own health - Self-esteem, Assertiveness skills - Adhering to own values - Menstrual Health and Hygiene - Nutrition &amp; Mental health</td>
</tr>
<tr>
<td>Basic Element</td>
<td>Health Facility Setting</td>
<td>Community Based Setting</td>
<td>Primary &amp; Secondary School-Based Setting</td>
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<tr>
<td>HIV and STI</td>
<td>Provide:</td>
<td></td>
<td>Provide information and counselling on:</td>
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<tr>
<td></td>
<td>- HIV &amp; STI Screening, treatment and management</td>
<td>- Prophylaxis according to national guidelines</td>
<td>- Prevention and Treatment of HIV and STI - ART adherence counselling - VMMC</td>
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<td></td>
<td>- Provide free condoms</td>
<td>- Provide discreet access to free condoms</td>
<td>- HCT and STI Counselling - VMMC</td>
<td></td>
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<tr>
<td></td>
<td>- TB Screening</td>
<td>- Prophylaxis according to national guidelines</td>
<td>- ART adherence counselling</td>
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<tr>
<td></td>
<td>- ART and ART adherence counselling</td>
<td>- ART counselling</td>
<td>- VMMC</td>
<td></td>
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<tr>
<td>Family Planning (with focus on contraceptives and condoms)</td>
<td>Provide counselling and services e.g.:</td>
<td>Provide counselling and services on:</td>
<td>Provide information and counselling on:</td>
<td>Provide information and counselling on:</td>
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<tr>
<td></td>
<td>- Promote the use of dual protection</td>
<td>- Promote the use of dual protection</td>
<td>- HCT and STI Counselling - VMMC</td>
<td>- Abstinence and consequences of early sexual activity and pregnancy.</td>
</tr>
<tr>
<td>Safe Motherhood</td>
<td>Provide:</td>
<td>Provide:</td>
<td>Provide information and counselling on:</td>
<td>Provide information and counselling on:</td>
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<td>- PMTCT</td>
<td>- PMTCT</td>
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<td>- Antenatal Care</td>
<td>- Antenatal Care</td>
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<td></td>
<td>- Labour and delivery Postnatal care</td>
<td>- Breast feeding and nutrition</td>
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<td></td>
<td>- Basic Obstetric care</td>
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<td>- Breast feeding and nutrition</td>
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<tr>
<td>Post-Abortion Care</td>
<td>Provide:</td>
<td>Provide:</td>
<td>Provide information and counselling on:</td>
<td>Provide information and counselling on:</td>
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<td></td>
<td>- Antenatal Care</td>
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<td>- Breast feeding and nutrition</td>
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<tr>
<td>Basic Element</td>
<td>Health Facility Setting</td>
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<td>Tertiary Institution Setting</td>
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<tr>
<td><strong>Cancer Screening</strong></td>
<td>Provide: -Breast examination and information on cancer of the cervix and HPV Vaccination -HPV Vaccination -Cervical Cancer Screening</td>
<td>Provide: -Breast examination and information on cancer of the cervix and HPV Vaccination</td>
<td>Provide information -Breast examination and information on cancer of the cervix and HPV Vaccination</td>
<td>Provide information -Breast examination and information on cancer of the cervix and HPV Vaccination</td>
</tr>
<tr>
<td><strong>Sexual Gender Based Violence</strong></td>
<td>Provide: -Emergency Contraceptives HTS services; STI services if necessary -Post Rape Care.</td>
<td>Provide: -Information and counselling on SGBV and referral for comprehensive post rape care.</td>
<td>Provide information and counselling on: Sexual abuse and SGBV.</td>
<td>Provide information and counselling on: Sexual abuse and SGBV.</td>
</tr>
<tr>
<td><strong>ALL SERVICES</strong></td>
<td>-Referral, tracking and feedback for specialised services or services not available on site -Provide information and educational materials that are relevant to each element and are appealing in design, language, and colour to young people.</td>
<td>-Referral, tracking and feedback for specialised services or services not available on site. -Provide information and educational materials that are relevant to each element and are appealing in design, language, and colour to young people.</td>
<td>-Referral, tracking and feedback for specialised services or services not available on site. Provide information and educational materials that are relevant to each element and are appealing in design, language, and colour to young people.</td>
<td>Provide information and educational materials that are relevant to each element and are appealing in design, language, and colour to young people.</td>
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</tbody>
</table>

*Adapted from the National Guidelines on Clinical Youth Friendly Sexual and Reproductive Health Service Provision (YFSP)*
Meaningful Involvement of Young People:

Involving youth in SRH programmes is a strategy that gives voice to young people so that they can influence the delivery of programmes and services. Such a strategy builds upon the influences that young people have on each other. Involving youth in the management, decision-making and governance of programmes allows for representation and for a youth perspective. Youth involvement in programme implementation, however, most often occurs in the provision of education and support to peers. Young people’s meaningful involvement in peer programmes can take advantage of the relationships among young people that influence what they learn and how they behave. Building on their existing social networks, young people are generally involved in one or more of the following activities: Counselling; holding group activities; exchanging coping and communication skills in small groups; learning to model or “role-play” behaviours; building communication, negotiation and refusal skills; engaging in interactive techniques like media, puppets, simulation exercises; challenging and changing group norms and providing commodities; making referrals for services. Programmes that involve youth as peer educators or promoters have been described anecdotally as effective in creating a demand for SRH services, including family planning and HIV/STI services; distributing contraceptives; referring youth to other services and changing social and cultural norms leading to risk behaviours.

Measuring the impact of participation and involvement in programmes is indeed challenging, and rarely included in evaluations of behaviour-change trials. Evidence about how to best manage the involvement of young people is still weak, and only a limited number of peer programmes have undergone systematic evaluations (Bond, 2003). In one UNAIDS needs assessment conducted worldwide, peer-education programme managers stated that, among other things, they wanted more information on how to select peer educators and how to measure programme effectiveness (Kerrigan, 1999; Kerrigan and Weiss, 2000). A commitment of resources and effort to conduct thorough evaluations is needed in order to draw firm conclusions about what really works.

Key Questions in Involving Youth in Programmes

- What are the stated strategy, goals, messages and expectations of the programme?
- What level of decision-making authority do youth have in programmes and services?
- What youth population is the programme designed to reach?
- How can youth be recruited? What characteristics should be identified?
- What type of training is offered to (and required for) young people? How is performance monitored?
- How is quality of performance sustained?
- What mechanisms for supervision and support are in place?
- How long can young people be expected to participate in a programme? What motivates participation?
- What frustrates or discourages participation?
- What continuing education is offered to (or needed by) young people who are participating?
HANDOUT 3.5.6

EXERCISE – MAPPING YOUR COMMUNITY

In your small group, brainstorm what types of organizations, structures and systems are needed for support of adolescent sexual and reproductive health.

Draw on a flip chart where these can be found in your local community. Place the major landmarks and streets on the map so that someone could actually locate the services from your map.

Think about how accessible each kind of support is to adolescents.

You will be asked to present your map to the whole group.

In the presentation, point out what is available and discuss what is also perhaps missing and where adolescents would need to be linked or referred.

Be sure to include formal as well as informal sources.
Reporting, Monitoring, Evaluation and Evidence Building at YFS Centres

Health Facilities will routinely collect data on various aspects of health service delivery including reporting on patients’ treatment, care provided and progress. Several SRHR registers are currently in use at all levels of service delivery. These registers should be used to record information on young people receiving youth friendly services at health facilities. Whatever method is used to gather information should enable disaggregation by gender and by different age groups according to the stratification provided in these guidelines. It is also important that health facilities collect information on youth friendly service performance and monitor and evaluate aspects of quality, efficiency, effectiveness, relevance, and sustainability of service provision.

### List of SRH Related Health Facility Registers

1. Daily Attendance Registers (at youth centres)
2. Family Planning Registers
3. Outpatient Registers
4. HTSHTC Registers
5. ANC, Delivery and Post Natal Registers
6. VMMC Registers
7. TB Registers
8. E-PMS³ Registers
9. Tally Sheets (T5)
10. National AIDS Reporting Form (NARF)

Adapted from the National Guidelines on Clinical Youth Friendly Sexual and Reproductive Health Service Provision (YFSP)

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³³ An electronic system to collect and manage HIV and TB data at the patient level, with the ultimate aim of phasing out paper registers throughout the country.
SESSION 6 SUMMARY

MODULE III: Interpersonal Communication with Adolescents

SESSION 6: Communicating about Sexuality

Time: 1 hour, 20 minutes

Objectives:
By the end of the session, participants will be able to:
- Demonstrate the ability to use sexual terms with other participants.
- Appreciate and give reasons the use of slang language by adolescents when communicating sexuality issues.
- State 4 basic rules for talking to adolescents about sexuality.

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>10 min</td>
<td>Role Play</td>
<td>Flip chart, Computer, LCD</td>
</tr>
<tr>
<td>2. Sexual Terms</td>
<td>15 min</td>
<td>Word Exercise</td>
<td>Newsprint, HO 2.5.1</td>
</tr>
<tr>
<td>3. Use of Sexual Slang</td>
<td>15 min</td>
<td>Role Play, Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>4. “Basic” Guidelines when Talking to Adolescents About sexuality</td>
<td>15 min</td>
<td>Lecture, Discussion</td>
<td></td>
</tr>
<tr>
<td>5. Comprehensive sexuality Education</td>
<td>10 min</td>
<td>Lecture, Discussion</td>
<td></td>
</tr>
<tr>
<td>6. Conclusion and Summary</td>
<td>15 min</td>
<td>Discussion</td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES


1. **INTRODUCTION – Role Play (15 min)**

**Step 1:**
- Role plays a counselling session with a young person (with facilitator or a participant acting as a counsellor and another participant acting as the adolescent). Role play that the counsellor cannot bear to use any specific sexual terms but needs to explain something like using condoms or having intercourse. This should be humorous, but make the point that many of us are not equipped to easily discuss the content of much of our work - sex and sexuality.
- Process the role play and invite participants to explain why using correct yet understandable language is important when working with adolescents.
- Display objectives on PowerPoint slide.

Many adults find it difficult to communicate with youth about sex and sexuality. They find it especially difficult to use sexual terms or to use the sexual slang which many youth use. As a result, youth may be given inadequate information. It is important that anyone counselling youth becomes familiar and comfortable with the use of sexual terms and with youths’ use of sexual slang. Comfort will usually develop with repeated exposure and use of the words.

3. **SEXUAL TERMS – Word Exercise (15 min)**

**Step 2:**
Show participants the word exercise list written on a flip chart or PowerPoint slide (HO 2.5.1)
Have participants tick words they would find difficult to talk about with adolescents. Ask participants to explain what the words mean. Conclude the activity using the discussion questions below:
- How did you feel when I explained what to do during this activity?
- Are any of the words the kind that youth sometimes use? What does it mean when people use those words?
- Are there any words missing from our lists?
- How would you have felt if your principal (director, pastor, leader and so on) had walked into the room during the activity? Why?
- How do you feel about the words listed for “man” compared to those listed for “woman”? (Generally, words for woman are usually more negative than words for man.)

**Examples of sexual terms:**
- Anus
- Breast
- Homosexual
- Intercourse
- Masturbation
- Menstruation
- Oral sex
- Penis
- Testicles
- Vagina

3. **SEXUAL SLANG – Discussion (15 min)**

**Step 3:**
- Ask the participants if they used sexual slang words when they were young. Do they remember why they used those words? How did adults react to their using slang as young people? Do they still use the same slang now as adults? Do they think that today’s youth use slang that is more offensive than the slang they used as young people?
- Ask participants why young people use slang words when talking about sexuality. Record responses on a flip chart and discuss.

People often use slang terms when talking about any aspect of sexuality. Reasons for using slang words:
- When one does not know the correct term.
- When one does not feel comfortable using the right term.
- To disguise communication so that adults will not understand them.
To create some kind of identity.

Emphasise that service providers need to appreciate and respect the use of slang by adolescents and it’s their responsibility to understand the sexual slang used by adolescents in their respective communities. However, service providers are not obliged to respond or counsel adolescents in slang but ensure dignity and professionalism.

4. **BASIC GUIDELINES WHEN COMMUNICATING WITH ADOLESCENTS – Role Play (20 min)**

**Step 4:**

<table>
<thead>
<tr>
<th>Explain the basic ground rules for communicating about sex to youths. Ask the participants if they agree with these rules. Ask if there is anything missing.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Role play:</strong> Ask one participant to role play a young person seeking sexual information and one participant to volunteer to be the service provider who will assist the youth. Also ask the client to throw in some slang in the session. The rest of the participants will observe and make notes for feedback on areas done well and those that need improvement.</td>
</tr>
<tr>
<td><strong>Process:</strong></td>
</tr>
<tr>
<td>• Ask participants if the service provider was youth friendly.</td>
</tr>
<tr>
<td>• Was the service provider comfortable in talking about sex?</td>
</tr>
<tr>
<td>• Ask the participant who role played as the adolescent whether the service provider met his or her needs.</td>
</tr>
<tr>
<td>• Ask for any comments from the group about the role play.</td>
</tr>
<tr>
<td>• Summarise section by giving the guidelines below</td>
</tr>
<tr>
<td>• Distribute HO 2.5.2 (What to do and what to avoid when communicating with adolescents)</td>
</tr>
</tbody>
</table>

**Basic guidelines when communicating with Adolescents**

- Speak frankly. Acknowledge your feelings. If you do not know the answer, say so, then find out.
- Give simple, direct answers you know are accurate.
- Be “approachable”. Do not get upset or become agitated. Keep cool.
- Let the adolescent know that no question is wrong to ask, and that even subjects that can be embarrassing are good to talk over with you.
- Respond in the same way to boys and girls when they ask questions.
- Create lines of communication and keep them open.

5. **CONCLUSION – Discussion (15 min)**

**Step 5:**

- **Summarize the session by discussing the applicability of the basic guidelines when communicating with adolescents.**
There are some words we all know and should be able to define. Which ones would you find it hard to talk about with adolescents?

<table>
<thead>
<tr>
<th>Head</th>
<th>Teeth</th>
<th>Walk</th>
<th>Sneeze</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nose</td>
<td>Lips</td>
<td>Run</td>
<td>Cough</td>
</tr>
<tr>
<td>Eye</td>
<td>Skin</td>
<td>Urinate</td>
<td>Masturbate</td>
</tr>
<tr>
<td>Ear</td>
<td>Clitoris</td>
<td>Eat</td>
<td>Laugh</td>
</tr>
<tr>
<td>Vagina</td>
<td>Stomach</td>
<td>Drink</td>
<td>Cry</td>
</tr>
<tr>
<td>Toe</td>
<td>Uterus</td>
<td>Ejaculate</td>
<td>Menstruate</td>
</tr>
<tr>
<td>Finger</td>
<td>Back</td>
<td>Swallow</td>
<td>Love</td>
</tr>
<tr>
<td>Mouth</td>
<td>Spine</td>
<td>Taste</td>
<td>Like</td>
</tr>
<tr>
<td>Penis</td>
<td>Anus</td>
<td>Orgasm</td>
<td>Intercourse</td>
</tr>
<tr>
<td>Tongue</td>
<td>Hips</td>
<td>Vulva</td>
<td>Foot</td>
</tr>
<tr>
<td>Thighs</td>
<td>Scrotum</td>
<td>Testicles</td>
<td>Buttocks</td>
</tr>
<tr>
<td>Kissing</td>
<td>Neck</td>
<td>Shoulder</td>
<td>Breasts</td>
</tr>
</tbody>
</table>

(Adapted from a publication of the Parent Education Programme of Planned Parenthood of New York City)
### HANDOUT 3.6.2

**WHAT TO DO AND WHAT NOT TO DO WHEN COMMUNICATING WITH ADOLESCENTS**

<table>
<thead>
<tr>
<th>DO</th>
<th>AVOID</th>
</tr>
</thead>
<tbody>
<tr>
<td>● <strong>Be truthful</strong> about what you know and what you do not know</td>
<td>● Giving inaccurate information (to scare them or to make them ‘behave’).</td>
</tr>
<tr>
<td>● <strong>Be professional</strong> and technically competent</td>
<td>● Threatening to break confidentiality ‘for their own good’.</td>
</tr>
<tr>
<td>● Use words and concepts which they can understand and relate to.</td>
<td>● Giving them only the information that you think they will understand</td>
</tr>
<tr>
<td>● Use pictures and flip charts</td>
<td>● Using medical terms they will not understand</td>
</tr>
<tr>
<td>● Treat them with <strong>respect</strong> in terms of how to speak and how you</td>
<td>● Talking down to them, shouting, getting angry, or blaming them</td>
</tr>
<tr>
<td>● <strong>Give all the information/choices and then help them decide</strong></td>
<td>● Telling them what to do because you know best and they a ‘young’.</td>
</tr>
<tr>
<td>● Treat all adolescents <strong>equally</strong></td>
<td>● Being judgemental about their behaviour, showing disapproval, or</td>
</tr>
<tr>
<td>● <strong>Be understanding and supportive even if you do not approve</strong></td>
<td>imposing your own values</td>
</tr>
<tr>
<td>● Accept that they may choose to show their individuality in dress</td>
<td>● Being critical of their appearance or behaviour, unless it relates</td>
</tr>
<tr>
<td>or language</td>
<td>to their health well-being</td>
</tr>
</tbody>
</table>


**NB:** The process of de-sensitizing and de-mystifying sexual behaviours so that people can talk about sexual acts in a casual and non-judgmental way is called the Sexual Attitude Reassessment.
SESSION 7 SUMMARY

MODULE II: Interpersonal Communication with Adolescents

SESSION 7: Using Learning Aids

Time: 1 hour, 15 minutes

Objectives:
By the end of the session, participants will be able to:
- Identify 4 types of learning aids that could be used.
- Identify learning aids that are suitable for people with disabilities
- Explain at least 4 benefits of using learning aids.
- Demonstrate the development and effective use of at least 3 learning aids.

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Introduction</td>
<td>5 min</td>
<td>Lecture, Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>8. Definitions</td>
<td>5 min</td>
<td>Brainstorm</td>
<td>Newsprint and markers</td>
</tr>
<tr>
<td>9. Qualities of Good Learning Aids</td>
<td>20 min</td>
<td>Discussion</td>
<td>HO 2.6.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HO 2.6.2</td>
</tr>
<tr>
<td>10. Ways of reaching out to those people with disabilities.</td>
<td>10 min</td>
<td>Discussion</td>
<td>Newsprint and markers</td>
</tr>
<tr>
<td>11. Advantages of Using Learning Aids</td>
<td>10min</td>
<td>Brainstorming</td>
<td>P A System</td>
</tr>
<tr>
<td>12. Practice</td>
<td>20 min</td>
<td>Role Play</td>
<td>HO 2.6.3</td>
</tr>
<tr>
<td>13. Conclusion</td>
<td>5 min</td>
<td>Lecture, Discussion</td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES


1. **INTRODUCTION – Presentation, Discussion (5 min)**

**Step 1:**
- Introduce the topic and display flipchart with the session’s objectives.
- Explain that this session will cover: the importance of learning aids; the different types of learning aids; and how to use learning aids.

2. **DEFINITION – Brainstorming, Presentation (5 min)**

**Step 2:**
- Ask the participants to define learning aids. Ask: “What learning aids are available to clinic providers for counselling purposes”? Record responses on newsprint. Add any the group may have missed. Discuss responses.
- Brainstorm: Ask participant about the types of learning aids they know and record responses.
- Share Chinese Proverb. Describe findings on using learning aids.
- Emphasize the importance of learning aids for increasing retention.

**Learning Aids** are anything that helps people learn through seeing. Learning aids can show words, pictures or numbers. A demonstration is also a type of learning aid.

**Learning Aids That Can Be Given To Adolescents:** Leaflets, Brochures, flyers, pamphlets, Comics, and Magazines

**Learning Aids That Can Be Shown To Adolescents:** Flipcharts, Posters, Wall Charts, Photographs, Flash Cards, Puppets, Exhibits, Bulletin Boards, Flannel Boards, Videos, Films, Models, Diagrams and Demonstrations.

**Chinese Proverb – What I hear I Forget; What I see I remember; What I do I Know**

Using learning aids during teaching improves learning:

- We learn - 1% through hearing
- We learn - 3% through seeing
- We retain - 20% of what we hear, 50% of what we see and hear, and 90% of what we see, hear and do.

Learning aids are not, however, a replacement for high quality one-to-one counselling. They are meant as a tool to assist the counselling process. Sometimes it is easy for a provider to over-rely on learning aids and to hand out pamphlets or point to posters without adequate explanation. This is understandable given the time pressures providers often face but one must guard against this habits.

3. **QUALITIES OF GOOD LEARNING AIDS – Discussion (30 min)**
Step 3:

Begin by asking participants what makes a good learning aid.

Record their responses on a flip chart. Then summarize the important points, adding those that have been missed.

Show examples of learning aids for participants to use. Use anything available, including posters, flipbook pages, videos, audios, pictorials and magazine advertisements. Some should be examples of bad learning aids, some should illustrate the qualities of good learning aids. For each example ask:

- How would you rate this learning aid? Why?
- Is it easy to use?
- What about the lettering - is it easy to read?
- What message does this convey?
- Could it be improved? How?
- Who is the intended audience? (For whom is it designed?)

Next draw two pictures on a flip chart. One should show a young girl standing next to a packet of condoms that is as big as she is. The other should show the girl and a condom drawn to scale. Ask the participants which is a better drawing and why.

Good learning aids share the following characteristics, all of which help ensure the ability of the learning aid to communicate the desired message.

- Words and pictures should be easy to see.
- Words and pictures should be easy to understand.
- Information should be clear and uncluttered. Too many figures, objects, or actions may distract or confuse your audience. A good learning aid shows only one idea and gives only the necessary information. Pictures should explain themselves.
- The learning aid should be well organised. If both words and pictures are used, make sure the text is clearly linked with the illustrations to avoid confusion.
- The viewer's attention should be drawn to the important information.
- The people for whom the aid is intended should find it interesting.
- Trust your instincts. If you think the learning aid is not good, then probably it is not.
- Language should be appropriate for the audience. Words should be few and simple, especially for audiences with low levels of literacy.
- Messages should be appropriate for the audience.

4. WAYS OF REACHING OUT TO PEOPLE WITH DISABILITIES - Demonstration and discussion (10 min)

Step 4

- Ask what learning aids can be used for the different sub groups of people with disabilities
- Identify learning aids to use with different sub groups of people with disabilities

People with disabilities need health care and health programs for the same reasons anyone else does—to stay well, active, and a part of the community.

Having a disability does not mean a person is not healthy or that he or she cannot be healthy. Being healthy means the same thing for all of us—getting and staying well so we can lead full, active lives. That means having the tools and information to make healthy choices and knowing how to prevent illness. The following are some of the learning aids for reaching out to those with disabilities.

Deaf and dumb:
Pictures, stories, videos with subtitles, posters and magazines
Blind:
Audio recordings of talk shows, dramas or even books, videos
The use of Braille is ideal to ensure that those who are visually impaired can read.

Physically challenged:
Pictures, stories, videos with subtitles, magazines and posters

Mentally challenged:
Puppets, dolls, magazines, pamphlets, pictorials

5. **ADVANTAGES OF USING LEARNING AIDS – Discussion (10 min)**

Step 5:
- **Ask:** What are the advantages of using learning aids in counselling youth? What are some possible disadvantages?
- **Distribute HO 2.6.1, “Advantages and Disadvantages of Using Learning Aids” and HO 2.6.2 “Advantages, Disadvantages, and Uses of Specific Learning Aids” and discuss. Ask the group if anything should be added to the handouts.

Advantages of Using Learning Aids

- Attract the youth’s attention.
- Can trigger discussion and help bring up questions from adolescents.
- Can make something small big enough to be visible.
- Can be used to compare similarities and differences.
- Show steps in doing something.
- Show development.
- Can make complex ideas easy to understand.
- Can show something that cannot be seen in real life.
- Can help when discussing a sensitive topic.
- Youth can take print materials home as reminders.
- Youth can share print materials with friends.

Giving leaflets to youth is like giving a prescription for medication. The leaflet “goes with” the method.

6. **PRACTICE – Role Play (30 min)**

Step 6:

**Role Play:** Inform the group that everyone will now practice using visual aids in counselling. Divide the participants into groups of three. Distribute HO 2.6.3, “Role Play: Practicing Counselling With Visual Aids”.

Read through the handout with them and discuss any questions. Tell participants you will be checking in with each group and letting them know how much time is left for the entire activity.

After forty minutes, gather all the groups and ask volunteers to comment on what happened during the role play and what lessons were learned about using visual aids in counselling.
7. CONCLUSION – Discussion (5 min)

Step 7:

- Ask participants: What two things did they learn in the session?
- Summarize the session by going through the types of learning aids, and the advantages and disadvantages, and uses of some specifics barriers to using some learning aids.
General Advantages and Disadvantages of Using Learning Aids

**Advantages of Using Learning Aids**

- Attract the youth attention.
- Can trigger discussion and help bring up questions from youth.
- Can make something small big enough to be visible.
- Can be used to compare similarities and differences.
- Show steps in doing something.
- Show changes (such as the growth of a foetus from conception to delivery).
- Can make complex ideas easy to understand.
- Can show something that cannot be seen in real life.
- Can help when discussing a sensitive topic such as STI.
- Youth can take print materials home as reminders.
- Youth can share print materials with friends.

**Disadvantages of using Learning Aids**

- No opportunity for discussion unless the Presenter reviews with the youth.
- Can be expensive because they are easily destroyed.
- Making them requires time for pre-testing.
- Cannot communicate many written messages.
- Some are not good for large groups.
- Adolescents may not remember everything if there are too many messages.
- May need skills and materials to make them.
- Usually not as good for demonstration as real object or person.

**N.B.** LEARNING AIDS CANNOT TAKE THE PLACE OF HIGH QUALITY COUNSELLING DELIVERY OF INFORMATION.
## Table: Advantages, Disadvantages and Uses of Specific Learning Aids

<table>
<thead>
<tr>
<th>TYPE OF LEARNING AID</th>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
<th>USES</th>
</tr>
</thead>
</table>
| Models               | - Close to reality; will lead to better understanding  
                      - Can be made larger for clearer viewing  
                      - Allows use of all senses | - May need skills and materials to make them  
                      - Can be expensive  
                      - Cannot be used with large groups  
                      - Easily damaged  
                      - Usually not as good for a demonstration as real object or person | - Demonstrations  
                      - Teaching and practising skills  
                      - Showing internal body parts (organs)  
                      - Used with individuals and small groups |
| Real Objects         | - Presents reality  
                      - Allows use of all senses  
                      - Very effective for teaching and clinical skills | - May not be available  
                      - Usually not for large groups  
                      - Cannot be used for sensitive or personal demonstrations (for example, use of malnourished child from audience or putting on condom) | - Giving instructions, demonstrations (such as preparing oral rehydration solution or using a pill packet)  
                      - Good for individuals or small groups |
| Pamphlets Booklets Leaflets | - Can be given out to large numbers of people  
                               - Can be read at the youth’s own speed as often as he or she wants  
                               - Can be shared with youth’s family and friends  
                               - Easily produced | - No opportunity for discussion unless provider reviews with youth  
                               - Less effective with people who do not read  
                               - Paper is not strong  
                               - Easily lost  
                               - Can be expensive | - For people who can read  
                               - To present words and pictures  
                               - For detailed information or instructions  
                               - To disseminate information to a lot of people  
                               - To remind people of what you have taught |
<table>
<thead>
<tr>
<th>TYPE OF LEARNING AID</th>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
<th>USES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video</td>
<td>People like to watch</td>
<td>Expensive equipment</td>
<td>For small or medium-sized groups or individuals.</td>
</tr>
<tr>
<td></td>
<td>Good for small and medium-sized groups</td>
<td>Equipment hard to maintain</td>
<td>At meetings or exhibitions</td>
</tr>
<tr>
<td></td>
<td>Can be repeated</td>
<td>Need training to use</td>
<td>To emphasize messages</td>
</tr>
<tr>
<td></td>
<td>Can be paused for discussion or rewound to emphasize point</td>
<td>Equipment and videos sometimes hard to get</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Easy to make messages for a particular group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posters (usually have one message, a slogan and a picture)</td>
<td>Can be made locally</td>
<td>Messages may not be understood by audience; may need explanation</td>
<td>To reinforce messages</td>
</tr>
<tr>
<td>Charts (usually have a lot of information)</td>
<td>Can be used repeatedly</td>
<td>Can be expensive because they are easily destroyed</td>
<td>For small or large groups</td>
</tr>
<tr>
<td></td>
<td>Can show things that cannot be easily demonstrated on real objects (such as sex organs)</td>
<td>Cannot communicate many written messages</td>
<td>To be put in places where easily seen</td>
</tr>
<tr>
<td></td>
<td>Good for many topics</td>
<td></td>
<td>To promote an idea, event, or service</td>
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<td></td>
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<td></td>
<td>Can be used in counselling</td>
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<tr>
<td>Flipcharts, Flipbooks</td>
<td>Can be made locally</td>
<td>Not good for large groups</td>
<td>For step-by-step presentation (such as instructions or a story)</td>
</tr>
<tr>
<td></td>
<td>Can be made to suit needs of individual groups</td>
<td>If not well made, charts may tear when flipping over</td>
<td>For small groups or individuals</td>
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<tr>
<td></td>
<td>Good for maintaining audience interest</td>
<td>Audience may not remember everything if there are too many pages</td>
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<tr>
<td></td>
<td>Can be used repeatedly</td>
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<tr>
<td>Flyers</td>
<td>Can be given out to a large number of people</td>
<td>No opportunity for discussion unless reviews with youth</td>
<td>For people who can read</td>
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<td></td>
<td>Can be read at a youth’s own speed as often he/she desires</td>
<td>Less effective with people who do not read</td>
<td>To present words and pictures</td>
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</table>
INSTRUCTIONS:

- Read the two scenarios.
- Select a scenario to role play.
- Decide which role to play: the counsellor, the youth, or the observer. The observer’s role is to act as a timer and also watch the use of learning aids.
- Begin the role play, focusing on the use of learning aids rather than an entire counselling sequence.
- Observer should stop the role play after giving adequate time for the counsellor to illustrate use of learning aids.
- Observer processes role play by asking the counsellor their opinion about their performance, then asking the youth. Observer then gives feedback.
- Group members change roles, select another scenario and continue with #4 through #6 activities until everyone has a chance to role play the counsellor’s role.

Scenarios:

- A mother brings her 13-year-old daughter who has started menstruating and is requesting the counsellor to talk to her daughter about menstrual hygiene.
- A single mother asks the counsellor to talk to a 16-year-old boy about facts of growing up.
- OR any other relevant scenario.
SESSION 8 SUMMARY
MODULE II: Interpersonal Communication with Adolescents

SESSION 8: Counselling Process

Time: 2 hours, 40 minutes

Objectives:
By the end of the session, participants will be able to:
- Define counselling.
- State at least 4 aims of counselling.
- Describe 6 important steps in counselling.
- Describe at least 5 important areas to emphasize when counselling young people.
- Describe at least 3 difficult moments that can occur in counselling.
- List at least 3 strategies to respond to each difficulty.

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
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<tbody>
<tr>
<td>1. Introduction</td>
<td>5 min</td>
<td>Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>2. Counselling Definition</td>
<td>5 min</td>
<td>Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>3. The Aim of Counselling</td>
<td>15 min</td>
<td>Role Play</td>
<td></td>
</tr>
<tr>
<td>4. GATHER Process</td>
<td>30 min</td>
<td>Lecture, Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>5. The Counselling Process</td>
<td>45 min</td>
<td>Role play</td>
<td>HO 2.7.1</td>
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<tr>
<td>6. Identifying Challenging Adolescents</td>
<td>10 min</td>
<td>Brainstorming</td>
<td></td>
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<tr>
<td>7. Developing Strategies for Challenging Situations</td>
<td>45 min</td>
<td>Group Work Discussion</td>
<td>HO 2.7.2</td>
</tr>
<tr>
<td>8. Conclusion</td>
<td>5 min</td>
<td>Individual Work</td>
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REFERENCES


1. INTRODUCTION – Discussion (5 min)

Step 1:
- Introduce the topic by asking participants to place themselves in the role of youth counsellor. “If you had to describe how it feels to counsel a young person, discussing sensitive matters like sexuality in just one word, what would that word be”?
- Ask participants for the words they selected, why, and how it feels to discuss these issues with young people. Do you think youth ever feel uncomfortable discussing these issues? Why or why not? Make the connection to the benefits of training in youth counselling.
- Post session objectives or write on Flip chart and present.

2. DEFINITION – Presentation (5 min)

Step 2:
- Remind participants of past training they have received.
- Ask them to explain what counselling is. Record their responses on a flip chart. Summarize the points.
- Define counselling

Counselling is one person helping another make a decision or solve a problem, to explore their feelings and find ways of dealing with them with an understanding of the facts and emotions involved. In this instance, the person to be counselled is an adolescent.

3. THE AIM OF COUNSELLING – Role Play (15 min)

Step 3:

Ask one of the participants to act as a new person in town who is looking for a place to eat. Present at least three different restaurants, describing the food, neighbourhood, cost, and details on how to get there. After describing the restaurants, make a recommendation of the one you think the new person would like the most.

Afterwards, ask the following discussion questions:

1. Who chose the restaurant?
2. What assumptions did the speaker make about the new person?
3. Ask the participant who played the new person how she or he felt about being told where to eat.
4. Ask the “Advisor” if they felt they needed to recommend a restaurant and to have an opinion. Why?

Explain that this role play illustrated advising.

Ask, “If I were counselling this person, how could I have helped her to make her own choice? What questions should I have asked”? Some possible responses include:

1. What kind of place are you looking for?
2. What kind of food do you like?
3. How much do you want to spend?
4. Do you want someplace close by?

A counselling relationship assumes that it is the adolescent’s responsibility to make decisions. In the advising relationship, the helper gives advice as an “expert” and takes on more responsibility for the youth behaviour. Both counselling and advising involve giving information, in counselling the adolescent should take responsibility for his/her behaviour.

Counselling aims to help adolescents:
Understand their situation more clearly
Identify a range of options for improving that situation
Make choices which fit their values, characteristics, feelings and needs.
Make their own decisions and act upon them
Cope better with problems
Develop life skills such as being able to talk about sex with a partner

4. **GATHER PROCESS – Mini Lecture, Discussion (30 min)**

**Step 4:**
- Ask the participants how they would organize the counselling process.
- Post the acronym “GATHER” and remind them of previous training events where they had learned this model. Explain the model, with some emphasis on “R”, because of the need to help adolescents get the services they need.
- Ask participants to give examples of adolescents needing referrals; List possible referral points in their community: health centre, crisis centres, church, school authorities, community elders, youth organizations or a police officer.

Counselling consists of six steps, described by the word GATHER:
- **G**: Greet the adolescent.
- **A**: Ask adolescents about themselves.
- **T**: Tell adolescents about their options.
- **H**: Help adolescents make a decision.
- **E**: Explain and answer questions.
- **R**: Refer youth to another provider if necessary or schedule a return visit.

5. **THE COUNSELLING PROCESS – Role Play Or Video (45 min)**

**Step 5:**
- Ask participants how they can encourage the adolescent to speak freely. “How would you create rapport”?
- How they would encourage the adolescent to ask questions, and discuss their responses.
- List ways that adolescents can reduce their risk of STI/HIV infection.
- How they would give unbiased information and list key points.
- How they would ensure that the chosen option has been understood
- Ask participants which health issues need to be referred to other providers and why it is necessary to schedule a return visit.
- Show video that outlines GATHER process or if you have approximately one hour, you can arrange a role play. OR Role play (optional - one hour)
- Put participants into groups of four. Allow them 20 minutes to develop a role play with one playing the part of a youth with a problem and the other the counsellor. The other two in the group will observe. Then take turns in presenting their role play for the entire group to observe and discuss.

**COUNSELLING STEPS**

**GREET adolescent:**
- Introduce yourself.
- Offer a seat.
- Make eye contact.
- Encourage the young person to speak freely.
- Establish rapport; ensure confidentiality and privacy, as well as youth comfort.

**ASK adolescent about themselves:**
Explore their:
- Reason for visiting.
- Knowledge about reproductive health.
- Concerns.
- Reproductive goals.
- Partner's attitudes, if any.
- If breastfeeding, how fully and for how long.
- The behavioural risks of both adolescent and partner for STIs and HIV infection.

If adolescent in on a repeat visit, ask about problems, satisfaction and changes in reproductive health goals. Ask any other pertinent and relevant questions

TELL adolescents about reproductive health issues and about their options:
- Review all Reproductive Health Information that the adolescent is unfamiliar with.
- Encourage the adolescent to ask questions.
- Explore the adolescent attitudes toward health issues.
- Give correct, unbiased information.
- Give information relevant to the adolescent reason for visiting.
- Use learning aids appropriately and effectively.
- Discuss ways the adolescent can reduce the risk of STIs/HIV infection.

HELP the adolescents to make a decision:
- Ask what the adolescent wants.
- Encourage and ensure youth makes her or his own decision.
- Ask if the adolescent discussed the issue with anybody.
- If desired option is inappropriate, explain why and help the adolescent make another decision.
- If breastfeeding, review the methods and assist the adolescent to choose a suitable contraceptive method.

EXPLAIN the chosen option and answer questions:
- Give full information about the options, warning signs and how to manage them.
- Explain full information about the option.
- Use appropriate learning aids effectively (such as models and samples).
- Give adolescent leaflets or pamphlets to take home.
- Ask the adolescent to repeat important information to make sure he or she understood completely.

REFER adolescent for additional support services or schedule a return visit:
- Refer adolescent to other providers or centres for further management or services if necessary.
- Give the adolescent a return appointment if necessary.
- Encourage the adolescent to come anytime with questions or problems.
- Follow up

Not every counselling session consists of all six of these elements. Some may simply involve repeating some elements. Every counselling situation should be tailored to the adolescent's needs. Adolescents making a repeat visit, in particular, have specific needs that should be met with specific responses. Adolescents often talk with counsellors several times before they decide to act. A counsellor should be prepared to see the adolescent as often as the situation demands.

6. IDENTIFYING CHALLENGES – Brainstorming (10 min)

Step 6:
• Ask the group to describe a difficult situation they have experienced as counsellors. Encourage participants to be as specific as possible. Ask participants how these situations make them, as counsellors, feel or behave.

• Inform participants that this session is a “walk on the dark side” of counselling or dealing with the inevitable surprises. Every counsellor has experienced difficult moments, which exposes some challenges. The skill is how the counsellor copes with these situations. So, it’s not IF something happens but WHEN something happens, what can be done?

• Tell participants that this session will be a discussion of various scenarios identified by the participants.

• Have them select a recorder and reporter.

Highlight typical difficult situations with adolescents:

• Silence – adolescent does not talk.
• Youth cannot stop crying.
• Counsellor believes there is no solution to the problem.
• The adolescent threatens suicide.
• The counsellor makes a mistake.
• Counsellor does not know the answer to a factual question.
• The adolescent refuses help.
• The adolescent is uncomfortable with the counsellor's sex or age.
• The counsellor is short of time.
• The counsellor cannot establish rapport.
• The counsellor and the adolescent know each other socially.
• The adolescent talks continuously and inappropriately.
• The adolescent asks personal questions about the counsellor.
• The counsellor is embarrassed by the subject matter.

The purpose of the session is to:

• Develop awareness about one's own particular dislikes, blind spots, or fears about making counselling mistakes or dealing with "unexpected" situations; and

• Develop strategies to respond.

7. DEVELOPING STRATEGIES FOR CHALLENGING COUNSELLING SITUATIONS – Group Work, Discussion (45 min)

Step 7:

Small Group Work:
Divide participants into groups of five. Using the brainstormed list of challenges, assign one or two challenges to each group and ask them to develop at least three different ways a counsellor might handle the situation. Distribute newsprint and have them list their solutions.

Group Presentations:
Ask each group to describe their scenarios and the strategies they devised for coping and/or resolving it. Be sure to note and reinforce how any of the scenarios might relate to difficulties described during the introductory exercise of the session. Ask other participants to contribute their ideas about responding to the challenge.

Application:
Ask participants to write down the number of the scenarios they would find most difficult to deal with, then have them turn to another person and share what they wrote and why they made that choice.

If you have extra time, take situations that were discussed during the introductory exercise and work with the group to develop strategies for responding to them.
When counsellors help adolescents, they progress through this series of interconnected and overlapping steps. The counsellor’s first task is to establish rapport with the adolescent. Communicating caring and receptivity through verbal and non-verbal behaviour will influence the outcome. Especially with the adolescent, the counsellor is the expert-partner who helps, not the one who directs, criticises or makes the decision that might be socially appropriate but that the adolescent will not implement once the counselling is done.

The counsellor and the adolescent are partners but it is the young person who knows his or her world best and is the decider. They exchange information and discuss the adolescent’s feelings, attitudes and concerns. Throughout, the counsellor adapts the counselling process to each of the adolescent’s needs. Through this interaction, the adolescent makes a decision, acts on it, and evaluates his or her action.

8. CONCLUSION – Discussion (5 min)

Conclude by reviewing the Counselling Process and emphasizing the need to help adolescents make their own decisions. Ask participants to list ways they will adapt their personal counselling style to better suit the adolescent.
Handout 3.8.1

Counselling Process

Greet the adolescent:
- Introduce yourself.
- Offer a seat.
- Make eye contact.
- Encourage the youth to speak freely.
- Establish rapport; ensure confidentiality and privacy as well as youth comfort.

Ask the adolescent about:
- Reason for visiting.
- Knowledge about Reproductive Health.
- Concerns.
- Reproductive goals.
- Partner's attitudes, if applicable.
- If breastfeeding.
- The behavioural risks of both youth and partner for STD including HIV infection.

If adolescent is on a return visit, ask about:
- Problems.
- Satisfaction.
- Changes in reproductive health goals.

Tell the adolescent about reproductive the health issue:
- Give correct, unbiased information
- Encourage the questions
- Explore the young person's attitudes toward health issue
- Give information relevant to the adolescent reason for visit
- Use learning aids appropriately and effectively
- Discuss ways the adolescent can reduce her or his risk of HIV infection

Help the adolescent make decision:
- Ask what the adolescent wants to do. If undecided, clarify the reasons.
- Encourage and ensure that the adolescent makes her or his own choice.
- Ask if the adolescent discussed with anybody.

Explain how to use or get the chosen option:
- Give full information about the option.
- Use appropriate learning aids effectively (such as models and samples).
- Give adolescent leaflets or pamphlets to take home.
- Ask the adolescent to repeat important information to make sure the youth understood completely.

Refer schedule return visit:
- Refer to another centre or provider for further services if necessary.
- Encourage the adolescent to come anytime with questions or problems.
- Give the youth a return appointment if necessary.
Sometimes there are challenging times when an Adolescent Counsellor will experience difficulty in counselling the youth. Some typical examples of difficult situations are discussed below.

1. **Silence**
The adolescent may be unwilling or unable to speak for a period of time. This is generally common among young people who may be angry or anxious. If this happens at the beginning of the session, it is best for the counsellor, after waiting a little while, to draw the attention of the adolescent by saying:

   "I can see that it is a bit difficult for you to talk (reflected feeling), It is often that way when someone first comes to see me."

The counsellor may alternatively say, "I wonder if you are not feeling a bit anxious?"一般 the counsellor should wait and observe carefully whether the adolescent makes an effort to express her or his feelings or thoughts. The counsellor should not try to break the silence because the silence may be a result of some thoughtfulness on the part of the adolescent.

2. **The Adolescent Cries**
Crying is usually a way of releasing emotions. If the adolescent cries or sobs, the counsellor should offer verbal comfort and let the person finish. The counsellor needs to exercise extreme care when offering comfort. Touching of the opposite sex on the hand or shoulder may be misinterpreted and may frighten the adolescent. The counsellor should stick to verbal comfort and establish a professional relationship rather than a social one. Crying may also be done to elicit sympathy or stop further exploration of a discussion topic.

3. **Counsellor Believes There is No Solution to the Problem**
It is important for the counsellor not to fall into the trap of "Not Knowing How to Proceed". This usually happens when the adolescent counsellor focuses on the problem but not the person. One of the methods of dealing with such an adolescent who insists on solving his or her problem is to say, "While I am not able to change some things in your experience, getting to know you is always better and helpful". Another important thing for the counsellor to remember is not to jump to conclusions before exploring more fully the youth. For example a youth may hint on an incestuous feeling, and the counsellor assumes that sexual intercourse took place.

4. **The Adolescent Threatens Suicide**
If a adolescent threatens to commit suicide it may be appropriate to say, "It is virtually impossible to stop anyone from taking his or her own lives if one wishes to do so. But however, I would be terribly sad if that were to happen". The Youth Counsellor should not panic when the adolescent threatens to do so. Focus should still be on showing the youth that you care and giving the youth hope. It is always important that the counsellor shows concern for the adolescent and mentions that he or she respects the adolescent’s feelings. If rapport had already been built, the counsellor is in a better position to use his or her discretion on how best to deal with the situation.

5. **The Counsellor Makes a Mistake**
The youth counsellor can make a mistake, such as a factual error about something or giving incorrect information. The youth counsellor must always acknowledge that he or she has made a mistake. In general the youth counsellor should realise that his or her most important role in establishing a good relationship with the youth is to be honest and show respect and confidence to the adolescent.

6. **The Counsellor Does not Know the Answer to a Factual Question**
It is good practice for a youth counsellor to always admit that she/he does not know but will get the information for the adolescent. Alternatively the counsellor could identify other sources of information for the adolescent and refer.
7. **Adolescent Refuses Help**
The adolescent counsellor needs to probe gently for the reason why help is being refused. It may be appropriate to say, "Well, I can understand how you feel, and I am not sure whether I can help. But perhaps we could take a few minutes just to see what you think, and together we can decide whether it might be worth while talking a bit more". If the youth still refuses to talk, then stress the positive. "At least you did come, we have met each other". Try to suggest another appointment, if possible, and leave it open to the adolescent.

8. **The Adolescent Is Uncomfortable with the Counsellor's Sex**
The youth counsellor may start by saying something like this, "I wonder if you were expecting to see a man or a woman". Once the issue is open, the counsellor may proceed as follows, "Some young people are at first more comfortable with someone of the same or opposite sex, but in my experience that usually becomes less important once we get to know each other. Why don't we try to continue and see how we get on". Encouraging the youth to talk usually helps the adolescent to feel accepted. The youth counsellor should keep on trying to give confidence to the adolescent.

9. **The Counsellor is Short of Time**
It is beneficial for the youth to know how much time he or she will be with the counsellor. It is important for the youth counsellor to state at the onset the reason for the shortage of time. Apologize and indicate that you can meet again. Suggest a specific date and time.

10. **The Counsellor Cannot Establish Rapport**
If rapport is difficult to establish, the counsellor should ask for help from others in reviewing the sessions to understand better where the difficulty may lie.

If discussions with a different experienced counsellor prove difficult to arrange, the youth counsellor should continue working to help the youth feel better about expressing himself or herself.

11. **The Counsellor and Adolescent Know Each Other**
The adolescent counsellor and youth might come from the same community and know each other well. Counselling may be difficult but if the youth and the youth counsellor have a casual relationship, the counselling session may proceed, taking into account that confidentiality will be respected. If this is not possible, arrange for someone else to do the counselling.

12. **The Adolescent Talks Continuously and Inappropriately**
This situation may arise from anxiety that may make talking difficult. The counsellor may interrupt after a while, for example, by saying: "Excuse me, I wonder if you realise that for some time you have been repeating the same thing. Are you feeling a bit nervous or finding it hard to talk about other things?" This may help the adolescent focus on the conversation about herself or himself and may help stop the inappropriate talk.

13. **The Adolescent Asks a Personal Question of the Counsellor**
Usually it is not advisable for the youth counsellor to respond to personal questions about herself or himself because:

i) It takes the attention away from the adolescent.

ii) It may lead to a series of questions that may be private in nature, which the counsellor may refuse or be embarrassed to answer.

If the questions are answered, this may send the wrong message to the adolescent, suggesting that something is wrong with the youth counsellor. It is better to respond to a personal question by saying that is not helpful to the adolescent for the counsellor to talk about herself or himself.

14. **The Counsellor is Embarrassed by the Subject Matter**
Sometimes the adolescent may say something that embarrasses the counsellor. If that happens, it is usually necessary for the counsellor to acknowledge his or her discomfort. This is especially true since the youth probably will be aware of the youth counsellor's discomfort, especially if the counsellor has responded visibly or
emotionally. This situation may be turned to an advantage if the counsellor can acknowledge his or her own feelings and then return to the subject the youth raised earlier.
## SESSION 9 SUMMARY

### MODULE II: Interpersonal Communication with Adolescents

### SESSION 9: Giving a Group Talk

**Time:** 2 hours, 45 minutes

### Objectives:

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

- Define a group talk.
- Describe the process for conducting a group talk.
- List the 7 steps for preparing a group talk.
- Plan and present a group talk.

### CONTENT/ACTIVITY | DURATION | METHODOLOGY | RESOURCES
--- | --- | --- | ---
1. Introduction | 10 min | Present Objectives OR Exercise | Prepared article for exercise,
2. Definition | 10 min | Discussion | 
3. Personal Experiences | 15 min | Discussion | 
4. Audience Assessment | 20 min | Presentation | Computer, LCD
5. Plan and Prepare | 20 min | Individual & Group Work | HO 2.8.1
6. Conducting the Talk | 20 min | Exercises | HO 2.8.3; HO 2.8.4
7. Evaluating the Talk | 15 min | Exercises | HO 2.8.5
8. Practice | 50 min | Group Work | 
9. Summary | 5 min | Discussion | 

### REFERENCES


1. **INTRODUCTION – Presentation, Exercise (10 min)**

**Step 1:**

Begin the session by showing and presenting the session's objectives. **OR**

**Exercise:** (5 min) Clip a story from a newspaper about 2 or 3 paragraphs long. With no introduction, casually mention to the group, “...some of you probably saw this in the newspaper the other day”. Read the article aloud somewhat rapidly in a dry voice as though giving the impression that the article is unimportant.

Continue by asking the participants eight to ten prepared questions about the story. It is unlikely that anyone will be able to answer all the questions.

Ask, “You all heard the story, yet few could remember much. Why”? Possible answers include; disinterest, no objective, lack of enthusiasm of speaker, and no advance reward.

Ask, “If I had told you initially that you would win money, would you have listened more attentively? Why”?

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<th>Step 1:</th>
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2. **DEFINITION OF GROUP TALK – Brainstorming (10 min)**

**Step 2:**

- *Explain that this exercise demonstrates the need to effectively communicate to an audience how they will benefit from listening to a group talk to establish interest.*
- *Ask participants to define a group talk. Discuss the importance of group participation.*

A group talk involves communication among a number of people, usually encouraged by a leader or “facilitator”, with a lot of group interaction and participation.

**Group participation is important because:**

- Participants become involved in the discussion.
- Participants share common ideas and concerns and come up with solutions.
- The facilitator receives immediate feedback on the group’s interests and concerns.
- Participants share their feelings and reveal social attitudes.
- Participants can be influenced by others in the group to change their attitudes and behaviour.
- Misconceptions can be corrected.
- Better understanding results when members ask questions and join in discussions.

3. **PERSONAL EXPERIENCES – Discussion (15 min)**

**Step 3:**

- *Ask participants when in their work as Service Providers they might give group talks and lead discussions. Possible answers include certain times of the week or day, or perhaps never.*
- *Ask participants if they have given group talks in the past, were they successful? What were the difficulties? Were they scared to give the talk? Ask if anyone has attended a good group talk. Ask if anyone has attended a poor one. What made it a good talk or a poor talk?*

People are often scared of giving group talks. This is a time when participants can talk about some of their past experiences and let go of some of the anxiety they may feel about this session. They will recognize that many others share their feelings and frustrations about giving group talks. It is common even for professionals knowledgeable in their field to experience anxiety when speaking before a group.
4. **AUDIENCE ASSESSMENT – Presentation, Discussion (20 min)**

**Step 3:**

Present the Group Talk outline and describe each step briefly.

**Assessing the Audience**

Ask participants what information is needed about the target audience **before** giving a presentation or conducting a talk? Summarize answers from the group and add missing points. Ask participants to list possible **sources** where they can learn about the audience’s information needs. Write the points on newsprint or a chalkboard. Summarize what participants have said and add any points they have missed. Ask how a speaker can determine the audience’s information needs **during** a group talk. Record responses on newsprint, add any missing points and summarize.

**Role Play:**

In order to emphasize the importance of audience analysis, have a participant volunteer to give a short talk on a given topic. Have that person leave the room while the larger group decides who they will be as an audience. Have them decide on their age, socio-economic status, knowledge of the speaker’s topic, and attitudes toward the topic. Have the “speaker” return and begin the talk without any information on the audience’s background and attempt to engage the audience in the talk. In most cases, it is unlikely that the speaker will meet the audience’s needs or capture their attention.

Discuss this exercise. Ask what the facilitator could have done and can do in the future to ensure that the audience will be interested in the subject. Answers include: when possible, go to the representatives of the audience and discuss the topic in advance. Ask the group if there is anything else they would like to add.

After approximately five minutes shift the focus and have the speaker attempt to assess the audience’s needs during the talk.

**The Group Talk Process** involves four steps:

1. **Assess** the target audience and their needs.
2. **Plan** and prepare for the talk.
3. **Conduct** the talk.
4. **Evaluate** its effectiveness.

**Step 1**

- **Assess the Target Audience**

The facilitator collects information about the audience in order to identify their priority information needs. For a talk on Adolescents Sexual and Reproductive Health, the facilitator might collect information on the audience’s knowledge; attitudes; language; culture; religious beliefs; educational level; average family size and approximate ages.

Possible **sources/ways** of collecting audience’s information needs **before** planning a talk are:

- Reviewing recent research reports conducted in the area, such as Reproductive Health Survey Reports or a focus group discussion report.
- Examining records and registration books for common problems and the average age.
- Observing common trends in the community. Which questions are frequently asked? What kinds of problems have you and other community leaders seen recently?
- Reviewing the cultural and social characteristics of the community. What is the social background of your audience? What are their religious beliefs? What is the average family size?
- Discussing with knowledgeable people in the community.

The group facilitator can also assess the audience’s information needs **during** a group talk using the following
techniques:
- Paying attention to the audience members’ facial expressions and body language.
- Asking the audience specific questions about the topic to determine their level of knowledge.
- Asking the audience directly about what they want to learn and what they already know about the topic.
- Asking questions to encourage discussion among members that will reveal their information needs.

5. PLAN AND PREPARE – Individual and Group Work (20 min)

Step 4:
- Show the “7 Steps to Preparing a Group Talk”. Explain each step and distribute the companion handout.
- Ask participants to brainstorm the barriers they might encounter in preparing for a talk. Have them discuss the frustrations they might have encountered in previous talks. Examples might include: inability to secure a quiet place, insufficient preparation time and obstacles to limiting group size.
- Distribute HO 2.8.1. “Group Talk Outline” and discuss each step in the handout.
- Exercise: Present a group talk topic to the larger group. Separate the participants into groups of four or five, assigning each group an imaginary audience. Have each smaller group brainstorm together to fill out the group talk outline. Have each group present their outline to the larger group. Discuss the differences and similarities among the groups. How do the objectives change with different audiences?

Step 2. Plan and Prepare for the Talk

Steps in planning and preparing a group talk:
- Identify the topic.
- Choose a conducive venue with enough space.
- Identify the audience and their characteristics.
- Set objectives, content and teaching methodology.
- Implementation.
- Go over the main points of topic.
- Have questions for discussion.
- Identify and prepare learning aids where necessary.

6. CONDUCTING THE TALK – Exercise (20 min)

Step 5:
Discuss the steps to be taken in conducting a group talk. Distribute HO 2.8.2 “Group Talk Preparation” and HO 2.8.3 “Techniques for Conducting a Group Talk”. Review and discuss with group.

Exercise: Hand out a piece of paper to each participant with a group talk topic such as STI prevention.

Ask each participant to prepare an opening to the discussion. This should be done rather quickly (about 3 minutes) so as to minimize anxiety about creating the ‘perfect’ introduction. The presenter may also want to use imaginary visual aids. Have each participant present their opening to a small group.

Does this opening:
1. Introduce the topic?
2. Capture the audience’s attention?
3. Establish audience rapport?
4. Explain why this an important topic?
5. Establish the speaker’s expertise on the topic?
6. State how the audience will benefit from being part of this talk?
7. Create anticipation for the rest of the presentation?

After each presentation have the group give the speaker feedback.
Step 3: Conducting the Talk
- Analyse the audience
- Introduce the topic
- Explain the purpose of the talk
- Deliver presentation
- Use learning aids where necessary
- Evaluate the group talk

7. EVALUATING THE TALK – Exercise (15 min)

Step 6:

Ask participants:
- Explain why it is important to evaluate a group talk?
- When should a service provider evaluate a group talk?
- What are two methods a service provider can use to assess the effectiveness of a group talk?

Exercise (30 min): Ask a participant to volunteer to evaluate this entire group talk session. Have the volunteer ask the group questions to determine their level of satisfaction with the session and knowledge of the material. The volunteer may want to ask the group to demonstrate their knowledge through an activity. Coach the volunteer in this exercise if necessary and offer suggestions.

Possible questions include: How do they feel about the session? What did they learn? What do they intend to do as a result of the session? Was anything lacking? Why is group participation important?

Distribute and review the handout HO 2.8.4 “Steps in Conducting a Group Talk”. Ask participants for any questions or comments.

Some ways to informally evaluate a group talk during the session are to:
- Pick a few key points that were covered and ask for volunteers to explain them.
- Ask for a demonstration of something shown to the group.
- Ask the group their opinion of the talk and whether they want additional or different information.
- Ask group members to assess their level of understanding and interest.
- Ask the group what they intend to do as a result of the talk.
- Pick a few key points that were covered and ask for volunteers to explain them.
- Ask for a demonstration of something shown to the group.
- Ask the group their opinion of the talk and whether they want additional or different information.
- Ask group members to make an assessment, of their level of understanding and interest.
- Ask the group what they intend to do as a result of the talk.

It is important to evaluate a group or motivational talk because it helps the facilitator to:
- Assess the audience’s understanding and interest;
- Analyze audience needs in preparation for future talk(s);
- Improve the organization and delivery of future group talks;
- Assess the impact or effectiveness of the talk and to determine if the objectives were met.

Providers can evaluate their talk while preparing the talk, at the beginning of the group or motivation talk, during the talk and at the end of it. Providers can evaluate their talk with either an informal or a formal evaluation. An informal evaluation includes the methods listed earlier for use during the talk: Observe the audience’s non-verbal communication. Listen to the statements.

To evaluate a group talk more formally, the facilitator can:
- Ask a colleague to observe the talk and give feedback.
• Have group participants complete a questionnaire (after the talk) that assesses their understanding and interest in the topic and rates the facilitator’s performance.

8. **PRACTICE – Group Work (50 min)**

**Step 7:**

**Exercise:** Separate participants into small groups and ask one participant to volunteer to deliver a talk to the small group on a topic of their choice. Allow the speaker time for preparation.

Ask participants to observe and to fill in HO 2.8.5, “Checklist for Observation of a Group Talk” during the speaker’s presentation.

After the talk, have the group discuss and offer feedback on the talk. Rotate roles with as many participants speaking as time permits.

9. **CONCLUSION AND SUMMARY – (Reflection 5 min)**

**Step 8:**

• Ask the group to describe one strength they now have regarding giving group talks and one area (skill) they would like to develop.

• Ask them to identify what would keep them from implementing this skill in their work situation. Strategize with the group how to overcome these obstacles.
7 Steps to Preparing a Group Talk

- Choose a quiet place with enough space.
- Avoid places with disturbances.
- Limit the group size.
- Determine the best time for the talk.
- Design objectives for the talk and prepare an outline.
- Write a list of questions to stimulate discussion and evaluate the talk.
- Keep the talk within allocated time.

Group Talk Outline

- Topic of the talk.
- Audience (describe the people who will hear the talk).
- Objective(s) of the talk (describe what you want the audience to know or do after the talk).
- Main points (think about and list the most important points of your talk).
- Questions for discussion (develop questions you can ask the audience to stimulate discussion).
- Learning aids (consider which posters, flip charts, pamphlets, or models you will use to illustrate the main points).
Group Talk Preparation

Find out as much as possible about the audience before you plan your presentation: who they are, what their interests are, and what their previous contact with youth is.

Prepare notes for the presentation. Help the audience keep track of what you are saying by organizing the points clearly.

Think about the words you will use. Use short sentences and words. Avoid long, drawn-out descriptions, jargon, abbreviations, and technical language. Keep your illustrations brief and to the point.

Prepare your flip charts in advance if possible. Do not use light-coloured markers, as they are not visible from a distance. If you are presenting to a large group, use large print, and do not write on the bottom 1/4 of the page.

Take markers and masking tape with you if you anticipate needing them. Take sufficient numbers of printed materials or handouts with you.

If someone is introducing you, you may want to write out suggested ideas for him or her to use. Your suggestions can include “rapport builders” with your audience, such as a common group membership, past contact with them, or your knowledge about the youth.

Check the room or place where the talk will be given. Ideally, the room should be arranged for the comfort of the participants. However, you may have no control over how the participants are arranged, although you can make changes in where you will stand. You do not want to be too distant from the nearest member of the audience.

If you are using a microphone, make sure it is in good working order so that you do not have to tap it or make adjustments after you begin.

Position learning aids where you want them. If you are showing a film, make sure the screen is in the proper position and that the projector is functioning properly.
An effective opening: The opening sets the tone for the presentation and can “make or break” it. A good opening will:

- Capture the audience’s attention.
- Establish audience rapport.
- Introduce the topic.
- Create anticipation for the rest of the presentation.

Do this by sharing a personal anecdote, asking relevant questions, or stating a benefit to be gained by the listeners.

The purpose of the talk: Facilitators should tell the audience what they are going to talk about. Basic information should be worked into the opening or presented immediately afterward. This helps to set expectations and establish interest.

The main body of the talk: This comprises all the information that needs to be given during the talk. It may be organized as a list of major points, each with supporting evidence including facts, figures, and examples and rationale for the presentation. It is the heart of the talk.

The closing: The end of the talk is one of the most important elements of the entire presentation. It should paraphrase key points, restate the most important point, and contain a benefit statement that explains to the audience why the talk is of personal importance to them.
Steps in Conducting a Group Talk

Step 1: ASSESS THE AUDIENCE’S INFORMATION NEEDS

It is important for Presenters to know the characteristics of their target audience before designing a talk. In other words: Who are they? What do they know? What do they want or need to know?

Find out the audience’s:
- Level of Reproductive Health knowledge
- Attitudes
- Culture
- Religious beliefs
- Educational level
- Approximate ages

This information can be collected by:
- Conducting a community analysis by conducting a survey or looking at clinic records.
- Talking with representatives of the target audience.
- Recalling Reproductive Health questions that they have asked during previous talks.

Step 2: PLANNING A TALK

The Presenters should follow several steps in order to plan a talk:

- Prepare and design the talk objectives: What are the goals of the talk? What should the audience know about reproductive health at the end of the talk?
- Prepare an outline of the talk: Write out step by step how you will present the information. See the “Group Talk Outline” handout.
- Plan the timing of the talk: Is the talk planned at a convenient time for the selected audience?
- Choose or confirm the venue: Is the location convenient for the selected audience? Is it comfortable and free of too many distractions?
- Select and prepare appropriate learning aids: Learning aids are crucial if you want to keep an audience’s attention and reinforce information. A picture is worth a thousand words! And a demonstration is perhaps worth even more! If you do not have access to prepared learning aids, try your hand at making some of your own.
- Design appropriate questions to stimulate and evaluate the talk: People love to talk and well-thought-out questions will stimulate your audience to participate in discussion. Good questions will also help you to know whether they understand and are learning what you want them to learn.

Develop the Content Using the Group Talk Outline

By following these steps, Presenters will be able to decide which information is the most important to include in the talk. It will also help them to use questions to stimulate discussion and to bring the most appropriate learning aids. The group talk outline should include the following:

Objectives: Every good talk has a purpose or an aim that is derived from the audience’s information needs.

Topic: Every talk should have a main topic or subject. A talk is likely to be successful if the topic is well defined.

Audience: The outline should state who the intended audience is.

Main Points: The talk should cover the most important items of information about the topic. Each main point will probably have several sub-points as well.
Questions for Discussion: Throughout the talk, the Presenters should ask questions to stimulate discussion around the main points.

Learning Aids: A good talk is not complete unless it is accompanied by learning aids. These should be used to illustrate key points and to help make concepts and ideas more clear. The outline should also identify which booklets or pamphlets will be given to the members of the audience after the talk.

Step 3: CONDUCTING THE TALK
Talks are most interesting when they:
- Last no longer than 20 minutes.
- Are well organized.
- Involve the audience.

One of the best ways to involve the audience is to encourage discussion. Presenters need very good listening, questioning, paraphrasing and summarizing skills to facilitate discussions.

Following is a list of steps that you should follow when conducting a group talk:
- Introduce yourself and the topic of the talk.
- Encourage group participation.
- Guide and stimulate discussion.
- Encourage participants to respond to each other’s questions.
- Give clear, correct information and answers, using relevant learning aids.
- Establish eye contact.
- Use simple, clear, culturally accepted and understandable language.

Stay calm. All speakers experience nervousness, some of which creates a feeling of excitement that is advantageous to most presentations. At a certain point, though, symptoms of anxiety can be counterproductive to the presentation’s success so you should note the following:
- Adequate preparation is the best way to stay calm. It will help you to become “message-conscious rather than self-conscious”.
- In most instances, the audience wants the speaker to succeed.

Develop presence. Presence is that quality of a speaker that draws attention and that can be developed. A presenter who has it will exhibit many of the following qualities:
- A pleasant appearance;
- The effective use of body language including natural, open gestures;
- A well-paced delivery style, with effective use of the pause for emphasis and reinforcement;
- A well-pitched voice, loud enough to be heard well without being grating or obnoxious;
- A genuine enthusiasm and sincerity;
- Effective eye contact with the audience;
- A natural, relaxed style that puts the audience at ease.

Structure the presentation. Explain to participants that a good talk must have a structure or a sequence to it. Every talk, therefore, has the following parts:
An effective opening: The opening sets the tone for the presentation and can “make or break” it. A good opening will:
- Capture the audience’s attention.
- Glue the audience in on the facilitator’s presentation style.
- Raise the comfort level of the audience.
- Introduce the topic.

Any number of techniques such as personal anecdotes, jokes or relevant questions can be used as an opening.
and to warm up the audience.

**The purpose of the talk:** Presenters should tell the people what they are going to talk about. Basic information should be worked into the opening or presented immediately afterward. This helps to set expectations and establish interest.

**The main body of the talk:** This comprises all the information that needs to be given during the talk. It may be organized as a list of major points, each with supporting evidence including facts, figures, and examples and rationale for the presentation.

**The closing:** The end of the talk is one of the most important elements of the entire presentation. It should summarize or restate the most important points, and contain a benefit statement which explains to the audience why the talk is of personal importance to them.

**Questions for discussion:** Presenters should have several questions ready for the group to discuss, if that is part of their plan.

**Use learning aids.** The effective use of learning aids encourages the audience to make greater use of their senses. Presenters should use learning aids to make their talks more interesting and lively.

**Facilitate group discussion.** During the talk, it is important for the Presenter to ensure that group members can see and hear each other and consider themselves as equal partners in the discussion. Presenter can help to achieve this atmosphere by asking the participants to sit in a semi-circle or circle. The Presenter should:

- Give group members a chance to contribute.
- Acknowledge their contributions.
- Avoid taking sides when settling conflicts.
- Know and be friendly with individual members.
- Summarize important points.

The Presenter should ensure that all members’ opinions are respected and that no member dominates the discussion. The Presenter can discourage dominating personalities from speaking all the time and encourage the quiet ones to talk by saying something like, “Annah, we’ve already heard a lot from you on this subject today. Let’s hear what Jennifer has to say”.

Questions are a Presenter’s most powerful tool. People cannot avoid thinking, even when asked a hypothetical question. Presenters should know what questions they want the group to answer, and encourage people to share their knowledge and experience: “Annah, you have expertise in this area, what do you think about...?” Key questions can be found in the goals of the discussion.

The Presenter should encourage discussion in the group by asking open-ended questions. These are questions that cannot be answered by a simple one-word answer such as yes or no. The Presenter must realize that although he or she may have more Reproductive Health knowledge, group members know their own lives and problems much better.

If a participant asks a question, the Presenter should direct the question back to the group to see if anyone can answer it. The Presenter should also:

- Summarize key points of the discussion when necessary.
- Build on the participants’ contributions.
- Draw in the shy members and prevent the talkative ones from dominating the discussion.

**Step 4: EVALUATING THE GROUP TALK**

You already know that evaluation is an important part of the communication process. You should know why it is important to evaluate a group talk, when the Presenter should do this and how it could be done.
WHY? It is important to evaluate a group or motivation talk because it helps the Presenter to:
- Assess the audience’s understanding and interest.
- Analyze audience needs in preparation for future talks.
- Improve the organization and delivery of future group talks.
- Assess the impact or effectiveness of the talk and determine if the objectives were met.

WHEN? Presenters can evaluate their talk while preparing the talk, at the beginning of the group or motivation talk, during the talk and at the end of it.

HOW? Presenters can evaluate their talk by either doing an informal or a formal evaluation. In carrying out an informal evaluation, the Presenter should:
- Observe the audience’s non-verbal communication.
- Listen to the statements that group members make to assess their level of understanding and interest.
- Ask the group what they intend to do as a result of the talk.
- If Presenters want a more formal evaluation, they should:
  - Ask their supervisor to observe them while conducting a group talk and give feedback.
  - Have group participants complete a questionnaire following the talk to assess their understanding and interest in the topic and how they would rate the Presenter’s performance.
HANDOUT 3.9.5

Checklist for Observation of a Group Talk

Check off each behaviour observed during the group discussion.

**Assessment and Preparation:**

- Introduces topic.
- Asks questions to assess participants' interest and level of understanding of the subject.
- Outlines the talk, including objectives, main points, and discussion questions.

**Facilitation of the Discussion:**

- Encourages participants to participate.
- Uses open-ended questions.
- Answers questions clearly.
- Adjusts the topic to suit the participants' expressed interests and concerns.
- Uses appropriate learning aids to illustrate important points.
- Paraphrases and summarizes participants' statements.
- Maintains eye contact with all group members.

**Evaluation:**

- Asks questions to assess the quality of the talk.
**SESSION 1: Planning, M & E and Sustaining ASRH Programmes**

**Time:** 1 hour, 40 minutes

**Objectives:**
By the end of the session, participants will be able to:
- Define key concepts for Planning, Monitoring and Evaluation.
- Describe the Project cycle.
- State at least 5 reasons for conducting Monitoring and Evaluation (M & E).
- Describe the Monitoring and Evaluation Framework.
- State and define key ASRH indicators.
- State mechanisms for sustaining ASRH programmes.

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>5 min</td>
<td>Brainstorming</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>2. Basic Planning M&amp;E concepts</td>
<td>10 min</td>
<td>Mini lecture</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>3. The Project Cycle</td>
<td>15 min</td>
<td>Brainstorm</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>4. Reasons for conducting M&amp;E</td>
<td>10 min</td>
<td>Discussion</td>
<td>HO 3.4.1</td>
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<tr>
<td>5. M&amp;E Framework</td>
<td>15 min</td>
<td>Group work</td>
<td>HO 3.4.2</td>
</tr>
<tr>
<td>6. Understanding M&amp;E data collection tools</td>
<td>10 min</td>
<td>Discussion</td>
<td>ASRH Data Collection tools</td>
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<td>7. Mechanisms for sustaining ASRH programmes</td>
<td>10 min</td>
<td>Discussion</td>
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<td>6. Community Participation</td>
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<td>7. Planning Exercise</td>
<td>20 min</td>
<td>Discussion</td>
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<tr>
<td>9. Conclusion and Summary</td>
<td>5 min</td>
<td>Discussion</td>
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**REFERENCES**

1. INTRODUCTION – Brainstorming (5 min)

Step 1:
- Ask participants what comes to their minds when someone mentions the words: planning, monitoring and evaluation?
- Ask participants their understanding of planning, monitoring and evaluation. What is it? Why is it done and what does it entail? When and who carries it out? Who needs uses M&E Information?

2. DEFINE KEY CONCEPTS IN PLANNING, MONITORING AND EVALUATION – Mini Lecture (10 min)

Step 2:
- Present the definitions and explain how different one is from the other.
- Use Handout 3.4.1 to develop PowerPoint presentation on definition of terms

This section defines the main terms used in planning, monitoring and evaluation. The key terms to define are planning, monitoring, evaluation, indicator, M&E Framework, input, process, output, outcome and impact.

3. THE PROJECT CYCLE – Mini Lecture, Discussion (15 min)

Step 3:
- In pairs, ask participants to discuss the project cycle, giving justification for each stage.
- Show the slide with the project cycle and discuss each stage, with participants sharing what they discussed in the buzz groups.
- Refer and Distribute Handout 3.4.2

The Project Cycle

- Assessment/Situational Analysis and Planning: Where are we now?, Where do we want to go? How will we get there?
- Implementation and Monitoring: Is the project is on the right track, is it meeting its objectives and using its resources as planned?
- Evaluation: What changes have occurred as a result of project activities?
- Adaptation: What are the lessons learnt, can they be replicated in future?

4. REASONS FOR CONDUCTING PLANNING, M & E – Discussion (10 min)

Step 4:
- Lead a discussion on the reasons for conducting Planning, M and E.
- Introduce the Logical Framework (Handout 3.4.3)
- Discuss how relevant is M and E in ASRH programming.

Planning: It means setting performance expectations and goals for groups and individuals to channel their efforts toward achieving organizational objectives. Refer to Handout 3.4.3 for the characteristics and steps in planning as well as the use of the logical framework.

The Logical Framework Approach

The Logical Framework Approach (LFA) is a project design methodology: a means to articulate a common interpretation of objectives of a project and how they will be achieved. It is an analytical, presentational and management tool mainly used in the design, M & E of development projects. The product of this approach is Logical framework, which is a document, commonly known as the LogFrame of 4 x 4 matrix.
It helps planners to:
- Analyse the existing situation during activity preparation.
- Establish a logical hierarchy of means by which objectives will be reached.
- Identify the potential risks to achieving the objectives, and to sustainable outcomes.
- Establish how outputs and outcomes might best be monitored and evaluated.
- To present a summary of the project in a standard format, and
- Monitor and review activities during implementation.

The LogFrame runs through a matrix with a series of connected propositions:
- If activities are implemented, and assumptions hold, then outputs will be delivered.
- If outputs are delivered, and assumptions hold, then the purpose will be achieved.
- If the purpose is achieved, and assumptions hold, then the goal will be achieved.

**LOGICAL FRAMEWORK**

<table>
<thead>
<tr>
<th>Overall Objective</th>
<th>Intervention Logic</th>
<th>Objectively Verifiable Indicators</th>
<th>Source of Verification</th>
<th>Assumptions</th>
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<tbody>
<tr>
<td>Purpose</td>
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<td>Results</td>
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<td>Activities</td>
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<td>Preconditions</td>
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**Monitoring** - is a continuous process that aims primarily to provide project management and give the main stakeholders early indications of progress or lack of progress towards achieving project objectives. Monitoring also detects early signs of the project's success or failure. Monitoring assists to address any impediments to progress and make adjustments so that results can be achieved within the designated timeframe. Monitoring is an internal process that also looks at project processes (both programmatic and financial) and makes changes in assumptions and risks associated with target groups, institutions or the surrounding environment.

**Evaluation** - is a time-bound exercise that attempts to assess the relevance, performance and success of current or completed projects, systematically and objectively. Evaluation determines to what extent the intervention has been successful in terms of its impact, effectiveness, sustainability of results, and contribution to capacity development. Evaluation, more than monitoring, asks fundamental questions on the how and why of the overall progress and results of an intervention in order to improve performance and generate lessons learned. When carried out after project completion, evaluation can contribute to extracting lessons to be applied in other projects. Evaluations at the midpoint of the project or programme also provide timely learning that can suggest mid-course adjustments.
Monitoring and Evaluation serves the following purposes:

- To measure progress against set targets or objectives (what, how, when, why)
- To check whether programme activities are on schedule
- To identify challenges so as to make timely corrective action (making informed decisions on the way forward)
- For accountability to community - donors, community leadership, board members and other stakeholders: to demonstrate effective and efficient use of resources; preserving institutional memory and learning purposes: What did we do? What did we achieve? and What did we do well and what worked well?
- To influence policy

In general, evaluation should address five fundamental criteria:

i. **Relevance**: What is the value of the intervention in relation to stakeholders’ needs, to national priorities, to partners’ policies, and to global references such as the MDGs? To what extent are the objectives of the project/programme still valid?

ii. **Effectiveness**: What target groups have been reached? To what extent has the project or programme achieved satisfactory results in relation to its stated objectives?

iii. **Efficiency**: To what extent has the project/programme used its resources economically to achieve its objectives?

iv. **Impact**: What are the wider social, economic, and environmental effects on communities and nature?

v. **Sustainability**: Are the activities and impacts likely to continue after external support is terminated? Will aspects of the project / programme be replicated elsewhere (perhaps with adaptations)?

THE MONITORING & EVALUATION FRAMEWORK – *Group Work, Discussion (15 min)*

**Step 5:**

- Ask participants to go into groups and plan an ASRH programme for their organisation.
- Groups are to present their planned programme in plenary.
- Discuss.
- Use HO 3.4.4

The M & E framework is a structure used to measure performance of ASRH programmes. It defines inputs, processes, outputs, outcomes, and impact and the tools to use for data collection. It also defines how people, data and time interact so that the performance of the health providers and services can be meaningfully assessed and improved.

**6. UNDERSTANDING M&E DATA COLLECTION TOOLS/CHECKLISTS – Discussion (10 Min)**

**Step 6:**

- To guide the discussion, ask the following questions:
  - *Why is it important to collect ASRH data? What are the key ASRH indicators?*
  - *What tools are we currently using for ASRH data collection? Go through some examples.*
  - *What are the challenges in ASRH data collection and how to address them?*

How do we monitor and evaluate

- Routine collection, processing, analysis, dissemination, feedback and utilization of data: forms, registers, T5, MIS.
- Quality assurance: coverage; completeness;
- Observation e.g. young people’s behaviours.
- Rapid assessments at intervals.
- Surveys
To increase collection of accurate data, service providers need to:

- Appreciate the importance of data collection
- Familiarise with reporting systems and requirements (flow of data)
- Familiarise with indicators (core ASRH indicators)
- Familiarise with forms and tools to correctly complete them and accurately interpret data on them
- Have ability to assess data accuracy, precision, reliability, validity and integrity

Service Providers need to closely monitor:

- Distribution and use of materials
- Youth Services on demand
- Accessing of services by youth
- Acceptance of the messages by youth
- Number of referrals
- Issues in the suggestion box and views on the programme

7. SUSTAINABILITY OF ASRH PROGRAMMES – Discussion (10 min)

Step 7:

- Participants to brainstorm on experiences and challenges in sustaining ASRH programmes
- Present Handout 3.4.5

ASRH programmes may be sustained through:

- Community involvement, especially young people in: a) Planning (Advocacy and sensitization of local leadership; Local resource mobilization strategies: Use of existing local resources, - Multiple sectoral approach and in developing an exit strategy). b) Implementation and c) Monitoring & Evaluation.

- Capacity building of service providers

- Setting up and working with structures and committees on ASRH programming

- Establishing internal mechanisms for funding ASRH service provision

8. COMMUNITY PARTICIPATION - Brainstorming/Role Plays (10min)

Step 8:

- Participants to brainstorm on ways to enhance community and parental participation in ASRH programs
- Present Case and Handout 3.4.5

Introduction:

Implementing agencies, health staff and adolescents may embrace ASRH programs, but these programs are unlikely to be sustainable if they do not have the support of the local community, including parents. In order to have lasting effects, a program should lead not only to changes in the knowledge, skills and behaviors of individuals (in this case, adolescents), but also to social and structural changes.

Discuss the process of consultation with parents, community members, health workers and adolescents in a conflict-affected community to develop a strategy addressing the ASRH problem of adolescent girls who are selling sex.
**CONCLUSION – Discussion (5 min)**

Summarize the session by highlighting how community participation can improve ASRH programming.
10. **PLANNING EXERCISE FOR ASRH PROGRAMMES – Groupwork and Discussion (20 Min)**

**Step 8:**
- Put participants into groups and ask them to design/plan a YFS at their respective facility and list the changes to be made. Make them use handouts 3.4.2 and 3.4.3.
- Groups make their presentations followed by discussion.

9. **CONCLUSION – Discussion (5 min)**

Summarize the session by highlighting the importance of Planning, Monitoring and Evaluation in ASRH programming and the role of young people.
**HANDOUT 4.1.1**

**Basic Planning, Monitoring and Evaluation Concepts**

**Planning** - process of setting out targets, developing approaches, outlining the implementation arrangements and allocating resources to achieve targets for ASRH programmes. It is important to understand the planning cycle.

**Monitoring** - is a continuous process that aims primarily to provide project management and give the main stakeholders early indications of progress or lack of progress towards achieving project objectives. A progress analysis during project implementation through monitoring serves to validate the initial assessment of relevance, effectiveness and efficiency or to fill in the gaps. It may also detect early signs of the project’s success or failure. Monitoring assists to address any impediments to progress and make adjustments so that results can be achieved within the designated timeframe. Monitoring is an internal process that also looks at project processes (both programmatic and financial) and makes changes in assumptions and risks associated with target groups, institutions or the surrounding environment.

**Evaluation** - is a time-bound exercise that attempts to assess the relevance, performance and success of current or completed projects, systematically and objectively. Evaluation determines to what extent the intervention has been successful in terms of its impact, effectiveness, sustainability of results, and contribution to capacity development. Evaluation, more than monitoring, asks fundamental questions on the how and why of the overall progress and results of an intervention in order to improve performance and generate lessons learned. When carried out after project completion, evaluation can contribute to extracting lessons to be applied in other projects. Evaluations at the midpoint of the project or programme also provide timely learning that can suggest mid-course adjustments.

**Indicator** - An objectively and verifiable measure of achievement of set objectives. Indicators provide the measuring stick to determine whether the goal, targets, and outputs have been achieved. A good indicator should be: **Valid**: Measures the effect it is supposed to measure; **Reliable**: Gives same result if measured in the same way; **Precise**: Is operationally defined so people are clear about what they are measuring; **Timely**: Can be measured at an interval that is appropriate to the level of change expected; **Comparable**: Can be compared across different target groups or project approaches. Indicators can be quantitative (statistical measures) or qualitative (explanatory/ interpretative judgment). They include key inputs, process, outputs, outcomes and impact.

**M&E Framework** - A structure used to measure performance of ASRH programmes. Include Inputs, processes, outputs, outcomes, and impacts.

**Input** – Resources required to implement ASRH programmes, e.g. human resources, financial resources, infrastructure.

**Process** - Transforming inputs into activities e.g. recruiting and training of service providers, distribution of IEC materials, recruitment of Youth Centre Staff, training and orientation of Youth Center Staff and implementation of intervention activities.

**Output** - Immediate results of the activities implemented, such as the number of personnel trained, number of deliveries conducted at programme level, number of youth reached by Peer Educators, number of youth counselled on HIV and AIDS, number of youth that accessed family planning services; number of youth treated for STIs; number of male condom pieces distributed to youth; number of female condom pieces distributed to youth.

**Outcome** - Intermediate results of activities implemented. Unlike outputs, outcomes are measured at the population level such as contraceptive prevalence rates or percent of births with skilled birth attendants; rate of unintended or unwanted pregnancies among youth; number of STI cases among youth; rate of HIV transmission.
among youth; HIV prevalence rate among adolescents

**Impact:** long-term effects that are the logical consequence of the achievement of the outcomes, such as the Adolescent Fertility Rate
A Project is a set of actions undertaken by any group – including managers, researchers, community members, and any other stakeholders – to achieve defined goals and objectives. A project cycle is a four stage process through which practically every project goes through. However, the four phases of the project cycle should however be viewed as iterative steps, not as a linear set of sequential steps. The cycle defines key decisions, information requirements and responsibilities for informed decision making at each stage. The project cycle consists of four stages: assessment and planning, implementation and monitoring, evaluation, and adaptation. Each stage has its own characteristics and requires specific knowledge and skills.

The assessment phase is sometimes also called the identification phase, as in this period the “why?” of the project is the important question to ask. In this stage the real problems and issues that need to be addressed, are identified. The assessment phase is followed by a planning phase in which goals and objectives are defined and the feasibility of the project is carefully researched. Then an action plan is made, resources are determined and the use of the resources is planned. At this stage it is already important to think about and identify indicators to be used to monitor and to evaluate the project.

In the implementation phase, during which the project is actually carried out, continuous monitoring needs to take place, in order to watch whether the project is on the right track, is meeting its objectives and is using its resources as planned.

During the evaluation phase the project is measured against its objectives, both to see if objectives have been met, but also to see how this was done and what the impact of the project is. In other words what changes have occurred as a result of project activities?

On the basis of the evaluation, adaptation of the project can take place and lessons learnt can be identified and used for future planning. The project cycle is a continuously ongoing one; after evaluation and adaptation, the planning starts again, followed by implementation e.t.c.
Extracted from: http://www.networklearning.org/index
PRINCIPLES AND STEPS IN PLANNING

PRINCIPLES OF PLANNING:

Planning is goal-oriented: it is made to achieve the desired objective of a project. It identifies the action that would lead to desired goals quickly & economically.

Planning is looking ahead: it is based on peeping in the future, analyzing it and predicting it, thus planning is based on forecasting.

Planning is an intellectual process: Planning, though not a mere guesswork is a mental exercise involving creative thinking, sound judgment and imagination. It is based on goals, facts and considered estimates.

Planning involves choice and decision making: Planning essentially involves choice among various alternatives. Thus, decision making is an integral part of planning.

Planning is a Continuous Process: Planning is a never ending function due to the changing environments. Plans are therefore prepared for specific period of time and at the end of that period, plans are subjected to revaluation and review in the light of new requirements and changing conditions.

Planning is designed for efficiency: Planning leads to accomplishment of objectives at the minimum possible cost. It avoids wastage of resources and ensures adequate and optimum utilization of resources. It therefore leads to proper utilization of human capital, money, materials, methods and machines.

Planning is Flexible: because planning is done for the future, planning must provide enough room to cope with the changes in clients’ needs and government policies etc. Under changed circumstances, the original plan of action must be revised and updated to make it more practical.

THE PLANNING STEPS:

THE LOGICAL FRAMEWORK APPROACH (LFA):

The Logical Framework Approach (LFA) is a project design methodology: a means to articulate a common interpretation of objectives of a project and how they will be achieved. It is an analytical, presentational and
management tool mainly used in the design, M & E of development projects. The product of this approach is Logical framework, which is a document, commonly known as the LogFrame of 4 x 4 matrix.

**The Logical Framework: Sample**

<table>
<thead>
<tr>
<th>Expected Result</th>
<th>Indicator</th>
<th>Data Source</th>
<th>Frequency</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
<td>Decreased rates of pregnancy among adolescents</td>
<td>Adolescent fertility rate (Births per 1000 girls)</td>
<td>Survey</td>
<td>5 Yearly</td>
</tr>
<tr>
<td></td>
<td>Decreased premarital sex among the adolescents</td>
<td>Median age at first sexual intercourse among the age group 15-24 years</td>
<td>Survey</td>
<td>5 Yearly</td>
</tr>
<tr>
<td></td>
<td>Increase age of sexual debut</td>
<td>Percentage of adolescents reporting use of condoms in their last sex</td>
<td>Survey</td>
<td>5 Yearly</td>
</tr>
<tr>
<td></td>
<td>Increased use of condoms among sexually active adolescents</td>
<td>Age at first marriage</td>
<td>Survey</td>
<td>5 Yearly</td>
</tr>
<tr>
<td>Outcome</td>
<td>Increased age of marriage</td>
<td>Number of condoms distributed to adolescents</td>
<td>Condom Register</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Increased adolescents' ability to say no to sex</td>
<td>Number of young people who accessed contraception</td>
<td>FP Register</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Increased adolescents' ability to use contraception</td>
<td>Number of functional youth friendly corners by approach</td>
<td>Program Reports</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Increased adolescents' access to condoms, contraception and clinical services in a friendly way</td>
<td>Number of adolescents trained on Life Skills</td>
<td>Training Reports</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Output</td>
<td>Increased adolescents' ability to say no to sex</td>
<td>Number of condoms distributed to adolescents</td>
<td>Condom Register</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Increased adolescents' ability to use contraception</td>
<td>Number of young people who accessed contraception</td>
<td>FP Register</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Increased adolescents' access to condoms, contraception and clinical services in a friendly way</td>
<td>Number of adolescents trained on Life Skills</td>
<td>Training Reports</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

| Processes       | Develop awareness programs to encourage parents/guardians to discuss SRH issues with adolescents |
|                 | Initiate community mobilization campaigns to address harmful practices on ASRH |
|                 | Train and build capacity of service providers in provision of youth friendly SRH services |
|                 | Provide life skills education emphasizing how to say no to sex to adolescents |
|                 | Establish and maintain a peer education program to reach adolescents with SRH messages |
|                 | Advocate for development and enforcement of policies that support provision of friendly SRH services to adolescents |
|                 | Establish and support mechanisms/systems for meaningful involvement of young people in SRH programming |
|                 | Support the establishment of youth friendly corners in health facilities, schools and communities |

| Inputs          | Funds, Training Manuals and materials, Condoms, Family Planning Commodities, I.E.C Materials, Youth Friendly Corner Materials, e.t.c |
HANDOUT 4.1.4

Adapt Figure 3 page 50 from Adolescents Sexual and Reproductive Health a Toolkit for Humanitarian Settings, September 2009

ASRH Problem (1)
Adolescent girls selling sex

Baseline ASRH Situation (2)
From IRA and situational analysis:
- Many unaccompanied adolescents in the community
- Few adult role models or supportive adults in community
- Poor understanding among adolescents of how HIV is transmitted
- Condoms not readily accessible to adolescents in the community
- Adolescent use of alcohol is common
- No RH services directed toward adolescents in the past

Community Processes or Outputs (5)
Community task force established to identify unaccompanied adolescents and unite them with families in the community;
- Skills training for girls provided by a local NGO;
- Counseling and support for adolescent sex workers provided;
- Adolescent-friendly RH services provide STI treatment;
- HIV counseling and testing for adolescent sex workers; Peer RH educators and condom distributors trained.

Individual Change (4)
Adolescent girls no longer engage in

GOALS (3)
Adolescent sexual and reproductive health in the community is improved;
Unaccompanied adolescents in the community have livelihood security.

Structural Change (4)
Facility and community based RH information and services provided

Social Change (4)
Community systems identify and support unaccompanied adolescents.
MONITORING AND EVALUATION FRAMEWORK

The Results Chain:

A result is a describable or measurable change that derived from a cause and effect relationship.

Monitoring and Evaluation Framework

A monitoring and evaluation framework outlines the plan for monitoring in concrete steps. It lists each indicator from the log frame; presents how indicators are defined and calculated; defines Who, What, When, How by: identifying who is responsible, what the data source, how to collect the information or data, when and how often an indicator is measured. Refer to example below.
<table>
<thead>
<tr>
<th>Expected Results</th>
<th>Indicator</th>
<th>Indicator Definition</th>
<th>Data source</th>
<th>Collection Method</th>
<th>Frequency</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased access to modern contraception by young people</td>
<td>Number of young people who accessed modern contraception</td>
<td>Total number of young people (aged 15-24 years) who received a modern contraception in the reporting period</td>
<td>Family Planning Register</td>
<td>Routine monitoring</td>
<td>Quarterly</td>
<td>MoHCW</td>
</tr>
</tbody>
</table>
SUSTAINING ASRH PROGRAMMES

The sustainability of programmes is a major concern for implementers, beneficiaries and donors. Over recent years, several definitions of sustainability have emerged:

*The capacity of a programme to continue to achieve programme objectives and to adapt and respond to change over time: (Smith and Colvin, 2000)*

*The capacity of an implementing partner to provide quality reproductive health services at a steady or growing level to underserved populations while decreasing dependence on external aid: (SEATS, 2000)*

*The probability that an organization’s programme activities and services will continue to produce benefits of sufficient value to their clients that they will generate local resources to support them at a steady or growing level: (Sclafani, undated)*

In the field of ASRH in developing countries, there is scant experience about the ways in which programmes have been successfully sustained; for how long and at what levels. The primary concerns of ASRH programmes continue to relate to programme effectiveness, outreach to vulnerable populations, involvement of young people, and gaining political and institutional support, all of which are necessary requirements for sustained programming.

**Elements of Sustained Programmes:**

Since there is no single definition or perspective on how to sustain programmes, it may be more useful to consider possible elements that contribute to the sustained delivery of programme benefits and impact in the target populations. These elements are relevant to youth programming at any phase. However, even when a programme has demonstrated its effectiveness, and has had some success in being institutionalized, without political and financial support its sustainability will be called into question. Furthermore, changes in the external environment, policies, and programmes may undermine efforts at sustainability.

i) **Institutional elements include:** Procurement and management system; Quality of care/quality improvement; Effectiveness of annual planning and evaluation cycle; Marketing capabilities; Diversification of services and service integration; Human resources/training capabilities; Level of community involvement; “Leveraging” and coordination with other institutions and programmes and Degree of internal policy commitment.

ii) **Financial elements include:** Financial plan; Presence of functioning user-fee system; Revenue-generation sources other than fee-for-service/user fees; Financial planning, allocation, budgeting and management capabilities. One of the key components of financial sustainability is the ability of a programme or service to generate revenue (in addition to effectively managing existing resources). ASRH programmes face particular challenges in this area given that many young people are limited in their ability to pay for services (Newton, 2000) and (because of their age) do not represent a political constituency that can easily influence policies and resource priorities. These constraints, once again, highlight the need for family, community and other stakeholder support in advocating for youth programmes and in calling for continued investment.

**Key Questions in Sustaining Youth Programmes**

- Is the project leadership committed to achieving sustainability?
- Is there an accounting and management system in place to support operations?
- Is there a programme-management system in place to support operations?
- Is there a plan to assess client needs and satisfaction?
• Do managers promote community involvement and participation?
• Is reliance on donor support decreasing over time and is there a diversification of donor base?
• Are other sources of funds able to increasingly cover operations costs?
Overview
Many individuals and institutions have important contributions to make to promoting healthy development in adolescents and in preventing and responding to health problems in them, if and when they arise. Health service providers have important contributions to make in addressing adolescent sexual and reproductive health. However, shortcomings have been noted in their professional capabilities and in their human qualities influenced by socio-cultural factors as a result of which they are unable and sometimes unwilling to deal with adolescents in an effective and sensitive manner.

This Training of Trainers Module was developed to fill these gaps. It provides a comprehensive training programme that can be used by trainers to equip facilitators who can run the five day ASRH training workshop. The module uses participatory techniques based on a variety of theoretical frameworks to ensure that future trainers are skilled and confident in their abilities to train health service providers and serve as informed resources for their peers.

Preparation for the workshop
It is suggested that all participants read the Standard National ASRH Training Manual prior to the training. This will help them appreciate its focus, concepts and increase their ability to assimilate content from the different sessions during the training.

Outline of the Workshop
The Training of Trainers Workshop provides an opportunity for participants to learn, share ideas, information and experiences, and put their skills into practice. By the end of the training, participants should be in a position to convene and facilitate a workshop with minimal supportive supervision.

The TOT Workshop Programme

<table>
<thead>
<tr>
<th>TIME</th>
<th>DAY 1</th>
<th>DAY 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800 - 1000</td>
<td>Welcome and Introductions Expectations and Objectives Ground Rules Official Opening</td>
<td>Recap</td>
</tr>
<tr>
<td></td>
<td>Planning and evaluating the training</td>
<td>Group Work &amp; Presentations (Module I, Sessions 5-8)</td>
</tr>
<tr>
<td>1000 - 1030</td>
<td>TEA</td>
<td>Group Work (Module II, Sessions 1-4)</td>
</tr>
<tr>
<td>1030 - 1300</td>
<td>Structure and Content of the ASRH training Manual</td>
<td>Group Presentations (Module II, Sessions 1-4)</td>
</tr>
<tr>
<td></td>
<td>Facilitation Techniques and Principles of Learning</td>
<td>Group Work &amp; Presentations (Module II, Sessions 5-8)</td>
</tr>
<tr>
<td>1300 - 1400</td>
<td>LUNCH</td>
<td>LUNCH</td>
</tr>
<tr>
<td>1400 - 1530</td>
<td>Group Work (Module I, Sessions 1-4)</td>
<td>Group Work &amp; Presentations (Module III, Sessions 1-4)</td>
</tr>
<tr>
<td>1530 - 1545</td>
<td>TEA</td>
<td>TEA</td>
</tr>
<tr>
<td>1545 - 1700</td>
<td>Group Presentations (Module I, Sessions 1-4)</td>
<td>Evaluating a Workshop</td>
</tr>
</tbody>
</table>

NOTE: Highlight the importance of a recap every morning from day two to the last day.

Participants
The Training of Trainers workshop is intended for Service Providers who have undergone the 5 day Training on...
Equipment and Materials

- The Standard National ASRH Training Manual
- National Adolescent Sexual and Reproductive Health Strategy
- And all relevant materials listed in the Facilitators Guide in the ASRH training manual

Purpose of the Training of Trainers Workshop

- The main purpose of the Training of Trainers Workshop is to strengthen the capacity of Service Providers in organising and conducting workshops on youth friendly SRH service provision.

Workshop Objectives

- Provide information on planning and preparing ASRH training workshop for service providers
- Provide an overview of interactive and participatory techniques and methodologies for facilitating an ASRH training workshop
- Develop the participants’ facilitation and evaluation skills when conducting ASRH trainings
SESSION 1 SUMMARY
Training of Trainers Module

SESSION 1: Welcome and Introductions

Time: 1 hour

Objectives:
By the end of the session, participants will be able to:
- Welcome participants to a workshop
- Help workshop participants to get to know each other
- Manage an official opening of a workshop
- Conduct an activity on setting ground rules for a workshop
- Carry out an exercise that brings out expectations and concerns of participants at a workshop
- Present workshop objectives

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Welcome</td>
<td>10 min</td>
<td>Talk</td>
<td></td>
</tr>
<tr>
<td>2. Introductions and</td>
<td>20 min</td>
<td>Exercise</td>
<td>Newsprint, pen</td>
</tr>
<tr>
<td>Expectations</td>
<td></td>
<td></td>
<td>Flipchart, markers</td>
</tr>
<tr>
<td>3. Ground Rules</td>
<td>10 min</td>
<td>Brainstorming</td>
<td>Flipchart, markers</td>
</tr>
<tr>
<td>4. Workshop Objectives</td>
<td>10 min</td>
<td>Presentation,</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>5. Official Opening</td>
<td>10 min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Optional)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES


1. **WELCOME - Talk (5 min)**

**Step 1:**
- Host organisational staff welcomes participants as they arrive at the training room.
- If sitting arrangement has been pre-determined, ask each participant to sit in his/her designated space where his/her name tag has been placed.
- Welcome the participants to the training and introduce yourself and all facilitators.
- Highlight to the participants that even this first session, is part of the training of trainers.

2. **INTRODUCTIONS AND WORKSHOP EXPECTATIONS – Exercise (15 min)**

**Step 2:**
- Ask participants to introduce each other in pairs, note each other's name, organisation, nature of work, and indicate two workshop expectations.
- Each participant introduces the other and highlight their workshop expectations.
- List workshop expectations on a flipchart.
- Note that depending on the context, alternative and more relevant activities to introduce the participants may be adopted.

3. **GROUND RULES – Brainstorming (5 min)**

**Step 3:**
- Brainstorm with participants possible ground rules to guide the workshop (for example, switching off cell phones, respecting others' opinions, etc.)
- List the ground rules on a flip chart and post on a wall.

4. **WORKSHOP OBJECTIVES - Presentation (5 min)**

**Step 4:**
- Review participants expectations of the workshop.
- Present the workshop objectives.
- Allow a few minutes for a discussion.

5. **OFFICIAL OPENING – (10 min)**

**Step 5:**
- Observe all protocol and introduce your Guest of Honour.
- Guest of Honour officially opens the workshop.
- Note that if there is no planned official opening, the welcome remarks from the host organisation staff will suffice.

Many stand-alone workshops and courses are preceded by a formal opening ceremony in which representatives from key government departments and organizations are invited to speak. The formal opening is an opportunity to reflect on the importance accorded to adolescent health issues at national or regional level and to reiterate the need/continuing need for this. When planning a formal opening, invite the speakers some time ahead and provide them with a copy of your provisional programme and the time available for speeches. The speakers should provide factual information on adolescent sexual and reproductive health issues, resources available and ways of strengthening health-service delivery. You have to confirm with the speakers that they have this information.

You should have a list of available back-up speakers for the opening ceremony in the event that key representatives are not available to attend at that time. It is important to minimize the risk that speeches in the opening ceremony run into the time of the modules. One way to ensure this is to arrange for the opening to take place on the evening before the workshop. If this is not possible, stress the importance of keeping each speech...
to time and arrange for a coffee break immediately after the opening: this provides a target in terms of time, as well as an opportunity for guests and dignitaries to leave before the working sessions begin.
SESSION 2: Workshop Planning and Preparations

Time: 2 hours, 25 minutes

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

- Plan for an ASRH training workshop for service providers
- Prepare the logistics required before, during and after the workshop.
- Familiarise themselves with the content in the ASRH Training Manual
- Invite participants and contributors to an ASRH training workshop.

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recap: Why ASRH?</td>
<td>20 min</td>
<td>Presentation, Discussion</td>
<td>Computer, LCD</td>
</tr>
<tr>
<td>2. Planning an ASRH training workshop</td>
<td>15 min</td>
<td>Group work</td>
<td>Flip chart, markers</td>
</tr>
<tr>
<td>2. Preparations before and during the workshop</td>
<td>20 min</td>
<td>Group work</td>
<td>Flipchart, markers</td>
</tr>
<tr>
<td>3. Structure and Content of the ASRH training Manual</td>
<td>45 min</td>
<td>Presentation, Discussion</td>
<td>Computer, LCD HO 4.2.1</td>
</tr>
<tr>
<td>4. Facilitation Techniques</td>
<td>45 min</td>
<td>Brainstorming, Discussion</td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES


1. WHY ADOLESCENTS SEXUAL AND REPRODUCTIVE HEALTH – Presentation, Discussion (20 min)

Step 1:
- Make a presentation on definitions of adolescence, adolescent, young people and youths (information in Module 1, Session 1);
- Discuss why it is important to focus on adolescent sexual and reproductive health;
- Highlight to the participants that in the upcoming sections they will be practicing facilitation of the different sessions in the ASRH training manual.

2. PLANNING AND PREPARING THE WORKSHOP – Group Work (15 min)

Step 2:
- Divide participants into three groups to brainstorm and discuss the following (10 min):
  - Group 1: Materials needed for the Facilitator in preparation for training
  - Group 2: Materials needed for the Facilitator and participant during the training
  - Group 3: Materials needed by the Facilitator for the training:
    - List the items on a Flip chart
    - Each group makes a presentation
    - Discuss and list additional contributions from the discussion.

3. ORGANISING THE TRAINING – Group Work (20 min)

Step 3:
- Divide participants into three groups to brainstorm and discuss (5 min):
  - Group 1: What needs to be done by the Facilitator before the training?
  - Group 2: What is expected of the Facilitator for him/her to run a successful training?
  - Group 3: What is the role of a Facilitator during training?
- Ask groups to make presentations and discuss.
- Use the information in the Facilitators’ Guide in the ASRH Training Manual as guide.
- Emphasize the role of a Facilitator.

Highlight to the participants that during the planning stage they are to identify co-facilitators, guest speakers and the official for the official opening of the workshop.

4. CONTENT OF THE ASRH TRAINING MANUAL – Discussion (30 min)

Step 4:
- Make sure that each participant has a copy of the Standard National ASRH Training Manual
- Use the Facilitator’s Guide to discuss the structure of the Manual, number of modules, and session topics under each module.
- Brainstorm why the manual is divided as such?
- Talk about the session content structure (i.e. Session Summary, Handouts, References, Step by step presentation of activities in each session and workshop objectives).
- Discuss support materials needed to run the ASRH training (use Handout 5.2.1)
- Identify sessions that you may require the services of a specialist and make necessary arrangements for their participation.

4.1 Support Materials to run the ASRH Training
In order for the training to be locally relevant, it is essential to collect data on the status of adolescent health, both nationally and at the provincial or regional level, before the workshop begins. This information should be made available to the participants either beforehand (if possible) or alternatively, it should be provided during registration or during the opening ceremony.
Such information would:

- Establish a profile on adolescents which includes demographic data, socioeconomic information, as well as the scale and nature of health problems and problem behaviours;
- Provide background information on existing laws and policies that affect adolescent health and development;
- Provide information on three main approaches to Youth Friendly Service provision;
- Indicate the government departments and nongovernmental organizations which are involved in the area of adolescent health and development.

It would be useful for a higher level representative from the organisers of the workshop to prepare a keynote address, or background paper, in advance of the workshop on the key issues facing adolescents.

4.2 Drawing on the Expertise of Specialists and other Contributors

Once the workshop structure has been decided and the health issues and problems selected, the facilitation team should decide which resource individuals, if any, they would like to invite.

We advise that you spend some time reading the rest of these preparation notes and the selected health issue modules so that you can be clear about the role that these specialists could play. For example, when discussing issues of mental health you may want a psychologist or a psychiatrist to present or be present, or in the module on laws and policies you may require the services of a lawyer.

5. FACILITATION TECHNIQUES AND METHODOLOGIES – Brainstorming, Discussion (40 min)

**Step 5:**

- **Brainstorm different facilitation techniques that can be employed in a workshop.**
- **List them on a Flip chart.**
- **Discuss the advantages and disadvantages of each methodology?**
- **Discuss the advantages of using different participatory techniques in facilitating a workshop.**
- **Use the Facilitators’ Guide for this activity.**
1. What information do we have about adolescents in the country/region?
   - Demographic data broken down by age and sex
   - Social and economic status (including opportunities and levels of – education, employment, family and social support, and access to basic necessities such as clean water, food and shelter)
   - Health status (including the leading causes of disease and death)
   - Groups and subgroups of adolescents who are especially vulnerable to health and social problems (for example adolescents living with HIV, adolescents in difficult circumstances)

2. What information do we have about the health services that are available to and used by adolescents?

3. What information do we have about:
   - Existing laws and policies relating to adolescent sexual and reproductive health and rights (for example the age of consent to sexual intercourse, access to contraception)
   - Principles and practices of national institutions, such as national medical associations, which affect the availability and accessibility of health information and services for adolescents (such as confidentiality in the context of sexual and reproductive health, HIV status)

4. What information do we have about ongoing actions to promote and safeguard the health of adolescents, and to help them develop into well adjusted adults?
   - Which government departments carry out or support programmes in this field at the national level?
   - What are the responsibilities of provincial and district level government departments in this field and what mechanisms are in place?
   - Which nongovernmental organisations carry out or support activities in the field, at national and/or provincial and district levels?

5. What training opportunities are there to help health care providers and other professionals serving adolescents to respond more effectively and sensitively to the needs of adolescents?
SESSION 3 SUMMARY
Training of Trainers Module

SEASON 3: Practicing Facilitation

Time: 5 hours

Objectives:
By the end of the session, participants will be able to:
- Plan a session
- Deliver the session through multiple methodologies (presentation, role play, exercise, brainstorming and discussions)

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Module I, Sessions 1 - 4</td>
<td>1 hour</td>
<td>As indicated in Session</td>
<td>As indicated in Session</td>
</tr>
<tr>
<td>2. Module II</td>
<td>1 hour</td>
<td>Sessions 1 - 4</td>
<td></td>
</tr>
<tr>
<td>3. Module II</td>
<td>1 hour</td>
<td>Sessions 5 - 9</td>
<td></td>
</tr>
<tr>
<td>4. Module III</td>
<td>1 hour</td>
<td>Sessions 1 - 6</td>
<td></td>
</tr>
<tr>
<td>5. Module III and IV</td>
<td>1 hour</td>
<td>Sessions 7 - 9, Session 1</td>
<td></td>
</tr>
</tbody>
</table>

Step 1:
- This session is meant to give participants an opportunity to plan and deliver a session (use role plays, brainstorming, exercises and discussions).
- At any given time, divide participants into four groups. Make new groups after each presentation.
- Each group focuses on a session as indicated in the session summary above. (Note: Trainer may suggest areas to put emphasis on in the presentations, and may leave out those that are easier, for individual reading).
- Each group presents on the assigned session.
- Distribute Handout 4.3.1 and ask participants to assess the facilitation. Emphasize that you need constructive criticism.
- At the end of each presentation, discuss facilitation skills, areas of strength and weakness, and suggestions for improvement. (Ensure that all participants have presented).
- Discuss the session content and ask participants for areas that need clarity.
- Summarise each session and highlight critical sections, especially those with new information (e.g. adolescents living with HIV, Tanners Scale, adolescents living in difficult circumstances, youth friendly services, laws and policies, Planning, M&E and Sustaining ASRH programmes).
# HANDOUT 5.3.1

## Facilitation Skills Checklist

<table>
<thead>
<tr>
<th>Skill</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective introduction/opening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voice projection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Movements/Mannerisms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observation of non-verbal communication from the participants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questioning and Responding to questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comment on the content (key issues)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of participatory methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concluding the presentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flow of the session</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Questions to the Presenter:

- How do you feel about the way you delivered this session?
- What can you say were your major strengths?
- What can you say were your major weaknesses, limitations and challenges?
- In future, how could you do it differently?
SESSION 4 SUMMARY
Training of Trainers Module

SESSION 4: Workshop Evaluation Methods

Time: 45 minutes

Objectives:
By the end of the session, participants will be able to:
- Assess participants’ knowledge levels on ASRH before and after the workshop.
- Administer different workshop evaluation methods daily.
- Carry out an overall workshop evaluation.

<table>
<thead>
<tr>
<th>CONTENT/ACTIVITY</th>
<th>DURATION</th>
<th>METHODOLOGY</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pre/Post test Questionnaire</td>
<td>25 min</td>
<td>Discussion</td>
<td>Pre/Post test</td>
</tr>
<tr>
<td>2. Daily Evaluation</td>
<td>15 min</td>
<td>Brainstorming</td>
<td>Flipchart, markers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discussion</td>
<td>Newsprint, pen</td>
</tr>
<tr>
<td>3. Overall Workshop Evaluation</td>
<td>20 min</td>
<td>Discussion</td>
<td>Workshop evaluation questionnaire</td>
</tr>
</tbody>
</table>

REFERENCES


1. **PRE/POST TEST – Discussion (15 min)**

Step 1:
- Explain the evaluation methods of a workshop which include the pre-test, daily evaluations, end of workshop evaluation and a post test.
- Highlight the importance of a pre-test and post test in a workshop.
- Indicate to participants that they are expected to work out an answer sheet for pre/post test.
- Mark and grade the pre-test survey and record them for comparison with the post test written at the end of the training.
- Share with participants the results of the two assessments.

2. **DAILY EVALUATION – Brainstorming, Discussion (15 min)**

Step 2:
- Brainstorm on methods of workshop evaluation on a daily basis.
- Discuss the importance of such assessments throughout the training workshop.
- Highlight that other methodologies may be used in place of the one highlighted below.

Below are three suggested ways of keeping track of the participants perceptions on the training workshop on a daily basis as it progresses. By getting their early reactions you will be able to make changes immediately, rather than receiving complaints at the end of the workshop when it is too late to respond to them. These assessment methods are the mood meter, individual note and group discussions.

a) **The Mood Meter**

As its name suggests, the Mood Meter allows you to get a sense of the group's mood as it changes during the workshop.

Draw three faces on a flip chart depicting a happy face, neutral and a sad face. Explain that the three faces indicate the following:

- **satisfied**
- **neutral**
- **not satisfied**

Put the Mood Meter in an accessible location but one that is not in a busy place like a corridor.

At the end of each day or each session, ask each participant to mark a spot, according to how they feel, on the Mood Meter. Draw a line through the middle of the spots to create a simple graph that charts the “ups” and “downs” of the group. Use the Mood Meter as a means of tracking the group’s feelings about how the workshop is proceeding, and as a starting point for discussion. Address those issues that you can rectify immediately.

b) **Individual Notes**

Another way of assessing the participants’ mood on the training programme is to ask each participant at the end of the day, to write down on a piece of paper:

- what they enjoyed most about the day;
• what they did not like
• and a suggestion for improvement

Review the notes and address areas of concern pointed out.

c) Discussion groups
If you are interested in getting more in-depth feedback from the participants after a particular module, you could hold a discussion group with a small group of interested persons. Ask about five participants if they are willing to talk about the session, and let them discuss a small number of questions. You can use the questions given below to guide your discussion, or you could develop your own questions.

• How do you feel about this module?
• Which sessions worked best?
• Which sessions did not work well?
• What could we have done differently?
• What did you get out of the module?

Remember that the point of such a discussion is for you to hear the participants’ opinions. Try not to talk much yourself, and listen to criticism without becoming defensive. There is no need to respond directly to any criticism.

3. OVERALL WORKSHOP EVALUATION – Discussion (15 min)

Step 3:
• Discuss the need for an overall workshop evaluation at the end of the workshop.
• Highlight the importance of using findings from the evaluation for planning and facilitate future workshops.
APPENDICES: Appendix 1

APPENDIX 1 – HINTS ON PREPARING FOR THE WORKSHOP

PREPARATION TASKS

1. __ Identify training needs

2. __ Identify target group (participation)

3. __ Select dates for training workshop

4. __ Develop budget and obtain necessary approvals

5. __ Organise workshop files

6. __ Reserve training space

7. __ Make tentative lodging arrangements

8. __ Develop workshop

9. __ Arrange programme agenda

10. __ Develop curriculum, session plans

11. __ Identify resource persons and special guests

12. __ Arrange for logistical support (e.g., drivers, secretarial help) as necessary

13. __ Send invitation to speakers, resource persons, and special guests

14. __ Send confirmation letter to participants with programme summary and arrangement information

15. __ Finalise lodging arrangements

16. __ Make arrangements for meals and refreshments for breaks

17. __ Order and prepare certificates

18. __ Arrange transportation to airport, train, bus pickups, field trips

19. __ Order training materials and supplies such as news print, markers, markers, masking tape, transparencies

20. __ Arrange for equipment by reviewing session content to identify what is needed and when it is needed. This includes projectors, models, posters, video equipment, etc.

21. __ Prepare trainer material and handouts

22. __ Plan and organise opening ceremony

23. __ Arrange for press coverage, as appropriate

24. __ Plan and reserve space/transport/food/ for special events

25. __ Make room arrangements, including large conference room with adequate seating, smaller rooms for group work, adequate ventilation/heating or air-conditioning if available, lighting, etc.

26. __ Arrange for daily room cleanup

27. __ Prepare orientation packet with information on the area and the training site

28. __ Prepare participant folder: name tags, welcome letter, programme schedule, participant list, pens and paper

29. __ Make sure evaluation forms are prepared
## DURING THE PROGRAMME

1. __ Make sure that all the equipment and materials are available and working before needed.  

2. __ Manage and monitor registration, reception, opening ceremonies, sessions  

3. __ Manage and monitor meals, breaks, special events and closing ceremonies  

4. __ Maintain workshop files  

5. __ Prepare participants address list  

6. __ Monitor expenses in relation to established budget  

7. __ Assist participants with departure arrangements  

8. __ Optional: Arrange for group photo  

9. __ Arrange programme agenda  

## AFTER THE PROGRAMME

1. __ Meet with the staff to discuss problems and success and giver general feedback  

2. __ Pay final bills, closing  

3. __ Send thank you letters to all those who helped with the programme  

4. __ Complete or update materials or manuals for trainers  

5. __ Tabulate evaluation results  

6. __ Draft, edit, and reproduce final report and recommendations  

7. __ Evaluate training impact
APPENDIX 2: DAILY EVALUATION FORM

Instructions: For each item, tick the box that best reflects your opinion. Your comments are also welcome.

1. Objectives of the sessions were:
   - Very clear
   - Clear
   - Not clear

   Comments:
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………

2. The objectives of the sessions were:
   - Completely met
   - Mostly met
   - Insufficiently met

   Comments:
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………

3. The length of the sessions was:
   - Too long
   - Adequate
   - Too short

   Comments:
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………

4. Clearness of presentation was:
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

   …………………………………………………………………………………………………
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………

5. Organisation of the content:
APPENDIX: Appendix 3

APPENDIX 3: FINAL WORKSHOP EVALUATION FORM

Instructions: For each item, tick the box that best reflects your opinion. Your honest responses will help us improve future training. Your comments are also welcome.

1. Objectives and goal of the training were:

   - Very clear
   - Clear
   - Not clear

   Comments:

   …………………………………………………………………………………………………
   ………………………………………………………………………………………………
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………

6. Trainers' knowledge of the subject:

   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

   …………………………………………………………………………………………………
   ………………………………………………………………………………………………
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………

7. Five key lessons learnt

   …………………………………………………………………………………………………
   ………………………………………………………………………………………………
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………

Thank you for your participation
2. The objective of the training were:

- Completely met
- Mostly met
- Insufficiently met

Comments:

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........................................................................................................................................
........................................................................................................................................

3. The length of the training was:

- Too long
- Adequate
- Too short

Comments:

........................................................................................................................................
........................................................................................................................................

Please rate the following aspects of the training and comment:

4. Clarity of presentation

- Excellent
- Very Good
- Good
- Fair
- Poor

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

5. Organisation of the content

- Excellent
- Very Good
- Good
- Fair
- Poor

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

6. Trainers' knowledge of the subject

- Excellent
- Very Good
- Good
- Fair
- Poor

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........................................................................................................................................
........................................................................................................................................
7. Training methods used

- Excellent
- Very Good
- Good
- Fair
- Poor

8. The workshop content maintained my interest:

- All the time
- Most of the time
- Some of the time

Comments:

9. The material presented in the course was:

- Almost all new to me
- Mostly new to me
- Mostly known to me

Comments:

10. The skills I acquired are

- Directly applicable to my everyday work
- Somewhat applicable to my everyday work
- Not very applicable to my everyday work

Comments:
11. The training facilities were:
- Very satisfactory
- Somewhat satisfactory
- Unsatisfactory

Comments:

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12. The logistical arrangements (transportation, lodging, etc.) were:
- Very satisfactory
- Somewhat satisfactory
- Unsatisfactory

Instructions: Please answer the questions below.

13. Which topics or activities did you find least useful?

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----------------------------------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------------------------

14. In future workshops, would you allow more time for some topics or activities? If yes, which ones?

----------------------------------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------------------------

15. What suggestions for improvement do you have for the trainers?

----------------------------------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------------------------

16. Would you recommend your colleagues to attend the same training?
- Strongly agree
- Agree
- Disagree
- Strongly disagree

----------------------------------------------------------------------------------------------------------------------------------
17. What additional suggestions do you have for improving future trainings?
APPENDIX 4: STANDARD NATIONAL ASRH TRAINING PRE/POST TEST QUESTIONNAIRE

NAME:………………………………………………………. DATE:……………………………………

DESIGNATION: ………………………………………

SECTION A: OVERVIEW OF ASRH AND OPERATING ENVIRONMENT

Please indicate whether each statement is True (T) or False (F).

1. T F Worldwide, most women hospitalised for abortion complications are over 20 years.

2. T F The persons described fit the social and biological definition of Adolescent:
   T F An 8 year old female who is responsible for the care of a young sister.
   T F A 15 year old male who has developed secondary sexual characteristics.
   T F A 19 year old male who works as a teacher and supports his wife and child.
   T F A 14 year old female who has just had her first menstrual period.

3. List at least four sub groups of adolescents who need special attention in Youth Friendly Service provision?
   a) ......................................................................................................................................
   b) ......................................................................................................................................
   c) ......................................................................................................................................
   d) ......................................................................................................................................

4. Essentially, because of the mode of transmission, there are two groups of adolescents living with HIV. These two groups are:
   a) ......................................................................................................................................
   b) ......................................................................................................................................

5. Mention any three sexual and reproductive health rights for adolescents
   a) ......................................................................................................................................
   b) ......................................................................................................................................
   c) ......................................................................................................................................

5. Mention any two laws, two policies and two strategies that seek to address the sexual and reproductive health rights for adolescents in Zimbabwe
   a) ......................................................................................................................................
SECTION B: CHALLENGES ADOLESCENTS FACE TODAY

1. T F Adolescents are at higher risk for STI's because they are more likely to have multiple partners than adults.

2. T F Emergency contraceptive pills must be initiated within one week after unprotected intercourse to prevent pregnancy.

3. T F Oral contraceptives prevent against pregnancies and STI's.

4. T F Oral contraceptives are medically contraindicated for adolescents because of their age.

5. T F Most adolescents use contraception the first time they have sex.

   a) ........................................................................................................
   b) ........................................................................................................
   c) ........................................................................................................

7. List five (5) different ways that a person can express their sexuality besides sexual intercourse.
   1. ........................................................................................................
   2. ........................................................................................................
   3. ........................................................................................................
   4. ........................................................................................................
   5. ........................................................................................................

8. List five (4) different ways that a person can do to prevent HIV infection.
   1. ........................................................................................................
   2. ........................................................................................................
   3. ........................................................................................................
   4. ........................................................................................................
SECTION C: INTERPERSONAL COMMUNICATION AND COUNSELLING

Circle T if the statement is True and (F) if it is False.

(a) T F Counselling clients is one way of improving the quality of care.
(b) T F Privacy, closeness of client/provider seating and use of learning during counselling are positive Factors of counselling.
(c) T F Professional counsellors are needed for counselling to be effective in FP/RH services.

Circle T if the statement is True and (F) if it is False.

述 The following contribute to the promotion of positive client/provider interpersonal relationships.

(a) T F Explaining all the FP methods in details to all new FP clients.
(b) T F Closing the door of the counselling room.
(c) T F Explaining at the beginning the steps that will be followed during client/provider session.
(d) T F Maintaining culturally acceptable eye contact during client / provider session.

述 List any four (4) verbal communication skills useful to encourage a client to speak freely with the FP/RH provider.

a) ........................................................................................................

b) ........................................................................................................

c) ........................................................................................................

d) ........................................................................................................

述 List any four (4) non-verbal communication skills useful to encourage a client to speak freely with the FP/RH provider.

a) ........................................................................................................

b) ........................................................................................................

c) ........................................................................................................

d) ........................................................................................................

4. Define the phrase ‘Youth Counselling’.

........................................................................................................

........................................................................................................
5. How does a client counselling session differ from client education session?

6. Name at least 2 pillars and 2 Benefits of CSE?

   a) ..................................................................................................................
   b) ..................................................................................................................
   c) ..................................................................................................................
   d) ..................................................................................................................

SECTION D: SEXUALLY TRANSMITTED INFECTIONS (STIs) AND HIV AND AIDS

Circle T if the statement is True and (F) if it is False.

(a) T F Bacterial infections such as gonorrhoea and Chlamydia are only a concern for women and do not affect men.

(b) T F Viral STI's cannot be cured.

(c) T F Pregnant women with an STI/HIV may transmit the infection to their newborn babies.

   T F The presence of another STI does not increase the risk of HIV transmission.

1. Which of the following STI's are curable? Circle all that apply.

   (a) Syphilis
   (b) HIV and AIDS
   (c) Human Papiloma Virus
   (d) Gonorrhoea
   (e) Chlamydia
   (f) Herpes
2. Which of the following factors contribute to the spread of STI’s? Circle all that apply.

(a) Inadequate or inaccessible health and social services, including STI diagnosis and treatment services and drug supply.

(b) Sex education in schools.

(c) Gender inequality and poverty.

(d) Legal and cultural obstacles to condom promotion and use.

3. Please indicate whether the following statements are True (T) or False (F)

(a) T F Reaching male adolescents is not critical to STI prevention programmes as long as women are provided with services.

(b) T F STI’s are often asymptotic in women and they tend to go untreated.

(c) T F About 70% of assisting STI infections are among youth aged 15 – 24 years.

(d) T F Young men are biological vulnerable to STI’s than young women.

4. Service providers should emphasise the four (4) Cs of STI management. What are the four (4) Cs? Circle all that apply.

(a) Counselling and education to prevent further infection.

(b) Condom promotion.

(c) Complication awareness.

(d) Community participation.

(e) Compliance with treatment.

(f) Contacting partners for diagnosis.

5. Circle the correct answer.

Urethral discharge and scrotal swelling are symptoms associated with the following STIs.

(a) Hepatitis B

(b) Human Papiloma Virus (HPV)

(c) Syphilis

(d) Gonorrhoea

SECTION E: SRHR AND HIV LINKAGES AND INTEGRATION

1. List at least four (4) characteristics of Youth Friendly SRH Services Provision.

a) _________________________________
2. Name at least 5 standards of Youth Friendly SRH Service Provision?
   a) .................................................................
   b) .................................................................
   c) .................................................................
   d) .................................................................
   e) .................................................................

3. Name at least 3 characteristics of Youth Friendly SRH Service Provision?
   a) .................................................................
   b) .................................................................
   c) .................................................................
   d) .................................................................
   e) .................................................................

4. Name at least 5 Benefits of SRH and HIV Linkages and Integration
   a) .................................................................
   b) .................................................................
   c) .................................................................
   d) .................................................................
   e) .................................................................

SECTION F: PLANNING, MONITORING & EVALUATION

1. Describe a Project Cycle and its phases/stages

2. Describe the following terms:
Monitoring

Evaluation

Community Participation:

END
APPENDIX 5: LIST OF PEOPLE WHO PARTICIPATED IN THE DEVELOPMENT PROCESS