

# Integrated **HIV** **and AIDS, SRHR** **and SGBV**

## Demand Generation 2 Home Visit Guide



## Health Development Fund

Supporting the National Health Strategy  
to improve access to quality health  
care in Zimbabwe



Integrated **HIV**  
**and AIDS, SRHR**  
**and SGBV** | Demand Generation 2  
Home Visit  
Guide

FACILITATOR'S MANUAL

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Zimbabwe National Family Planning Council (ZNFPC)

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## List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ALAFA	AIDS Lesotho Alliance to fight HIV and AIDS
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BCF	Behaviour Change Facilitator
CHW	Community Health Worker
EMTCT	Elimination of Mother to Child Transmission
FACT	Family AIDS Caring Trust
GIZ	Deutsche Gesellschaft fuer Internationale Zusammenarbeit (GIZ) GmbH
HIV	Human Immuno-Deficiency Virus
IPC	Interpersonal Communication
ISP	Integrated Support Programme for Sexual and Reproductive Health and HIV Prevention
IUCD	Intrauterine Contraceptive Device
MAC	Matebeleland AIDS Council
MASO	Midlands AIDS Support Organization
MC	Male Circumcision
MoHCC	Ministry of Health and Child Care
MoWYA	Ministry of Women and Youth Affairs
NAC	National AIDS Council
PEP	Post-Exposure Prophylaxis
PMTCT	Prevention of Mother to Child Transmission
RDS	Regai Dzive Shiri
SafAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SBCC	Social and Behaviour Change Communication
SGBV	Sexual and Gender Based Violence
SRH	Sexual and Reproductive Health
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
VIAC	Visual Inspection with Acetic Acid and Cervicography
VMMC	Voluntary Male Medical Circumcision
WHO	World Health Organization
WVZ	World Vision Zimbabwe
ZAPSO	Zimbabwe AIDS Prevention and Support Organization
ZiChiRe	Zimbabwe Community Health Research
ZNASP III	Zimbabwe National AIDS Strategic Plan
ZNFPCC	Zimbabwe National Family Planning Council

## Preface

Ministry of Health and Child Care (MoHCC), Ministry of Women Affairs, Gender and Community Development (MWAGCD), Zimbabwe National Family Planning Council (ZNFPC) and National AIDS Council (NAC) and other partners are contributing to the Health Development Fund (HDF) 2016-2020. With support from DFID, Irish Aid and the Government of Sweden, this programme is implemented within the context of the National Health Sector Strategy (2016-2020).

This programme aims to increase knowledge and utilisation of integrated HIV prevention, SRHR and SGBV services. It uses interpersonal communication techniques for demand generation through trained Behaviour Change Facilitators (BCFs) or other Community Health Workers (CHWs) who visit families in their homes. Building rapport with these families, the facilitators educate and inform families, couples and individuals on the various topics and then make referrals to the most appropriate HIV and AIDS, SRHR and SGBV services within the families' own community. Given the wide range of topics that could be addressed within these themes, it is important that the facilitators have tools and skills to quickly assess the family's health needs and then present a custom-made information and education programme that addresses these needs.

The guide was reviewed and updated to equip the BCFs with appropriate skills and tools and has been designed to guide the facilitators in assisting families and community members to know more about HIV and AIDS, SRHR and SGBV, in an interactive and learner friendly manner. It is hoped that as a result of this work the beneficiaries will positively change their behaviour, and access available HIV, SRHR and SGBV services. It is recognised that changing an individual's behaviour remains the responsibility of that individual. However, creating an environment that supports and encourages positive behaviour change requires effort and commitment from a multitude of players. The BCFs are key agents in this endeavour.

Providing information and education is only one component of changing an individual's behaviour. The BCFs, working with support and guidance of the implementing partner organisations, are aware of this limitation. As a result, they will draw on the expertise and skills of other organisations and stakeholders located within their communities. These organisations and stakeholders, from faith-based entities to health facilities, to law enforcement agencies and support groups, are equipped with diverse skill-sets to assist individuals and communities in changing their behaviour. As a result, individuals that require information beyond the expertise of the BCF will be referred to these organisations for services.

Working together, these organisations and BCFs will strive to improve the health of their communities. In that vein, we would like to thank individuals and organisations that have contributed in any way to the development of this guide.

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## Introduction

Zimbabwe experienced an extremely challenging environment during the 2000-2008 period. This was characterized by hyper-inflation, a complex political and humanitarian situation and a breakdown of social service delivery as well as a near collapse of the health system. The health system is currently recovering from the impact of these challenges. Although the nation experienced some economic recovery from 2009 to 2012, economic growth further declined in the period 2013 to 2016 and prospects for the next five years are predicted to still remain sluggish.

The HIV epidemic has also impacted on a number of other Sexual and Reproductive Health (SRH) related conditions including the high burden of cervical cancer and increase in gender-based violence. Conversely, unmet needs for family planning, especially among adolescents, and Sexual and Gender-Based Violence (SGBV) have also played a role in the pressing situation in the country. Adolescent pregnancy remains a major challenge and contributor to maternal and child mortality, usually leading to ill-health and poverty. This highlights the need for appropriate interventions centred on social and behaviour change communication to positively impact on the sexual and reproductive health of people.

The Social and Behaviour Change Communication Programme for Integrated Sexual and Reproductive Health and Rights, HIV and AIDS, and Sexual and Gender Based Violence is a nationally owned program funded by various partners through a combination of parallel and pooled funding streams along four mutually reinforcing programmatic pillars:

- Socially marketed integrated SRHR, HIV and AIDS and SGBV services and mass media;
- Public sector integrated SRHR, HIV and AIDS and SGBV services and community-based Social and Behaviour Change Communication (SBCC);
- Family Planning commodities; and
- Research and Evaluation.

The Social and Behaviour Change Communication (SBCC) Programme is consistent with the National Health Strategy for Zimbabwe 2016-2020, the Zimbabwe National Family Planning Strategy (ZNFPS) 2016-2020, the Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2015-2020, the National Adolescent and Youth Sexual and Reproductive Health (ASRH) Strategy II: 2016-2020, and the Zimbabwe National Gender Based Violence Strategy 2012-2015. The overall goal of the SBCC Programme is to contribute to improving sexual and reproductive health through reducing the incidence of maternal morbidity and mortality among women, cervical cancer, HIV and SGBV. This will ultimately contribute to Ministry of Health and Child Care's vision "to have the highest possible level of health and quality of life for all Zimbabweans". The programme will also promote attainment of the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset) and the Sustainable Development Goals (SDGs).

The national social and behaviour change program was initially implemented in 26 districts supported through ESP funding (2007 to 2009) and was scaled-up to the remaining 36 districts through Global Fund support. The program will support the retention of 800 community BCFs to enhance the delivery of a broad range of integrated HIV prevention, SRHR and SGBV mitigating messages and services.

*NB: The use of the door-to-door approach to reach families, couples and individuals will enhance information dissemination through Inter Personal Communication (IPC). This entails community BCFs visiting all households in the district and going through a personal risk and needs assessment tool with the family members, leaving the families with specific recommendations of HIV, SRHR and SGBV services available to them. Particular attention will be paid to mobilizing service uptake by couples, including sero-discordant couples.*

*The program delivers a broad range of integrated HIV prevention, SRH and GBV messages and services.*

## The Structure of this Manual

This Manual is separated into four parts:

1. A short description about the overall program and your role
2. The risk assessment tool and guidelines for planning a home visit.
3. Exercises in each unit to run during the home visit
4. A resource section


These four sections work together like this.

**Section 1** describes the overall program and your role in the program as well as answer some questions you may have about how to implement home visits.

**Section 2** is dedicated to the risk assessment tool. This tool needs to be used before you run any of the exercises with members of a household. The reason for this tool is to make sure that you run the exercises that are the most relevant to the members of the household. For example, if one of your allocated households is made up of a young couple who live with their five-year-old daughter and three-year-old son, you do not want to waste any of their time running a session on teenage pregnancy. The latter part of section 2 also provides some guidelines on how to plan and run a home visit. This section includes some guidance on sensitive issues while discussing sexual issues with family groups.

**Section 3** of the manual is filled with activities for discussion about HIV, STIs, sexual and gender based violence, voluntary medical male circumcision, cervical cancer, adolescent pregnancy, family planning and contraception. These, together with the posters and the risk assessment are the “tools” of this toolkit. At the end of each unit there is information “Facilitator's Information” that you can refer to when delivering your sessions. It is important to note that not all sessions require you to go through all the information.

The last section, **section 4**, is a resource section with additional information about some of the topics in the manual. There is also space in this section for you to add in additional information about the services and institutions that offer assistance in the communities where you will be working.



# **Section One:**

## **The Social and Behaviour Change Communication Programme**

## Why Are We Here and How Does This Work?

There have been several successes in Zimbabwean programs recently resulting in a reduction of risky sexual behaviour in a number of population groups. However, there are still a number of challenges. The SBCC programme is aimed at overcoming these challenges by equipping you as a Behaviour Change Facilitator (BCF), to work with family groups. Working with these small groups is called Inter Personal Communication (IPC).

A lot of the focus of this programme is to improve the sexual and reproductive health of women and girls through reducing the incidence of maternal morbidity and mortality, cervical cancer, HIV and Sexual and Gender Based Violence (SGBV).

The overall goal of this programme is to facilitate behaviour change among people in order to improve their health outcomes / choices. It is not enough to simply provide people with information about which choices are better for them, and the contact details of the service providers that could help them. As we will learn a little later, behaviour change is a process – not simply a once off event. You will be equipped with tools and skills to inform the families you visit and to help them move towards making healthier lifestyle choices.

When all these pieces are added together they will contribute to the vision of the Ministry of Health and Child Care (MoHCC) of having the highest possible level of health and quality of life for all citizens of Zimbabwe. So, thank you for your participation and your effort – you are part of the national plan.

## Characteristics of an Effective Behaviour Change Facilitator

The success or failure of this programme depends largely on how you work within your community. The main characteristics that we would like to see you have or develop are:

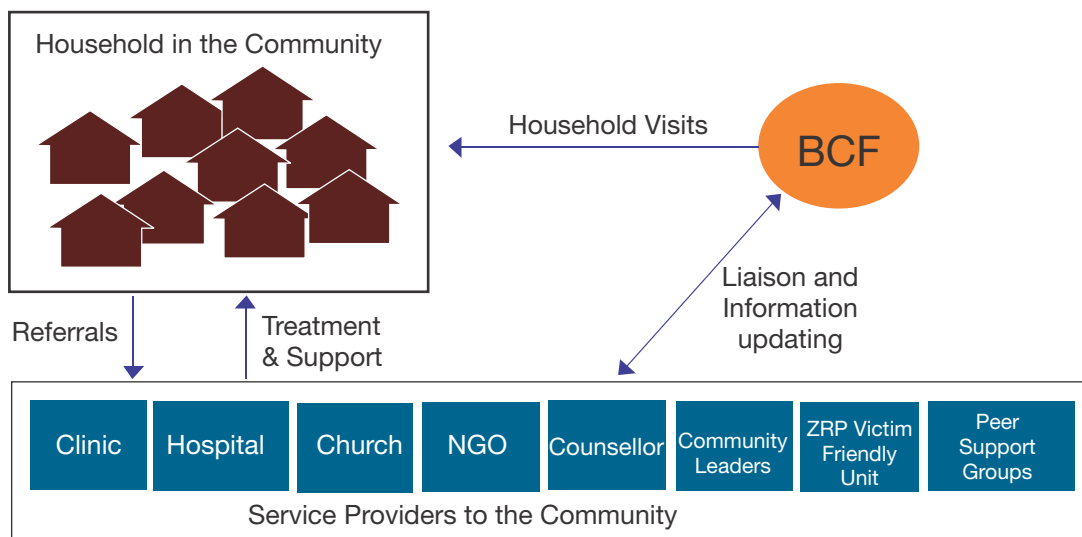
- The ability to communicate clearly and persuasively with your colleagues and peers.
- Good interpersonal skills including listening skills.
- Uphold confidentiality and treat people with respect.
- A socio-cultural background similar to that of the community (including age, sex and social class).
- Being accepted and respected by the community.
- Being strongly motivated to work towards STI and HIV and AIDS risk reduction, eliminating adolescent pregnancy and SGBV in communities.
- Being self-confident and show potential for leadership.
- The time and energy to devote to this work. This means the ability to work irregular hours and be available and accessible to the target group.
- The potential to be a role model.
- The ability to get to the location of the target audience.
- Being motivated by concern for the health of the community. The ability to listen to others without bias or assumptions.
- Being able to speak the languages of the community.

We are asking you to help change others' behaviour in a positive way. But behaviour change is not a simple process – it moves through a range of stages and sometimes can even move backwards!



Remember, your job is to assist the participants to change their own behaviour, and not to force them to change their behaviour or to provide them with the medical or counselling services that they might need. You are part of a larger network of people and organisations that are willing to help. Make use of this network to give the services that you are not able to, or have not been trained to provide. You may develop a list of service providers in your community, and highlight the services offered and where such services are available.





## Kinds of Behaviour Change

### Short-Term Behaviour

Changes in short-term behaviours are those that can be achieved quickly and mostly involve a one-time effort on the part of the individual. For example, deciding not to eat cake and sweets for a month, so that you might lose some weight in time for a family wedding is short term behaviour change. After the wedding you are likely to revert to your old ways of eating.

### Long-term behaviour

Long-term behaviour change, on the other hand, requires a person to modify and sustain a particular behaviour over a period of time. Stopping smoking is an example of long-term behaviour change. Similarly, in the case of STIs or HIV, people may have to modify their behaviour and maintain these changes for the rest of their lives.

## The Behaviour Change Process

Education is not just about imparting knowledge, but about allowing and encouraging that knowledge to make a difference. Learning takes place when people apply the knowledge imparted to them. The main purpose of our work is to bring about change.

This type of behaviour change involves participants of equal standing talking among themselves and determining a course of action. This is in sharp contrast with more top-down- approaches in which authorities tell people that they should change their risk behaviour. This is why your sessions will have a lot of participant interaction and discussion. We express our thinking through talking and discussing. It is important that no one feels disadvantaged during discussions. The full participation of people facilitates collective dialogue on common problems, and therefore is critical to successful behaviour change.

***“Learning is not just learning things, but learning the meaning of things. Learning is learning to think. Learning should lead to change. If there is no change, there is no learning.” John Dewey***

Behaviour change involves using a combination of channels of communication to create a demand for information and services related to the health themes of this training material and to stimulate open discussion on the underlying factors for risk, high risk behaviours and stigma. You, with the knowledge and skills delivered in this training session, can play an important role in helping members of the community reduce their exposure to this risk by changing their behaviours.

Bringing about behavioural change is a difficult process. The task is further complicated by the sensitive and personal nature of the issues, as they deal largely with sex and sexuality. A variety of approaches and messages will

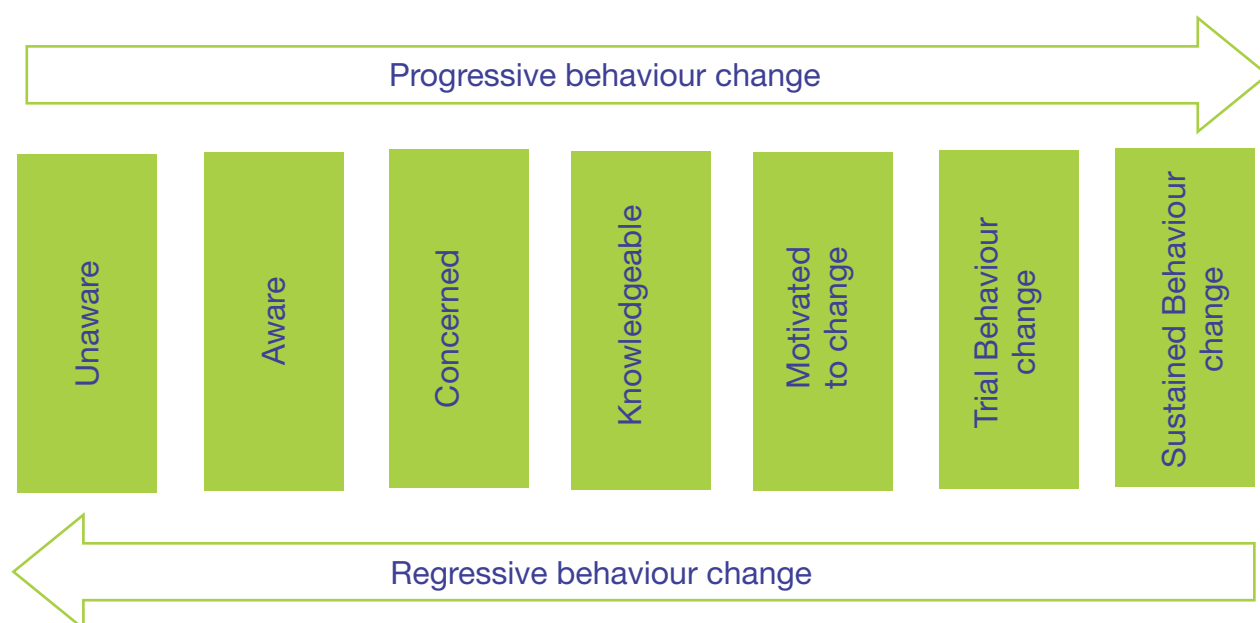
be needed to help community members make consistent behavioural changes over time.

Change requires self-examination, self-reflection and self-understanding (insight), hard work (effort) and determination (will). The exercises in the material involve self-investigation, thinking, talking one-on-one and in small groups, sharing thoughts and feelings, and listening to the thinking and feelings of others. The exercises outlined in this guide will help participants move step-by-step from being unaware to aware, concerned and knowledgeable, willing to try the new behaviour and finally to sustained behaviour change.

Although the guide is straight forward, answers are not provided for every question or issue that may come up. We are confident that with your experience and your interest in assisting community members and family groups to embrace change, you will find creative and appropriate solutions to the issues that we have not identified. It is always a good idea to remember how you resolved these issues so that you can share them with your colleagues, so that they might learn from your experience. In addition, you are encouraged to familiarise yourself with “Facilitator's Information”, which will enable you to provide relevant information and answers to questions related to the specific exercises.

### Steps in the Behaviour Change Process

As we mentioned above, the behaviour change process is not a straightforward one. It has a number of steps that have to be taken in the process, and sometimes a person might even choose to move backwards, rather than forward. Your job is not to ensure that families move from the first to the last step in one visit, but rather to provide them with enough advice, skills, information, support and encouragement to move from where they are in the behaviour change chain to the next step.



#### Unaware / Aware

Initially a person is unaware that a particular behaviour may be dangerous. The first step in a behavioural change programme is to make people aware. For example, to promote safer sex practices, people first need basic information on Sexually Transmitted Infections and HIV. This information could be provided through various channels and through interpersonal communication, communication provided through NGOs, community-based organizations or by health care workers and people like yourselves.

#### Concerned

Individuals who are aware of an issue may not be concerned about it. Information must be given in such a way that the audience feels it applies to them. Mass media approaches aimed at the general population are less likely to be effective in creating concern and overcoming denial, particularly among those at greatest risk. Targeted communication and interpersonal approaches are more useful.

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### **Knowledgeable and skilled**

Once individuals are concerned, they may acquire more knowledge by talking to friends, social workers or health care providers about how to avoid infection or how to decrease risk. More interpersonal communication approaches are needed at this stage, especially training programmes to build skills in discussing sex and sexuality and in negotiating responsible sexual behaviour.

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### **Motivated and ready to change**

Individuals might now begin to think seriously about the need to protect themselves and their loved ones from HIV or other STIs. This is when they might become motivated and ready to change. They may think about this for a long time and decide not to have multiple sexual partners or perhaps begin to use condoms.

For this stage of change to become permanent it is important that there is a supportive environment. In other words, if someone wants to buy condoms or be tested for cervical cancer, it is important that condoms are available or that the clinic offers an opportunity to be tested for cervical cancer. If the environment is not supportive the chances are high that an individual will take a step backwards in the behaviour change chain.

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### **Trial change of behaviour**

At this stage when individuals are in an appropriate situation they then decide to try the new behaviour. After the experience they will evaluate the results of trying this new behaviour and if the experience has been too difficult or embarrassing, then they may not repeat the behaviour again for a long time. To maintain a person at this level of change, the supporting environment and encouragement from friends and family is vital to support the person to repeat the trial at another time.

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### **Maintenance or adoption of new behaviour**

Avoiding relapses to past behaviours that put the person at risk in the first place is a challenge. Friends and family as well as supportive members of the community may have a role to play in reinforcing the positive behaviours and encouraging their continuation.

Different members of the different households will be at different stages of this behaviour change process. Your job is to encourage and support them to move progressively up the behaviour change chain.

As a result of your visit people might change their behaviour totally, or they might move only one step closer to changing their behaviour. If either of these things happens, you have done your job. Don't get discouraged if you don't see immediate change, this process takes time. No matter where a person is on the behaviour change spectrum, there is always something you can do to support them.

---

Stage of Change	What you can do
Unaware	Provide basic information on situation.
Informed	Encourage participants to learn new facts and present them with options to change their behaviour.
Concerned	Motivate participants, for example, by informing them of the benefits of changing behaviour.
Knowledgeable	Tell participants what they can do to change their behaviour, such as going to the clinic to receive treatment. These suggestions have to be appropriate for the individual.
Motivated to change	Point or direct the participant to support services and encourage their use. Ensure that these services are available.
Ready to change	Tell participants about the benefit of using the service.
Trial assessment of behaviour change	Provide an opportunity to practice new skills and new behaviour. Reinforce what you want participants to do to continue the new behaviour.
Sustained behaviour	Tell participants they are doing the right thing to change. Create an environment that promotes the new behaviour.

## Learning and Change

Helping people to change their behaviour is not just about providing them with knowledge. While information and facts are important, it is also important that people can appreciate the value in changing their behaviour and have the skills to make this happen.

This training course is about equipping you to:

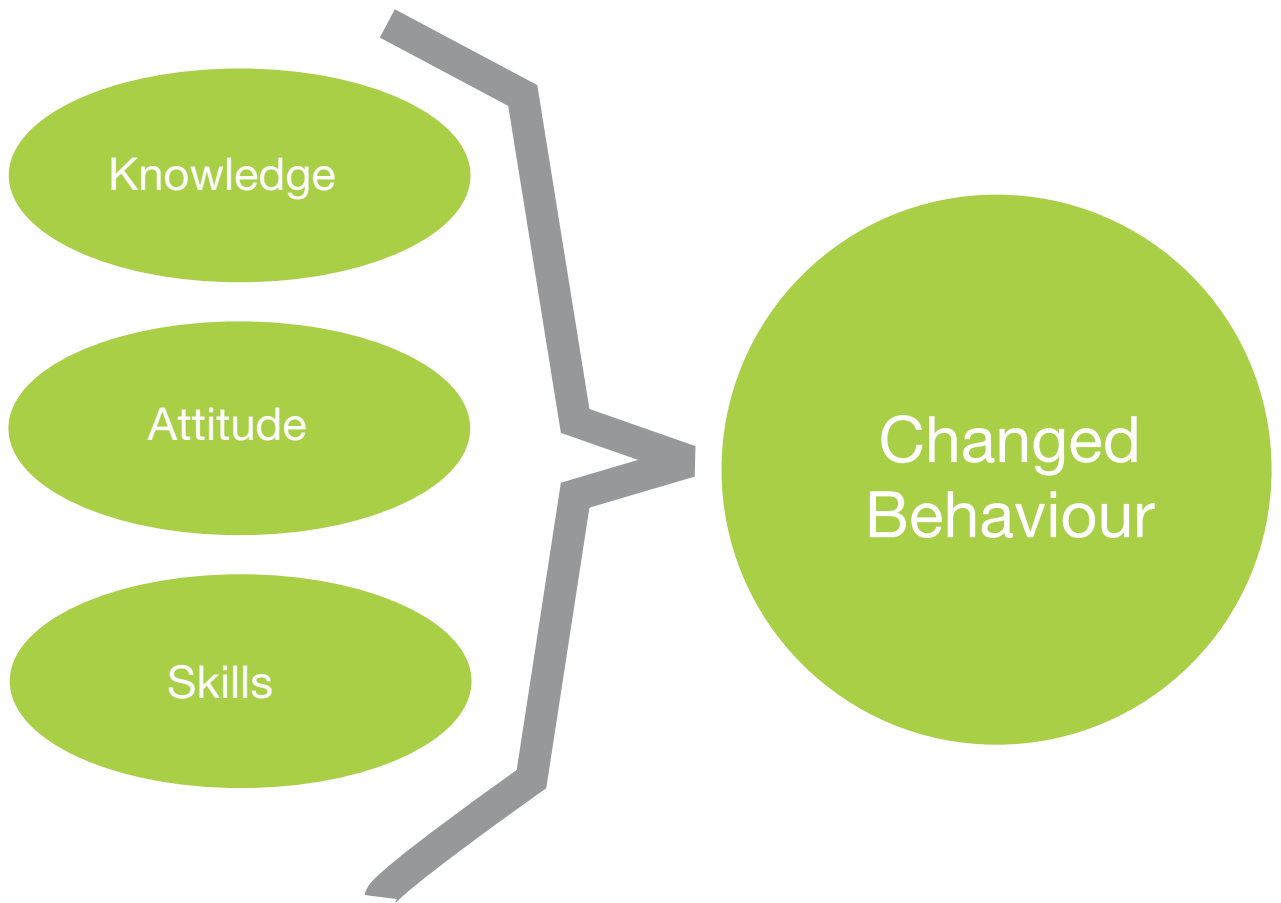
- ➔ Provide information to improve people's **KNOWLEDGE**
- ➔ Help people adjust their **ATTITUDE** by showing them the value of change
- ➔ Equip people with **SKILLS** they need to make and sustain the change.

Learning can facilitate change and change can facilitate learning. Your task is to prepare your participants to change behaviour and sustain this change successfully. The impact of learning will be seen in the participant's everyday experiences: do they change their high risk sexual behaviour, do they implement the objectives of the course, and do they become advocates for change?

The solution to this lies in the planning of the activities for the learning process. Some of the exercises in the next section focus on increasing levels of knowledge, others focus on changing participant's attitudes and some try to equip the participants with new skills.

Learners are guided through knowledge to understand and internalize the core common or universal values and attitudes, in order to make responsible choices. Skills have to be practiced in order to implement these choices.

The aim is therefore to inspire your participants to gather information, and also to guide them to experience a sense of meaning and density in terms of which choices, about sexual behaviour, can be made and implemented.







# **Section Two:**

## **The Risk Assessment Tool**

Given that this toolkit has so much information in it, you have to make sure that you choose the right tools for the job at hand. Imagine if you needed to clean up a spill in your kitchen at home, the right tool for the job would be a cloth or a mop. What if you only had a hammer and a screwdriver? Can you picture trying to clean up spilled tea with a hammer?

These tools are very similar. There might be little need to tell people about sero-discordance, if both husband and wife are HIV positive. Similarly, entirely telling a household that has only women, about the benefits of voluntary medical male circumcision will have limited benefit.

To help you choose the right tool for the job, we have designed a simple Assessment tool. In this tool you answer a number of questions.

### How to determine the topics to cover in a household?

When you enter a family's home you need to explain that you have a lot of information to share, but you have a limited time to do so. We suggest that you explain that you want to prioritise the information that the family needs to hear and that there are a number of ways of finding out which information is important. One way is to read out all the topics and to get the participants to choose which topics they would like to hear about first. Another way is to run the risk assessment tool.

Explain that the risk assessment tool is simply a list of questions that the husband and wife (and any other adults in the household) answer separately and confidentially. No one else will know the answers that they provide. Explain that the tool will determine which topics are most important for the family to hear about.

Some sections of the tool only need to be answered by men, and some only need to be answered by women. When you hand out the tool, explain this to the participants and ask them to answer only the sections that are required.

They also only need to answer the questions with a YES or a NO. If they are not sure of the answer tell them to answer NO. If you need to you can help those participants that cannot read or write, to answer the questions. IF they prefer they might want to get a family member to help them answer the questions. Explain that after they have answered the questions, no record will be kept of their answers and you will wipe the sheets clean. Show them how you will do this by writing on the assessment sheet and then wiping it clean with a cloth.

After you have given the participants an opportunity to answer the questions, collect their answer cards and determine the topics as shown in the example below.

Here is an example of part of the risk assessment tool.

<b>HIV and AIDS</b>		
Have you been tested for HIV in the last six months?	Yes	No
Do you know your HIV status?	Yes	No
Are you aware of your partner's HIV status?	Yes	No
Have you had sex with someone other than your partner in the last six months?	Yes	No
Have you had sex without a condom (with anyone) in the last six months?	Yes	No
Have you ever been diagnosed with a sexually transmitted infection (treated or untreated)?	Yes	No
Have you ever given or received money, food or other goods in return for sex?	Yes	No

The participants simply answer the questions with a YES or a NO. A completed sheet might look like this in the picture below.

HIV and AIDS			
Have you been tested for HIV in the last six months?	Yes	No	
Do you know your HIV status?	Yes	No	
Are you aware of your partner's HIV status?	Yes	No	
Have you had sex with someone other than your partner in the last six months?	Yes	No	
Have you had sex without a condom (with anyone) in the last six months?	Yes	No	
Have you ever been diagnosed with a sexually transmitted infection (treated or untreated)?	Yes	No	
Have you ever given or received money, food or other goods in return for sex?	Yes	No	

Your assessment / rating tool looks this this.

HIV	Person 1	Person 2	Person 3	Person 4	Person 5		
	Green No	Green No	Green No	Green No	Green No		
	Red Yes	Red Yes	Red Yes	Red Yes	Red Yes		
Total Score							
0	1	2	3	4	5	6	7
Lower Risk				Higher Risk			

To capture a score, simply count the number of GREEN NO answers and RED YES answers. If the YES and NO answers are equal, automatically the individual is at risk.

In the case of the person who answered the questions above, the sheet would look like this:

HIV	Person 1	Person 2	Person 3	Person 4	Person 5		
	1	Green No	Green No	Green No	Green No		
	1	Red Yes	Red Yes	Red Yes	Red Yes		
Total Score	2						
0	1	2	3	4	5	6	7
Lower Risk				Higher Risk			

Now add the scores together and plot the answer on the number line.

HIV	Person 1		Person 2		Person 3		Person 4		Person 5		
	1		Green No		Green No		Green No		Green No		
	1		Red Yes		Red Yes		Red Yes		Red Yes		
Total Score	2										
0	1	<del>2</del>	3	4	5	6	7				
Lower Risk				Higher Risk							

The result above shows that the individual who completed the section has a lower risk of contracting HIV. A score of four and above indicates risk and there is need to conduct a session on the particular topics associated with what the individual is at risk of.

Imagine if this person's wife also answered the questions, and her scoring looked like this.

HIV	Person 1		Person 2		Person 3		Person 4		Person 5		
	1		2		Green No		Green No		Green No		
	1		3		Red Yes		Red Yes		Red Yes		
Total Score	2		5								
0	1	<del>2</del>	3	4	<del>5</del>	6	7				
Lower Risk							Higher Risk				

This would show that the wife is at risk of contracting HIV compared to the husband.

To determine the topics to prioritise, count the number of respondents on the higher risk side of a particular health issue on the scoring sheet. Prioritise the health issue with highest number of respondents showing risk. If you have equal number of respondents on each side of the scoring scale, you would have to conduct sessions on that particular health issue.

So, if you encounter a household with six people, and four are at risk of contracting or spreading HIV, whilst three are at risk for cervical cancer, and two are not using contraception, you would have to conduct sessions on HIV first because it had the highest number of people who showed risk. Where there is provision for follow up visits in that household, you would then conduct sessions on cervical cancer, followed by family planning and contraception, and if necessary, address other emerging issues. However, if you have an equal number of people on different health issues; you still have to make a decision on which topics to prioritise. In this case you may ask the participants to choose.

There are some exercises in the manual with several activities and because of limited time, you may not be able to conduct all the activities in that exercise. An example of such exercises would be HIV Testing Services and Stigma and Discrimination. You should therefore use your discretion and pick the most suitable activity or activities to conduct based on your observations, and the amount of time you have at the household.

Below is a list of specific topics that you would need to cover for a particular health issue.

High Risk Topic	Topics to cover
<b>HIV and AIDS</b>	HIV Transmission Sexual Networks HIV Testing Services (HTS) Condom use Gender norms and HIV Transmission Stigma and Discrimination Sexually Transmitted Infections Living in a Sero-discordant Relationship
<b>Family Planning</b>	Family Planning and Contraception Condom use Maternal, Newborn and Child Health
<b>Cervical Cancer</b>	Oversized Pumpkin: Cancer Awareness Condom Use Sexually Transmitted Infections Gender Norms and HIV Transmission
<b>Sexual and Gender Based Violence</b>	SGBV Gender Norms and HIV Transmission
<b>Male Circumcision</b>	VMMC Condom Use Oversized Pumpkin: Cancer Awareness
<b>Reproductive Health for Young People</b>	Human Reproduction Adolescent Pregnancy Family Planning and Contraception Condom Use Maternal, Newborn and Child Health Sexual Networks

This is only one example of the Risk Assessment tool. In some assessments only the husband (or male members of the household) need to answer. In some assessments only the wife (or the female members of the household) need to answer.

**VERY IMPORTANT:** This tool is for YOUR use only. This is not a scientific tool that determines if the respondents have a high or low risk profile regarding the health issues covered in this training. This tool is simply to allow YOU to focus your training more effectively.

In some sections of the assessment, only the husband (or male members of the household) need to answer. In some assessments only the wife (or the female members of the household) need to answer.

**VERY IMPORTANT:** This tool is for YOUR use only. This is not a scientific tool that determines if the respondents have a high or low risk profile regarding the health issues covered in this training. This tool is simply to allow YOU to focus your training more effectively.

-In a household where there are a number of potential participants for a service (e.g. cervical cancer screening or male circumcision) then get all of the participants to answer the questions relating to that topic before deciding whether to run the session. In a household with a grandfather, a father, an uncle and two unmarried sons (19 and 22 years old) a scorecard might look like this.



	Person 1	Person 2	Person 3	Person 4	Person 5
Male Circumcision	1	1	1	1	0
	3	2	3	1	2
	4	3	4	2	2
Score	4	3	4	2	2
0	1	<del>2</del>	<del>3</del>	<del>4</del>	<del>5</del>
Lower Risk					Higher Risk

As you can see, each person has been allocated a score, and each score has been marked on the number line. This shows that the household has a medium to high risk profile, and it might be a good idea to educate the male members of the household on circumcision.

Only get the adult members of the household to answer the questions on the Risk Assessment Tool. If there are adolescents below the age of 18 in the household, ask the parents' permission before you allow the adolescents to answer any of the questions.

You should be able to decide which sessions to run with the family, depending on the results of the Risk Assessment Tool. However, remember the tool does not replace your ability to “read” people or situations. This is a characteristic that makes you a good BCF. Your ability to observe and understand the concerns about people are not replaced by the Risk Assessment Tool. For example, if you identify someone who is at risk of a health issue e.g. cervical cancer or male circumcision but either of these topics have not scored as high priority to be discussed in that household, you should refer them to relevant services. Use the tool as a guideline and not as a rulebook.

Do not be afraid to change your mind when you are in the middle of conducting sessions, if the need arises. For example, you might be conducting the communication sessions and were planning on conducting the adolescent pregnancy sessions afterward. You realize that there is a problem with communication between the father and the daughters of the family. You might feel that conducting the adolescent pregnancy sessions might result in arguments between the father and the daughters after you leave. As a result, you might choose to conduct other sessions on Stigma or HIV awareness. You might also, with the permission of the parents, choose to conduct the adolescent pregnancy sessions with only the daughters and the mother present.

As an example of deciding which exercises to conduct during a visit, imagine that, after getting a couple to complete the tool you conduct the assessment and decide that there is a need to conduct a session in cervical cancer and male circumcision. However, since you are supposed to ensure that household members can communicate openly you should conduct some communication exercises first. As a result, your “timetable” might end up looking like this:

#### Conduct:

Unit 2: Building a Relationship House

Unit 3: Exercise 2: Communication between couples

Unit 18: The Oversized Pumpkin: Cancer Awareness

Unit 13: Exercise 4: Voluntary Medical Male Circumcision

Close: Leave information about SRH, HIV and AIDS and SGBV services and refer where necessary.

**Remember:** Each home visit session should begin with a communication exercise from units one to five for rapport building.

## The Risk Assessment Tool

HIV and AIDS		
Have you been tested for HIV in the last six months?	Yes	No
Do you know your HIV status?	Yes	No
Are you aware of your partner's HIV status ?	Yes	No

Have you had sex with someone other than your partner in the last six months?	Yes	No
Have you had sex without a condom in the last six months?	Yes	No
Have you ever been diagnosed with a sexually transmitted infection (treated or untreated)?	Yes	No
Have you ever given or received money, food, or other goods in return for sex?	Yes	No

Family Planning		
Have you and your partner discussed how many children you should have as a couple?	Yes	No
Do you agree as a couple on the type of contraception to use?	Yes	No

Do you and your partner use contraception?	Yes	No
Have you been sexually active in the last 12 months?	Yes	No

Cervical Cancer (for women only)		
Have you ever been screened for cervical cancer?	Yes	No
Were you older than 17 when you had your first sexual intercourse?	Yes	No
Do you usually use a condom when you have sexual intercourse?	Yes	No

Have you had sexual intercourse with more than one partner?	Yes	No
Are you older than 30?	Yes	No
Have you ever been diagnosed with herpes?	Yes	No

Sexual and Gender Based Violence (SGBV)		
Would you report an incident of sexual and gender based violence in your home/community?	Yes	No

## The Risk Assessment Tool

Is your partner justified for beating you for any wrong doing?	Yes	No
Have you ever beaten or been beaten by your partner?	Yes	No
Have you ever felt physically, emotionally and sexually threatened by your partner or other people?	Yes	No
Have you ever been forced to have sex against your will?	Yes	No

<b>Male Circumcision (men only)</b>		
Are you circumcised?	Yes	No
Do you always use a condom when you have sex with someone other than your partner?	Yes	No
Would you get circumcised to reduce your chances of contracting HIV?	Yes	No
Would you get circumcised to reduce your partner's risk of contracting cervical cancer?	Yes	No

<b>Reproductive Health for Young People (18-24 year olds only)</b>		
Do you feel confident accessing RH services such as STI screening, pregnancy testing or family planning services at your local clinic?	Yes	No
Have you been sexually active in the last 12 months?	Yes	No
Have you ever been sexually abused?	Yes	No
Do you feel you might fall pregnant or make someone pregnant?	Yes	No
Have you ever had or performed oral sex?	Yes	No
Do you have a long term boyfriend or girlfriend?	Yes	No

## The Risk Assessment Scoring Tool

<b>HIV</b>	Person 1		Person 2		Person 3		Person 4		Person 5		
Score											
0	1	2	3	4	5	6	7				
Lower Risk				Higher Risk							

<b>Family Planning</b>	Person 1		Person 2		Person 3		Person 4		Person 5		
Score											
0	1		2		3		4				
Lower Risk				Higher Risk							

<b>Male Circumcision</b>	Person 1		Person 2		Person 3		Person 4		Person 5		
Score											
0	1		2		3		4				
Lower Risk				Higher Risk							

SRHR for Young People	Person 1		Person 2		Person 3		Person 4		Person 5		
Score											
0	1	2	3	4	5	6					
Lower Risk						Higher Risk					

Sexual and Gender Based Violence	Person 1	Person 2	Person 3	Person 4	Person 5
Score					
0	1	2	3	4	
Lower Risk					Higher Risk

	Person 1		Person 2		Person 3		Person 4		Person 5	
Cervical Cancer										
Score										
0	1	2	3	4	5	6				
Lower Risk			Higher Risk							

## Planning a Home Visit

Remember you will be providing your services in another person's home. You might be used to training in other, less personal training environments. To train in someone's home needs special consideration. For example, in a normal training environment you can move any of the furniture around to achieve your objective. It is unlikely you will be able to do this in a private home. Also, in a normal training environment you are often training people that have a limited, or no knowledge of one another. In a family environment the participants know the best and the worst of one another. Therefore, you need to be more sensitive to these complex inter-relationships.

### What is MY role?

Your role in visiting the participants in their home is threefold. Remember: Knowledge, Skills and Attitude. In the course of the visits, you will:

- Give the participants information that they might not otherwise have. This includes information about service providers that can help them further if they need assistance or medical help.
- Get the participants to talk more openly about the health related issues that you will address. This is about changing attitudes. If you manage to achieve this it means that the conversations among the family members will happen after you leave, and that behaviours will change, even if you are not there.
- Provide the participants with a safe space to express ideas and to practice skills relating to implementing changed behaviour.

### What is expected after the interventions?

You will have two home visits, each lasting about two hours. However, you can have more than two visits per household if there is need. At the end of each visit, it is hoped that members of the household will make contact with the relevant service provider that will be able to assist them with the next step in behaviour change. Your organizations will be able to assess the impact of this change through the reports that you submit as well as through the reports from the other service providers.

### What is interactive training? Why do we play games?

Some people think that playing games is childish and a waste of time. Some people think that learning can only take place in a classroom or another formal setting. However, we learn all the time, no matter what the situation, and often as adults, we learn better by DOING rather than by HEARING.

Remember you need to change ATTITUDES and SKILLS, not just give information. People need the time and space to practice new behaviour. They can start by doing this in the games and role plays that you have in these exercises.

### Setting up the environment

Remember that you will be having a conversation with a group of people for about two hours. In this time, people can become quite distracted. Also, remember that you are meeting in people's homes where they are often busy with other things. All of these "other things" could be potential distractions to the training. It could be a radio, a television or neighbours dropping in for chat. In an environment that has many distractions it will be difficult for your participants to hear, understand and absorb the message.

There are some things you can do to create a better environment for getting the message across. It is necessary to consider the following:

1. Lighting - is it too dark or too bright
2. Warmth – is it too hot or too cold
3. Noise levels – is it too noisy
4. Air flow – is there air flow – too little and the delegates will fall asleep.

In places that are too dark, people will tend to fall asleep. Similarly, when it is too hot. If it is too cold, people will not be able to concentrate, and where there is no air flow, people will also grow tired quickly.

You need to be able to change these things, with the permission of your host.

If the television or the radio is playing, you might politely ask one of the parents if they could turn it off for the duration of the visit. It is important that the TV or radio is turned OFF and not simply turned down in volume. Even a soft background noise can be distracting, and in the case of television, the moving images will distract the participants' focus from your lessons.

### How to use Posters and write on Flip Charts?

Everyone should be able to see the poster and the parts that are being pointed to. Writing should be clear and neat – many people are nervous and write in small letters – the writing should be able to be seen and read by the person furthest from the posters. If necessary, pass the posters or flip chart around the group and let participants see and read.

### How do I facilitate discussion and answer questions?

A central role of the BCF is that of a facilitator. The facilitator has to draw conversation out of the participants and answer some questions. Ask questions, but do not answer your own questions. Ask probing questions. Ask for action oriented steps. A person that dominates a session adopts a teaching role and is not a facilitator.

Encourage your group to ask questions by stopping often and asking if people have questions. Listen to people as they state their opinions. Make sure one person does not dominate conversations. Your answers should ALWAYS be correct, or you should be comfortable to say you do not know. You MUST NEVER give an incorrect answer. Answering questions should be a gentle process, where the questioner is encouraged.

### Issues relating to legislation

You need to be aware of what the law states regarding the health issues. Government regulations deal with things like anti-retroviral, mother to child transmission, voluntary medical male circumcision, access to contraceptives and cervical cancer treatment. Although we have tried to include information that is as up to date as possible, we strongly encourage you to link up with organizations in your ward that are familiar with recent government policies and legislation to ensure that the material you train is as up to date as possible.

### Issues relating to culture and gender

Issues relating to culture and gender are intrinsically tied to the topic and, as a result, may be prominent discussion topics in your training environment. Some of the material and demonstration techniques are quite explicit although are not designed to cause offence. For example, in settings where sex is discussed openly, the posters of human reproductive organs might only cause a few giggles, and in more traditionally conservative areas, this demonstration may cause severe embarrassment. This is something that you as a BCF need to be aware of and find and implement a solution.

Also, be aware that group dynamics can change significantly in groups made up predominantly of a single gender. The dynamics are further influenced by the gender of the trainer. So, for example, the dynamics within a group of women being trained by a woman will be completely different to the same group being trained by a man.

Similarly, as a BCF you need to be sensitive to the social norms within a specific community. If oral sex is something that is taboo within a community, be aware of this and ensure that participants do not disengage from the material simply because you cover something which they are uncomfortable or unfamiliar with. While not altogether advisable, you may choose to edit out certain content of the training material if you think it may cause offence.

*“Culture is important for understanding the HIV and AIDS epidemic in sub-Saharan Africa. It helps to explain, in part, the high HIV and AIDS prevalence rates, particularly among women. Numerous cultural beliefs and practices, such as wife/husband inheritance, polygamy, spirit appeasement, lack of communication about sexual matters between men and women, gender inequity, and culturally-sanctioned extramarital affairs and infidelity among men, have been tied to the high rates of sexually transmitted infections and illnesses (STIs) including HIV. However, there are also positive cultural beliefs and practices that may help in reducing HIV infection. Some of these include the traditional roles of aunts and uncles in advising young people about life, including sexual matters. Such practices may be very useful if included in HIV prevention activities”.<sup>1</sup>*

<sup>1</sup> SafAIDS, *Inter-linkages between Culture, Gender Based Violence, HIV and AIDS and Women's Rights* 2008

Remember, you are training in a family environment. Parents are often very defensive of their children and will want to protect them from issues and discussions that they think might be offensive or cause them harm. For example, you might encounter a protective father who does not want you to speak to his teenage daughters about pregnancy. When you ask why, he will tell you that he does not want to give them any information that might “encourage” them. You, as a guest in the home, need to be sensitive to this and to find a gentle way of overcoming this challenge.

You also need to be aware of the potential embarrassment between family members of talking about sexually explicit material. If necessary, ask if you can separate the family members into gender specific groups. (That being said, there are some topics that are best run exclusively with the husband and wife as a couple, apart from other family members). Or perhaps in cases where two or more households share a dwelling, separate the participants into family groups. Some exercises which may have explicit material have text boxes with instructions on the specific group to target.

## Time Constraints



As the BCF, you will have to assess the overall objective of your intervention. This means that you will have to decide, after your assessment, which exercises will be most useful for the family. This means that you will have to know your exercises well, and you will have to have all of your resources available, so that you don't start looking for things half way through a session.

Whatever the overall objective you decide on, we would strongly suggest that you do not run more than you think your participants can handle. Even though we estimate your home visits to last about two hours, if after an hour and a half you find that your group are tired, do not try to finish the last thirty minutes. Important information from one training session can easily be lost through trying to facilitate a group that is tired. Rather have a good ninety-minute session, than a longer session that the participants regret hosting.

## Issues of perspective

Given that we are dealing with people, they often have their own ideas and opinions, especially when it comes to issues relating to sexuality and gender relations. It is important to listen to these and to appreciate your participants for who they are. You may disagree with their opinions and ideas, but the only thing you are allowed to correct them on is FACTS. To antagonize someone by aggressively disagreeing with them over an idea or a perception will only serve to alienate you from the group. After such a disagreement nothing you say, even if the participants agree with you, will be taken seriously.

The challenge for you is to convince your participants to listen to your ideas, opinions AND facts and in this way decide to change their own behaviour.

While a number of the training interventions have been designed to ensure maximum personal input from the participants; to ensure their physical participation in the learning; their mental “buy-in” is vital to the success of the intervention. To achieve this, you, as the BCF, are encouraged to personalize the material as much as possible, use first person pronouns, (I, we, you), and apply the learning to yourself before asking the participants to apply it to their own families. Remember, one of the first steps in behaviour change is to ensure that the message is appropriate and applicable to the audience. You can do this by using personal pronouns.

In addition, your knowledge of the material and the health conditions is vitally important in the interpretation of the setting and dealing with the variety of the issues that participants may raise during the training. Together with the sensitivity of the material, there is much misinformation available. While participants' heads may acknowledge the illegitimacy of some of this information, their hearts and societal pressure might refuse to discard the thoughts. It is not your responsibility as a BCF to re-educate participants, but rather to re-inform them regarding the correct information and the importance of protecting their families and communities. In a number of cases, it may not be possible to assign a “right” or “wrong” value to an answer or situation. It will be more important to acknowledge the underlying principle or concern of the participant and acknowledge the possible unspoken fear relating to the issues.



By way of example, a participant may raise the question of mosquitoes transmitting HIV. As a source of information he mentions a newspaper report that he had heard about arguing that mosquitoes could in fact spread the disease. When it becomes clear that facts would not resolve the concern, the BCF could tactfully acknowledge the concern that the participant has, and suggest that the participant speak with the service providers about his concerns, thus retaining the participant in the “learning loop”. A “correction” may have resulted in the participant “switching off” for the rest of the session.

### **Potential Embarrassment**

The material relating to HIV and AIDS is sexually unambiguous. This may cause some discomfort and unease amongst the participants. It is important that for effective learning to take place that the participants feel secure in their environment.

One of the most effective ways of transmitting this security is for the trainer to radiate confidence in the training material. If the trainer appears embarrassed by the words and materials used in the training, the participants might also appear uncomfortable with the material and learning objectives, thus hampering their ability to absorb and personalize the information. For this reason, we would encourage you to be more than familiar with the training material, the terminology and issues relating to all of the health issues including those related to HIV and AIDS.

You also need to be aware of the sensitivities and cultural restrictions about visiting a household when the head of the house is not present, or when there are only children present. As a guideline, we suggest that you should NEVER try to run a session with children without the express permission of the parents. A male BCF should never try to run sessions with only women participants and similarly a female BCF should not run sessions with only male participants.

**In summary: You are in control of the session, not the other way around. Make decisions that you think are best at the time, in order to ensure that you can assist the behaviour change process. You should NEVER leave the family in a worse position than when you arrived.**

## Engaging People Living with Disabilities

A Behaviour Change Facilitator has two major roles;

1. Mainstreaming disability in the existing programme: identify people living with disabilities (PLWDs), conduct Home Visits with them, and make necessary referrals to relevant services including HIV Testing Services (HTS), Sexual and Gender Based Violence (SGBV) and make follow ups on the PLWDs to check whether they have accessed referred services.
2. Liaising with disability organisations in the province or district (Identifying the disability organisations and referring people living with disabilities to organisations of disabled people (ODPs)

### Involving People Living with Disabilities

- Always introduce yourself by name ('Hello Sihle, it's Khumbulani') and explain why you are there.
- When you first speak to the person, a handshake helps orient her to where you are.
- If you are in a group, explain who else is with you. Identify yourself each time you speak.
- Use the person's name often, to make it clear when you are speaking to her.
- Speak directly to the person, not to her assistant or companions, and speak normally and clearly. Remember that people with visual impairments do not necessarily get the extra care.
- Use of sign language or sign language interpreter for Deaf person.
- Find out how the person likes to communicate – there are a variety of different ways, including speech, sign language, finger spelling, writing or gestures and body language.
- Even if you are communicating through a sign language interpreter, it is important to remember that you are still talking to the Deaf person. Talk directly to her, not to the interpreter – for example, 'what do you think?' not 'what does she think?'
- Treat people with courtesy and respect. For example, don't leave someone behind by walking off too quickly.
- Treat each person with respect and be sensitive to his / her individual needs and behaviour.
- Different people find different things difficult. Find out each person's preferred way of communicating (how he / she likes to speak and be spoken to, how he / she likes to be touched or not).
- Be sensitive to how you behave and how your actions might cause someone to react – don't panic or respond aggressively.
- People with learning difficulties may take more time to understand or respond to what they hear. Some people may find it difficult to concentrate. It might be helpful to think about the ways you communicate with people who do not have the same first language as you, or who are illiterate. In general:
  - Speak normally and clearly.
  - Use simple, short words – if you have to think about what a word really means, don't use it.
  - Use real-life examples and words for real things – people with learning difficulties may find abstract concepts difficult.
  - Use short sentences and express one point at a time – people with learning difficulties may find it difficult to remember a list of different things.
- People living with disabilities (PLWDs) are generally excluded from SRHR, HIV and AIDS and SGBV information and services since as they are somehow considered not to be sexually active (asexual). The negative attitudes towards people with disability such as stereotyping (retarded, dumb), beliefs that PLWDs have a lesser position in society or that they have a diminished capacity to contribute due to their impairment affect these people's access to healthcare services. As a BCF, you should make sure families understand that people with disabilities have the same health care needs as everyone else and need to be supported so that they exercise their right to healthcare.
- **You should also be sensitive to the needs and realities of PLWDs when conducting activities and exercises.**

# **Section Three:**

## **The Toolkit**

## The Toolkit

Just like any normal toolkit has a number of tools, this one consists of a number of parts. This toolkit has the following:

- This manual
- A Risk Assessment Score Sheet
- Five Risk Assessment Cards
- Six erasable marker pens
- A cloth
- A set of A3 posters
- A set of cards (A4 size) for you to cut up.
- Two balls of wool or string.

Some exercises in the manual will require you to make some cards. If you have not been supplied with the set of (A4 size) cards for you to cut up, you should be able to find cardboard from counter books/exercise books or empty cereal boxes. Make sure you have a container to keep these cards in, as you will need to use them repeatedly.

In the previous section we explained about the Risk Assessment Tool and you will be trained on how to use this.

How to use the rest of the tools will be explained later in this section?

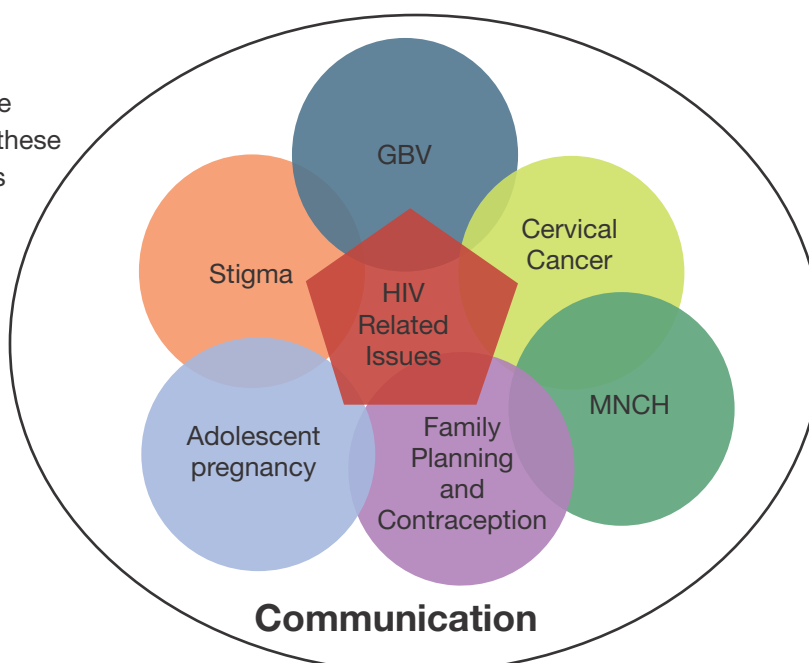
### The Exercises

As mentioned in the previous section there are eight overall themes in this toolkit. You can choose to mix and match exercises to best achieve what you want within the household. Don't expect to get this mix right the first time around. As you use this principle more, so you will use exercises that are the most appropriate without even thinking about it.

Just as a reminder there are eight themes that the exercises speak to:

- Communication
- SGBV
- Cervical Cancer (and other cancers)
- Adolescent Pregnancy
- Family Planning and Contraception
- Stigma
- MNCH (ANC, and PNC including immunisation)
- HIV and related issues (including TB, STIs, Sero-Discordance, Condom use, ART, PrEP, PEP, PMTCT and VMMC)

The diagram illustrates the interrelationship between these themes. HIV related issues are core to the whole course, but all of the health related themes are contained within the need for improved and better communication.



Because you are working with family units, communication between the family members is essential. Communication is listed as the first theme, because a large focus of this toolkit is on communicating within the family unit regarding the health themes. It is no good asking a couple to speak about sero-discordance if they do not understand and practice good communication skills. Similarly, it will do no good to ask a mother or father to speak to a daughter about contraception and risks associated with pregnancy if they do not practice open communication techniques.

As a result, it is strongly recommended that you begin each home visit with at least one communication exercise. You might choose to focus on communication between the adult partners or between the adults and the children or simply between the family members as a whole. Whichever area you decide to concentrate on, involve the family members in improving their communication skills. Refer to handouts on Tips for communication in the Annex section.

The exercises follow on the next page and are laid out in a table format. The parts of the table are described on the next page. Remember that not every exercise contains every section of the table.

#### Exercise Number and Title

Purpose	This section tells you why the exercise is important and provides you with some guidance about when to use it.
Objectives	This section tells you what the expected outcomes of the experience will be.
Time Required	This tells you approximately how long the exercise will take. However, be aware that exercises often take longer with larger groups.
Setting	If you need to be outside to run the session or if you need to be in a large room, this section will warn you of this in advance.
Other Requirements	This section tells you what other materials you might need to use in the exercise. Most of these materials have been included in your toolkit. Other materials (water, cups, bucket, etc.) should be available at the house you are visiting.
Method	This is the step by step process of how to run the exercise
Processing	Processing is a follow on from Method, and it is in this section that the discussions are done and learning takes place.
Hints, Suggestions and Challenges	In this part we give you some advice of things to look out for when running the exercise, or problems that you may encounter, or suggestions about how to run the exercise differently if you have a different audience.
Remember this	Use this as a final thought to leave with the participants. Remember, you are trying to change behaviour and part of this process is about the participants taking action for themselves. In this section you get participants to think about SPECIFIC things that they can do rather than generic actions that might be the responsibility of the community. Try to get them to think about actions that they as individuals might be able to take.

**When you are running your session, do not read the purpose and objectives aloud to the participants. This information is for your benefit. It is your role as a BCF to make sure that the participants achieve the objectives outlined in the exercise.**



**REMEMBER**

Please remember that although some of the exercises suggest that you separate the participants into two groups, many of the exercises can be run with a smaller number of people. They just need to be adjusted a little. Remember you can also participate in a number of the exercises as a participant, if you need to. With practice you will be able to run these exercises with any number of people.

# Exercise 1:

## My Connected Family



### PURPOSE

This exercise serves as a foundation unit. It is important that members of the family unit recognize that they have a level of interdependence. While there may be some conflict or problems between members of the family unit, all of the members are dependent on all of the others. As a result, the exercise should look to improve communication between members, to ensure that the family unit remains strong.

**Time Required: 15 minutes**



### OBJECTIVES

The exercise will allow participants to recognize the interdependence of the family members, and how family members are connected to one another as well as getting them to recognize the impact of one member of the family being absent from the family unit, for any reason.

### Other requirements

- Ball of string or wool
- Three to six volunteers
- Name cards identifying the respective roles (worn around the volunteers' necks)

### Setting

A room large enough for the group to stand comfortably in a circle.

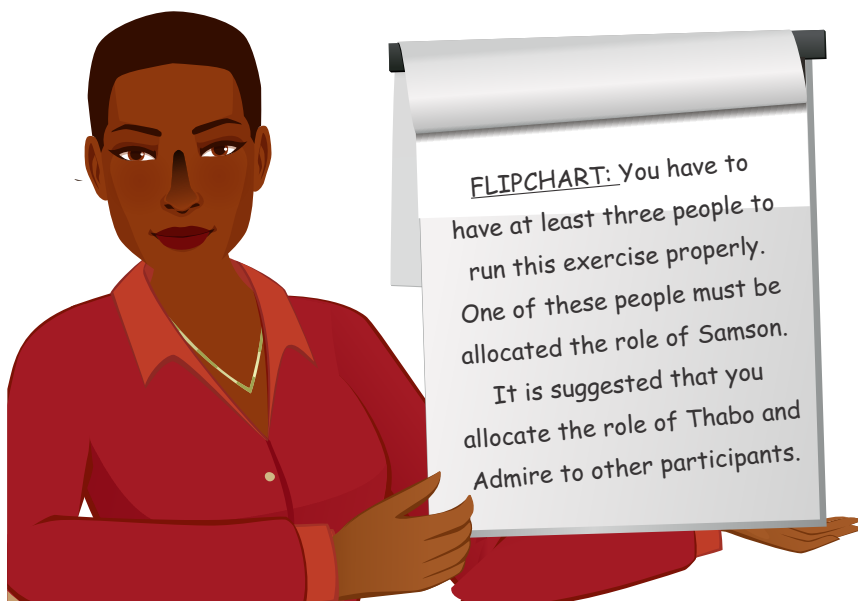
### METHOD

1. Ask the participants to stand in a circle
2. Assign names to each of the participants, according to the name list, by handing out the name cards (if you have not been provided with name cards, you should make yours from either empty cereal boxes or hardcover of counter books/exercise books).

3. Ask the delegates to display the cards with their given names.
4. Explain that you are going to read a story. As you read a character's name the person who holds the string must hold onto the string or wool and pass the ball of thread to the person playing that character. Demonstrate how to do this, as you were trained.
5. Give the ball of wool to Samson and as you tell the story get the participants to pass on the ball to the next character that you mention, while still holding tightly onto the wool.
6. The wool gets passed on between the participants as their characters' names are read out. This creates a web of relationships in the family unit.
7. At the end of the story tell people to keep hold of their thread, and to step back as far as they can.
8. This should make the "web" tight.
9. Show how tight the thread is and comment on how connected everyone is – even if sometimes the relationships between people are strained. Everyone is dependent on one another in this unit.
10. Then tell everyone to keep hold of their thread, but say that Samson leaves the family unit.
11. Ask Samson ONLY to drop his string.
12. Then ask everyone to try and move further backwards. They should be able to take one or two steps backward.
13. Ask people to make observations about what has happened. Ask what people feel about what happened.
14. Point out that as a result of only one person leaving the family unit, the whole fabric of the family unit is looser and people are now further apart.

## PROCESSING

The learning happens during the game and discussion.





Name cards

Samson	Tatenda	Admire
Ruth	Rudo	
Thabo	Nomusa	

### Story for My Connected Family

Samson was angry. All he had wanted to do was to go to the variety show at school. When he has asked his mother Ruth, she mentioned that he still had some chores to do and suggested that he do these before asking his father Thabo. When Samson approached Thabo, the answer was the same, "Not until your chores are done". They didn't understand that he wanted to see if he could catch another glimpse of Rudo. Samson had seen Rudo at school earlier in the year and had admired her even then. Not that he thought she even knew he existed!

But back to reality. Chores. Of course the chores needed to be finished, but they were going to take such a long time. He needed to finish weeding the vegetable garden with Thabo and his older brother Admire and then Ruth had asked him to help with some jobs in the house.

All because Nomusa, his grandmother was coming. By the time he finished, the variety show at school would nearly be over.

Tatenda was dancing around the kitchen table, in her pink dress. Samson's little sister looked very cute, but she could be irritating as well. Now was one of the irritating times. "Samson has a girlfriend; Samson has a girlfriend" she chanted as she skipped. Samson glared at her and then saw Admire coming in through the door. He stopped and grinned. "What's this I hear about my little brother?" "Nothing" replied Samson lowering his head to hide his embarrassment.

"Not nothing" squealed Tatenda in delight, ignoring the look that Samson shot at her.

"You be quiet, Tatenda" chided Admire gently. He grinned at Samson, "I know that Dad (Thabo), asked you to help weed the garden, but I also know that some things are more important. I know that Grandmother (Nomusa) is coming tomorrow and Mum (Ruth) wants the house to be neat, but I also know that you have other things on your mind – even without the hint from Tatenda." Tatenda looked on at the exchange between the brothers.

"Yes?" said Samson, hesitantly looking at Admire.

"You go to the variety show at school. I'll do the weeding for Dad (Thabo) and help Mum (Ruth) out. Go and enjoy yourself. But be back in time to greet Grandmother (Nomusa) when she arrives tomorrow!"

"Thanks, Admire! I owe you!" yelled Samson as he raced out the door. His mind was already on Rudo.

# Exercise 2:

## Building a Relationship House

### PURPOSE

Having established a family network, and recognizing that family members are interdependent, it is important to provide participants with the tools to improve these relationships. The exercise looks at some components needed to build better communication between people.

It could be used in a wider family setting, but it is of particular importance to promoting communication in couples. Please note that not all of the techniques are applicable in all family situations (e.g. caressing as a means of communication would not be appropriate between parents and children).

### OBJECTIVES

By the end of this exercise, participants will understand that communication is made up of different components and is not limited to talking. Participants will also be able to identify ways in which they can improve their interpersonal communication

**Time Required: 30 minutes**



### Other Requirements

- A set of “building block cards
- “A Strong Relationship House” poster

### METHOD

1. Ask participants to brainstorm the different types of relationships they have with people.
2. Explain that there are many different kinds of relationships: with parents, children, friends, community members, church members, employers, etc.
3. Explain that good relationships do not just happen by themselves, but that they need to be BUILT and maintained to be successful. Explain that building a relationship is similar to building a house. It is hard work, and after it is built, it has to be maintained and looked after.
4. Ask the participants to give some feedback about what they think is important in building and maintaining a relationship.
5. As various components of building a relationship are mentioned, write these on your flipchart or on a piece of paper that the group can see.
6. Hand the set of cards to the participants (if you have been provided with the set of cards) and ask them to assemble a house with the cards and to compare the building materials on the cards with what they thought was important

**OR**

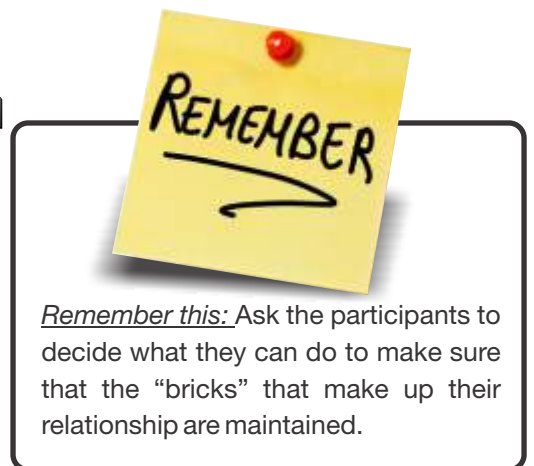
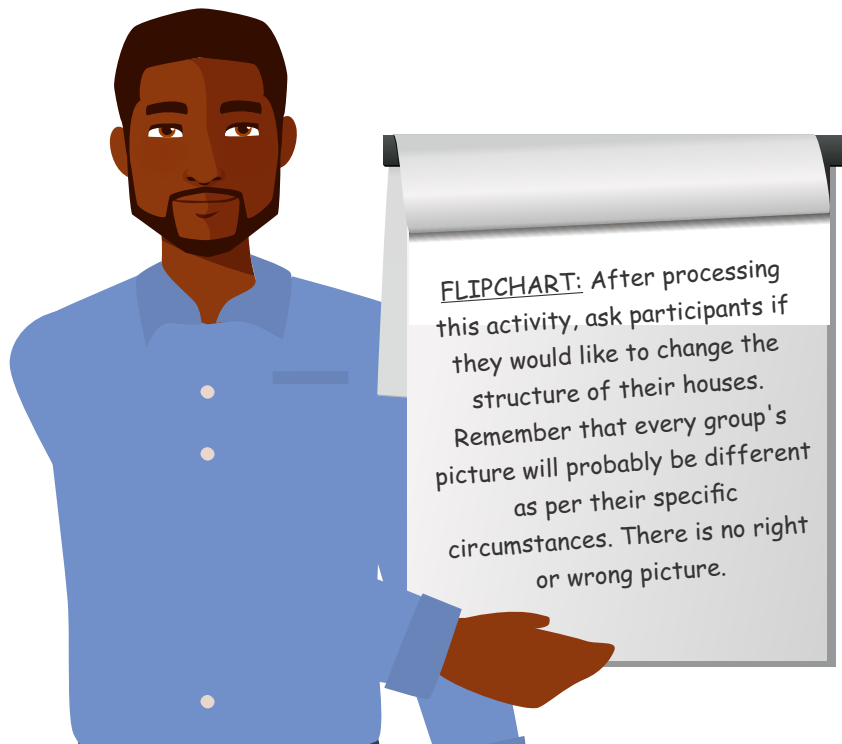
Ask participants to draw a relationship house highlighting what constitutes the foundation, the bricks, the door and the roof. They should compare the building materials with what they thought was important or what they initially mentioned.

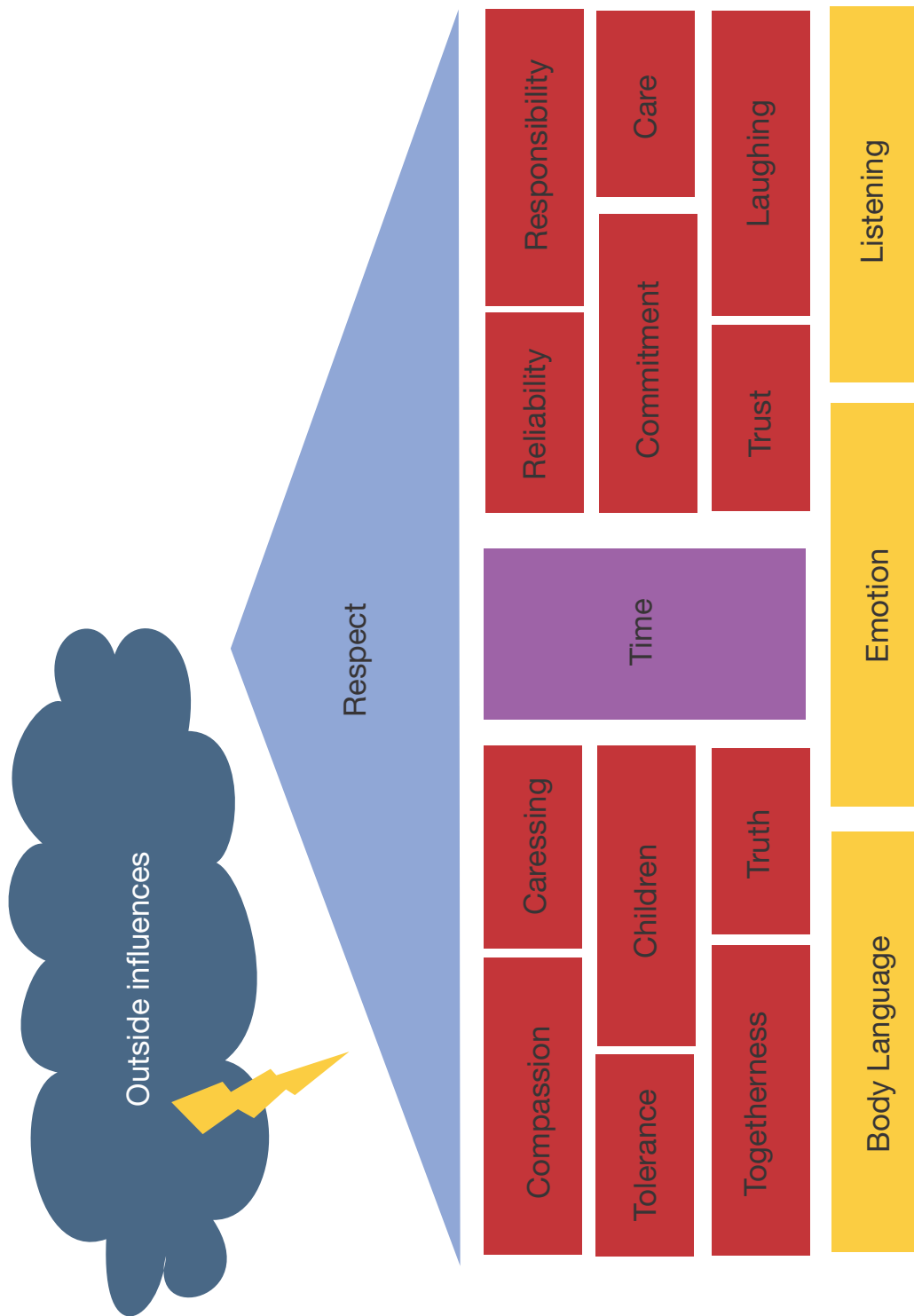
- a. They must choose the words from the foundation list to determine what constitutes the foundation.
  - b. They must choose the words from the bricks list to determine what constitutes the walls.
  - c. Explain that TIME is the door to the house. Without TIME, no relationship will last no matter which bricks are used to build the walls.
  - d. The participants need to talk to one another to decide which bricks are important to them to build their relationship house.
7. Explain that there is no correct or incorrect pattern for the bricks. The individuals must discuss what they think is important and which bricks support one another.
  8. If necessary, let the group see the House of Communication poster to show what a house COULD look like. But explain that the group does not have to copy this pattern

## PROCESSING

Explain the following and ask participants to give examples from their own lives:

- ✓ **Foundation:**
  - ➔ All of the foundation bricks relate to different types of communication.
  - ➔ Communication is done in a number of ways; including using body language, emotion, talking and listening.
- ✓ **The bricks**
  - ➔ Need to be maintained regularly
  - ➔ All the bricks are important, without one, there would be a hole in the wall and the house would be weakened. However, you need to choose the most appropriate bricks for the relationship.
  - ➔ Are there any bricks that the participants think should be included but are not?
- **The door**
  - ➔ Time is a central part of each relationship. Without this, there is no opportunity to “get into” or “access” the relationship.
  - ➔ Some people struggle to find time to spend together. Sometimes this needs some planning. Some suggestions are:
    - Agree that you will meet together at a certain time during the day or the evening, even if it is only for 15 minutes.
    - Do things that you both enjoy doing.
    - Make time in your day to help one another with normal daily activities.
    - Remember short periods of time together more frequently are often better than longer periods of time infrequently.
- ✓ **The roof**
  - ➔ All of the building blocks are covered by respect. You need to have respect for another person to have a relationship with them.
  - ➔ Respect can be shown in different ways including listening to another's point of view, appreciating what another person does for you, giving another person space and freedom to express themselves and supporting a person when they need support, even if they have not asked for it.



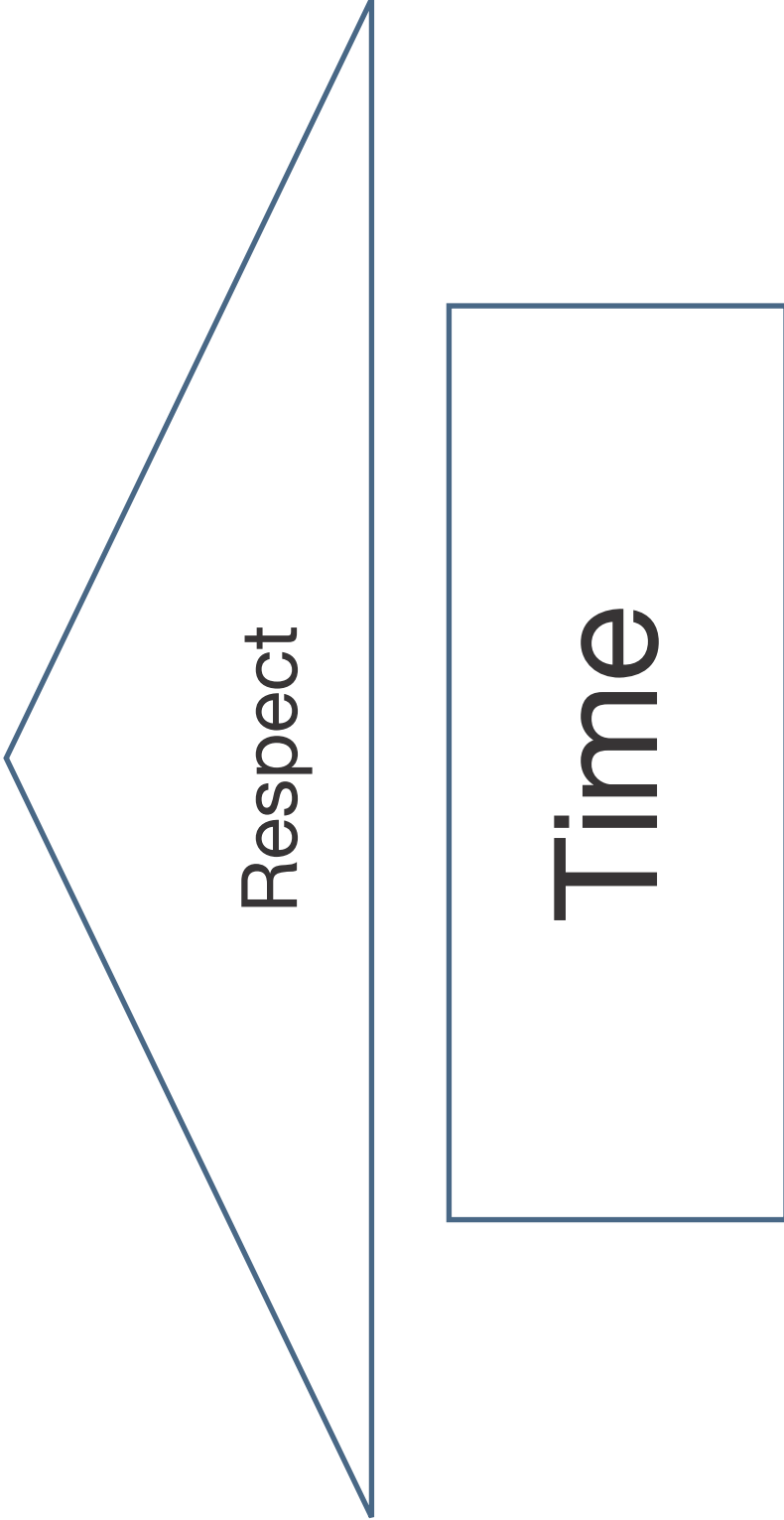


## Bricks List

Compassion	Dependability	Emotions
Caressing	Appreciation	Family
Reliability	Communication	Enjoyment
Respect	Sharing	Holidays
Tolerance	Trust	Eating
Commitment	Responsibility	Faith
Care	Laughing	Doing things
Truth	Smiling	Chores
Children	Parents	Providing
Housekeeping		

## Foundation List

Body language	Touching
Emotions	Listening
Acknowledgements	Love



# Exercise 3:

## Communication: How Things Have Changed<sup>2</sup>

### PURPOSE

Part of communication is understanding one another's perspectives. Often we are not aware of how others view us, and because of this lack of awareness we misunderstand their choices. This tool involves creating a timeline of attitudes and behaviours of different generations living in the same household.

This exercise will open up conversation between different generations by allowing others to see things from our own perspective. It will assist in showing how values and practices (especially sexual values and practices) have changed over time.

### OBJECTIVES

This exercise will stimulate conversation among participants on how and why behaviours and practices have changed over the years. As a result, it will build understanding among participants of other participants' perspectives.

**Time Required: 20 minutes**



### METHOD

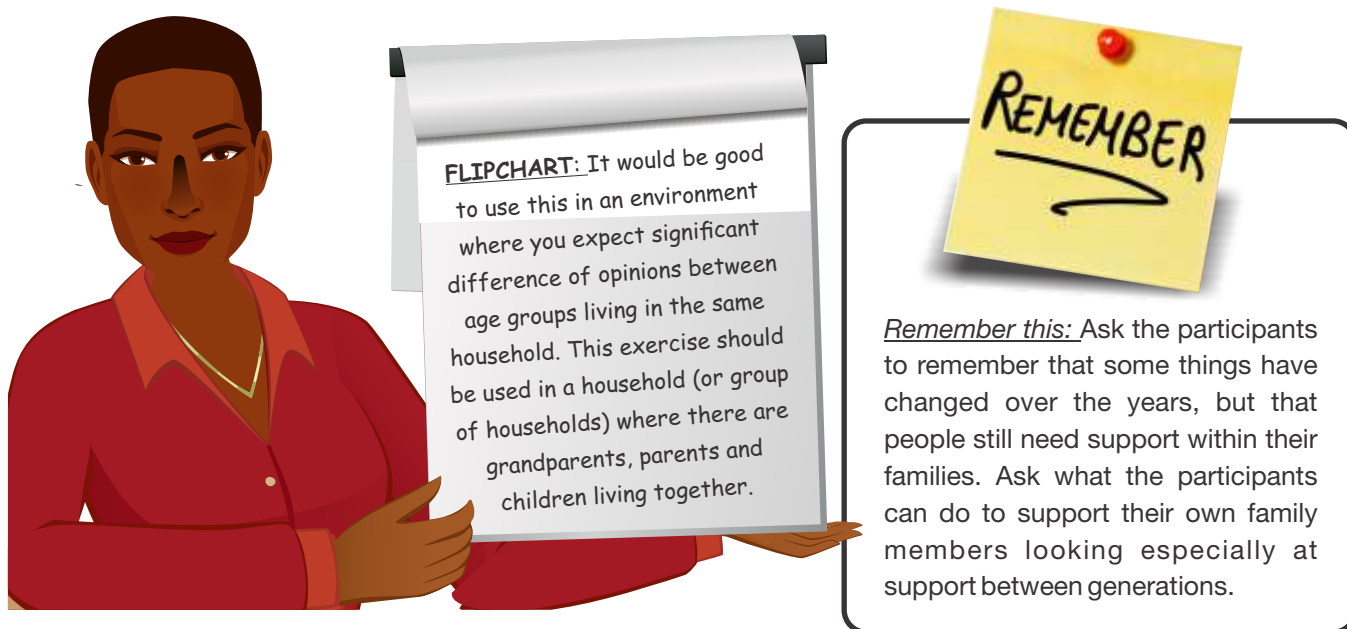
1. Divide the participants into two groups – one to represent younger people and one to represent older people. If there are enough people for each group make a third group of older participants, the grandparents.
2. Ask each group to develop a “portrait” of how they see or saw themselves as young people. They need to act out this portrait by adopting various poses. One member of each group must narrate or present the “portrait” to the others.
3. To assist them in this task, ask questions about how the social and sexual lifestyles of the community might have changed over the years; for example:
  - a. What types of work do people do?
  - b. How many children does a typical family have?
  - c. At what age do people reach puberty?
  - d. What age are people first having sex?
  - e. How do young people learn about sex?
  - f. How old are women and men when they marry?
  - g. Who makes decisions within a marriage?
  - h. What problems happen between married people?
  - i. How common is divorce?
  - j. What forms of sexual violence are common?
4. Encourage the groups to discuss the questions and to show some of their answers in their portrait.
5. Give the groups about three minutes to plan their scene and then ask them to come together as one large group.
6. Ask the groups to display their scenes, starting with the oldest group.
7. After the final presentation ask the participants to pick out similarities and differences between the scenes.
8. Ask the participants to identify the positive changes.
9. Ask the participants to identify ways in which the younger people could learn from the older generation(s) and what the older participants might do to assist members of the younger group.
10. Encourage parents and children to communicate openly with each other.

<sup>2</sup> Developed from International HIV AIDS Alliance “Keep the Best, Change the Rest” June 2007



**TIP:** Be prepared for this tool to reveal differences of opinion about changes that have, or have not, taken place through the generations. Welcome difference of opinion but ensure that these are expressed with courtesy and in the spirit of learning more and supporting one another.

Challenge overly simple views, such as that the past was 'all good' and the present is 'all bad'. Encourage the participants to think about things that have stayed the same between the generations, as well as things that have changed. Remind the participants to not only state their views, but to explain them. Keep asking them, "Why do you think that?"



Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGO, church, social services, counsellor, etc.) that will be able to assist them if they need more help or have more questions. Give out referral slips and refer participants to relevant service providers.

# Exercise 4:

## Communication Between Couples

### PURPOSE

In this exercise, the need for communication between couples is emphasized through an exercise. The exercise **should** be conducted with couples only. In polygamous unions, there is need for sensitivity to understand what they are comfortable with in delivering the session. The exercise illustrates the need for good communication between couples in any setting, including family planning, raising children and even household finances.

### OBJECTIVES

By the end of the exercise, participants will understand the challenges that couples can face in communicating effectively and will identify some strategies for addressing these challenges.

Time Required: 25 minutes



### Other Requirements

- A piece of paper and a pen or pencil for each couple

### Setting

Space for the participants to be able to sit as a couple and talk privately

### METHOD

1. Divide the participants into pairs
2. Ensure that husbands and wives are placed together and that long term couples are placed in the same team.
3. Tell the couple that they are not allowed to talk or to communicate with one another.
4. Ask the participants to imagine their dream house. Money is no object and they can choose to build it anywhere they want.
5. Emphasize that the couple are not allowed to talk to one another.
6. Hand each couple a piece of paper and a pen.
7. Ask the couples to draw their dream house on the paper while they are BOTH using the same pen – and remind them they are not allowed to communicate.
8. Allow some time for the couples to draw their houses.
9. Show the house designs and drawings to the whole group.

### PROCESSING

1. Ask the participants the following:
  - a. How did they feel during the exercise?
  - b. How did they manage to complete their drawing?
  - c. What challenges did they encounter?
  - d. Did one member of the couple “give in”?
2. Ask the couples if it would have been easier to complete the challenge if they had been able to communicate?
3. Point out the following:
  - a. As couples they often face challenges and it is vital to ensure that communication between the couple is reliable and ongoing.
  - b. To allow one person to dominate is not effective communication
  - c. To allocate blame or to force behaviour from a partner is not effective communication.
4. Ask the couples to have a short session where they identify challenges to their own communication styles.
5. Some challenges might include:
  - a. Trying to communicate important things in a short period of time

- b. Trying to communicate when one of the couple is under stress
  - c. Placing blame on the other person for an issue that is in the past
  - d. Not accepting responsibility for a problem
6. Ask the couples to identify behaviour that they might change to improve their communication. Suggestions might include:
- a. Agreeing to talk about the same issue
  - b. Setting aside a time every week for talking to one another with no distractions (TV, radio, children, family, neighbours)
  - c. Talking to one another about the problem rather than trying to place blame
  - d. Agreeing on small steps to overcome the challenge and then helping one another to implement these steps.
7. End this session by pointing out that living in a relationship has challenges and is not easy. However, this challenge can be overcome and one of the strategies for winning is good communication between the couple.
8. Move on to the health related topic that you have chosen to address with these couples: cervical cancer, sero-discordance, male circumcision, disclosure, etc.



**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGOs, church, social services, counsellor, etc.) that will be able to assist them if they need more help or have more questions. Give out referral slips and refer participants to relevant service providers.**

# Exercise 5:

## Religion and Culture<sup>3</sup>

### PURPOSE

This exercise will promote understanding of religion and culture, and their associated traditions. Cultural differences can exist across generations and social groups. The exercise aims to help participants to understand harmful traditional practices that violate human rights and have negative influences on sexual and reproductive health. The exercise allows participants to focus on the specific practices in their area.

**Time Required: 20 minutes**



### METHOD

1. Ask each participant to consider a tradition about sexuality or reproduction that is important to a culture (a generation, religion, racial group, etc.) that they are a part of. Go all the way around the group with each participant saying a tradition that is part of their culture.
2. Tell participants some traditions can be good for people of a given culture.
3. Ask participants to identify traditions and cultural practices that are harmful, and those that are not. Participants should give reasons for their classifications. Tell participants that sometimes traditions can be harmful. Engage participants to talk about the harmful effects of such practices. (Examples include practices such as virgin pledging (*kuripa ngozi*) labia elongation - which is usually described as a form of female genital mutilation (FGM), child marriage, bethrothment (*kuzvarira*), wife (widow) inheritance; and beating up a wife as a way of disciplining her etc.).
4. Ask participants to discuss the roles family play (particularly aunties and uncles) in providing SRHR education and other positive traditional influences.

### FACILITATOR'S INFORMATION

Culture and tradition play a significant role in shaping the way people behave and lead their lives.

*"Culture is a way of life as practiced by a particular group of people. Culture can be defined by a particular place or part of the country or a specific age group or religion."*

For example, in certain areas boys have to undergo male circumcision at a certain age after birth.

*A tradition is a belief or behaviour passed down within a cultural group that has symbolic meaning or special significance with origins in the past.*

For example, some societies do not allow 'lobola' payments to be done in November.

**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGOs, church, ZRP-Victim Friendly Unit, social services, counsellor, etc.) that will be able to assist them if they need more help or have more questions. Give out referral slips and refer participants to relevant service providers.**

### OBJECTIVES

By the end of this exercise, participants should:

- ✓ Learn about beliefs, cultures and traditions and how they influence Sexual and Reproductive Health and Rights (SRHR).
- ✓ Be able to identify traditional practices in their community that are harmful and reasons.
- ✓ Explain ways of addressing harmful traditions and practices.
- ✓ Identify ways of reinforcing good traditions and practices
- ✓ Demonstrate commitment to preventing child and forced marriages and other harmful practices in their community.

<sup>3</sup> Adapted from UNFPA (2016) Comprehensive Sexuality Education Manual for Out of School Young People pages 389 - 406

# Exercise 6: Power Relations

## PURPOSE

Power is often seen in a one-dimensional setting. It is either perceived as being “good” or “bad” depending on the situation or perception of the individual. The exercise shows that power can be positive and negative, and that both types of power can evoke a range of emotions. The exercises also illustrate that power relations are evident in all aspects of our lives.

**Time Required: 15 minutes**



## Other Requirements

- Flipcharts and markers

## OBJECTIVES

By the end of the exercise the participants will be able to identify the emotions associated with power and how they affect us and identify the roles, activities and tasks of men and women in their communities. The participants will also be able to discuss the effect of these different roles, activities and tasks on relationships between men and women.

## METHOD

1. Ask individuals to identify the most powerful person they know personally. (Tell them they are not allowed to mention anyone famous unless they know them personally).
2. Get the participants to consider the following:
  - ➔ What do you admire about these people?
  - ➔ What do you fear about these people?
3. Divide the flip chart into two columns and write these qualities on the flip chart under the respective headings.
4. Divide the group into pairs.
5. Ask each pair to produce a still image, like a statue. The image will show one person in a position of power and the other in a powerless position. Allow them a few minutes to prepare their statue. Ask the participants to swap around (so that the powerful figure becomes the powerless and vice versa) and prepare a second statue.
6. When they have prepared both statues, give each pair the opportunity to show both of their statues to the rest of the group. Ask for quick comments about what participants observe. Ask both members of each statue to express what they are feeling in one word (proud, scared or humble).
7. Ask participants to discuss the following in pairs. Allow 10 minutes for discussion and allow participants to report back to the big group.
  - ➔ Which of the two positions felt more familiar to you?
  - ➔ Can you relate any of the emotions you felt to situations in your lives?
  - ➔ What did you feel for the powerless person when they were in the powerful position and vice versa.



Remember this: Ask the participants what they can do to change their own behaviour and encourage those in their family or community who may feel powerless.

### **FACILITATOR'S INFORMATION: DIFFERENT FORMS OF POWER**

Power is defined as “the ability or capacity to effectively communicate an idea, influence people and take action – and can be experienced individually or collectively”. Therefore, power entails use of resources, ideas, knowledge and tools to effectively influence people or situations.

Power can be categorised as follows: power over, power with, and power within.

**Power over:** entails the ability to control others, or to impose views, needs or desires over them or over a situation. Such power can be positive or negative, depending on how it is used.

**Power with:** entails power that is gained from working with others to claim our rights and to achieve collective goals. It refers to the power that we give each other when we cooperate, and when we use each other's different strengths, knowledge and ideas.

**Power within:** entails the individual skills and feelings of self-esteem, value and dignity that give someone the confidence to claim their own rights

**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGOs, ZRP-Victim Friendly Unit, social services, counsellor, etc.) that will be able to assist them if they need more help or have more questions. Give out referral slips and refer participants to relevant stakeholders.**

<sup>4</sup> Adapted from Plan International (2016) Living free from Gender-Based Violence. In *Girls Champions of Change: Curriculum for Gender Equality and Girls Rights*. Working, UK: Plan International pg.7

# Exercise 7:

## Human Reproduction and Hygiene

### Activity 7.1: Body Mapping

#### PURPOSE

In many settings, especially in families, people are reluctant to speak openly about parts of their body due to cultural reasons or other reasons such as modesty, fear or shame. Often, families also have their own names for various body parts. This activity ensures that all of the family members are aware of the names of the various body parts, and that all of the family members “talk the same language” when it comes to the names for these body parts. It is not essential that the participants use the correct names, but it is essential that they all agree to use the same names for the same body parts.

#### OBJECTIVES

This activity allows the group to use the language with which they feel most comfortable in describing their body and its functions. In doing so, the group learns about their own bodies and that of the other gender.

Time Required: 20 minutes



#### Other Requirements

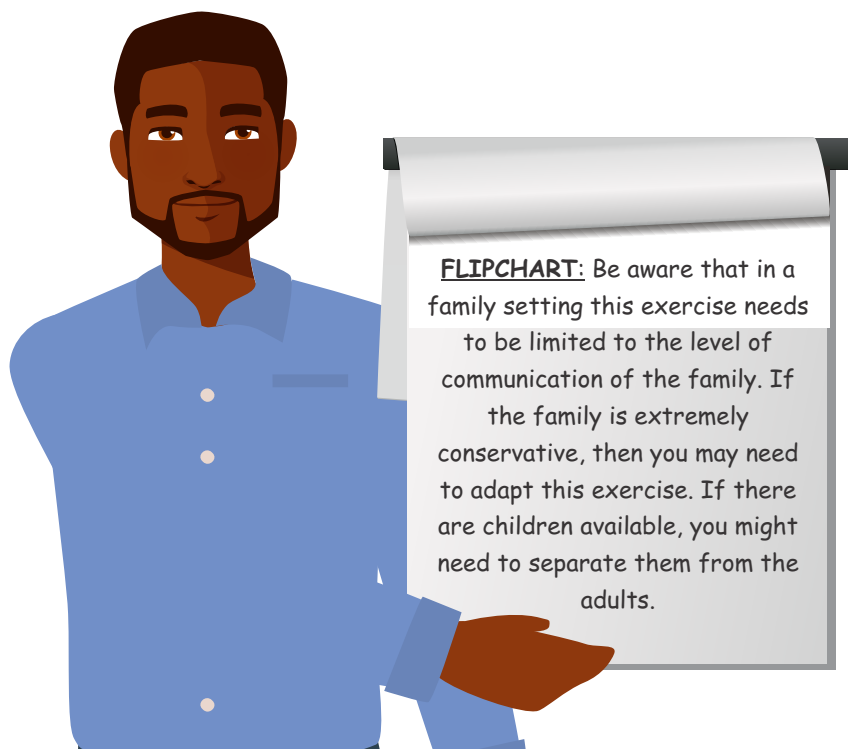
- Outline of a body
- Body mapping cards
- Paper for participants to write on

#### METHOD

1. Explain that you are going to share what you know about how your bodies work.
2. **If it is feasible, separate the participants into gender specific groups.**
3. Ensure that each group work with BOTH male and female cards (if you have not been provided with the body mapping cards you should make the cards using either empty boxes or hardcover from used counter books/exercise books).
4. Give the card containing the body outlines to the group.
5. Ask the participants to indicate, by shading in the parts of the body that are most often visible and the parts that are most often covered by clothes.
6. Explain, especially if there are younger participants, that because these areas are covered by clothes, these are areas that we generally don't talk about in public. We limit our conversation about these parts to people we trust, including our family members.
7. Ask participants to identify body parts they particularly like, then those which they dislike and to give reasons.
8. Ask the participants to draw or mention any body part that makes them feel uncomfortable or embarrassed.
9. Keep interacting with the participants and ask them to elaborate on answers from time to time.
10. Hand the body part cards to the groups.
11. Ask the participants to show where these body parts are located on the body outlines.
12. Ask the participants to describe the body parts on the cards using slang or everyday words or phrases. Encourage them to use any words or phrases they know, in any language. As these words are mentioned, write them on the flipchart. Once everyone has finished come together and read through the list carefully and slowly.
13. Ask the following questions:
  - a. Were you embarrassed to see, write or hear any of the slang words?
  - b. When do we use slang words and when do we use correct words? Why?
  - c. Do some of the words seem overly harsh or abusive?
  - d. What does it mean when people use them?
14. Did people forget phrases with a positive connotation? (Such as making love)? Why?
15. Explain that this is an exercise to get us more relaxed talking about such a topic.



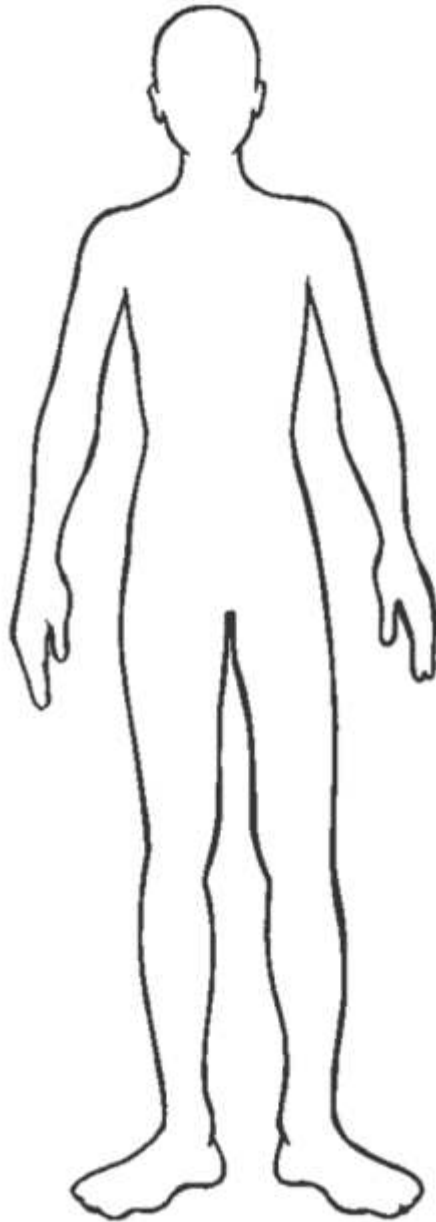
TIP: This session should enable the participants to decide on local names that are acceptable to use for the different body parts and an opportunity to mention, in discussion, body parts that are associated with sex with which the participants might otherwise have difficulty.



Remember this: Encourage your participants to speak openly in their family about these body parts, but emphasize that they must still speak about them with respect for their own bodies, the bodies of others, and with respect for their culture.



## Body Mapping Outline



Body mapping cards

Man	Woman
Penis	Vagina
Testicles	Breasts
Glans	Labia
Scrotum	Clitoris
Foreskin	Cervix

## Activity 7.2: Male and Female Reproductive Organs

### PURPOSE

Lessons in this activity focus on aspects of the human reproductive system. While these lessons are valuable, the information is often lost if participants have no context in which to place this information. This activity provides participants with that context by simply exposing them to the male and female reproductive systems in a fast and fun manner.

### OBJECTIVES

By the end of this activity, participants will know the parts that make up the human reproductive system.

**Time Required: 15 minutes**

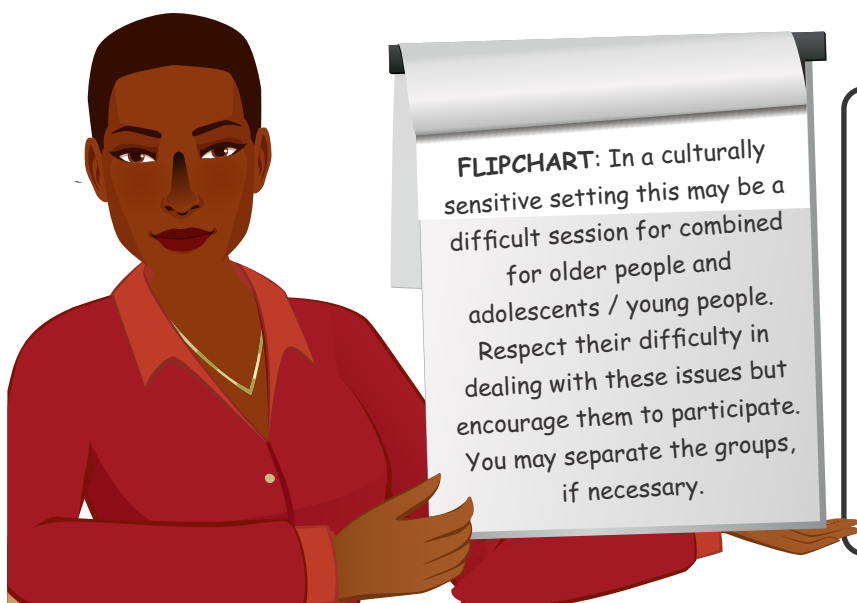


### Other Requirements

- Labelled Male and Female Reproductive Organs Posters

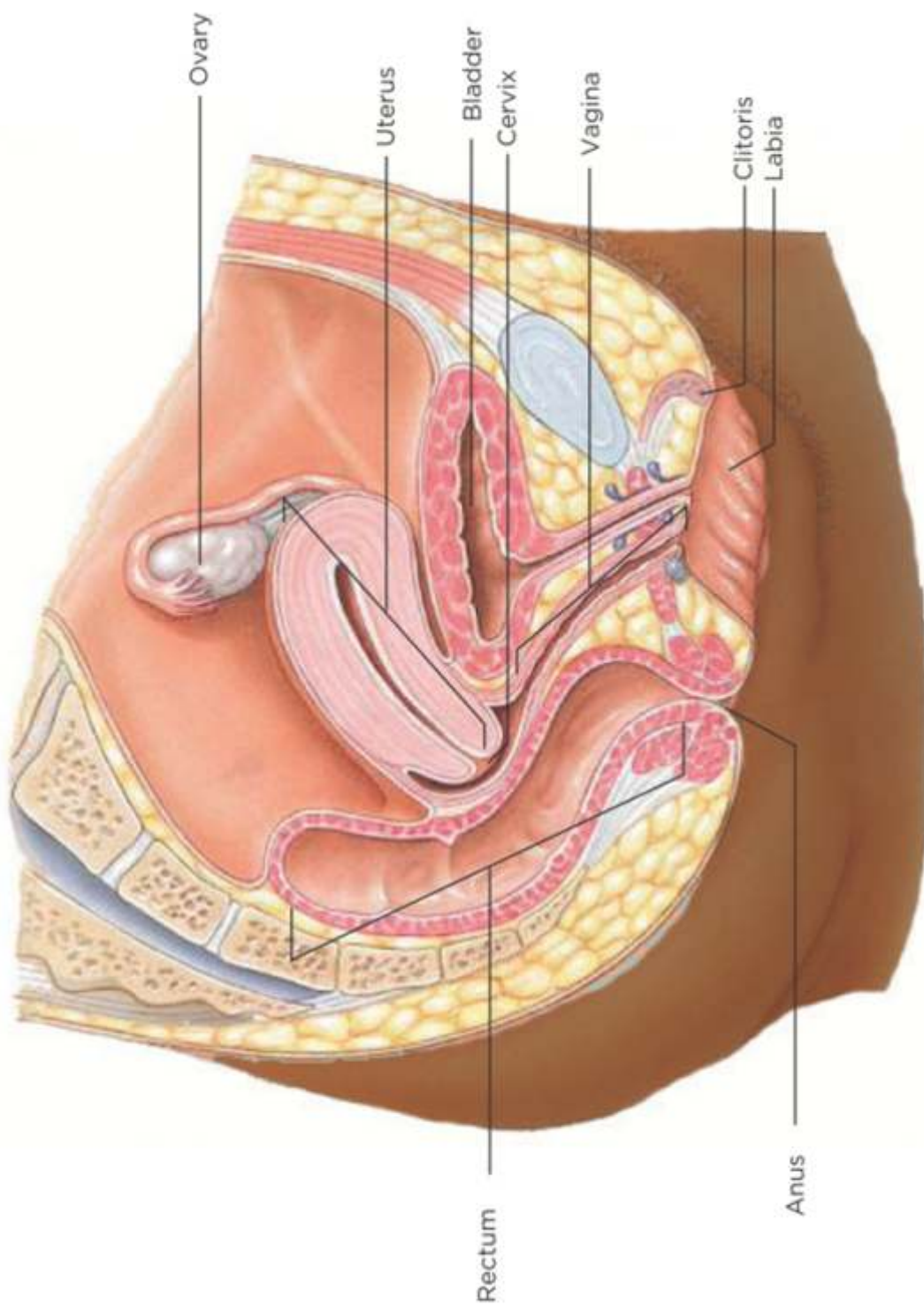
### METHOD AND PROCESSING

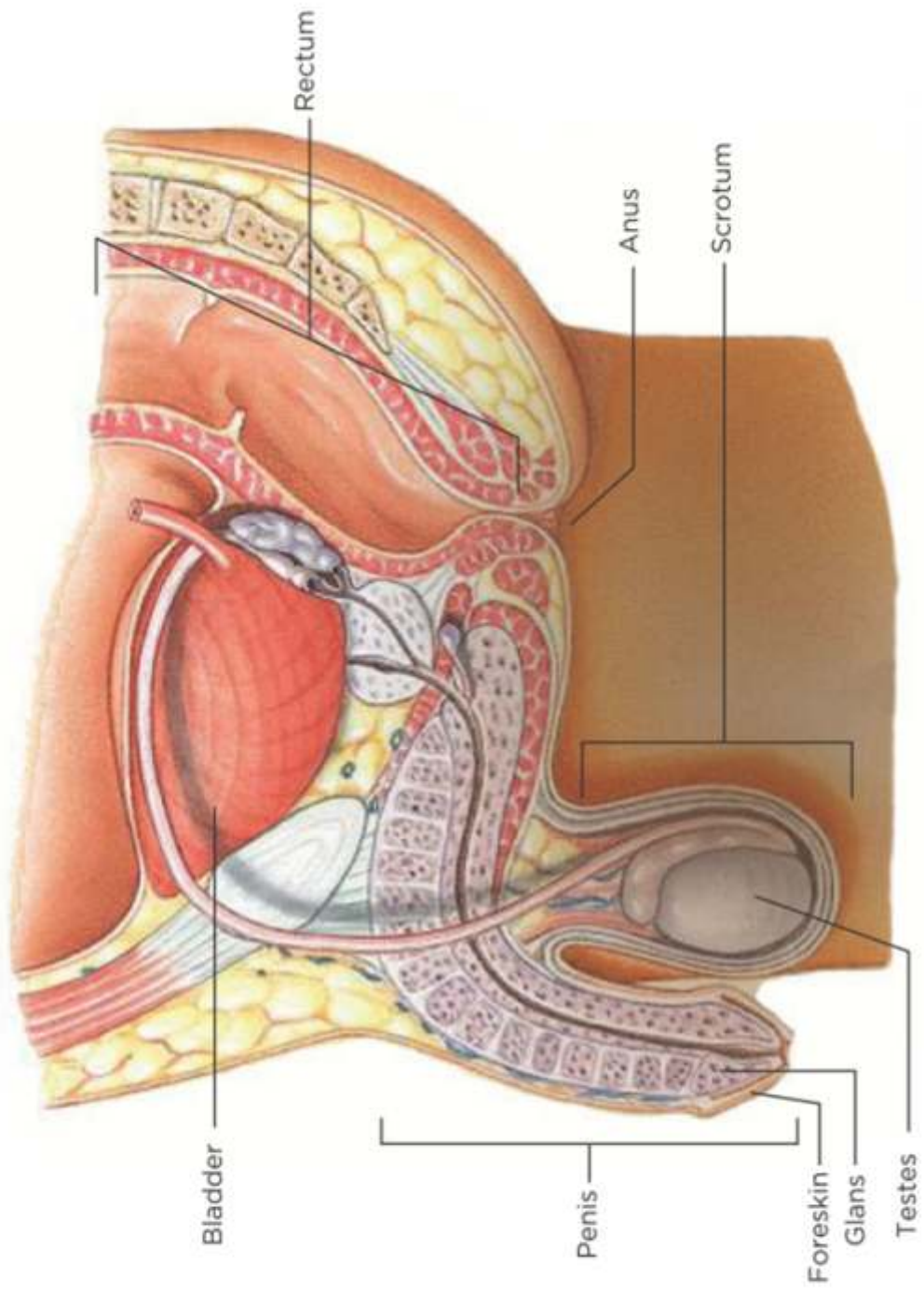
1. Show participants the pictures of male and female reproductive organs and ask the participants what the pictures represent. (Explain that these pictures are of the male and the female reproductive systems).
2. Ask participants to explain the purpose for the different parts of the male and female reproductive organs.
3. Take some time to explain the basics of human reproduction and ask if there are any questions.
4. Point out the ovaries and their purpose and the testes and their purpose. You can also use the posters to point out parts of the reproductive systems related to cervical cancer (cervix) and male circumcision (foreskin), and highlight the importance of personal hygiene (menstrual and penile hygiene) related to human reproduction system.
5. Ask boys / men what they know about menstruation, and what girls / women know about wet dreams and the implication of these processes in human reproduction. Use facilitator's information provided to guide the discussion and correct any misconceptions.
6. Pause often during this session to ask if there are questions.



Remember this: Remind the participants that men and women have different reproductive systems, and these differences should be respected whenever we speak about these body parts.

**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGOs, social services, counsellor, etc.) that will be able to assist them if they need more help or have more questions. Give out referral slips and refer participants to relevant stakeholders.**





## FACILITATOR'S INFORMATION

### Male and Female Reproductive Organs<sup>5</sup>

#### **The Female Reproductive Organs**

The female reproductive organs are those parts of the body that are directly involved in sexual exercise, pregnancy, and childbearing. They comprise of external parts, internal parts and also the breasts.

#### **External reproductive organs (Vulva)**

The vulva is the area surrounding the opening of the vagina, which can be seen from the outside. This consists of the clitoris, vagina opening, labia majora and labia minora.

#### **Internal reproductive organs**

These are organs of the female body that are located inside the lower part of the abdomen, called the pelvis, and are protected by bones and muscles. They consist of the vagina, the uterus (womb), two ovaries, and two fallopian tubes.

The ovaries are two small egg-shaped organs on either side of the uterus that store eggs and release one mature egg each month during a girl/ woman's reproductive years of life.

The fallopian tubes are two hollow-like structures that connect the ovaries to the uterus on either side. After the mature egg has been released from one of the ovaries, it travels down the fallopian tubes to the uterus.

The uterus (womb) is the muscular organ inside a woman's body where the baby grows. The cervix is sometimes called the opening/neck/mouth of the womb. It connects the uterus to the vagina and normally has a very small opening. This protects the uterus from infections.

#### **The Male Reproductive Organs**

The reproductive organs of the male are those parts that are directly involved in sexual exercise; they consist of the external and internal parts.

#### **External reproductive organs**

These are the male organs that are on the outside and can be seen or felt. They comprise the penis, the scrotum and the testes.

**The penis** - The penis is the organ that carries the semen with the sperm during the process of ejaculation. The head or tip of the penis is known as the glans and is the most sensitive part of the penis. The foreskin covers the head of the penis. Usually the penis produces a whitish creamy substance called smegma, which helps the foreskin to slide back smoothly. When smegma accumulates under the foreskin, it causes a bad smell or even infection. It has three functions; urination, sexual pleasure and reproduction.

**The scrotum** - It is a sac of skin containing the testes, found between the thighs. The scrotum protects the testes and helps regulate the temperature of the sperm.

**The testes (testicles)** - They are two sex glands that produce sperm and male hormones. The sperm fertilize the woman's egg to start the process of reproduction.

#### **Internal reproductive organs**

The internal male reproductive organs lie within the lower part of the abdomen called the pelvis that is protected by the bones and muscles (see figure above). They consist of the epididymis, the vas deferens, the seminal vesicles, the prostate, and the Cowper's gland.

<sup>5</sup> Adapted from The German Foundation for World Population (DSW) Ethiopia (2006) Youth 2 Youth Initiative for Sexual and Reproductive Health. Sexual and Reproductive Health Training Manual for Young People, pp37-50

**Prostate**

Situated below the bladder, the prostate produces fluid that makes up part of the semen; it helps create a good environment for the sperm in the penile urethra and vagina, aids movement of the sperm and provides nutrients for the sperm.

**Changes During Adolescence<sup>6</sup>**

Adolescence is the time in life when boys and girls transition from childhood to adulthood and it is characterised by physical, emotional (psychological) and social changes. Below is a table summarizing the changes an adolescent experience.

<sup>6</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People*, pg. 57-58



Developmental Stage	Early Adolescence (10 to 13 years old)	Middle Adolescence (14 to 16 years old)	Late Adolescence (17 to 19 years)
	<ul style="list-style-type: none"> <li>Transition to adolescence</li> <li>Characterized by puberty</li> </ul>	<ul style="list-style-type: none"> <li>Essence of adolescence</li> <li>Strong peer-group influence</li> </ul>	<ul style="list-style-type: none"> <li>Transition to adulthood</li> <li>Assumption of adult roles</li> </ul>
<b>Physical Changes</b>	<ul style="list-style-type: none"> <li>Breast budding</li> <li>First ovulation and menstruation</li> <li>Growth of pubic and underarm hair</li> <li>Change in body shape (Hips, thighs and bottom widen)</li> <li>Skin becomes oilier, may get pimples and acne</li> <li>Wet dreams</li> </ul>	<ul style="list-style-type: none"> <li>Adult breast size</li> <li>First ovulation and menstruation</li> <li>Growth of pubic and underarm hair</li> <li>Change in body shape (hips, thighs and bottom widen), fat tissue increases</li> <li>Skin becomes oilier, may get pimples and acne</li> </ul>	<ul style="list-style-type: none"> <li>Adult breast size</li> <li>Skin becomes oilier, may get pimples and acne</li> </ul>
Girls			
Boys	<ul style="list-style-type: none"> <li>Growth of scrotum and testes</li> <li>Change in voice and body (shoulders broaden and chest gets wider)</li> <li>Lengthening of the penis</li> <li>Growth of pubic, facial and underarm hair</li> <li>May have temporary breast growth</li> <li>First ejaculation, wet dreams</li> </ul>	<ul style="list-style-type: none"> <li>Growth of scrotum and testes</li> <li>Change in voice and body (shoulders broaden and chest gets wider)</li> <li>Lengthening of the penis</li> <li>Growth of pubic, facial and underarm hair</li> <li>Gain in muscular strength</li> </ul>	<ul style="list-style-type: none"> <li>Change in voice and body (shoulders broaden and chest gets wider)</li> <li>Lengthening of the penis</li> <li>Growth of pubic, facial and underarm hair</li> <li>Gain in muscular strength</li> </ul>
<b>Independence</b>	<ul style="list-style-type: none"> <li>Challenges authority, parents and other family members</li> <li>Rejects things of childhood</li> <li>Desires more privacy</li> </ul>	<ul style="list-style-type: none"> <li>Detaches from parents towards peers</li> <li>Begins to develop own value system</li> </ul>	<ul style="list-style-type: none"> <li>Is emancipated: begins to work or pursue higher education</li> <li>Enters adult life</li> <li>Reintegrates into family as emerging adult</li> </ul>
<b>Cognitive Development</b>	<ul style="list-style-type: none"> <li>Finds abstract thought difficult</li> <li>Seeks to make more decisions</li> <li>Has wide mood swings</li> </ul>	<ul style="list-style-type: none"> <li>Starts to develop abstract thought</li> <li>Begins to respond based on analysis and potential consequences</li> <li>Has feelings that contribute to behaviour but do not control it</li> </ul>	<ul style="list-style-type: none"> <li>Firmly establishes abstract thought</li> <li>Demonstrates improved problem solving</li> <li>Is better able to resolve conflicts</li> </ul>

<b>Peer Group</b>	<ul style="list-style-type: none"> <li>• Has intense friendships with members of the same sex</li> <li>• Possibly has contact with members of the opposite sex in groups</li> </ul>	<ul style="list-style-type: none"> <li>• Forms strong peer allegiances</li> <li>• Begins to explore ability to attract partners</li> </ul>	<ul style="list-style-type: none"> <li>• Is less influenced by peers regarding decisions and values than before</li> <li>• Relates to individuals more than to peer group</li> </ul>
<b>Body image</b>	<ul style="list-style-type: none"> <li>• Is preoccupied with physical changes</li> <li>• Is critical of appearance</li> <li>• Is anxious about menstruation, wet dreams, masturbation, breast or penis size</li> </ul>	<ul style="list-style-type: none"> <li>• Is less concerned about body image than before</li> <li>• Is more interested in looking attractive</li> </ul>	<ul style="list-style-type: none"> <li>• Is usually comfortable with body image</li> <li>• Accepts personal appearance</li> </ul>
<b>Sexuality</b>	<ul style="list-style-type: none"> <li>• Begins to feel attracted to others</li> <li>• May begin to masturbate</li> <li>• May experiment with sex play</li> <li>• Compares own physical development with that of peers</li> </ul>	<ul style="list-style-type: none"> <li>• Shows an increase in sexual interest</li> <li>• May struggle with sexual identity</li> <li>• May initiate sex</li> </ul>	<ul style="list-style-type: none"> <li>• Begins to develop serious intimate relationships that replace group relationships as primary relationships</li> </ul>



## Menstruation<sup>7</sup>

Menstruation is a woman's monthly shedding of the lining of the uterus, and often lasts about 3 to 5 days (average). Blood and tissue exits a woman's body through the cervix and vagina. Women's menstrual period vary; the flow may be light, moderate or heavy and can vary in length from about 2 to 7 days; and with age, the cycle usually shortens and becomes more regular. Some problems associated with periods include the following: amenorrhea (no period), dysmenorrhea (painful period), and abnormal bleeding.

Menstruation starts between the ages of 9 and 16 and women will continue to menstruate regularly, unless they become pregnant, or until menopause, which happens between the ages of 45 and 55.

Once a girl begins ovulating, she is capable of becoming pregnant. It is important for every woman to know her own cycle.

## Wet Dreams<sup>8</sup>

Many, but not all, boys and some men have wet dreams. A wet dream is when a boy or man has an orgasm and ejaculates while sleeping. They start after the boy begins to produce sperm during puberty. When a boy has a wet dream, he may wake up to find his genital area wet. Many boys feel embarrassed by this but it is a natural part of growing up. You cannot stop wet dreams, but boys and men who do not masturbate or have sex are more likely to have wet dreams.

NB: Having erections and wet dreams does not necessarily mean that the adolescent should engage in sex.

## Hygiene During Menstruation

The vagina keeps itself clean in many ways and menstruation is one of the key ways. Lack of information, misconceptions and adverse attitudes to menstruation may however lead to a negative self-image among girls who are experiencing menses for the first time, and can result in a lack of self-esteem as they develop their personality as women.<sup>9</sup> The culture of 'silence' around menstruation increases the perception of menstruation as something shameful that needs to be hidden, and may reinforce misunderstandings and negative attitudes toward it.<sup>10</sup>

Women can make use of a variety of ways to maintain good personal hygiene during their menstrual period. The following methods are some of the ways that can be used (The facilitator should show examples if they are available)

**Clean pieces of cloth:** These are cut to fit in the panty area by sewing several layers of cotton cloth on top of each other. These must be clean. They must be washed thoroughly and hung in a private but sunny place to dry. They should not be shared.

**Pads or sanitary napkins:** These are designed to fit the panty area close to the body. They have strips of tape that keep them attached to the panties, and the panties help to hold the pads close to the opening of the vagina. Pads have a plastic lining to minimize the spill of blood. If a woman uses pads, she needs to throw them down a pit latrine, bury them, or burn them after use. They should not be left in the garbage pile or flushed down the toilet.

<sup>7</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People* pg. 68-69

<sup>8</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People* pg. 62

<sup>9</sup> <http://unesdoc.unesco.org/images/0022/002267/226792e.pdf>

<sup>10</sup> *ibid*

**Tampons:** These are small, compressed cotton objects, formed into solid, tube-like shapes, which are pushed up into the vagina during menstruation. The cotton softens as it absorbs the blood that comes into the vagina from the uterus. Attached to the tampon is a strong, soft cotton string, which hangs out of the vagina. Pulling this string removes the tampon.

A girl must always wash her hands before and after inserting a tampon. Tampons need to be changed often; they can cause infection if left in. One should never leave a tampon in for more than eight hours.

**Note to facilitator:** Whatever a girl uses, she should change it frequently to avoid staining or odour. If a girl's panties or clothes get stained with blood, she can soak them in cool, mildly salty water. Hot water will cause the blood to set and remain as a permanent stain.<sup>11</sup>

# Exercise 8: Sexually Transmitted Infections (STIs)<sup>12</sup>

## PURPOSE

This exercise aims to raise awareness on how STIs are spread, signs and symptoms of STIs and how they can be prevented, and to discuss the effects and consequences of STIs. It also seeks to dispel the myths and misconceptions about STIs and to discuss proper channels to follow if one thinks he/she has an STI.

**Time Required: 30 minutes**



## Other Requirements

- Flipchart paper / Exercise book / Piece of paper
- Marker pens
- Tape and scissors

## OBJECTIVES

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

- ✓ Explain what an STI is and how STIs are transmitted.
- ✓ List the common types of STIs.
- ✓ List at least three signs or symptoms of an STI.
- ✓ Explain the challenges of couple communication regarding STI disclosure and treatment.
- ✓ Explain the link between untreated STIs and HIV.
- ✓ List at least one possible consequence of not getting treated when you have an STI.
- ✓ Describe what a person should do if they think they have an STI.

Find out where people can get tested and treated for STIs in your community (including their traditional practices) and identify any places that provide youth-friendly services.

## METHOD

1. Write 'STI' at the top of flipchart paper. Ask the participants: What does STI stand for and how do you get an STI? Write their responses on flipchart paper.  
*Explain that STIs are usually transmitted through unprotected sex, but some can be transmitted from skin to skin contact alone (e.g., herpes and genital warts (HPV)).*
2. Ask the group to brainstorm the following and list their responses on the flipchart paper:
  - a. STIs they know
  - b. Any other names for those infections (slang)*If any of the following are missing, add them: gonorrhoea; chlamydia; syphilis; herpes; genital warts or human papillomavirus; hepatitis B; pubic lice; and scabies.*
3. If someone discovers that they have an STI, who do you think they SHOULD tell first? Why?
4. Ask participants to think about the possible consequences of disclosing an STI infection to a partner. Have participants brainstorm on the gender dynamics related to STI disclosure and treatment among couples or sexual partners.  
*(Possible consequences of disclosure for women – GBV, rejection, abandonment / marriage breakdown, stigma and discrimination)*
5. Encourage participants to also think about the consequences of non-disclosure and discuss ways of increasing couple communication around STIs.
6. Make three signs marked 'True', 'False' and 'Don't Know' and post them in the room.

<sup>12</sup> Adapted from UNFPA (2016) Comprehensive Sexuality Education Manual for Out of School Young People pg. 268-269

7. Point out the signs labelled 'True', 'False' and 'Don't Know/Unsure' that you posted in the room. Explain that you are going to read a statement and the participants should tell you how they feel about each statement – if they think it is true, they will shout “True!”
8. Read the statements and give participants time to think, say out their answer and give reasons for their answer.

## **PROCESSING**

1. Give the correct answer and add to the explanations or information given by the participants as needed.  
*Use the Facilitator Answer Key: STIs – True or False below as a guide to the answers. Give the explanations and additional information as you go through the answers*
2. Go through the basic facts about STIs and emphasize the early detection and treatment of STIs. Remind participants that anyone can get an STI

## STIs – True or False

Statement	Answer	Explanation
You won't get an STI if you only have oral sex	False	STIs can be transmitted through oral sex. You can get gonorrhoea in your throat, for example. Herpes and syphilis can also be spread through oral sex.
Only people who have lots of sex partners get STIs	False	Anyone who has unprotected sexual intercourse can get an STI, even if you have only one partner.
You cannot get STIs from toilet seats.	True	The germs that cause STIs cannot live in the open air or outside the human body so you cannot get an STI from a toilet seat
Many STIs can be transmitted to babies during pregnancy or birth	True	Many STIs, including gonorrhoea, chlamydia, syphilis, herpes, HIV, and hepatitis B and C, can be passed to a baby during pregnancy or birth. Human papillomavirus (HPV) and chancroid are however not transmitted to babies during pregnancy or birth.
You can have an STI even if you do not have any signs or symptoms	True	In more than <b>half of all cases</b> , a person with an STI has no signs or symptoms that they notice. Because many people do not have signs or symptoms that are noticeable, just looking at their genitals will not tell you if they have an STI or not. However, some people will have signs of STIs that you can see, like sores or warts
Some common signs of STIs on or around the genitals are unusual sores or lumps, itching, pain, pain when urinating, bad smells, and/or an unusual discharge	True	These are the most common signs of having an STI
Women have more noticeable signs and symptoms of STIs than men	False	Women are more likely not to have any noticeable signs or symptoms than men. They may have signs that are inside the vagina or they may have no signs at all
STIs caused by viruses cannot be cured	True	STIs caused by viruses (herpes, genital warts (HPV), hepatitis B and HIV have no cure (however they can be treated/managed). Those caused by bacteria (gonorrhoea, chlamydia, and syphilis) or by parasites (pubic lice and scabies) can be cured.
Passing urine after sex protects you from STIs	False	During sex, the bacteria and viruses that cause STIs enter the body very quickly. Urinating does not eliminate them but can help protect women from urinary tract infections
If you have an STI, you are at greater risk of getting HIV and of spreading HIV to your partners	True	If you have an STI, the skin or mucous membranes of your genitals may have a sore or be inflamed, making it easier for HIV to enter the body. The risk increases if STIs are not treated for a long time. If you have an STI and HIV, it is also more likely that you will transmit the virus when you have sex. In addition, having an STI is a sign that you are not using condoms correctly every time you have sex
STIs cannot lead to cancer	False	Some STIs can lead to cancer. Some types of genital warts (HPV) lead to cervical cancer. Hepatitis B can lead to liver cancer. STIs which are not treated for a long time also increases risks of cancers such as cervical cancer and cancer of the penis
STIs that are not treated can result in problems getting pregnant	True	Untreated STIs can cause infections in the upper reproductive tract of both men and women

## Basic Facts About STIs<sup>13</sup>

**How STIs are spread:** STIs are spread mostly through unprotected vaginal or anal sex. Some can be spread through oral sex, like herpes, genital warts and gonorrhoea. Some STIs, like herpes and genital warts (HPV), can be spread through skin-to-skin contact of the genitals. Some STIs, like gonorrhoea, chlamydia, syphilis, herpes, HIV, and hepatitis B and C, can be passed to a baby during pregnancy or birth. STIs are passed more easily from men to women than the reverse (because of a woman's anatomy).

**Types of STIs:** STIs are caused by bacteria, viruses and parasites. The most common STIs caused by bacteria are: gonorrhoea, chlamydia, chancroid and syphilis. They can be cured. The most common STIs caused by viruses are: human papillomavirus (HPV) or genital warts, herpes, hepatitis B and C, and HIV. They cannot be cured, but most can be treated. The most common STIs caused by parasites are: trichomoniasis, scabies and pubic lice. They can be cured.

**Signs and symptoms of STIs:** In more than half of all cases, STIs do not have any noticeable signs or symptoms. The most common signs and symptoms of STIs are on or around the genitals area: soreness, unusual sores or lumps, itching, pain, pain when urinating, bad smells, and/or an unusual discharge. Women have fewer noticeable signs and symptoms than men, this is because women's reproductive organs are largely internal (inside their body). Because STIs often don't have signs and symptoms, many people are not aware that they have one. So if you have had unprotected sex, you could have an STI and not know it.

**STIs and HIV:** STIs that cause sores (like chancroid, syphilis and herpes) or inflamed or irritated skin make it easier for HIV to be transmitted. When a person has HIV and an STI, they are more likely to pass the virus to their sexual partners.

**Consequences of untreated STIs:** Having an STI can be irritating, uncomfortable and very embarrassing. Because of shame and embarrassment, some people do not seek testing and treatment and hope the STI will go away on its own. This can lead to serious problems. When STIs are not treated early, they may cause problems like serious infection of the reproductive system (PID - pelvic inflammatory disease in women, inflammation of the testicles in men), infertility, cervical cancer (from HPV), liver cancer (from hepatitis B and C), serious damage to the nervous and cardiovascular system (from syphilis) and even death (from syphilis and HIV and AIDS).

**Preventing STIs:** Abstinence or not having sex is an effective way to avoid getting an STI. For those who are having sex, using male or female condoms correctly and consistently is an effective way of reducing the likelihood of getting an STI. There is also a vaccine for hepatitis B.

**If you think you may have an STI:** Do the following:

1. Go for testing and treatment as soon as you think something is wrong or you notice something that is not right or normal with your body.
2. Tell anyone with whom you have had unprotected sexual intercourse. Both of you must be treated to avoid re-infection.
3. Take all of the medicine given to you by the doctor, even if you feel better. You can start to feel better before the infection is completely gone. Go back for a check-up to make sure the infection is gone, even if you feel better.
4. Traditional medicine is usually not effective in treating STIs.
5. Avoid sex or use a condom each time you have sexual intercourse until you are cured. After you are cured, continue to use condoms to protect yourself from getting another STI.
6. If you get an STI, always tell your sex partners about the infection before you have sex with them and always use condoms. It is illegal to knowingly infect your sex partner with HIV or an STI.

<sup>13</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People* pg. 273-274

Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGOs, church, ZRP-Victim Friendly Unit, social services, counsellor, etc.) that will be able to assist them if they need more help or have more questions. Give out referral slips and refer participants to relevant service providers.

# Exercise 9: HIV and AIDS

This exercise ensures that participants have correct information regarding HIV transmission and prevention.

## Activity 9.1: HIV Transmission

### PURPOSE

This activity seeks to give participants correct information regarding the transmission of HIV. cards can be adapted to include local myths and rumours as they are generated. The important part is to ensure that the explanations given are correct. If the explanations are correct then the foundational understanding of the participants is sound. Participants will be able to dispel myths and rumours as they become more comfortable with the facts about HIV and STIs.

### OBJECTIVES

By the end of this activity participants will be able to:

- ✓ Demonstrate an understanding of the modes of HIV and transmission and how HIV is not transmitted.
- ✓ Understand the difference between HIV and AIDS
- ✓ Distinguish between what is true and false regarding HIV transmission.

Time Required: 40 minutes



### Other requirements

- Body fluids chart

### METHOD

1. Ask the group to mention all the bodily fluids they can think of. Tell them to use the words that they use in everyday speech.
2. Write these down on the flip chart as they mention them.
3. Explain that HIV is transmitted through the exchange of bodily fluids but that not ALL of the bodily fluids are infected with the virus.
4. Highlight the fluids on the flipchart that can transmit HIV by circling them or underlining them.
5. Explain that you are going to read a story to the group and that they must stop you whenever they hear you mention or refer to ANY bodily fluid.
6. Even if you don't say the word directly but a bodily fluid is referred to they should raise their hands.
7. Read the story about Ropa aloud to the group. Be sure to read slowly.
8. Ask volunteers to come forward and place a mark next to the fluids you mention in the story.

### PROCESSING

1. Read the Basics of HIV Transmission before running this session. We don't know if Ropa is HIV+.
2. Break the group into smaller discussion groups and ask the groups to decide whether Ropa is HIV+.
3. Introduce the Three Step Process to the group and explain the process
4. There are three steps to determining if a person could have been infected with HIV.
  - a. The virus mostly comes from the body of someone who is HIV+.
  - b. The virus must be in a bodily fluid that is infectious.
  - c. There must be an opportunity for the virus to enter the other person (sex, open wound, cut or scrape, etc.)
5. Go through the basics of HIV transmission (See Facilitator's Information).
6. If you are not sure if the virus was present, then there is a risk that HIV could have been transmitted.
7. Then ask them to decide that IF Ropa is positive, and when could she have been infected.
8. Go through the progression of HIV to AIDS for participants to understand the difference between HIV and AIDS.



### **Ropa's story – Transmission of HIV**

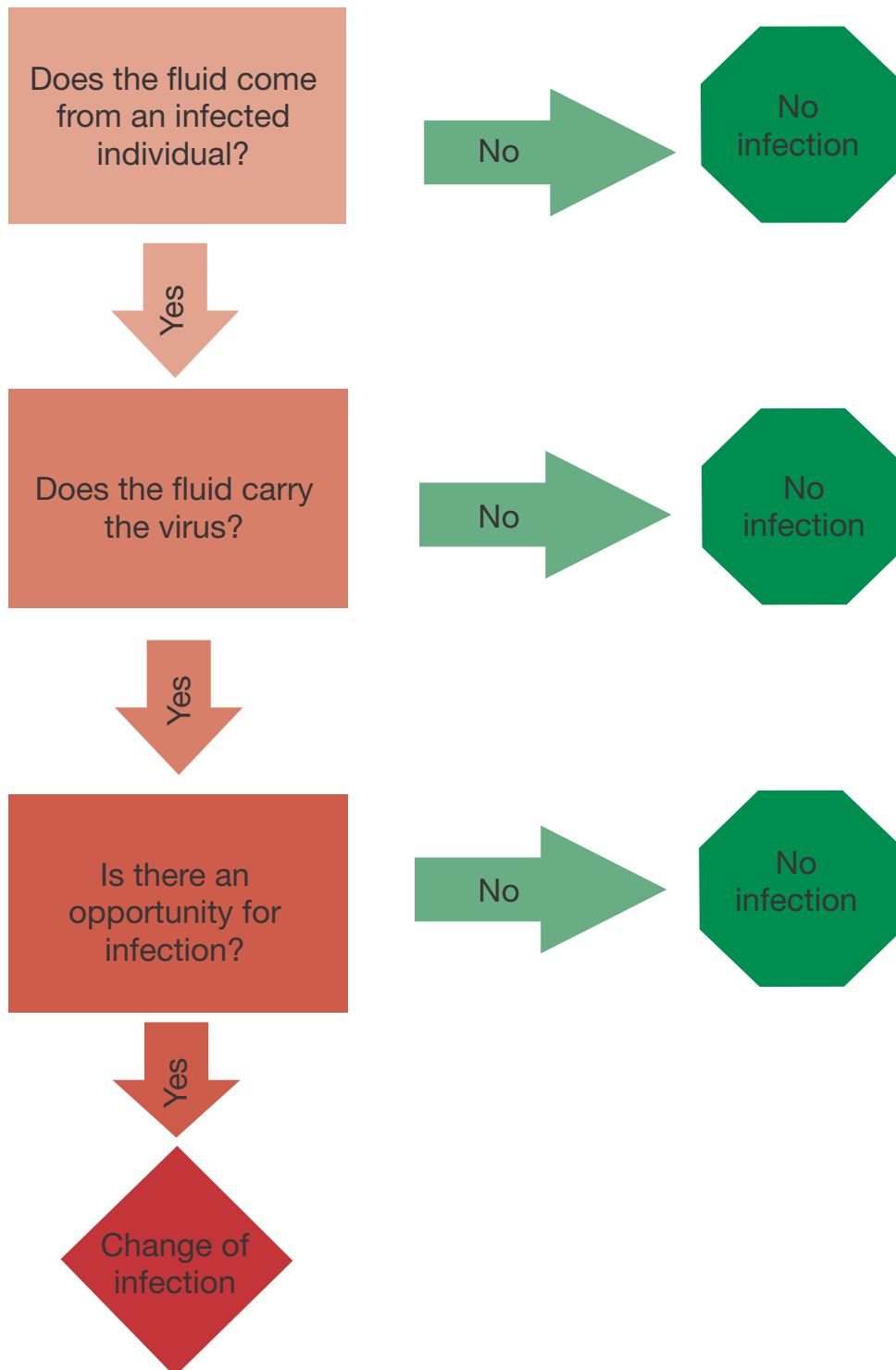
Ropa was 26 years old. She had been born and brought up in Mutare, but because there was no work in the area she moved to Harare to look for work. She had a four-year-old daughter that she left at home with her family as she was not sure she would be able to look after her in Harare.

When she arrived she had stayed with her aunt at first, she was thankful for the roof over her head and often helped out in the house, cooking and cleaning and sometimes preparing the vegetables for meals. Sometimes when she did this, she cut her fingers with the knife. But the house was crowded and her aunt's boyfriend made her feel uncomfortable. At one point in time he cornered her in the bedroom and forced her to perform oral sex on him. She knew that she would have to find a place to stay on her own, soon.

Ropa had an active social life as well and was very attractive. She liked to dance and enjoy herself with friends on the weekends. She often drank out of the glasses of her dancing partners or shared her drink with them and as they were all friends they often shared one another's food. She did not sleep with any of the friends as she had a boyfriend in Chegutu who she visited once a month. But it was difficult being alone, and she often flirted with her male friends. One of her friends offered to let her come and share his house, if she was willing to "return the favour". She thought about this for a long time, and decided that it would be best. The friend's house was also closer to work, so she could save money. She moved into the house and into her friend's bed as well. She broke up with her boyfriend at the same time because she never had sex with another person while she was "going steady" with someone.

One holiday Ropa was on her way home to Mutare when the taxi had an accident. She was thrown from the taxi and was cut badly on her leg and head. One of the other passengers tried to help her by bandaging up her leg, but he struggled as his arm was also badly cut.

A few weeks later Ropa had a fever, diarrhoea and a headache. She felt like she had flu, and decided to go to hospital. The sister asked if she wanted to be tested for HIV and she explained that she had been tested a year ago and the result was negative – so she couldn't have HIV.



# Bodily Fluids

## Infectious

Contains infectious amounts of HIV

Vaginal Fluids

Blood

Breast Milk

Pre-ejaculation  
and Semen

## Non-Infectious

Contains little or no HIV

Saliva is not  
considered  
infectious - only if it  
contains blood

Urine and Tears.  
Traces of HIV have  
been found in these fluids  
but not enough to be  
regarded as infectious.

Sweat, faeces and vomit. HIV has not been  
found in these, but they would be considered  
infectious if they contained blood. But, you can  
become infected with other disease through  
inappropriate handling of faeces.

## **FACILITATOR'S INFORMATION: Transmission of HIV**

**HIV** stands for human immunodeficiency virus. HIV is a virus that lives in humans and attacks the immune system.

**AIDS** is acquired immune deficiency syndrome. AIDS is caused by HIV. A person is diagnosed with AIDS when his or her immune system is so damaged by HIV that it is too weak to fight off infections.

### **Transmission of HIV:**

The ways that HIV can be transmitted are:

1. Through unprotected sex with someone who has HIV (vaginal, oral or anal sexual intercourse);
2. From an HIV-positive woman to her baby during pregnancy, birth or breastfeeding; and
3. Exchange of blood or blood-contaminated bodily fluids with someone who has HIV (usually from a used needle or something sharp, like a razor).

You **cannot** get HIV from mosquitoes, curses, witchcraft or living or working with someone who has HIV. Mosquitoes do not transmit HIV because HIV does not survive inside a mosquito (it is digested); and mosquitoes take blood from a person when they bite them, but they **do not** inject blood into the person they bite. So, there is no exchange of blood.

The five body fluids that can transmit HIV are:

1. Semen
2. Pre-ejaculate or pre-cum (the fluid that comes out of the penis when a man has an erection before he ejaculates)
3. Vaginal fluids
4. Blood
5. Breast milk

There is a risk of HIV being transmitted any time these fluids are exchanged between two people. For example, if there is an exchange of semen or vaginal fluids (with someone who is HIV-positive) during sexual intercourse without a condom, or an exchange of blood (with someone who has HIV) from sharing needles or other sharp instruments that have fresh blood on them. A person with a sexually transmitted infection (STI) can get infected with HIV more easily because STIs can cause sores and irritations of the skin that allow HIV to enter the body more easily. STIs also make it more likely that they will pass HIV on to their partners. Therefore, it is important for anyone with an STI and their partners to get treated.

Anyone who exchanges these body fluids can get HIV, whether they are in a high-risk group or not. There is still no cure or vaccine for HIV. There is, however, antiretroviral medicines that enable people with HIV to live long, healthy lives. Although antiretroviral therapy (ART) reduce the amount of HIV in the body fluids and therefore make it less likely that the person will transmit HIV, it does not eliminate the risk completely. So a person taking medicine for HIV can still transmit HIV.

### **Protection from HIV**

**Not having sex at all** (abstinence) prevents the sexual transmission of HIV. If you don't have sexual intercourse, semen, pre-ejaculate and vaginal fluids cannot be exchanged. However, the person may still get HIV from sharing needles or sharp, bloody instruments with a person who is infected.

**Condoms are effective** protection when they are used correctly and consistently when you have sex since they prevent the transmission of semen and vaginal fluids. However, apart from abstinence, no protective method is 100% effective.

Having **only your regular partner** prevents the sexual transmission of HIV **ONLY IF** that partner does not have HIV already and also has no other sex partners. You cannot be completely certain that another person does not have other partners. Many people have more than one sex partner and do not tell their other partners. Having only one partner does reduce the risk of getting HIV.

**Voluntary Medical Male Circumcision** reduces the man's risk of getting infected by 60%. Circumcised men are still encouraged to practice safer sexual practices – abstinence, correct and consistent use of condoms, being faithful to one partner, etc. **A man who is circumcised** can still get HIV if not practicing safer sex.

To protect yourself from getting HIV from blood:

- Do not share needles for injecting drugs;
- Do not get body piercings, tattoos, or get cut or pricked with needles, razors, or other sharp objects that have been used and not sterilized;
- Avoid direct contact with blood by using gloves or plastic bags.

How to know if a person is HIV-positive

It is impossible to know if a person has HIV by the way they look. Many people who are infected with HIV do not know that they are infected because they feel and look healthy. Many live for years without developing signs or symptoms of HIV infection. The only way for a person to know if they have HIV is to have an HIV test.

Encourage individuals and families to know their status by going for HIV Testing Services as a couple, as individuals or through use of HIV self-testing kits.

## Activity 9.2: Dispelling HIV and AIDS Myths and Misconceptions

### PURPOSE

This activity ensures that participants have correct information regarding HIV transmission and prevention. The cards can be adapted to include local myths and rumours as they are generated. The most important part of this activity is to ensure that the explanations given are correct. If the explanations are correct then the foundational understanding of the participants is sound. As participants become more comfortable with the facts about HIV and STIs, they will be able to dispel myths and rumours.

### OBJECTIVES

At the end of this activity participants will be able to distinguish between what is true and false regarding HIV transmission.

**Time Required: 20 minutes**



### Other Requirements

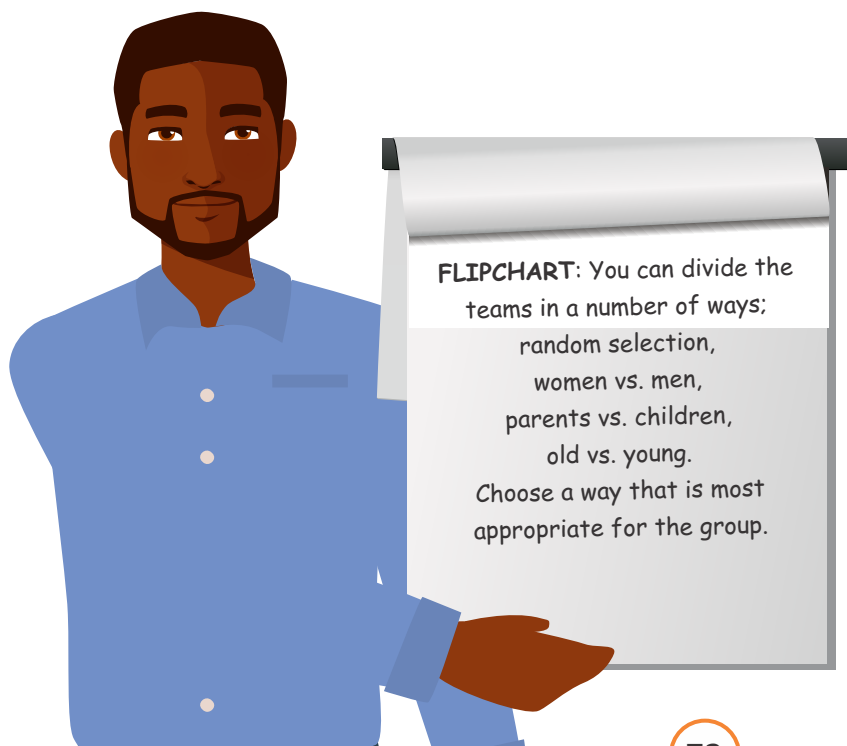
- MYTH and FACT cards
- Game cards
- Flipchart to keep score

### METHOD

1. Stick the two sets of MYTH and FACT cards on a wall or place them far apart on the table.
2. Explain that a myth is a story that is not true. There are many untrue stories about HIV and AIDS. Sometimes when people are scared, they believe stories that are not true. One should know the truth about HIV and AIDS so that one can protect oneself from infection. Facts are things that are true.
3. Divide the participants into two teams and tell them they are going to compete against each other.
4. Read out the statements and ask the participants to write their answer on a piece of paper for each statement, that is whether the statement is a MYTH or a FACT.
5. Award each team 2 points for each correct answer. Award each team 1 point for each incorrectly placed card.
6. The winning team is the team with the most points.

### PROCESSING

If there are any incorrectly answered statements, choose some of these and discuss why they are not correct. If they are myths, work with the participants to explain why they contain incorrect information. If all of the statements are correctly answered, then ask some of the participants to explain why some of the myths are myths. It is important that the reasoning here is fully understood.



Remember this: Remind participants that when it comes to HIV there are many rumours and myths. They should only speak the truth about these things, and if they are not sure about the facts, then they should find out from a reliable source, like the clinic.

Statement	Myth/Fact
You cannot get AIDS if you use the same toilet as someone who is HIV+	Fact
You cannot get AIDS by visiting someone who is HIV+	Fact
You can get AIDS if a mosquito bites you	Myth
HIV is passed on from one human to another human	Fact
You can get AIDS if you eat beetroot prepared by someone who is HIV+	Myth
The African potato can cure AIDS	Myth
You can get AIDS if you are a bad person	Myth
When people donate blood they get AIDS	Myth
If I am HIV+ I have got AIDS	Myth
You cannot get AIDS if you eat from the same plate as somebody who is HIV+	Fact
Bad people who wanted to hurt other people made HIV	Myth
If I get an injection I will get AIDS	Myth
I cannot protect myself against HIV	Myth
Only skinny people have AIDS	Myth
You can get AIDS if you eat an orange that has been injected with HIV	Myth
A mother can give her baby HIV	Fact
HIV only passes through broken skin	Myth
AIDS is caused by witchcraft	Myth
If you eat at a restaurant and the cook is HIV+ you cannot be infected by food he/she prepared	Fact
Only teenagers get AIDS	Myth
I can get AIDS if I live with somebody that has AIDS	Myth
You can see if a person has HIV	Myth
Only people with AIDS eat sadza made from sorghum mealie meal (“amabele” in Ndebele and “zviyo” in Shona)	Myth
I cannot get AIDS if I work with somebody who has AIDS	Fact
HIV can live outside the human body for a day or longer	Myth
If I am HIV+ I cannot do anything to stay healthy	Myth
If I have sores in my mouth I have got AIDS	Myth
If you have TB you also have HIV	Myth
TB in people living with HIV can be cured	Fact

## Activity 9.3: High and Low Risk Behaviours

### PURPOSE

People do not often regard themselves as risk takers, and as a result tend to see their own activities and behaviours as “safe”. The activity illustrates that some behaviours and activities are higher risk than others, allowing each individual to assess their own behaviour without disclosing this to others.

### OBJECTIVES

By the end of the activity participants will be able to identify types of behaviours that are “low risk” or “high risk”.

**Time Required: 15 minutes**



### Other Requirements

- Distinctly big cards
- Distinctly small cards
- Various behaviours describing situations where transmission may or may not take place

### Setting

Enough space for participants to move around freely. If necessary, move this exercise outside.

### METHOD

1. Place the Big Card and the Small Card at opposite ends of the room and tell participants that the Big Card signifies Higher Risk and the Small Card signifies Lower Risk.
2. Create a “safe area” near the door called “Not Sure”.
3. Explain that you will read out a situation and ask the participants to decide if this is a high risk or a low risk activity for transmitting HIV.
4. Ask individual participants to explain why they choose to stand in a certain area.

### PROCESSING

The point of the exercise is to allow people to see that low risk behaviour for one person, may be high-risk behaviour for another. Each individual has to take the responsibility for his or her own actions and decisions.

Ask: What can you do to lower your risk of exposure or risk of transmission?





## High/Low Risk Assessment

Behaviour	High/Low risk
Use the same bath, toilet or shower	LOW
Having sex without a condom	HIGH
Having sex with my long term partner	LOW/HIGH
Sitting next to a PLWHA	LOW
Having oral sex without a condom	LOW
Eating from the same plate	LOW
Breastfeeding by an HIV positive mother who is not on ART	HIGH
An HIV positive mother who is not on ART treatment can infect her baby during child birth	HIGH
Engaging in mutual masturbation	LOW
Having anal sex without a condom	HIGH
Getting a blood transfusion	LOW
Having unprotected sex with a prostitute	HIGH
Having sex with an STI infected person	HIGH
Being bitten by an insect	LOW

**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGOs, church, social services, counsellor, etc.) that will be able to assist them if they need more help or have more questions. Give out referral slips and refer household members to relevant service providers**

# Exercise 10: Gender Norms and HIV Transmission

## PURPOSE

As a facilitator, you know that men and women are not equal when it comes to susceptibility to contracting HIV and other STIs, to gender based violence as well as other reproductive health problems. The exercise seeks to increase participants' awareness of the same facts, and some of the reasons for that. Although many of the reasons are steeped in the unequal socio-economic status of women in society, some of the reasons are also biological. This exercise explores some of these reasons.

**Time Required: 30 minutes**



## Other Requirements

- A cup
- A bucket
- Two small balls, bean bags or pieces of newspaper rolled into a ball
- Male and Female reproductive organ posters

*(a cup, a bucket and bean bags or pieces of paper rolled into a ball can be sourced locally)*

## OBJECTIVES

By the end of the activity, participants will understand why women are more susceptible to contracting HIV.

## METHOD

1. Place the cup and the bucket on the far side of the room.
2. Draw a line on the floor half way across the room and separate the participants into two teams.
3. Tell each team to stand behind the line and to take turns to throw the ball into their "goal". The first team to score five goals, wins.
4. Explain that one team has a bucket as a goal and one team has a cup. Do not accept any comments or complaints from the team that has been allocated the cup as a goal.
5. Order the teams to start. Cheer both teams as they try to score goals. Congratulate the team that is the first to score five goals

## PROCESSING

1. Ask the participants to sit down.
2. Ask whether they thought the game was fair or not. Now listen to the complaints from the team that had a cup as a goal.
3. Ask why this made it difficult for the one team to score a goal.
4. Point out that when it comes to HIV infection, things are not fair between men and women either.
5. Show on the posters that the area of a vagina and the area of the penis that are exposed during sexual intercourse are very different in size.
6. The area of the vagina is about the size of your hand.
7. The area of the penis is about half the size of your little finger
8. Explain that when it comes to HIV infection, the area where HIV could gain entry is larger in a woman's body than in a man's.
9. As a result, women are more likely to be infected with HIV than men.
10. Point out that women are also more at risk than men because the semen which contains the virus, stays in the vagina for a longer period of time than the penis.

*This means that the vaginal tissue is more exposed to potential infection than the penile tissue.*

11. Ask the men present, if they consider it part of their cultural character to protect women.
  12. Point out that one of the ways they can protect women is by being aware of their own HIV status, using a condom when having sex and being circumcised.
  13. Participants should discuss other factors within the community that make women more susceptible to HIV than men. Use the points below to guide the discussion.
- ➔ Women, especially young women and girls, are 2-4 times more susceptible to HIV infection because they have a larger exposed mucosal area and, in young girls, an immature mucosal surface that is more liable to tearing.
  - ➔ Cultural and traditional practices, particularly harmful practices such as wife inheritance, widow cleansing (funeral rites that require the widow to sleep with a male in-law), polygamy, child marriage, rites of passage (virginity testing and traditional male circumcision) increase vulnerability to HIV infection.
  - ➔ When girls and women are kept ignorant of sexual matters, they are less empowered and therefore unable to protect themselves.
  - ➔ Gender violence, which is prevalent in our societies, increases the risks of HIV infection among women and girls.
  - ➔ Myths about sleeping with virgins as a cure for HIV and AIDS expose girls and young women to HIV infection.
  - ➔ Cultures that subordinate women to men increase women's vulnerability since the women do not have control over their sexuality, do not make decisions on when and how to have sex, and ultimately lack the opportunity to negotiate safe sex.
  - ➔ For HIV-positive women, childbirth increases the risk of fast progression to AIDS and opportunistic infections without treatment.
  - ➔ Poverty and the economic dependence of women on men increase risky behaviour by women, e.g. prostitution. Increased poverty and lack of decision-making about economic resources reduces women's ability to access medical remedies.

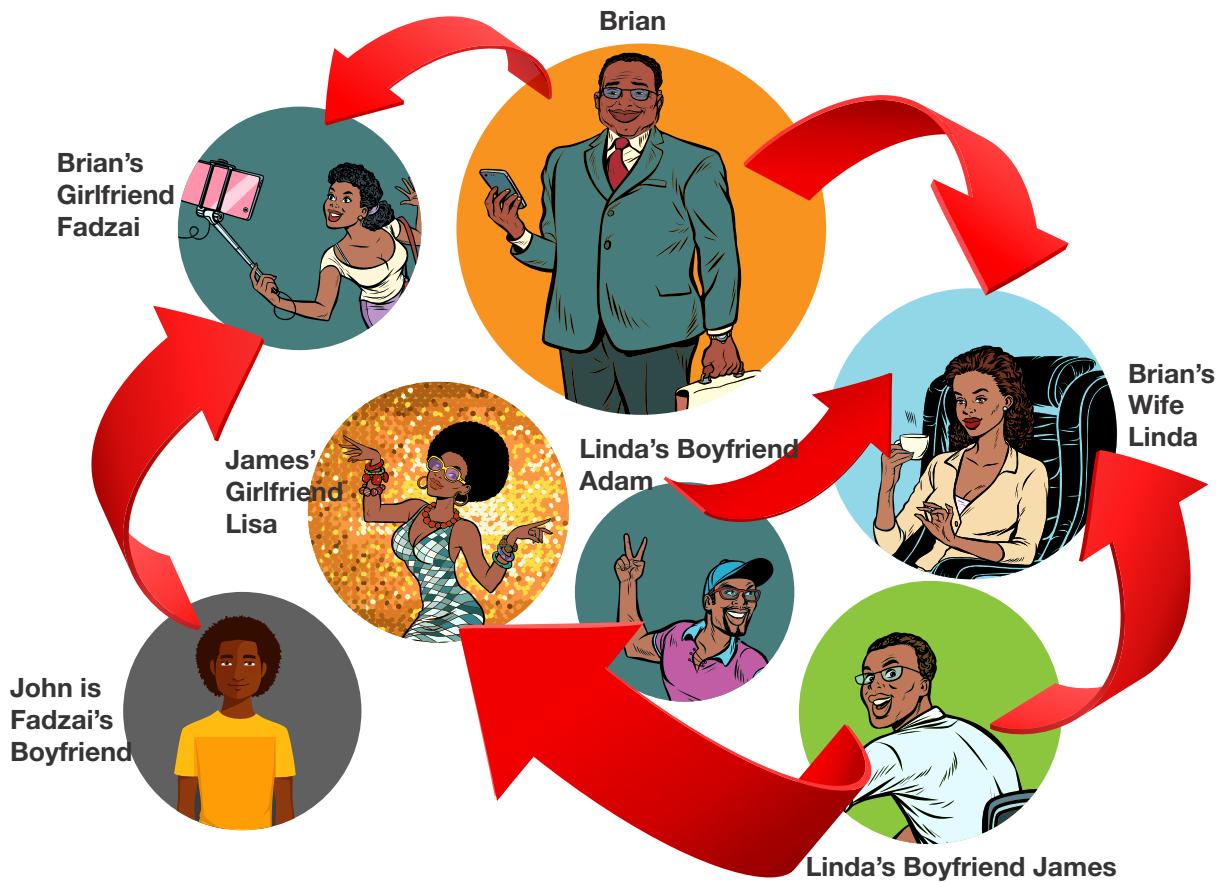


Remember this: Remind the female participants that they are more susceptible to contracting HIV and other STIs than men. Remind the men, that they have a role to play in preventing the transmission of HIV and STIs and should act in a responsible fashion.

**Remember to offer the participants the name and contact details of the nearest relevant organisation, counsellor or health care worker if they need to further discuss issues surrounding gender norms and HIV transmission.**

**Give out referral slips to the household members where they are needed.**

# Exercise 11: Sexual Networks



## PURPOSE

This exercise explains how multiple concurrent partners and sexual networks aid the spread of STIs and HIV.

## OBJECTIVE

By the end of the exercise, participants will understand:

- The role played by sexual networks in the spread of HIV
- How sexual networks combine with one another

Time Required: 30 minutes



## Other Requirements

- Two balls of wool of different colours
- Name cards
- Story of Peter's sexual network
- Story of Sibongile's sexual network

## METHOD

1. Hand out the name cards to the volunteers (you should be able to make your own cards from either empty boxes or hardcover from used counter books/exercise books, if you have not been provided with cards to use for this exercise).
2. Explain that you are going to read a story. As you read a character's name this person who holds the wool must hold onto it and pass on the ball of wool to the person playing that character.

3. Give the ball of wool to Peter and as you tell the story get the participants to pass the ball to the next role player that you mention, while still holding tightly onto the wool.
4. The wool gets passed on between the participants as their character's names are read out.
5. Read the story of Peter's sexual network. Point out the sexual network.
6. Ask participants to identify the danger of this network.
7. Give the second ball of wool or string to Sibongile.
8. Read the story of Sibongile's sexual network.
9. Pause at the place mentioned and point out that there are two sexual networks.
10. Ask the two groups to move apart while not letting go of their wool.
11. Continue with the story and allow the two sexual networks to join together.
12. Point out that the two networks have combined and that you will ask the participants to consider some questions about this.
13. Thank all of the participants and ask them to sit down.

## PROCESSING

1. Break the participants into smaller discussion groups
2. Ask them to discuss the following questions:
  - Why do people have sex with many others?
  - Should men and women both have many partners?
  - Does culture play a role in sexual networking?
  - Do you think that Joe knows Sibongile?
  - Do you think that Mary knows Fungai?
  - Do you think that these people could influence one another?
3. Ask each group to offer one suggestion to reduce sexual networking



Remember this: Remind older participants that they might think they are sexually safe, but that networks have a way of spreading. The only way to be sure of your status is to be tested.

## Name cards

Peter	Chipo	Sibongile
Mary	Joe	Zenzo
John	Tafadzwa	Garikai
Susan		Fungai

### Peter's Sexual Network

Peter is 28 years old. He lives with Mary, who is 25 years old. Peter and his friends think Mary is very beautiful, and Peter is proud to be seen with her.

But Mary is very demanding and stubborn. Peter says that she makes him feel like a child, always telling him what to do and has no respect. "She makes me feel like a worthless man. If you don't have money, you are nothing and a woman can show you no respect", says Peter. Because Peter works night shifts, he and Mary are only together for four nights in every month. Peter always complains that they do not have enough sex. "A man cannot be satisfied with 4 days in a month". What Peter does not know is that Mary feels the same, and so she is having a sexual relationship with John.

Peter's family lives in Harare and he goes to his home at the end of every month. When he is in Harare, Peter always meets up with his friend Susan. Their two families have known each other for a long time and it was expected that Peter and Susan would get married. They have one child together. Susan now lives in Masvingo. Peter says Susan does not want to marry him because she has "too many better choices in Masvingo". Susan and Peter still see each other when they are home in Harare because "we are used to it and because Susan always says that I am the best in bed", says Peter.

Three months ago, Peter found employment as a security guard at a new hotel. At the hotel he met Chipso. Chipso is 26 years old and works in the bar at the hotel. They have sex when they are working on the same shift together. Chipso thinks that Peter is very handsome. "She likes my manhood," says Peter. Peter and Chipso do not use condoms because Peter wants to have a baby with Chipso. Peter says, "She is the one for me. I love her and if we can have a baby, we will be together". Peter says it is also great to have Chipso as a girlfriend because she works in the bar and they can both get alcohol from the bar. Chipso has a steady boyfriend, Joe. She is thinking of breaking up with him, but at the moment he makes sure that she has transport to and from work and that she always has airtime on her phone, which is important. So she is thinking carefully about their future together.

### **Sibongile's Sexual Network**

Sibongile is a 32-year-old factory worker who lives in Mutare. Her first husband, Zenzo died in 2009 after a long battle with TB. He was 43 years old. Sibongile now lives with a new boyfriend, Garikai.

Garikai is a quiet man who keeps to himself a lot. Sibongile hates that he is old and boring, but he is a good provider. They met at an overnight prayer meeting. Garikai is a truck driver and is away from home a lot. Sibongile is sure he has other girlfriends or sex workers when he is on the road.

When Sibongile worked in the industrial area in town she started a relationship with Fungai. Fungai is a fun guy who takes her out partying all night. They always end up having sex. Sibongile does not use condoms because she says they make her fat. Sibongile's mother lives near the industrial area, so when she goes home to visit her every month, she meets up with Fungai.

Sibongile also has another boyfriend in town. His name is Tafadzwa and he is her "Minister of Transport". Whenever she needs a lift from Mutare to her mother's house, she calls him. Sibongile would rather give him sex than waste her money on transport.

***PAUSE HERE AND POINT OUT THAT THERE ARE TWO SEPERATE NETWORKS. WHEN EVERYONE CAN SEE THIS, READ THE REST OF THE STORY***

When Sibongile is short of cash, she sometimes works as a sex worker in Mutare. She does not use a condom with all her clients because they pay more for sex with no condom. One of her favourite clients is a guy, Joe. He always seems to have enough money to buy some drinks and sometimes dinner, before they have sex. She lets Joe have sex with no condom, because he always treats her well.

**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGOs, counsellor, etc.) that will be able to assist them. Give out referral slips and refer participants to relevant service providers**

# Exercise 12: Stigma and Discrimination

This exercise has four activities which enable participants to understand stigma and discrimination, how attitudes towards HIV can be a form of stigma, and ways to deal with stigma and discrimination. The first activity explores various forms of stigma and discrimination while the second and third focus on individuals' attitudes towards HIV. The final activity focuses on ways to mitigate stigma and discrimination.

## Activity 12.1: What is Stigma and Discrimination?<sup>14</sup>

### PURPOSE

This activity allows participants to reflect on stigma and discrimination, and how they affect people.

### OBJECTIVES

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

- Describe some of their own personal experiences of stigma and discrimination
- Identify some of the feelings involved in being stigmatized and how stigma and discrimination affects people
- Develop ways to reduce stigma

Time Required: 30 minutes



### Other Requirements

- Flipchart and markers

### METHOD

1. Ask your participants, what is stigma? (Answer: Unfavourable attitudes and beliefs directed toward someone, e.g., condemning others, shaming, blaming, isolating or rejecting, turning our backs on others, treating someone as different, treating others as outcasts, etc.)
2. What is discrimination? (Answer: discrimination is when someone is treated unfairly as a result of stigma or treated differently because of perceptions or prejudices about that person).
3. Ask the group to give examples of stigma and discrimination or share their experiences of stigma as well as how it affects people.

An example of stigma may include:

- When an HIV-positive person is discriminated against or avoided or rejected in a community or family because of misconceptions or misunderstandings about HIV and AIDS in that community.
4. Discuss the following questions:
    - i. Why is it that some people who have tested HIV-positive may not wish to talk about or disclose their status? [Stigma]
    - ii. What do you think causes the reluctance to talk about HIV and AIDS? Why do you think this is so? [Fear]
    - iii. How do the following people experience stigma?
      - a. An SGBV victim and survivor,
      - b. A woman with obstetric fistula, or
      - c. A person living with disability.
    - iv. How do adolescents and young people experience stigma and discrimination when accessing SRH services?
  5. How can we address stigma and discrimination in our families and communities?

<sup>14</sup> Population Council Zambia, 2013. Adolescent Girls Empowerment Program (AGEP): Health and Life Skills Curriculum



## FACILITATOR'S INFORMATION: BASIC INFORMATION ON STIGMA AND DISCRIMINATION

Stigma is when we look down on another person as being bad in some way; we assign negative labels to the person (e.g., “promiscuous”) and don't value him/her.

Discrimination is the action resulting from stigma when a person is treated differently (e.g., fired from work, kicked out of accommodation or school, stopped from attending meetings, not allowed to use the village borehole).

Stigmatization is a process:

- We identify and name the differences in someone
- We make negative judgments about a person – “he has been promiscuous;”
- We isolate or judge/ridicule the person – separating “him” from “us”; and
- The person who is stigmatized (isolated and judged) loses status.

Stigma and discrimination result in great suffering. People get hurt! It is WRONG – it is NOT ACCEPTABLE! HIV stigma hurts people living with HIV and drives the epidemic underground. Those stigmatized become silent and don't disclose their status to others – and as a result spread HIV.

Fear of stigma and discrimination can impact on the lives of people affected and infected by HIV and AIDS, people living with disability, and the adolescents. This shows that stigma can affect the individual, their families, communities and society as a whole.



Remember this: Remind participants that stigma isolates people, and that a supportive family and a supportive community do not practise stigma. Ask the participants what they can do as a family to reduce stigma within their own home, and within the community.

**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGOs, church, social services, counsellor, etc.) that will be able to provide assistance in dealing with stigma and discrimination issues. Give referral slips and refer household members to the relevant service provider**



## Activity 12.2: Sexual Networks and Stigma

### PURPOSE

This activity explains stigma in relation to sexual networks. Working from understanding what stigma is in the earlier activity, this activity allows people to explore what they might think about individuals who are HIV positive. Only by acknowledging our own views and attitudes can we begin to change them.

### OBJECTIVES

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

- Understand the concept of sexual networks
- Suggest ways to reduce stigma and discrimination associated with sexual networks

**Time Required: 20 minutes**



### Other Requirements

- Picture of a person lying in bed
- Description cards

### Setting

Small groups

### METHOD

1. Divide your participants into smaller groups (4 or 5 in a group).
2. Tell participants they are not allowed to talk to one another or to another group, until you tell them.
3. Tell participants you are to show them a picture and then give them a card with some information about the picture
4. Each group should discuss what they think about the picture.
5. Show participants the poster of the person lying in bed.
6. Make sure each person in each group has seen the picture and that no one talks.
7. Collect the picture and then hand out one description card to each group (if you do not have description cards, you can write the descriptions on separate pieces of paper).
8. Inform the groups that this card gives them some information on the picture.
9. The groups may now discuss the picture and the information they have and answer the questions on their cards.
10. After five minutes get the groups to report back IN NUMERICAL ORDER.
11. Get all of the groups to give their answers to question one, two and three, pointing out the differences between the groups' answers after each set of answers.

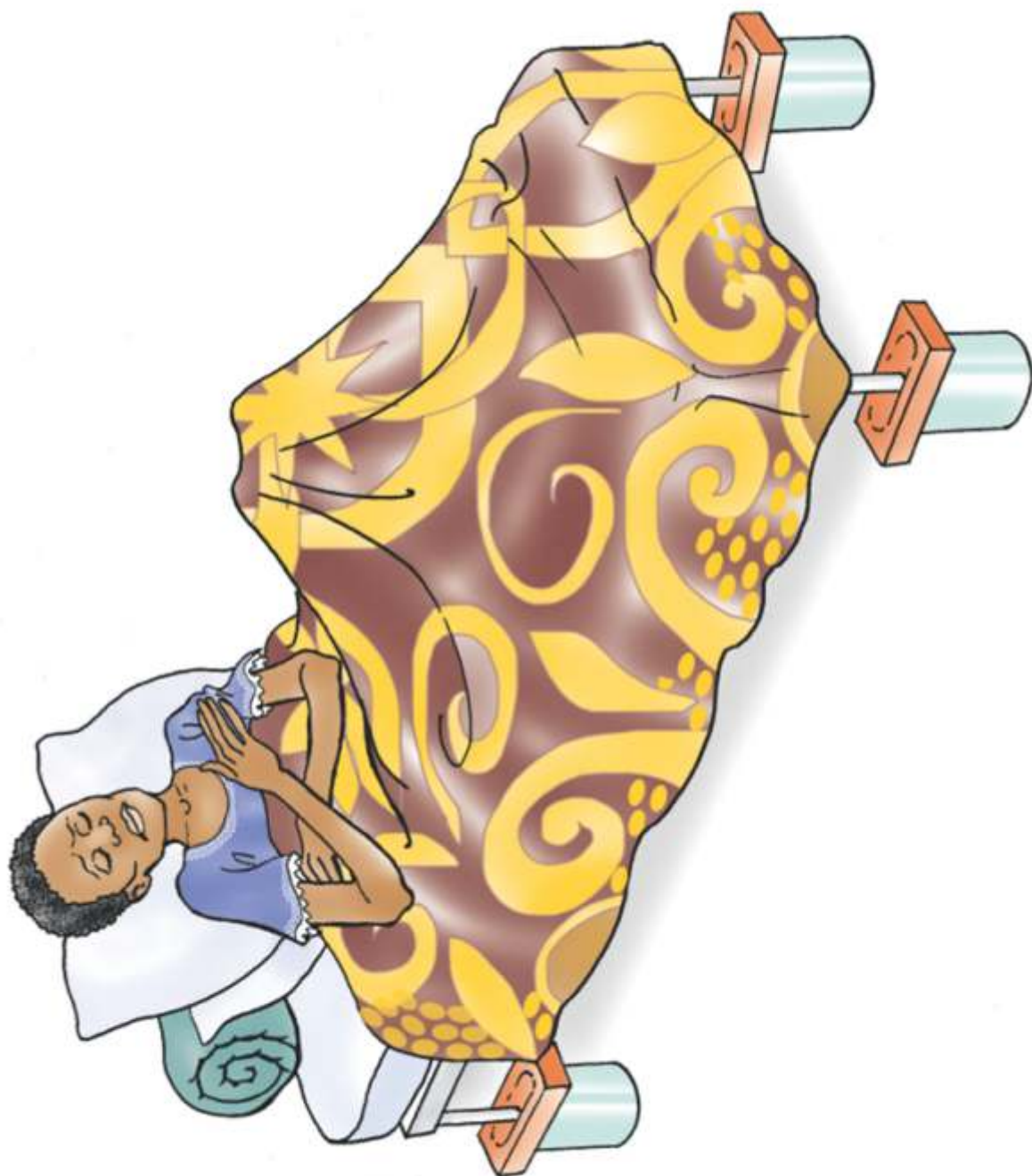
### PROCESSING

1. The feedback from the groups should range from discriminatory to supportive.
2. Group 2 for example will report that this was not the woman's fault; Group 5 might be more discriminatory about the sex worker.
3. Point out that all that the differences between the groups' answers relate to the circumstances that they know about the person.
4. Ask all of the participants if they think that the five people are connected to one another in some way.
5. Point out that all five are connected, and that this is a Sexual Network.

For many people, HOW a person got infected with HIV is important. Are they “guilty” or “innocent”?

**But, we need to ask ourselves: “What difference does it make how people contracted HIV?”** These quick decisions and judgments show us very clearly that we all tend to put people in boxes as we adhere to different kinds of stereotyping.

**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGOs, church, social services, counsellor, etc.) that will be able to provide assistance in dealing with stigma and discrimination issues. Give referral slips and refer household members to the relevant service provider.**



### **Scenario 1**

The person lying in the bed is a man. He was a miner in Johannesburg. He has a wife in Mufakose and girlfriend in Johannesburg and in Bulawayo. He is HIV+.

Whose fault is it that this person is HIV+?  
What could he have been done differently?  
Do you think this person is a victim of stigma?

### **Scenario 2**

The person lying in the bed is a woman. Her husband is a miner in Johannesburg. She slept with no one else but her husband. She is HIV+.

Whose fault is it that this person is HIV+? What could  
she have been done differently? Do you think this person  
is a victim of stigma?

### **Scenario 3**

The person lying in the bed is a woman. She is a girlfriend of a miner in Johannesburg. She had another boyfriend in her village Murehwa. She slept with her landlord to pay less rent. She is HIV+.

Whose fault is it that this person is HIV+? What could  
she have been done differently? Do you think this person  
is a victim of stigma?

### **Scenario 4**

The person lying in the bed is a man. He is a factory worker in Highfield. He was usually faithful to his wife, but a tenant offered to sleep with him if he reduced her rent. And once he was celebrating at a shebeen and was seduced by a sex worker. He is HIV+.

Whose fault is it that this person is HIV+?  
What could he have been done differently?  
Do you think this person is a victim of stigma?

### **Scenario 5**

The person lying in the bed is a woman. She is a sex worker. She was a factory worker in Highfield, but the factory closed down. She needed to look after her children. She is HIV+.

Whose fault is it that this person is HIV+?  
What could she have been done differently?  
Do you think this person is a victim of stigma?

## Activity 12.3: Your Attitude Towards HIV

### PURPOSE

Working from understanding what stigma is in the earlier activity, this activity allows people to explore what they might think about individuals who are HIV positive. Only by acknowledging our own views and attitudes can we begin to change them.

### OBJECTIVES

By the end of the activity, participants will acknowledge their own views about HIV and AIDS. The group will be able to realize the need for more information and discover their own negative thoughts, if any are prevalent

Time Required: 20 minutes



### Other Requirements

- Flipchart
- Marker pens
- Copy of the story “Your attitude towards HIV”

### METHOD

1. Read the first episode of the story “**Your attitude towards HIV**” to the group, or have one of the group members read it aloud.
2. Give a very short time for participants to share their views with one another.
3. Ask the group who should be awarded the chance to participate in the trial.
4. Ask the group to vote and record their votes for each episode on the flipchart (see the table below for guidance).
5. Read the next episode and ask the group to discuss and vote.
6. Read the final episode and ask the group to discuss and vote.

### PROCESSING

Ask the group to break into smaller groups and discuss some or all of the following questions:

- Why the number of votes changed from one vote to the next?
- What was your opinion about the characters in the story?
- How does stigmatization and stereotyping negatively impact on people living with HIV?
- How does this affect their feelings and their morale and productivity at work?
- Allow the groups to report back to the big group.

**Note to Facilitator:** This topic can become very heated, because many people feel very strongly about their opinion. You will have to be very strict with the time in this exercise. Some people may feel that their views were not heard and will want to speak to you after the session. You may want to speak to others in the group after the session, if you think they feel they were treated unfairly.

For many people, HOW a person got infected with HIV is important; it labels them “guilty” or “innocent”?

**But, we need to ask ourselves: “What difference does it make how people contracted HIV?”** These quick decisions and judgments show us very clearly that we all tend to put people in boxes as we adhere to different kinds of stereotyping.



*Remember this:* Ask the participants what they as Sista2Sista Club members can do to reduce stigma within their own homes and community.

## Story: “Your attitude towards HIV”

### EPISODE ONE

Exciting news! It has just come to our attention that a local donor has volunteered to provide food aid to an HIV positive member of the community for the rest of their life!

However, the project budget can only fund one person's food aid. This panel (the participants) has been asked to make recommendations on who would be the most appropriate person to receive this food aid.

The three potential candidates are:

- 1) Varaidzo, a sex worker,**
- 2) Ruth, a peer educator who works for the Ministry of Health and Child Care,**
- 3) Nothando, a domestic worker.**

Who should be awarded the chance to participate in the trial? Remember that this treatment could mean an extended life span for the recipient!

### EPISODE TWO

**Varaidzo, is a 20-year-old sex worker** who has been selling sex to truck drivers and sleeping with married men in her community for the past 10 years. She was born HIV positive and orphaned at the age of 3.

**Ruth, the peer educator,** was infected sexually. She is 25 years old and has been subsidizing her low income through working in a bar and is a “small house” (mistress to a married man).

**Nothando, the domestic worker,** does not really know how she got infected. She only discovered her HIV status two years after her husband's death when she wanted to re-marry and her new husband demanded she goes for an HIV test. She tried to think how this could be possible. It could have been during a tribal ritual when the traditional healer used the same unsterilized razor to cut a number of people. But Nothando's husband died of TB, which could have been AIDS-related, so he might have infected her.

Who should be awarded the chance to participate in the trial? Remember that this treatment could mean an extended life span for the recipient!

### EPISODE THREE

**Varaidzo** is quite wealthy as her parents owned a large herd of cattle which she inherited because she was an only child.

The question is; should Varaidzo not be given preference over Ruth and Nothando because she is a sex worker and inherited her late parents' cattle?

**Ruth, the peer educator,** does not have any medical aid and due to her HIV status she cannot get a life policy. This means that in the event of her death, her two children will be orphaned with no financial support. In the meantime, to help pay the ever increasing medical bills, Ruth is forced to keep her part time job as a cashier at the bar. Should Ruth be the one who receives the food aid?

**Nothando, the domestic worker,** has just been paid off because her employers found out that she is HIV+. Fortunately for Nothando, her late husband had taken out a life policy a year before he died. This policy has now paid out five thousand dollars.

Nothando's daughter and son in law have asked her to come and live with them in the city and to invest her money in their very successful business for a very good monthly return. Should Nothando be left to pay for her own food, or should the donor consider her because of her unfair dismissal?

Who should be awarded the chance to participate in the trial? Remember that this treatment could mean an extended life span for the recipient!

The scoring sheet should look like this:

	Varaidzo	Ruth	Nothando
After Episode One			
After Episode Two			
After Episode Three			

#### FACILITATOR'S INFORMATION: INTERPRETATION OF EPISODES

The voting may work out like this:

**After episode one,** most people may choose Ruth, as they will think she could still make a difference in the community. Most of the participants are likely to be negative towards Varaidzo, the sex worker, because they believe that she brought HIV on herself by being a sex worker and that she may even spread the virus.

**After episode two,** most people may prefer Nothando because she was “innocently” infected with HIV. Ruth is immediately rejected, as she is considered to have brought it upon herself – people assume that she is a sex worker or stripper at the bar.

**After episode three,** most people may revert to Nothando, because she has money and because they have now realized she was born with HIV. The most important objective of this exercise is to make the participants realize how quickly they judge and that they base their choices on limited information.

Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGOs, church, social services, counsellor, etc.) that will be able to provide assistance in dealing with stigma and discrimination issues related to sexual networks. Give referral slips and refer household members to the relevant service provider.

### Activity 12.4: Dealing with Stigma

#### PURPOSE

This activity opens up the opportunity for the participants to begin developing strategies to deal with stigma within their community.

#### OBJECTIVES

By the end of this activity, participants will be able to explore the unfairness of judgments against whole groups of people and to develop strategies to guard against this within their own community.

Time Required: 20 minutes



#### Other Requirements

- Four fresh tree leaves

#### Setting

Logistically it might be better to play this game after a break to allow the facilitator time to hide the objects.

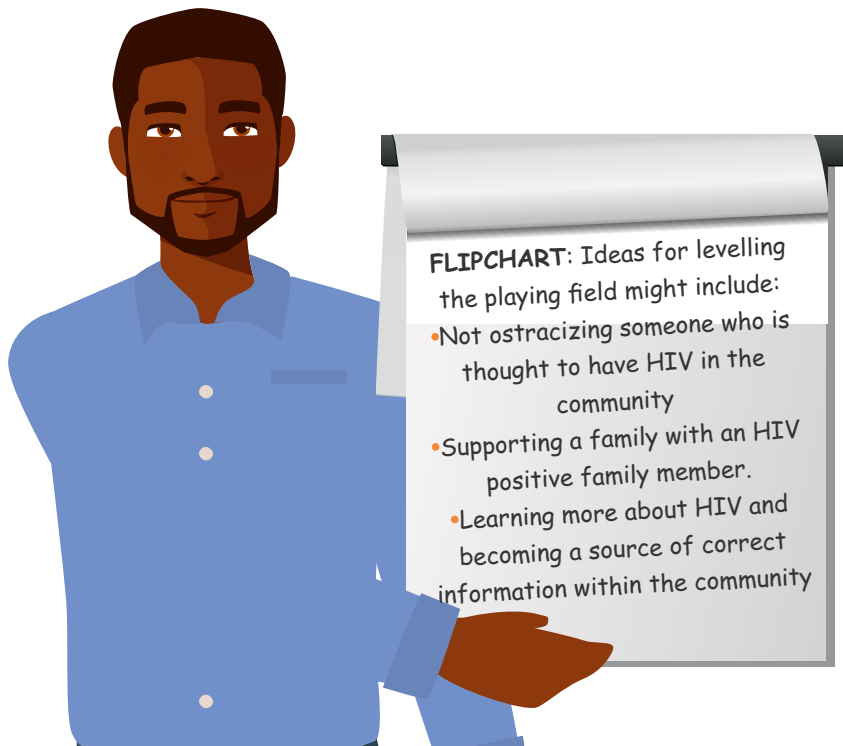


## METHOD

1. Divide the participants into two groups.
2. Explain that anyone who speaks during the game will be disqualified.
3. If two people are caught speaking, the team automatically loses. Instructions will be given to each team separately.
4. Call Team 1 together. Explain that they will have to listen carefully because you will give the instructions only once. They should not interrupt while you explain the rules and there will be no talking during the game or the team will be automatically disqualified. Using very obscure language and in a very quiet tone, explain that several articles have been concealed in the room. The objective of the game is to uncover them within the five minutes allotted without talking to anyone.
5. Call Team 2 together in a tight circle and in a whisper; tell them that you have hidden four tree leaves around the room. The team which uncovers the four objects first, wins. Be careful not to let the other team hear.
6. The game is over when Team 2 recovers all the objects. Praise Team 2 for winning. Scold Team 1 for not being able to complete the task. Let a few minutes pass for them to begin to feel the feelings associated with being blamed.
7. Confess that Team 2 was given answers at the start of the game and that you were only role-playing to illustrate a certain point. You wanted them to feel how it feels to be blamed for not achieving even though the other team had an unfair advantage and conditions were not equal.

## PROCESSING

1. Get both groups to discuss whether there are any “rules” in society that disadvantage certain groups of people including those who are HIV positive.
2. Ask the participants to remember that being HIV positive is not to be associated with blame.
3. Is there anything the group can do to “level the playing field”?



Remember this: Stigma is undeserved. What behaviours are being changed by the family to ensure that they are not practicing stigma?

Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGOs, church, social services, counsellor, etc.) that will be able to provide assistance in dealing with stigma and discrimination issues. Give referral slips and refer household members to the relevant service provider.

# Exercise 13: HIV Testing Services (HTS)<sup>15</sup>



This exercise raises participants' awareness on the importance of HIV testing and accessing HIV Testing Services (HTS). The exercise covers HIV testing; HIV treatment, care and support; disclosure of one's HIV status; and HIV prevention methods such as voluntary medical male circumcision (VMMC) and prevention of mother-to-child transmission (PMTCT).

## Activity 13.1: HIV Testing

### PURPOSE

This activity seeks to emphasise the advantages of being tested for HIV in order to know one's status.

### OBJECTIVES

By the end of this activity participants will:

- Understand the benefits of getting tested for HIV and knowing one's HIV status
- Be able to encourage each other to get tested for HIV
- Be able to identify HTS providers in their community

Time Required: 20 minutes



<sup>15</sup> Adapted from Home Visit Guide addendum



## Other requirements

- Flip chart and markers

## METHOD

1. Ask participants what are the benefits of knowing their HIV status. Highlight that it can be useful to get tested as a couple to know one another's HIV status.
2. Ask participants to consider fears and challenges around getting tested and knowing one's status. Discuss how the fears and challenges in getting tested for HIV can be overcome.
3. Split the participants into two groups and ask them to come up with messages to encourage family members whether adolescents, parents, pregnant women / adolescents and the elderly people to get tested for HIV.
4. Ask participants to identify HIV Testing Services available in their communities. Encourage participants to access the HIV Testing Services (HTS) available in their community.
5. Ask the participants to come up with a song to encourage HIV testing.

## FACILITATOR'S INFORMATION:

HTS is the gateway to accessing HIV services – counselling, linkage to appropriate HIV prevention, treatment and care services and other clinical and other support services. Some of the services include testing, counselling, antiretroviral therapy (ART), care and support, prevention of mother-to-child transmission of HIV (PMTCT), and voluntary medical male circumcision.

## Benefits of HIV testing for:

### a) The Individual: -

- Empowers the HIV negative individual to protect himself or herself from becoming infected with HIV
- Assists the HIV positive individual to live positively
- Offers the opportunity for treatment of HIV-related infections

### b) The Couple:

- Supports safer relationship
- Get to know your HIV status together
- Facilitates communication and disclosure of HIV status
- Supports the couples' linkage to HIV services such as treatment and care, PrEP and other appropriate services, including prevent mother-to-child transmission of HIV (PMTCT)
- Facilitates family planning decisions
- Allows the couple or family to plan the future together as well as support each other

### c) Community:

- Encourages others to get tested as large numbers of client's test HIV-negative
- Reduces stigma as more clients “go public” about being HIV positive

### d) Children and Adolescents:

- Facilitates early knowledge of HIV status.
- Improves access to HIV prevention, treatment, care and support services.

- Children requiring Post Exposure Prophylaxis may also be identified.
- Every child has an inherent right to life, to information about themselves and to appropriate health care and support

#### **HIV testing can either be done through**

- The client-initiated approach also known as Client-Initiated Testing and Counselling (CITC) formerly known as VCT, or
- The Provider-Initiated Testing and Counselling (PITC) approach. PITC refers to health care providers initiating the HIV testing process for all clients/patients attending health facilities.
- Community-based HIV testing
- Self-testing kit services

#### **HTS require that HIV testing be done:**

- With the patient's/client's consent
- With privacy and confidentiality measures in place
- Following relevant counselling procedures
- With supportive and prevention counselling offered to clients
- With accurate tests and ensure correct test results

#### **A Family Centred Approach to HIV testing:**



Provides awareness on all the information on HIV and the whole family can get tested

- Offers an opportunity to get tested and plan for the future together as a family
- Offers an opportunity for early treatment of HIV those who are HIV positive
- Gives people the opportunity to have respect for themselves and to protect themselves after the test
- Helps in breaking stigma, silence and discrimination surrounding HIV and AIDS at both the family and community level
- Empowers the person on how to deal with peer pressure, communication and negotiation skills, particularly for the adolescents
- Helps in making choices about sexual reproductive health, for both the adolescents and adults
- Provides an opportunity to make choices about HIV prevention strategies, which include Voluntary Medical Male Circumcision (VMMC) and abstinence

HIV testing gives you access to the following:



## **FACILITATOR'S INFORMATION: HIV TESTING<sup>16</sup>**

**How can a person know if they have HIV or not?** The only way for a person to know for sure if they have HIV or not is for them to get tested for the virus. A person can have HIV and still feel perfectly healthy. One cannot rely on symptoms to tell if you are infected. The symptoms of HIV are similar to many other illnesses and many people have no symptoms at all for many years.

**What is an HIV test?** The HIV test is a blood test that looks for antibodies to HIV in the blood.

**Where can you get tested for HIV?** HIV testing services are usually available at centres called Voluntary Counselling and Testing Centres, which are also known as VCT. HIV testing services may also be available at clinics and hospitals. Sometimes mobile outreaches are done in communities and people can get tested during the outreach. Additionally, self-testing kits are now available in Zimbabwe.

**What happens when you go for an HIV test?** When a person goes to get tested, they first see a trained counsellor in private. The counsellor explains the process for doing the test and what the results mean. The test results are always strictly confidential, which means that the counsellor must not reveal the test results to anyone except the person who was tested. HIV tests are voluntary, which means that it is the person's choice to get tested. No one can force them. If they agree to be tested, a blood sample will be taken.

The results will usually be given within an hour or less. When the results are given, the counsellor talks to them about their results, no matter what their status is. The counsellor will allow the person to express how they feel, help them to cope with the news and to make immediate plans, discuss how they can avoid passing the infection to others or be re-infected, and refer them about services so they can stay healthy, get more information and talk to others living with HIV, as needed. If the result is negative, the counsellor will help the person develop a plan to stay negative.

**Why do people get tested for HIV?** People get tested to find out their HIV status. People may want to know their HIV status:

- Before having sexual intercourse with a new partner;
- Before marriage;
- Before stopping use of condoms with a partner;
- Before getting pregnant;
- To be able to get care and treatment and protect their partners if they are positive;
- Because they put themselves at risk by having sex without a condom;
- Because they are worried about their status and want to know for sure;
- Because they think their partner may have had other partners and put them at risk;
- Because they are pregnant and want to be able to protect the baby if they are HIV positive;
- Because they don't feel well or the doctor suggested it or because they, their partner or baby have signs of AIDS;
- Because they have to provide HIV test results for an official reason. Nowadays it is uncommon to be asked for an HIV test for employment or a visa. Note that in Zimbabwe, it is illegal to be asked for an HIV test for employment.<sup>17</sup>

<sup>16</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education for Out of School Youth* pp. 294

<sup>17</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Manual for Out of School Young People*, pp289-295

## Activity 13.2: Couples HIV Testing

### PURPOSE

This activity emphasises the advantages of couples being tested together for HIV and disclose their status to each other and access prevention, treatment, and care services.

### OBJECTIVE

To encourage participants to get tested for HIV with their partners and support each other through the process.

Time Required: 20 minutes



### Other Requirements

- Three cards, one card labelled red, the other yellow and the other green

### Setting

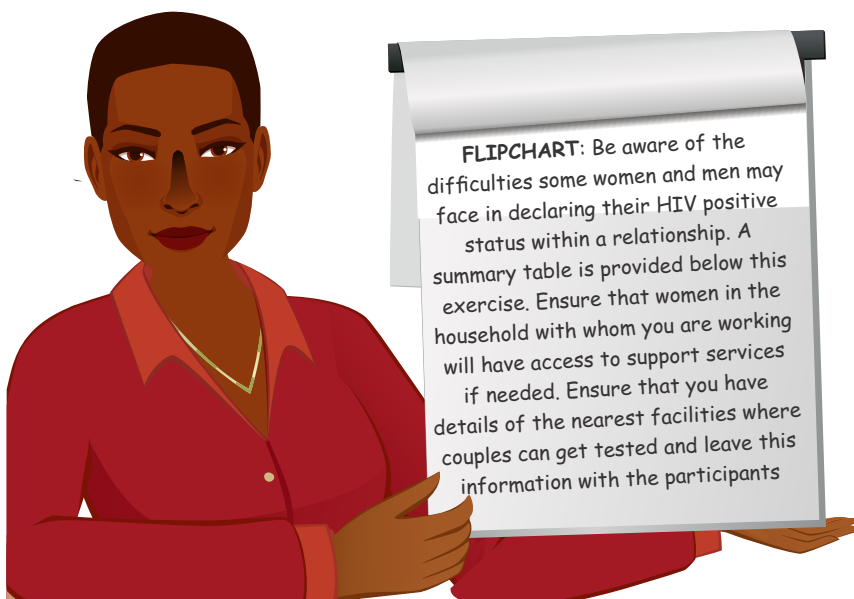
Space for the participants to be able to sit as a couple and talk.

### METHOD

1. Explain to the couple that they are going to perform a simple task and you will give them instructions separately.
2. Explain that you will say the instructions only once and they are not allowed to communicate with one another about the instruction.
3. Ask one of the participants to leave the room the room, and give the first instruction to the one remaining. The instruction is: Take an object (anything you can identify that is not heavy) outside.
4. Tell that person to leave the room and call in the other participant.
5. Give the second participant the other instruction: Take the same object and shift its position within the room.
6. Call in the first participant and ask both participants to perform their task as quickly as possible.
7. After they have finished their task, thank them for participating and ask how easy it was to get the task done

### PROCESSING

1. Ask participants if they had conflict or tension in performing their task.
2. Point out that sometimes it helps if a couple can hear the same information at the same time from the same source. This allows them to ask questions and to help one another understand the information better.
3. This is also true in being tested for HIV and knowing your status. It can be useful to get tested as a couple to know one another's HIV status. This helps build understanding between the couple and helps in understanding how the other person might be feeling.



Remember this: Ask couples if they know where they can get tested, and encourage them to make an appointment to get tested together.

## Benefits and Risks of Declaring One's Positive Status to a Partner

Benefits	Risks
Increased opportunities for receiving social support	Loss of economic support
Improved access to necessary medical care	Blame
Increased opportunities to discuss HIV risk reduction with partners	Physical and emotional abuse
Increased opportunities to carefully and thoughtfully plan for the future	Discrimination
	Disruption of family relationships
	Abandonment

## Activity 13.3: HIV Disclosure

### PURPOSE

This activity highlights the importance of disclosing HIV status to a partner / spouse,<sup>18</sup> children, parent(s), an infected child, and others in general. It seeks to empower participants to develop strategies to facilitate disclosure.

### OBJECTIVES

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

- Identify benefits of disclosing one's HIV status.
- Understand challenges faced by people in disclosing HIV status and develop ways to address these challenges

Time Required: 45 minutes



### Other Requirements

- Flipchart paper
- Marker pens
- Tape and scissors or Glue

### METHOD

1. Split participants into two groups and ask them to answer the following questions in ten minutes:
  - If someone discovers that they have HIV, who do you think they **SHOULD** tell? Why?
  - If someone discovers that they have HIV, when do you think they will be able to share the news with a) partner, b) parent / guardian, c) children, d) other people? Tell the participants to give reasons for their answers.

*HIV disclosure is the act of informing someone or people about HIV status. There are many different types of HIV disclosure:*

1. *Disclosing to a partner/spouse*
  2. *Disclosing to parents or family*
  3. *Disclosure of parents' HIV status to children*
  4. *Disclosure of HIV status to an infected child*
  5. *Disclosing to others*
2. Get the group back together and ask participants to present their answers. Generate a discussion from their answers and get an understanding of challenges of disclosure. Do not take too much time on this discussion.
  3. Tell the participants that we will look at these questions from two perspectives.
    - a. Let's first put ourselves in the shoes of a **person who discovers that he / she is HIV-positive and has to make the decision to tell his / her partner about it.**
      - What are some possible negative sides of telling a partner/spouse about your status? Why would you decide NOT to tell?  
(Possible answers: Fear of rejection or loss of relationship; person may leave you, so why tell them; may be discriminated against because of it; can be beaten, violence; loss of opportunity to have sex; fear that the person may tell others; don't know how to tell; feel embarrassed; relationship is not serious; person has not asked about one's status.)
      - What are the benefits of telling a partner/spouse about your status?  
(Possible answers: Being honest and open feels good (not hiding who you are); find out if the person really wants to be with you, really likes or loves you, being able to protect the partner from infection).
      - Given the benefits and negative sides of telling the partner, do you think persons who discover their HIV status will tell their partner / spouse that they have tested HIV-positive?

<sup>18</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People* p. 297 – 301.

b. Next let's put ourselves in the shoes of a person **who is living with HIV and is thinking about telling his / her children.**

- What are some possible negative sides of telling your children about your status? Why would you decide NOT to tell?  
(Possible answers: loss of relationship; children may despise you, so why tell them; rejection by children; fear that children may tell others; embarrassment.)
- What are some possible positive sides of telling your children about your status?  
(Possible answers: Being honest and open feels good; allows children to cope better with HIV; children and parents / caregivers psychologically adjusts to living with HIV; helps the parent adhere to treatment)
- Given the positive and negative sides of telling the partner, do you think persons living with HIV will tell their children that they are living with HIV?

4. **Suppose a child is born with HIV. At some point the child will need to be informed of his / her HIV status.** Now ask a parent / caregiver in the household to role play with another member in the household how this disclosure could take place. Ask participants what possible challenges / dilemmas parents / caregivers may face in disclosing the child's HIV status.
5. Facilitate a discussion to identify ways to address challenges associated with disclosure.
6. Tell participants that when disclosing HIV status:
- Identify someone that can be trusted or who is trustworthy who can assist with disclosure and talking about HIV-related issues. A trusted person can be a health worker, counsellor,
  - Think of all possibilities when considering disclosure and plan for those possibilities when disclosing

**Remember to offer the participants the name and contact details of the nearest service provider where they can get information and gain access to HIV Testing Services including testing, counselling and treatment. Offer participants the name of the service provider, counsellor or health care worker who will be able to assist them with navigating the difficulty of disclosing their HIV status. Give out referral slips to the household members where they are needed.**

#### **FACILITATOR'S INFORMATION: General information on disclosure**

HIV disclosure is the act of informing someone or people about HIV status. There are many different types of HIV disclosure:

1. Disclosing to a partner/spouse
2. Disclosing to parents or family
3. Disclosure of parents' HIV status to children
4. Disclosure of HIV status to an infected child
5. Disclosing to others

Knowing one's HIV status is recognised as an important prerequisite for effective adherence to antiretroviral therapy. Disclosure has also been associated with increased social support, behaviour change and HIV prevention in the long term.

An HIV-positive person has a **responsibility** to tell his / her partner(s). It is their partners' **right** to know so that they can also get tested and seek treatment early.

At times parents' / caregivers' feelings of shame and fear of stigma tend to discourage them from revealing their own or their children's HIV status. Stigma is a major barrier to disclosure of HIV status to children. Parents / Caregivers fear that children will face stigma and this fear often delays their decisions to disclose. As parents/caregivers and health



workers prepare for full disclosure, consideration should be made to help children manage the stigma of being infected or affected by HIV.

Children's immediate concerns after learning about their parents' / caregivers' HIV-positive status are about the parents' / caregivers' well-being. Children may become appropriately protective or, if these concerns are not addressed, overly protective of their caregiver.

### **Benefits of Disclosure<sup>19</sup>**

- Allows the infected and the affected to cope better with HIV - psychologically adjust to living with HIV
- Increases self-esteem of the HIV-positive person
- Facilitates adherence to treatment
- Works towards reducing stigma, discrimination, and misconceptions and myths regarding HIV
- Family-centred disclosure builds trust in relationships and improves healthy communication between parents and children

### **Disadvantages of Non-Disclosure**

- The HIV-positive person may suffer from depression. In some cases, this may lead to suicide
- The HIV-positive person may miss out on support and care from family members, peers and others
- Inappropriate actions, like refusal to take drugs amongst children and adolescents, and the urge to spread the infection
- Children who have not been disclosed to by parents / caregivers may discover their HIV status accidentally from other sources
- Self-blame and guilt

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<sup>19</sup> Adapted from Catholic Relief Services, 2009. *Psychosocial Care and Counselling for HIV infected Children and Adolescents: A Training Curriculum*, p.181 – 202.

## Activity 13.4: Voluntary Medical Male Circumcision

### PURPOSE

This activity seeks to open discussion on voluntary medical male circumcision (VMMC) amongst family members and to make male members aware of the benefits associated with this procedure.

### OBJECTIVES

By the end of this activity, participants will be able:

- To acquaint themselves with the concept and process of voluntary medical male circumcision
- To demystify the myths around male circumcision and address concerns regarding the procedure

Time Required: 45 minutes



### Other Requirements

- Male Reproductive Organ Poster
- Pictures of circumcised, uncircumcised and partially circumcised penis

This activity may require disaggregating participants by age or gender.

### METHOD AND PROCESSING

1. Ask participants to share what they know about circumcision (traditional circumcision and voluntary medical male circumcision). Show participants the pictures of circumcised, uncircumcised and partially circumcised penis and ask them to describe what they see.
2. Explain that this session is going to discuss voluntary medical male circumcision **ONLY**.
3. Explain that the foreskin can move backwards and forwards, exposing the glans.
4. Explain that without proper hygiene, smegma accumulates around the penis underneath the foreskin. The cells on the underside of the foreskin are very susceptible to infection and one way of protecting men against infection is to remove the foreskin through a process called circumcision.
7. Explain that this process simply involves removing the foreskin and it does not impair the man from having sex.
8. Explain that for surgical method, the operation time is short and that full recovery takes about 6 weeks or less. During this recovery period one should not have sexual intercourse.
9. Explain that another type of circumcision is neo-natal circumcision. This means removing the foreskin of a baby boy a few days after he is born.

The benefits of this process include the fact that the baby heals from the process far quicker than if the operation is performed when he is all grown.

Both the mother and the father should jointly make a decision about whether they would like their baby boy to be circumcised.

10. Share with the participants that there are other health benefits associated with circumcision.
11. Dispel the myths and misconceptions about male circumcision in their communities.

REMEMBER

Remember this: HIV does not live under the foreskin. Emphasize that circumcised men and boys should not abandon condoms and engage in unsafe sex. Also warn the women that being circumcised does not guarantee a man's HIV status to be negative. In addition, circumcision does NOTHING to protect women from contracting HIV.



## FACILITATOR'S INFORMATION

Voluntary Medical Male circumcision is the complete removal of the skin covering the head of the penis (foreskin). It is a safe and short procedure done by trained doctors and nurses who are certified to do so. In Zimbabwe VMMC is done through either the surgical method or the non-surgical method (for example PrePex)

### Benefits of Male Circumcision

Most benefits are preventative and as a result may only be realized long after the procedure.

Benefits of VMMC include: -

1. Improves personal hygiene
2. Reduces the risk of penile cancer
3. Reduces the risk of cervical cancer for female partner
4. Prevents inflammation of the glans and the foreskin
5. Reduces risk of some sexually transmitted infections (STIs) including; chancroid, syphilis
6. Reduces men's risk of getting infected with HIV by up to 60%
7. Prevents the inability to retract the foreskin and the inability to return the foreskin to its original size

### Key Messages to those who are circumcised:

- Abstain from sex for six weeks (42 days) after being circumcised – this is the healing period.
- It is important for the client to keep the wound dry and the bandage in place for the recommended time
- Avoid use of any medications (including herbs) on the wound
- Follow the recommended review days after circumcision
- Pay attention to how the wound is healing and contact the service provider for necessary care
- Circumcision only reduces the risk of contracting HIV by 60%
- After the healing period (6 weeks) use male or female condoms correctly and consistently during sex
- Be faithful to one sexual partner
- Continue abstaining from sex if not yet sexually active

### Myths and Misconceptions about male circumcision

**Myth:** Circumcision is a very painful procedure.

**Fact:** For surgical circumcision, generally, there is some pain from the injection (local anaesthetic) and no pain during the circumcision procedure. After the procedure, every client is given painkillers for managing pain during the healing process.

**Myth:** The foreskins are used for other purposes after being removed.

**Fact:** Just like other human waste materials, foreskins are disposed according to the Ministry of Health and Child Care Policy. They are incinerated (burning at very high temperatures).

**Myth:** When circumcised you can have unprotected sex with anyone.

**Fact:** Male circumcision only offers partial protection from HIV, that is, 60% and hence correct and consistent use of condoms is important, being faithful to one sexual partner and also abstaining from sex where necessary.

**Myth:** Male circumcision results in reduced enjoyment of sex for the man.

**Fact:** After circumcision, the man can continue to enjoy normal sexual activities. Some circumcised men have actually reported that circumcision prolongs their sexual pleasure.

**Remember to offer the participants the name and contact details of the nearest voluntary medical male circumcision service provider who will be able to provide circumcision services and address any misconceptions. Give referral slips and refer participants to service providers.**

## Activity 13.5: Prevention of Mother to Child Transmission of HIV (PMTCT)

### PURPOSE

This activity focuses on explaining possible ways in which an HIV positive mother can transmit HIV to her child during pregnancy, birth and breastfeeding. It also explains prevention of mother-to-child transmission of HIV (PMTCT), and the primary prevention of HIV among women of child bearing age.

**Time Required: 45 minutes**



### Other Requirements

- In Utero poster

### OBJECTIVES

By the end of this activity, participants will be able to:

- ✓ Discuss the implication of pregnancy in HIV infected women.
- ✓ Explain possible ways in which HIV can be transmitted from mother to child.
- ✓ Identify ways to prevent mother-to-child transmission of HIV as well as HIV prevention strategies for HIV negative pregnant and breastfeeding women.

### METHOD

1. Break the group into at least two smaller discussion groups.
2. Ask the groups to solve the following dilemma:  
*An HIV positive mother and an HIV positive father conceive a child. The child is born HIV negative. How is this possible?*
3. Ask the groups to present their findings at the end of the discussion.

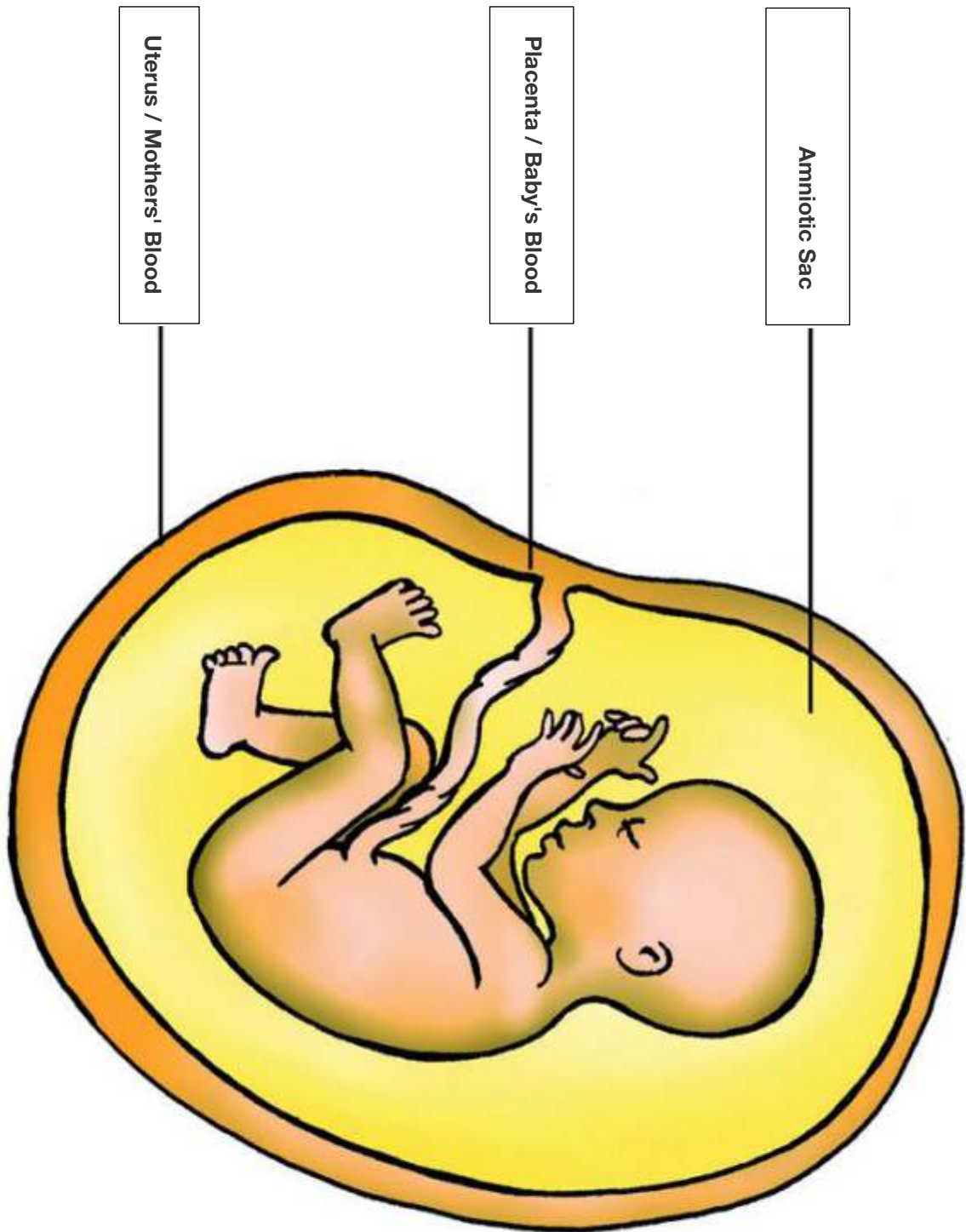
### PROCESSING

1. HIV is not contained in the sperm cell or the ovum, but rather in the semen (the fluid that carries the sperm) and the vaginal fluids that lubricates the vagina. So when the sperm and the ovum meet there is no virus in the newly formed cell.
2. Highlight the three steps HIV can be transmitted.
  - a. The virus must come from the body of someone who is HIV-positive
  - b. The virus must be in a bodily fluid that is infectious
  - c. There must be an opportunity for the virus to enter the other person (sex, open wound, cut, or scrape)
3. Highlight the three stages where HIV can be transmitted from mother to child. Ask at each stage whether there is an exchange of bodily fluids and whether there is a risk of HIV transmission.
4. Show that there is some risk at each stage, but that this does not mean the baby will be infected with HIV.
5. Emphasize the importance of HIV testing before pregnancy and re-testing during and after pregnancy, use of dual protection in pregnancy and post-delivery, and use of antenatal care (ANC 8+ visits, STI screening, etc.) and postnatal care (PNC) services.
6. Ask about treatment, care and support of mothers living with HIV, their children and their families as well as the importance of Early Infant Diagnosis (EID) and linkage to paediatric care and treatment.

### FACILITATOR'S INFORMATION: MOTHER TO CHILD TRANSMISSION OF HIV

MTCT does not only take place through the birthing process. There are 3 ways in which mother-to-child transmission (MTCT) of HIV can take place:

1. Firstly, a child can be infected with HIV in the womb through trans-placental transmission. Rates of infection are high when the mother's viral load is high, infected with STIs and the mother is poorly nourished and in poor health;
2. Secondly there is the trauma of the birthing process wherein secretions and bodily fluids including blood can be exchanged. The baby may have abrasions on his/her skin on account of invasive procedures during the pregnancy; and
3. Finally, MTCT can take place during breastfeeding as HIV can be found in breastmilk. If the child has mouth sores or lesions in the digestive system (ulcers), and the mother has lesions on her nipple; this may contribute to postnatal transmission



## FACILITATOR'S INFORMATION

### Breastfeeding

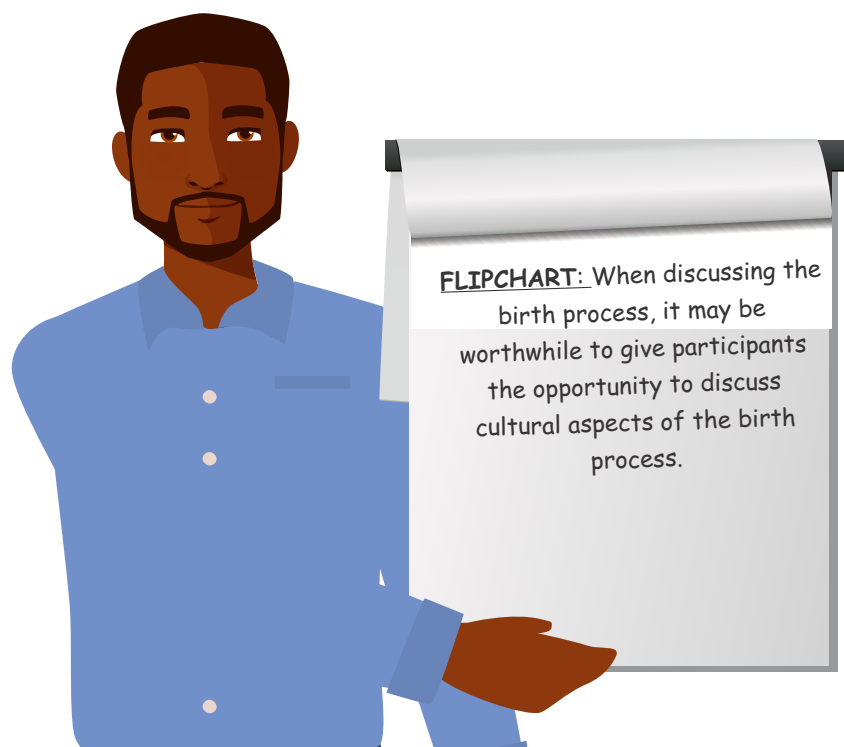
Even though the breast milk of an HIV+ mother may contain the HI virus, breastfeeding exclusively is OK as there should be no “leaks” in the stomach lining. Feeding with other food or liquid may cause small breaks in the stomach lining, mouth and throat. When a baby is then fed infected breast milk again, this may then allow the virus to “leak” into other parts of the body, causing an HIV infection.

### Ways to prevent MTCT during breastfeeding

Mixed feeding is the worst option for feeding a child during the first months of life. Breastfeeding is generally best but if formula feeding is to be done, then it must be done **EXCLUSIVELY** using fresh water, proper formula and clean conditions. Exclusive breastfeeding means no water, tea, coffee, porridge, formula milk etc., but only breast milk.

Other supportive action can include:

- Supporting the mother to keep going with breastfeeding despite difficulties, pain, discomfort and time/effort involved;
- Allowing mother time to exclusively breast feed
- If opting for formula feeding then partners or other family members can feed, clean bottles, make up formula in advance, etc.
- Bringing the mother tea/juice to stay hydrated while breastfeeding;
- Physically supporting the mother (position) or with pillows.
- Pressure to breastfeed often comes from the mother-in-law and other family members might be able to mediate here.
- Beliefs around breast is best and it is necessary to breastfeed to be a good mother are countered by beliefs that formula (and paying more) equals more concern for the infant's health.



### Summary sheet of MTCT risk factors

MTCT risk factors during pregnancy	<ul style="list-style-type: none"> <li>High viral load</li> <li>Viral, bacteria and parasitic placental infection (especially malaria)</li> <li>Sexually transmitted infections</li> <li>Maternal malnutrition (indirectly)</li> <li>High maternal viral load</li> <li>Non-adherence to ART and failure to utilize healthcare services as recommended by health workers</li> </ul>
MTCT risk factors during labour and delivery	<ul style="list-style-type: none"> <li>Rupture of membranes for more than 4 hours before labour begins</li> <li>Invasive delivery procedures</li> <li>First infant in a multiple birth</li> <li>High maternal viral load</li> <li>Duration of breastfeeding</li> </ul>
MTCT risk factors during breastfeeding	<ul style="list-style-type: none"> <li>Early mixed feeding of infant (breastmilk with replacement feeding)</li> <li>Inappropriate infant feeding behaviours and practices</li> <li>Breast abscesses/ inflammation or cracked nipples</li> <li>Maternal malnutrition</li> <li>Infant oral disease (e.g. thrush or mouth sores)</li> </ul>

**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGOs, church, social services, counsellor, etc.) that will be able to assist them if they need more help or have more questions on mother-to child transmission of HIV. Give referral slips and refer participants to service providers.**



## Activity 13.6: HIV Treatment

### PURPOSE

This activity discusses anti-retroviral therapy (ART), a combination of antiretroviral (ARVs) drugs to suppress the HIV virus, stop the progression of HIV disease as well as to prevent onward transmission of HIV.

The activity illustrates the difficulties in adhering to ARV treatment and the importance of adhering to treatment. It also highlights treatment as prevention.

**Time Required: 60 minutes**



### OBJECTIVES

By the end of this activity participants will be able to:

- ✓ Understand the role of ART in the prevention and control of HIV and AIDS.
- ✓ Identify difficulties in adhering to ART and suggest methods to assist friends and family members living with HIV.
- ✓ Understand PrEP and PEP as available options for preventing acquisition of HIV infection among uninfected persons at substantial risk.

### Other Requirements

- Story of Gertrude and the Vegetable Garden: The Invasion

### METHOD

1. Ask the participants to line up with their back against the wall.
2. Randomly allocate a two-digit number to each participant to remember.
3. Ask participants to hop two steps forward and add two to their number.
4. Ask people wearing footwear to take a step backward and subtract five from their number.
5. Ask the males in the group to hop three steps forward and add four to their number.
6. The female participants should hop five steps forward and add six to their number.
7. Ask the participants to name a popular artist and sing a line of their favourite song then ask each participants to state their third number (after subtracting five).

### PROCESSING

1. At the end of the game ask the participants how easy it was to remember their third number (after subtracting five) while being asked to do all these other things.
2. Explain that taking ART may not be as simple. Ask participants to highlight some of the challenges that people living with HIV experience in taking ART.
3. Discuss what they can do to assist friends or family members in taking their ARV medication.
4. Go through the Basics of TB transmission and explain the relationship between HIV and TB.
5. Explain to the participants that you are going to read a story and then discuss aspects of this story. Ask them to pay attention as you will expect them to answer some questions.
6. Read the story of Gertrude and the Vegetable Garden: The Invasion.
7. Stop where indicated and ask the following questions:
  - a. What should Gertrude do?
  - b. Leave the nest or destroy it?
  - c. Why should she do this?
  - d. What are the implications if she takes the other course of action?
8. After the questions have been answered take a vote to see which part of the story you should read next.
9. Finish the story according to the vote.
10. Explain that in Gertrude's case a small action rescued (or could have rescued) a whole crop of mangos. A small action can also sometimes rescue someone from getting HIV.
11. Gertrude could not do anything to stop the first two wasps from making their nest in her tree, but she could take action as soon as she saw there was a threat.
12. Similarly, someone might not be able to stop being exposed to HIV. Ask participants to think of ways that this might happen. For example:
  - e. Accidental exposure
  - f. Medical personnel getting needle stick injuries



g. Rape

13. Explain the following to the participants:

In cases of potential exposure to HIV, it is possible to get medicine to reduce the risk of being infected with HIV. This process is called Post Exposure Prophylaxis (PEP). If you have been potentially exposed to HIV you need to follow the following process:

- h. Go to your nearest service provider within 72 hours of exposure
- i. Get tested for HIV
- j. If you are HIV negative you will be given PEP medication
- k. Take the medication as prescribed

If you are HIV positive it means that you were already HIV positive before the exposure, and getting PEP will not help you.

There is another HIV prevention method, Pre-Exposure Prophylaxis (PrEP) in which people who do not have HIV but are at substantial risk take antiretroviral (ARVs) drugs daily to reduce their risk of becoming infected.

Some of the groups at substantial risk of HIV infection include:

- Sero-discordant couples (the HIV sero-negative partner)
- Adolescent girls and young women
- Men and women in relationships with partners of unknown status
- Key populations (including sex workers and men who have sex with men)

PrEP is offered as an additional HIV prevention choice and it is provided as part of combination HIV prevention approaches. It should be taken as prescribed by a health provider. PrEP does **NOT** prevent STIs, pregnancy, or protect one from HIV **after** exposure.

**Remind participants that:**

- ART prevents HIV from making copies of itself, which greatly reduces the amount of HIV in the body fluids (the viral load). It is not a cure for HIV.
- ART has to be taken every day for life.
- A person who tests positive for HIV should begin ART immediately.
- It is very important to take ART exactly as instructed by health care providers as well as lead a healthy lifestyle.
- If a person has side effects from ART, they should see their health care provider or visit their nearest health centre. They should not stop taking the medications unless told to by the health care provider.



### Gertrude and the Vegetable Garden: The Invasion

Gertrude is Samson, Admire and Tatenda's grandmother. She often visits the family and when she does she loves to take some fresh vegetables with her, to share. These vegetables are grown in her own vegetable garden in the small patch of land behind her house. She has many different types; spinach, corn, carrots, beetroot, sweet potatoes, onions, lettuce, potatoes and butternut.

However, her pride and joy of her vegetable garden is her mango tree. She says the tree was there before she was born and it certainly looks that way. It is tall and broad and its branches spread out across the garden. On hot summer days Gertrude is able to rest in its' shade. And of course, best of all are the mangos! Gertrude loves mangos. She eats them with almost every meal when they are in season and when there is too much she makes her famous atchar, which is so hot her neighbours know only to take a small helping with their sadza.

One afternoon Gertrude was sitting under her tree and listening to the wind blow gently through the branches. She heard a peculiar noise. It was a low buzzing noise. At first she thought she was imagining things, but the more she tried to ignore the sound the more prominent it became. Eventually she stood up and went in search of the noise. It did not take long to realize the noise was coming from the tree – high up in the branches. Gertrude went to her neighbour and borrowed a ladder. She placed it against the tree and climbed up carefully, one rung at a time. Soon she found the culprit. There – between the trunk and a branch was a nest. Not a nice nest with birds that tweet and sing. A horrible nest of stinging wasps. It was very small, as she watched only one or two wasps buzzed backwards and forwards.

**Stop HERE...**

#### **READ THIS SECTION IF THE VOTE IS TO DESTROY THE NEST**

Gertrude clambered down the ladder and found her bottle of poison spray. She carefully covered her mouth and nose and climbed the ladder again. Leaning over to make sure she got the nest first time, she sprayed. The wasps buzzed angrily and one of them landed on her arm. It tried to sting her but the poison was too strong and it died on her sleeve.

Smiling, Gertrude climbed down the ladder, put away the poison and returned the ladder to her neighbour. She went back to sit under her tree, knowing it was safe and she would have another magnificent crop of mangos in the coming summer.

#### **READ THIS SECTION IF THE VOTE IS TO LEAVE THE NEST**

Gertrude looked at the nest and thought, "Oh well, there are only two wasps. They can't do too much damage."

Gertrude climbed down the ladder and returned the ladder to her neighbour. She went back to sit under her tree, dreaming of the magnificent crop of mangos in the coming summer.

A few months later, the first mangos were ready to harvest. The air was heavy with the smell of the ripe fruit. Gertrude gently felt a couple of them and plucked them, already imagining the sweet juice on her tongue. She saw a small mark on the skin of the fruit but ignored it and cut open the mango. There, in the middle of the fruit were small writhing maggots.

The nest of wasps had grown over the months and the colony had laid their eggs in the ripening mangos. Now not only did Gertrude have huge nest of wasps to get rid of, she also had no crop of mangos. If only she had taken action, when the nest was small.

## FACILITATOR INFORMATION: ANTIRETROVIRAL THERAPY (ART)

**Antiretroviral drugs (ARVs)** are the drugs used to treat HIV.

**Antiretroviral Therapy (ART)** is the combination of drugs prescribed by the doctor to treat HIV. It may also include support to take the drugs correctly. HIV is always treated by taking multiple drugs at the same time, which is called **combination therapy**, in form of a **single dose ARV pill**.

**Post-exposure prophylaxis (PEP)** is a short-term antiretroviral treatment to reduce the chances of HIV infection **after** potential **exposure**, *either through sexual intercourse or occupationally*.

**Pre-exposure prophylaxis (PrEP)** is an HIV prevention method in which HIV negative people take antiretroviral drugs (ARVs) daily to reduce their risk of becoming infected.

**How ARVs work:** There are different types of ARVs that work in different ways, but all of them help to stop HIV from making copies of itself (replicating) within the immune system. If HIV cannot replicate, it is unable to damage the immune system and the person's immune system becomes strong again. This allows the person to remain healthy or to regain their health.

**Adherence:** Adherence means taking the drugs exactly as the health care worker told them to take them. It also means taking them every day for the rest of one's life. In ART, adherence involves taking medications in the correct amount, at the correct time and in the way they are prescribed, for example, on a full or empty stomach and eating and drinking the right things with the pills. It also means taking medications prescribed to treat other illnesses such as TB.

**Some barriers to treatment adherence include:**

- Experiencing side effects to ART drugs;
- Stopping taking ART because they feel better;
- Not understanding of the importance of adherence;
- Forgetting to take their medication due to alcohol consumption or for other reasons, like disruptions of daily routines, travel.

## FACILITATOR'S INFORMATION: TUBERCULOSIS (TB)

TB is the most common life-threatening opportunistic infection affecting people living with HIV.

Tuberculosis (TB) is caused by bacteria (*Mycobacterium tuberculosis*) that most often affect the lungs. TB can also affect other parts of the body, such as the brain, the kidneys, or the spine. TB is curable and preventable. A person with TB can die if they do not get treatment.

TB is spread from person to person through the air. When people with lung TB cough, sneeze or spit, they propel the TB germs into the air. A person needs to inhale only a few of these germs to become infected.

People living with HIV have a compromised immune system and hence are more vulnerable to TB. People who are infected with HIV are 20 to 30 times more likely to develop active TB, hence they are encouraged to go for TB screening. The risk of active TB is also greater in persons suffering from other conditions that impair the immune system.

When a person develops active TB, the symptoms (such as cough, fever, night sweats, or weight loss) may be mild for many months. This can lead to delays in seeking care, and results in transmission of the bacteria to others.

### **Symptoms and diagnosis**

Common symptoms of active lung TB are cough with sputum and blood at times, chest pains, weakness, weight loss, fever and night sweats.

Symptoms of TB disease in other parts of the body depend on the area affected.<sup>20</sup>

### **What should I do if I have been exposed to someone with TB disease?<sup>21</sup>**

People with TB disease are most likely to spread the germs to people they spend time with every day, such as family members or co-workers. If you have been around someone who has TB disease, you should go to your nearest health facility for tests.

**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGO, church, counsellor, etc.) that will be able to assist them if they need more help or have more questions on ART. Give referral slips and refer participants to service providers.**

<sup>20</sup> Adapted from CDC Factsheet TB Elimination "Tuberculosis: General Information" [available online at] <https://www.cdc.gov/tb/publications/factsheets/general/tb.pdf>

<sup>21</sup> *ibid*

## Exercise 14: Living in a Sero-discordant Relationship

### PURPOSE

This exercise introduces the concept of sero-discordance and demonstrates how sero-discordant couples can continue to have a safe sexual relationship. The exercise in this unit shows that condoms and anti-retroviral treatment (including PrEP) both play a role in ensuring the safety of this sexual relationship.

### OBJECTIVES

By the end of the exercise, participants will be aware of the existence of sero-discordant couples and at least two mechanisms that these couples can practice to have a safe and healthy sexual relationship.

Time Required: 15 minutes



### Other Requirements

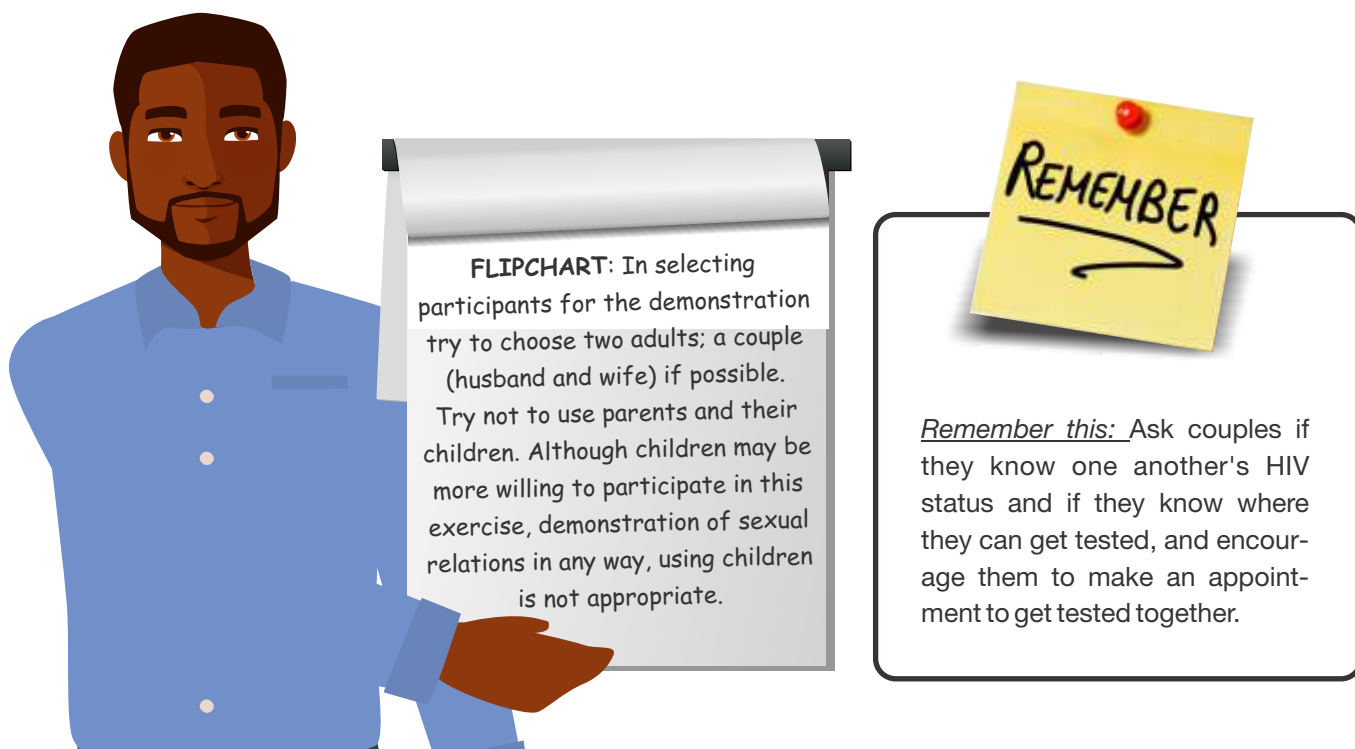
- Two plastic bags
- One tennis ball, or a ball of newspaper
- A small bucket of water
- A rag or a small towel

### Setting

It might be best to run part of this exercise outside.

### METHOD AND PROCESSING

1. Ask participants what sero-discordant couples are.
2. Ask for two volunteers (a male and female) from the group; explain that they are going to be throwing a ball to one another.
3. Explain that the two people are married to one another.
4. Ask the couple to throw the ball backwards and forwards between them. As a married couple they have a regular and healthy sex life. Explain that throwing the ball backwards and forward between the two represents the couple having sex.
5. Explain that one of the couple member begins to feel sick, gets tested and find out that they have HIV.
6. Submerge the ball in the water and ask the couple to throw the ball backwards and forwards to one another.
7. Explain that the water represents the HIV infection and it can be easily transmitted through sex. Ask the group what the couple can do to prevent the uninfected partner from contracting HIV.  
***(If the participants' level of knowledge about HIV is high, the chances are the participants will say the couple should use condoms, PrEP or adhere to ART).***
8. Ask the "HIV negative" partner to place the plastic bags on his or her hands.
9. Now submerge the ball in water again and ask the couple to throw the ball backwards and forwards to one another.
10. Show how the plastic bags prevent the person's hands from getting wet, and explain that a condom can also assist in preventing the transmission of HIV.
11. Ask the group if there is anything else the couple can do to prevent the uninfected partner from contracting HIV.
12. Explain that the infected partner should take medicine (ART) to reduce the amount of virus in his or her body.
13. Explain that if the water represents the virus in the infected person's body and they are taking the medicine correctly, then the amount of virus in the body drops.
14. Discard most of the water from the bowl and dip the ball into the remaining water. If necessary, dry the ball with the rag or towel.
15. Ask the couple to throw the ball backwards and forwards to one another.
16. Show how there is little chance of the HIV negative partner getting wet, especially if they still have plastic bags on their hands.
17. End the demonstration by pointing out that a combination of measures, including taking medicine and using a condom, can substantially reduce the risk of transmitting HIV amongst discordant couples.



#### **FACILITATOR'S INFORMATION: Possible reasons for sero-discordance and coping mechanisms<sup>22,23</sup>**

It is important to recognise that sero-discordant couples exist, and the negative partners remain at high risk of HIV infection without prevention strategies and safer sexual practices. Some of the reasons for sero-discordance in couples include:

1. Inherent resistance (immunity to HIV) - some people may be inherently resistant to HIV infection.
2. Decreased sexual frequencies between the couple – sexual frequencies between the couple not sufficient enough to transmit the infection.
3. Patients taking ART who have an undetectable viral load are extremely unlikely to infect their sexual partners.

#### **Emotional challenges facing couples of mixed HIV status (sero-discordant couples)<sup>24</sup>**

- Fear of HIV transmission
- Coping with uncertainty of potential illness
- Shifts in intimacy
- Dilemmas regarding how HIV has impacted reproductive alternatives

#### **Possible coping mechanisms**

- Disclosure
- Couple HIV testing and couple counselling
- Therefore, couples have to negotiate their sexual relations and agree on prevention strategies that work for them.

**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGOs, church, ZRP-Victim Friendly Unit, social services, counsellor, etc.) that will be able to assist them or have more questions on sero-discordance. Give referral slips and refer participants to service providers.**

<sup>22</sup> Ravikumar B C and Balakrishna P (2013) "Discordant HIV couple: Analysis of the possible contributing factors" *Indian Journal of Dermatology*

<sup>23</sup> Bunnel RE et al. (2005) "Living with discordance: Knowledge, challenges, and prevention strategies of HIV couples in Uganda" *PubMed*

<sup>24</sup> Beckerman N L (2004) "Couples Coping with Discordant HIV Status" *AIDS Patient Care and STDs*. 16(2): 55-59.  
<https://doi.org/10.1089/10872910252806090>

# Exercise 15: Adolescent Pregnancy

This exercise discusses causes and consequences of adolescent pregnancy as well as ways to prevent pregnancies among adolescents. The first exercise explores causes and consequences of adolescent pregnancy while the second exercise discusses myths and basic facts about adolescent pregnancy and HIV.

## Activity 15.1: What is Adolescent Pregnancy?

### PURPOSE

This activity seeks to increase awareness on contributing factors to adolescent pregnancy and the possible consequences associated with adolescent pregnancy (including abortion).

**Time Required: 45 minutes**



### Other Requirements

- Adolescent pregnancy cards

### METHOD

1. Prepare the Adolescent Pregnancy cards in advance.
2. Keep the pile of cards in column A separate from the pile of cards in column B
3. Spread out the column A cards and place them face down on the table, in a grid fashion (see the diagram below)
4. On another part of the table place the cards from column B face down in a similar grouping
5. Tell the participants that they have to choose a card from group A and then find the matching explanatory card from group B.
6. If they choose the incorrect card, they need to return both cards to their original places on the table face down and allow the next person a turn.
7. If they turn over the correct matching set, then they can keep both cards.
8. The person with the most matching sets at the end of the game wins.

**NB: This exercise can still be done with one adolescent.**

### PROCESSING

1. Explain that the game discussed only some aspects of adolescent pregnancy and issues surrounding this.
2. Ask participants about the factors contributing to adolescent pregnancy.
3. Remind the participants that one of the possible consequences of unprotected sexual intercourse is unintended pregnancy. Ask:
  - a. How does pregnancy happen? Refer to the facilitator's information on how pregnancy happens and give participants the correct answer.
  - b. How does a girl or young woman know that she is pregnant? What are the signs? (Answers: missed period; a positive pregnancy test; nausea and vomiting, breast tenderness; unusual tiredness; mood swings, irritability and emotional sensitivity; greater hunger and weight gain; food cravings or aversions to foods; sensitivity to aromas; frequent urination; heartburn and/or constipation; dizziness and/or fainting; low back pain; bloating, or sometimes no signs at all, or a girl does not recognize the signs as a possible pregnancy.)
  - c. How can pregnancy be confirmed? (Answer: At a health facility; home pregnancy tests available at pharmacies but results need to be confirmed at a health facility)

### OBJECTIVES

By the end of this activity, participants will be able to:

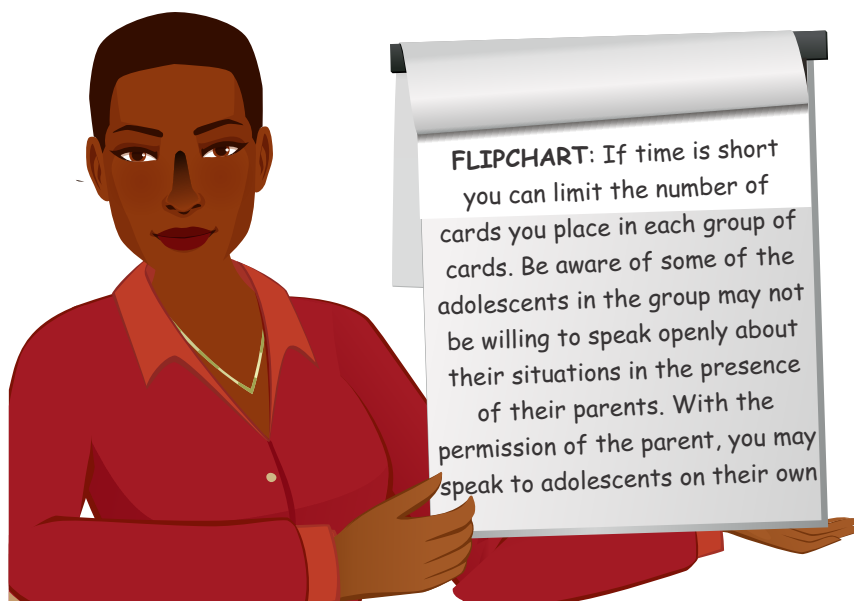
- ✓ Understand the factors contributing to adolescent pregnancy.
- ✓ Identify possible consequences (including complications) of adolescent pregnancy.
- ✓ Understand abortion and the risks associated with unsafe abortion



4. Highlight the possible consequences and the complications associated with adolescent pregnancy.
5. Ask participants the following:
  - What is abortion?
  - What are the risks of unsafe abortion?
  - What does the law say about abortion in Zimbabwe?

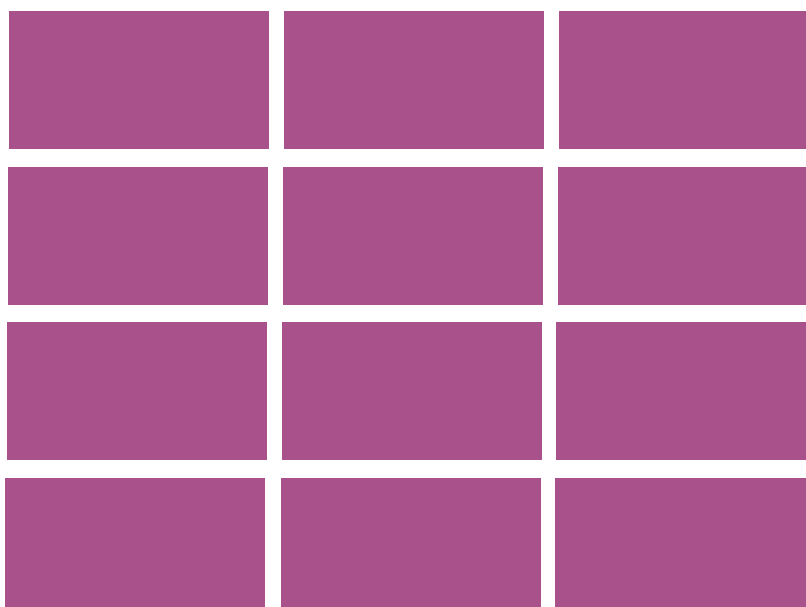
**Remember this:** Remind the participants that falling pregnant, or getting someone pregnant creates a lifetime of responsibility. Ask the younger participants to suggest practical ways they can change their behaviour to avoid pregnancy. Examples might include:

- Walk together in groups
- Do not stay out late or on your own with a person you like
- Respect a person's word when they say NO



**Remember to offer the participants, particularly adolescents the name and contact details of the nearest service provider (healthcare services, NGO, church, social services, counsellor, etc.) that will be able to assist them if they need help or have more questions. Give referral slips and refer participants to relevant service providers.**

**Placing the cards in a grid will look like this**





## Adolescent cards

A	B
There is no 100% effective method to prevent STIs or pregnancy.	Abstinence (not having sex) is the only 100% effective method for the prevention of STIs and pregnancy.
A girl cannot get pregnant the first time she has sex.	A girl can definitely get pregnant the first time she has sex, even if she has not started her period yet. Once a girl has ovulated (released an egg) for the first time, she can get pregnant.
A girl will not get pregnant if the guy pulls out before he ejaculates.	Even if the guy does not ejaculate some semen might have escaped from his penis, this has sperm in it too.
A girl cannot get pregnant if she has sex standing up.	You can get pregnant no matter what position you have in sex.
A girl will not get pregnant while she is having her period.	Although there are some times when it is more likely for a woman to get pregnant, it is never impossible. Always use protection.
If a girl urinates right after she has sex, she will not get pregnant.	Girls urinate from a different opening than where they have sex. So, urinating does not empty out the sperm, thus she can get pregnant.
Teenagers do not get STIs.	Every sexually active person is at risk of getting an STI if they do not practice safer sex.
You can tell by looking at someone that they have an STI	Often, symptoms for an STI do not show up right away and sometimes they do not show up at all. Just because someone has an STI does not mean you can see it. You could have an STI and not know it.
My boyfriend wants me to fall pregnant – it will show that he is a man	If your boyfriend needs you to become pregnant to show his masculinity, then he does not understand concepts like responsibility and commitment. Both of these are characteristics of being a man.
There is nothing wrong with becoming pregnant. It shows I am a woman.	Pregnancy leads to a lifelong commitment to your child. There are also other risks associated with having sex while young, like increasing your risk of contracting HIV and increasing your risk of cervical cancer later in life.
There is nothing that can be done to prevent HIV.	There are a lot of ways to protect yourself! The only sure way is not to have sex. If you do have sex you can protect yourself from contracting HIV by using a condom with lots of water-based lubricant every time. One way to reduce your risk is to have sex with only one person who is only having sex with you.

## FACILITATOR'S INFORMATION

### How Pregnancy Happens<sup>26</sup>

Once every menstrual cycle, one ovary releases an egg (ovulation). If the woman has unprotected sex at this time or in the five days immediately before it, she may become pregnant. Once the mature egg leaves the ovary, it begins to travel down the fallopian tube towards the uterus. It only lives up to 24 hours.

After the man ejaculates semen into the woman's vagina, the sperm contained in the semen begin to swim towards the egg. They swim up through the cervix, into the uterus and then into the fallopian tubes.

If the sperm find the egg, one of them may enter it. This joining of sperm and egg is called fertilization. The fertilized egg then begins dividing its cells as it travels down the fallopian tube to the uterus. When it reaches the uterus, it attaches itself to the lining. This is called implantation. Once implantation has happened, the woman is pregnant.

If the couple has unprotected sex, but the man does not ejaculate, some sperm may still enter the vagina in the pre-ejaculate. The pre-ejaculate or pre-cum is the small amount of fluid that comes out of the penis before ejaculation. Although this fluid, which comes from the Cowper's gland, does not naturally have sperm in it, it may contain sperm from a recent ejaculation or sperm may leak into the fluid before it leaves the body.

### Factors contributing to adolescent pregnancy<sup>27</sup>

- Early sexual debut
- Low level of education
- Child marriage, and socio-cultural and religious practices
- Living in or trying to escape poverty
- Lack of information on sexual and reproductive health (SRH) issues
- Inability to negotiate safer sex practices, including use of contraceptives
- Sexual violence
- Pressure from family, peers, and partner
- Lack of sex education and parental guidance
- Exposure to pornographic and sexually stimulating material, resulting in adolescents wanting to experiment

### Consequences of Adolescent Pregnancy

Adolescent pregnancy can have immediate and lasting consequences for a girl's health, education and income-earning potential. Consequences of adolescent pregnancy is a major health concern because of its association with higher morbidity and mortality for both the mother and child.

#### Health Risks to the Mother

Adolescent mothers suffer from stress and trauma when they realise that they are pregnant and the difficulty they face in deciding who to tell and what to do, as well as the negative response they receive from family and friends.

- Maternal death, illness and disability, including obstetric fistula, complications of unsafe abortion, STIs, including HIV as well as higher morbidity and mortality levels experienced by the children of adolescent mothers.
- Hypertension, which occurs mainly among women having their first child, is most prevalent in pregnancy complication that afflicts adolescent mothers.

#### Health Risks to Infants and Children

Children born to very young mothers are at increased risk of illness and death which are due to complications during pregnancy, child birth and post-natal period.

### Socio-Economic Consequences

#### Psycho-Social Consequences

<sup>26</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People* pg. 230

<sup>27</sup> Zimbabwe National Adolescent Fertility study pg. 8-10

- Adolescent pregnancy may also have psycho-social consequences. The young mother may be overwhelmed by the constant needs of the child and the baby may end up facing neglect from the adolescent mother.
- Women who become mothers in their teens are more likely to curtail their education as they are usually expelled from school.
- Adolescent pregnancy may result in child marriage and is also associated with domestic violence and family disruptions.
- Girls who become pregnant are also likely to suffer from stigma, rejection by parents and the man responsible for the pregnancy. Adolescent mothers have nowhere else to go except their parents' houses, and increased visibility in the society also means increased stigma. This stigma stems from the relation of adolescent pregnancy, contraceptive use, HIV and STIs to sexuality, thus it will forever remain bounded with morality and stigma. This stigma, during or after pregnancy, can lead to depression, social exclusion, low self-esteem and poor academic performance affecting the prospects of employment in the future.
- Early childbearing is highly stigmatized and girls report the trauma, fear, shame, and embarrassment of having to reveal an early pregnancy to family, partners and peers. A pregnant unmarried adolescent might be considered an embarrassment to the clan and is either abandoned or chased away from home, and therefore left with no guaranteed means of support both for the child and for herself.
- Pregnancy is also recognized as a reason for suicide among pregnant girls.
- Adolescent pregnancy affects the marriage prospects of young women and teen mothers are more likely to be single parents and, if married, are more likely to experience high divorce rates. The adolescent mother may also face rejection from the partner responsible for the pregnancy.

#### *Economic Consequences*

- As a result of little or no education, adolescent mothers are likely to have fewer skills and opportunities to find a job. Due to unemployment these adolescent mothers live in poverty.
- The adolescent mother may also face financial difficulties as it is expensive to raise the child as most are not employed.
- A girl who delays pregnancy is likely to stay in school and economically secure a more lucrative job or other income-earning opportunities.

#### **Abortion**

Abortion is the expulsion of the foetus from the uterus before it is sufficiently developed. The most common time for abortion to occur is between 8 and 13 weeks into the pregnancy.<sup>28</sup>

Abortion is generally illegal in Zimbabwe except under specific circumstances as stated in the Termination of Pregnancy Act (Chapter 15:10). According to this Act, a pregnancy may be terminated:

- (a) where the 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
- (b) 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
- (c) where there is a reasonable possibility that the foetus is conceived as a result of unlawful intercourse<sup>29</sup>

**Unsafe abortion** - An unsafe abortion is any abortion performed under conditions that represent a threat to the health of the pregnant woman. Generally, an abortion is considered unsafe when it is performed by an untrained (or poorly trained) person or using dirty instruments in unclean surroundings. **Unsafe abortion (back-door abortion) is illegal in Zimbabwe. However, if such an abortion is carried out, one should seek medical help.**

#### **Consequences of unsafe abortions**

The consequences of and complications arising from unsafe abortion are multiple and may occur immediately or later. They can be categorised as medical, psychological, social and economic.

<sup>28</sup> Adapted from German Foundation for World Population (DSW), 2006 "Sexual and Reproductive Health Training Manual for Young People" pg. 65

<sup>29</sup> Termination of Pregnancy Act [Chapter 15:10] Available at <http://www.parl.zim.gov.zw/acts-list/termination-of-pregnancy-act-15-10>

1. Medical complications include; Infection (like sepsis), haemorrhage (heavy bleeding), injuries to tissues and organs, generalised infection in the blood stream (septicaemia), anaemia (due to loss of blood), death
2. Psychological consequences arising from unsafe abortion include; depression, withdrawal and sexual dysfunction. Sometimes psychological problems may linger and require specialised care usually not available to adolescents because of the stigma attached to unmarried pregnancy.
3. Social complications of unsafe abortion include; dropping out of school, stigmatisation (disgrace and dishonour), rejection by the community, being forced to leave home, child marriage (often forced by parents), poverty, end of the relationship with the father of the child
4. Unsafe abortion has also economic impact including; hospital costs (which may be enormous) and impact of not being able to work or attend school.

## Activity 15.2: Making a Choice

### PURPOSE

The activity provides an opportunity for participants to discuss ways in which they might behave in sexually charged situations.

### OBJECTIVES

By the end of the activity participants will be able to assess and compare responsible and irresponsible behaviours as well as identify influences that shape responsible behaviour.

**Time Required: 40 minutes**

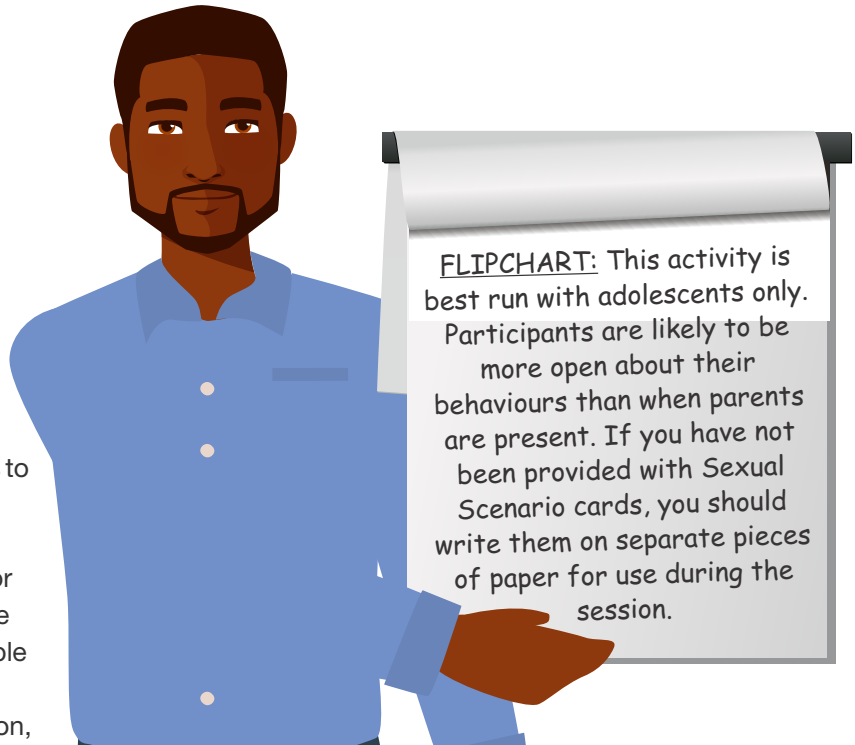


### Other Requirements

- Flip charts
- Sexual Scenarios

### METHOD AND PROCESSING

1. Tell the participants that you will read out some sexual scenarios.
2. Ask them to decide whether the behaviour in the scenario is responsible or irresponsible and give reasons.
3. Ask participants to identify influences to promote responsibility and those that promote irresponsibility.
4. Ask the participants to name people or role models they regard as responsible and what they think makes these people responsible. Remember they may not know of all of the behaviours of a person, but they can comment on the person's public behaviour.
5. End the session by explaining that no one is born "responsible." It is a skill we learn and practice throughout our lives, and it requires patience and self-discipline. One way we can learn to be more responsible is by watching responsible people. A mark of an adult is to behave in a responsible manner.
6. The discussions should allow for sufficient processing as well as indicate to the facilitator need for future emphasis.
7. Ask participants to identify ways of preventing pregnancy. If they list contraceptive methods and condoms; ask where they can be accessed.



**Remember this:** Remind participants that responsible behaviour is ongoing and not a once off decision. Encourage them to behave responsibly in every setting, not just regarding their sexual behaviour.

## Sexual Scenario Cards

<p>You meet someone attractive at a function (e.g., party, traditional ceremony, youth meeting) and the two of you leave together.</p> <p>The two of you decide to have sex, but neither of you has a condom.</p> <p>You decide to have sex anyway.</p>
<p>You meet someone attractive at a function (e.g., party, traditional ceremony, youth meeting) and the two of you leave together.</p> <p>The two of you decide have sex, but neither of you has a condom.</p> <p>Your partner is not so sure anymore, but you manage to persuade them to have sex with you.</p>
<p>Your friend (23 years old) brings his girlfriend home and asks you for a condom.</p> <p>You give him one.</p>
<p>Your friend (13 years old) brings his girlfriend home and asks you for a condom.</p> <p>You give him one.</p>
<p>Your friend's sister (17 years old) brings her boyfriend home and asks for a condom.</p> <p>You give her one.</p>
<p>Your best friend has told you that his ex-girlfriend told him she is HIV+.</p> <p>He won't go for a test because he knows that his present girlfriend is HIV negative.</p>
<p>Your girlfriend's younger sister is pregnant and now your partner wants to fall pregnant as well.</p> <p>She wants to have sex with you without using a condom.</p>
<p>Your neighbour has no job and four children to look after. Her family is not available to help her.</p> <p>Your boss offers to buy food for her family in return for sex. You choose to say nothing.</p>

**Remember to offer the participants, particularly adolescents the name and contact details of the nearest service provider (healthcare services, NGO, church, ZRP, social services, counsellor, etc.) that will be able to assist them in making constructive decisions in sexually charged situations or have more questions. Give referral slips and refer participants to relevant service providers.**

## Exercise 16: Family Planning and Contraception

This exercise introduces family planning and the various contraceptive methods that can be used to prevent pregnancy. It also covers condom use as a method of family and highlights the dual protection of condoms. Family Planning is often something that is thought of too late in the dynamics of a relationship. However, a spaced and planned family can have incredibly positive benefits to all of the members of the family. It is also important to realize that family planning is not simply avoiding pregnancy or simply avoiding having children. Family planning includes thinking about the life you want your children to have and planning for this.

### Activity 16.1: Family Planning

#### PURPOSE

This activity aims to explain family planning and the contraceptive methods used to prevent pregnancy, including short term (the pill, condoms) and long acting reversible methods (implants, IUCD and injectable) and benefits and disadvantages of each method.

Time Required: 20 minutes



#### OBJECTIVES

By the end of this activity participants will:

- ✓ Understand short term and long acting reversible methods of family planning and will be able to highlight the advantages and disadvantages of each method.
- ✓ Identify the most appropriate method for their families

#### Other Requirements

- Flip chart and marker pen
- Chart with advantages and disadvantages of contraceptive methods
- Samples of the following; contraceptive pills, male condom, female condom, an IUCD, a diaphragm

#### METHOD

1. Ask the participants to list how many times they eat and drink during one day. Some examples might be; Breakfast, Tea time, Lunch Time, after I come home from work, when I wake up, 10 o'clock etc.
2. As these are mentioned write them down on the left hand side of the flipchart
3. Then ask what they eat and drink at these times.
4. As they mention this list it on the right hand side of the flipchart
5. When they have finished listing their food, point out that all of the participants spread their eating throughout the day
6. Ask the following questions:
  - a. Why do you spread your meals, throughout the day?
  - b. If you had to eat all of this food (point to the right hand side of the flipchart) in one sitting, how would you feel
    - i. Immediately after finishing?
    - ii. At the end of the day?
7. Summarise by saying that we spread our eating throughout the day to make sure that we have energy for the whole day and so that we don't overload our bodies.

#### PROCESSING

1. Point out that family planning is much the same. Family planning does not mean not having children. Family planning also does not mean not having sex.
2. Family planning simply means deciding how many children you want and then planning when to have these.
3. The purpose of family planning is to make sure the mother and the father are not (physically, emotionally, socially and economically) overwhelmed and to make sure that the children are well looked after and cared for.
4. Couples can use a number of methods of family planning (contraception) to plan their family effectively.
5. Use the charts to summarize the family planning / contraceptive methods that are available to the participants.



If samples of the contraceptives are available, please show participants. each contraceptive method, for example oral contraceptives, injectable, condoms (male and female), IUCD (Intrauterine Contraceptive Device). **For children aged 10-15 years, emphasise abstinence.**

**Use Flip charts / Handouts / Posters or selected samples of key contraceptive methods promoted in Zimbabwe if available.**

6. Point out that some of the contraceptives are short term (the pill and condoms). Each time there is sexual intercourse, a condom has to be used correctly. Oral contraception has to be used consistently (everyday) to be effective, even if the woman does not have sex every day.
7. Other contraceptives are long acting and reversible (implants, IUCD and injectable).
8. Guide the participants in a discussion about the effectiveness, advantages and disadvantages of the various family planning methods.
9. As they mention these things turn over the correct cards and place them on the table in front of you, so that the participants can read them.
10. Summarize the discussion by pointing out that family planning is a good thing and that the couple need to decide the following for themselves:
  - a. How many children they would like to have?
  - b. When they would like to have children?
  - c. What method of family planning would be best for them to use, as a couple?
11. Conclude by telling the participants where they can get the various family planning methods and if there is a cost involved.

Remember this: Ask the couples who are present to take a few minutes to chat about their family planning methods that they think might work for them.

Remind participants that:

- 1 Condoms are still necessary to prevent transmission of HIV and other STIs, even if another method of family planning is being used.
- 2 Emphasise the DUAL PROTECTION purpose of condoms.
- 3 Other family planning methods prevent pregnancy **NOT** HIV transmission and STIs.
- 4 They should get more information on various family planning methods at health centres or from health providers.

### **Pregnancy Prevention<sup>30</sup>**

There are four main types of methods that prevent pregnancy:

1. Methods that rely on your behaviour, like abstinence, are called **behavioural methods**;
2. Methods that use hormones to interfere with ovulation, change the cervical mucus and the lining of the uterus to prevent sperm from meeting an egg and implantation, are called **hormonal methods** for example oral contraceptives and implants; and **emergency contraception**.
3. Methods that prevent the sperm and egg from meeting, are called **barrier methods** for example male and female condoms;
4. Methods that do not contain hormones, are called **non-hormonal** for example the Copper-T Intrauterine Contraceptive Device (IUCD)

**Pregnancy prevention is the responsibility of both partners.**

**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGO, church, social services, counsellor, etc.) that offer family planning services. Give referral slips and refer participants to relevant service providers.**

<sup>30</sup> Adapted from UNFPA (2016) Comprehensive Sexuality Education Manual for Out of School Young People pg. 246-247

## Contraceptive Chart

Group	Type	Definition	How it Works	Effectiveness	Advantages	Disadvantages	Side effects
Natural Methods	Abstinence	A state of not having sexual intercourse	No sexual intercourse occurs	100%	<ul style="list-style-type: none"> <li>No cost</li> <li>Natural</li> <li>Morally acceptable</li> <li>Avoids unwanted pregnancy</li> <li>Avoids STIs/HIV</li> </ul>	NIL	NIL
Barriers	Male Condom	A thin rubber sheath that covers the erect penis	Prevents sperm from entering into the vagina during sexual intercourse	98%	<ul style="list-style-type: none"> <li>No examination required before use</li> <li>Cheap and easily available</li> <li>Allows male responsibility for contraception</li> <li>Prevents spread of STI/HIV</li> </ul>	<ul style="list-style-type: none"> <li>Can tear or slip off if not worn properly</li> <li>Some may feel it will interfere with sexual act</li> </ul>	<ul style="list-style-type: none"> <li>Allergy to thin rubber</li> </ul>
	Female Condom	A strong soft plastic sheath inserted into the vagina	Same as male condom	98%	<ul style="list-style-type: none"> <li>Non-irritating</li> <li>Non-hormonal</li> <li>Does not interfere with a woman's monthly cycle</li> <li>Protects against STIs/HIV and pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>May be oily</li> <li>May be noisy</li> </ul>	<ul style="list-style-type: none"> <li>Allergy to poly-urethane (plastic)</li> </ul>
	Diaphragm	A shallow rubber cap that is put in the vagina to cover the cervix	Prevents sperms from entering the vagina	97%	<ul style="list-style-type: none"> <li>Protects against some STIs</li> <li>Decreases risk of cervical cancer</li> <li>Effective when used properly</li> </ul>	<ul style="list-style-type: none"> <li>High failure rate</li> <li>Needs sustained motivation</li> <li>May interfere with sexual act</li> <li>Requires trained</li> </ul>	<ul style="list-style-type: none"> <li>Allergies to rubber</li> <li>Can promote urinary tract</li> </ul>



Group	Type	Definition	How it Works	Effectiveness	Advantages	Disadvantages	Side effects
					<ul style="list-style-type: none"> <li>No systemic medication involved</li> </ul>	<ul style="list-style-type: none"> <li>provider for measurement</li> </ul>	<ul style="list-style-type: none"> <li>infections</li> </ul>
Spermicides	Foams, creams, pessaries or jellies	Inserted into the vagina before intercourse	Kill sperms in the vagina	97%	<ul style="list-style-type: none"> <li>Easy to insert</li> <li>Can be used by anyone</li> <li>No prescription needed</li> <li>Can be inserted just before intercourse</li> <li>No systemic effect</li> <li>May protect against cervical cancer</li> </ul>	<ul style="list-style-type: none"> <li>May interfere with sexual act</li> <li>May be messy</li> <li>Must be used before each act</li> <li>Needs sustained motivation</li> <li>High failure rate</li> </ul>	<ul style="list-style-type: none"> <li>Allergies</li> <li>May cause sensation of heat to woman or partner</li> </ul>
Oral contraceptives	Pills	These are hormonal pills	<ul style="list-style-type: none"> <li>Prevent the release of the ripe egg from the ovary</li> <li>Thickens the cervical mucus</li> <li>Prevent the inner lining of the womb from thickening in preparation</li> </ul>	99.9% (COC)	<ul style="list-style-type: none"> <li>Decrease amount of bleeding during a period</li> <li>Cheap, easily available</li> <li>Easy to take</li> <li>Does not interfere with sex act</li> <li>Reversible</li> </ul>	<ul style="list-style-type: none"> <li>COC decreases milk supply in breast-feeding mothers</li> <li>Needs sustained motivation</li> </ul>	<ul style="list-style-type: none"> <li>Weight gain</li> <li>Headache</li> <li>Nausea and vomiting</li> <li>Irregular bleeding patterns</li> <li>Missed periods</li> </ul>
	Combined Oral Contraceptives (COC)  Progestogen Only Pill (POP)	women take daily by mouth to prevent pregnancy		99.5% (POP)			

Group	Type	Definition	How it Works	Effectiveness	Advantages	Disadvantages	Side effects
			for pregnancy				
Injectable	Depo-Provera® Noristerate®	Injectable Contraceptive that contains hormone similar to that in the woman's body	<ul style="list-style-type: none"> <li>Prevent the release of the ripe egg from the ovary</li> <li>Thickens the cervical mucus</li> <li>Prevent the inner lining of the womb from thickening in preparation for pregnancy</li> </ul>	99.7%	<ul style="list-style-type: none"> <li>Very effective</li> <li>Long-acting</li> <li>Private</li> <li>Does not interfere with sex</li> <li>Easy to use</li> <li>Reversible</li> </ul>	<ul style="list-style-type: none"> <li>Requires qualified persons for injection</li> <li>Needs medical supervision</li> <li>Delays return to fertility</li> <li>Lack of period</li> </ul>	<ul style="list-style-type: none"> <li>Weight gain</li> <li>Headache</li> <li>Irregular periods</li> <li>Loss of libido</li> </ul>
Implants	Jadelle®	Two thin capsules filled with a hormone inserted under the skin of the woman's upper arm	<ul style="list-style-type: none"> <li>Prevent the release of the ripe egg from the ovary</li> <li>Thickens the cervical mucus</li> <li>Prevent the inner lining of the womb from thickening in preparation for pregnancy</li> </ul>	99.8%	<p>Immediate effectiveness</p> <p>Long-acting</p> <p>Reversible</p> <p>Highly effective</p> <p>Private</p>	<ul style="list-style-type: none"> <li>Needs to be inserted and removed by a trained person</li> </ul>	<ul style="list-style-type: none"> <li>Irregular bleeding patterns</li> <li>Weight gain</li> </ul>

Group	Type	Definition	How it Works	Effectiveness	Advantages	Disadvantages	Side effects
	Implanon	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.	<ul style="list-style-type: none"> <li>Prevent the release of the ripe egg from the ovary</li> <li>Thickens the cervical mucus</li> <li>Prevent the inner lining of the womb from thickening in preparation for pregnancy</li> </ul>	99.8%	<ul style="list-style-type: none"> <li>Immediate effectiveness</li> <li>Long-acting</li> <li>Reversible</li> <li>Highly effective</li> <li>Private</li> </ul>	<ul style="list-style-type: none"> <li>Needs to be inserted and removed by a trained person</li> </ul>	<ul style="list-style-type: none"> <li>Irregular bleeding patterns</li> <li>Weight gain</li> </ul>
Intra Uterine Device	Copper T® Multi-load®	Plastic device with copper which is inserted in the woman's uterus	<ul style="list-style-type: none"> <li>Prevents sperm from meeting and implanting</li> <li>Copper ions</li> <li>IUD weakens the sperm</li> </ul>	99.9%	<ul style="list-style-type: none"> <li>Very effective</li> <li>Last long</li> <li>Reversible</li> <li>Fewer check-ups</li> <li>Used for woman who cannot use hormones</li> </ul>	<ul style="list-style-type: none"> <li>Needs to be inserted by a trained person</li> <li>Not good for people at risk of STIs/HIV</li> </ul>	<ul style="list-style-type: none"> <li>Heavy bleeding for first 3 months</li> <li>Cramps</li> <li>Spotting</li> <li>Backache</li> </ul>
Permanent Methods	Tubal ligation (Females) Vasectomy (Males)	Tying and cutting of tubes of a woman or man to prevent pregnancy	<ul style="list-style-type: none"> <li>Prevents sperm from meeting the egg</li> </ul>	100%	<ul style="list-style-type: none"> <li>Very effective</li> <li>Permanent</li> <li>One lifetime procedure</li> </ul>	<ul style="list-style-type: none"> <li>Irreversible</li> <li>Small operation required</li> <li>Requires trained personnel</li> <li>Men do not become sterile immediately</li> </ul>	<ul style="list-style-type: none"> <li>Bleeding from site</li> <li>Infection</li> <li>Pain</li> </ul>

## Activity 16.2: Condom Use

### PURPOSE

This activity allows participants the opportunity to discuss reasonable counter arguments to excuses for not making use of condoms.

### OBJECTIVES

By the end of this activity, participants will be able to identify counter arguments to excuses for not wearing condoms.

Time Required: 20 minutes



### Other Requirements

- Excuses on slips of paper
- Male and female condoms

Recognise that it may be sensitive for young people, including adolescents, to openly talk about condom use among themselves or in the presence of parents / guardians, hence there might be need to separate young people and parents.

Write excuses people make to avoid using condoms on pieces of paper before the exercise (see table with condom excuses).

### METHOD AND PROCESSING

1. Ask participants to explore the excuses that people make to avoid using condoms and why they are willing to take the risk of exposing themselves to HIV, instead of protecting themselves.
2. Put the pieces of paper in a hat or plate and tell participants that they are going to pick a paper, read out the excuse and then give a counter argument.  
The first set of counter arguments are often similar to, "If you won't wear a condom, then you can't have sex". Explain that this is not a counter argument and is likely not to work in real life.
3. Write their counter arguments on the flipchart paper.
4. After all the pieces of paper have been picked ask participants to role play the given excuses and counter arguments.
5. Emphasise the DUAL PROTECTION of condoms (protection against HIV or STIs and pregnancy prevention).
6. Demonstrate how to wear the male or female condom to participants using relevant dummies or demonstration devices. **(Condom demonstrations should only be done with participants above 16 years of age).**

Cards with excuses

I don't know how to use a condom	The condom is not reliable and can be easily damaged
I am drunk and can't put on a condom	Condom can get stuck inside the woman
The condoms are too tight	A condom has virus in it
There is no condom available	There are defective condoms, they break
"Don't you trust me?"	Buying a condom is embarrassing and is a sign of promiscuity
Condom decreases sexual pleasure / satisfaction It is like eating candy / banana with its cover	Condoms make people more promiscuous
Not one of my friends uses condoms, why should I?	

## Counter arguments to excuses for not wearing condoms<sup>31</sup>

Note that the counter arguments provided below are just examples. Counter arguments are given based on circumstances and context.

Excuses	Counter arguments
I don't know how to use a condom	No one was born with knowledge on how to do certain things. But you can learn from health workers how to use condoms correctly and consistently.
I am drunk and can't put on a condom	"If you are too drunk to put on a condom, you should not have sex and put me at risk. It's totally irresponsible not to practice safer sex.
The condoms are too tight	There are different condoms to accommodate different penis sizes, and you have to get the right condom that fits your size.
There is no condom available	Some condoms are available for free at most public places (health centres, beer halls, and public toilets), and also available for purchase at various supermarkets, pharmacies and service stations at affordable prices.
"Don't you trust me?"	"Using a condom does not mean I do not trust you". It simply means you care enough to protect your partner and yourself from STIs, HIV and unintended pregnancy. Even if the partner is on another contraceptive method, they are not protected against STIs and pregnancy.
Condoms are unreliable and break easily	If condoms are kept in the recommended environment and used correctly, they are reliable and don't break easily.
"Why should I use a condom, I am not promiscuous"	One can use a condom with a partner and still be faithful. It shows that you are responsible.
"Condoms decrease my sexual pleasure / satisfaction" It is like eating candy/banana with its cover	There are different types of condoms that enhance sexual pleasure (e.g. some are ripped, extra thin and flavoured). Sex is just as pleasurable and arousing when condoms are used.
None of my friends use condoms, why should I?	If all of your friends are risking their lives and future, does this mean you should too? Avoid peer pressure.

<sup>31</sup> German Foundation for World Population (DSW), 2006. *Sexual and Reproductive Health Training Manual for Young People*. Pages 142

## FACILITATOR'S INFORMATION: HOW TO USE A MALE CONDOM<sup>32</sup>

Practice putting a condom on by following these steps:

1. **Check the expiry date** on the package. **Squeeze the condom package** and make sure there is still air in it. If there is no air, there is a hole in the package. If it is too old or has no air in it, don't use it.



Step 1



Step 2



Step 3



Step 4

2. When the penis is hard or erect, **carefully open the condom package** along the side with the jagged edge (not the smooth side). Do not use your teeth or a sharp object, like a knife or scissors; this could accidentally damage the condom.
3. **Remove the condom and determine the correct side to unroll.** Make sure it looks like a hat, with the tip coming up through the rolled edges so it will roll down. **If the man is not circumcised**, make sure the foreskin is rolled down before putting the condom on.

**Tip:** To increase the man's feeling when using a condom, put a drop or two of water-based lubricant or saliva in the tip before putting it on. Do **not** use body lotion, oil or Vaseline – this could cause the condom to break.

4. Place the rolled condom on the head of the penis and **pinch or hold the tip of the condom tightly** to remove the air. Leave a centimetre of space for the semen to make sure the condom does not burst or break when the man ejaculates.
5. While pinching or holding the tip with one hand, **unroll the condom all the way down** to the base of the penis with the other hand. Smooth out any air bubbles. You are now ready to have sexual intercourse.



Step 5



Step 6



Step 7

6. After ejaculation and before the penis gets soft, **hold the condom firmly at the base of the penis and carefully withdraw** from your partner. This prevents the condom from coming off the penis when you pull out and any spilling of the semen.
7. **Put it into the rubbish bin or pit toilet. Don't try to flush it down the toilet.** Wipe any semen off the penis. Use a new condom every time you have sex.

<sup>32</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People* 242

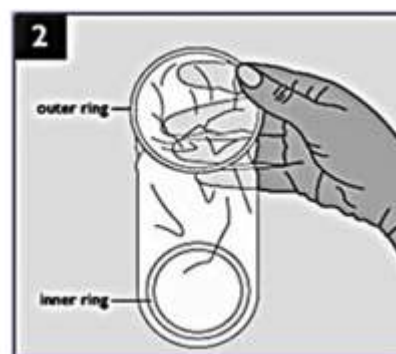
**For the female condom,** make sure the points in the information below are mentioned. If they are not, discuss them with the participants.

### FACILITATOR'S INFORMATION: HOW TO USE A FEMALE CONDOM<sup>33</sup>

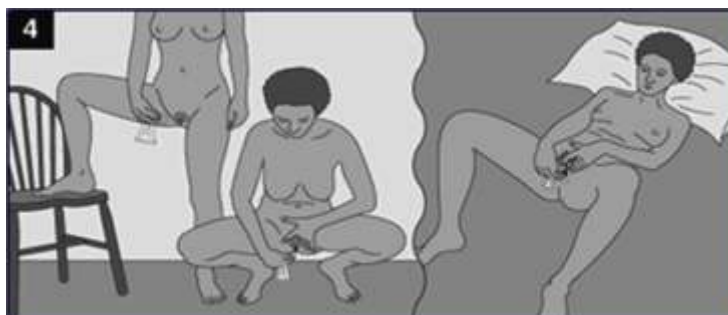
Follow these steps to use a female condom:

1. **Check the expiry date** on the package. **Squeeze the condom package** and make sure there is still air in it. If there is no air, there is a hole in the package. If it is too old or has no air in it, **don't use it**.
2. When you are ready to insert the condom (up to 8 hours before sex), **carefully open the package** and remove the condom. Tear the package at the notch on the top right – see picture 1. Do not open the package with your teeth or a sharp object like a knife or scissors.

The female condom is a long polyurethane bag with two rings. The outer ring is attached to the edge that opens. The inner ring is loose inside the bag. The outer ring will cover the area around the opening of the vagina. The inner ring is used for insertion and to help hold the condom in place during intercourse. **See picture 2 below**



3. Hold the condom with the **open end hanging down** and **squeeze the inner ring at the closed end** with two fingers so it becomes long and narrow or turns into a figure eight. **See picture 3.**

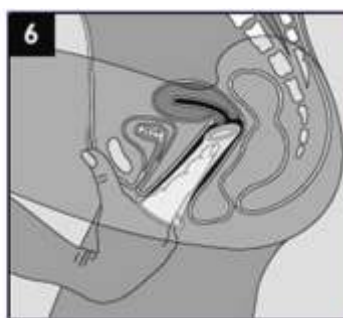
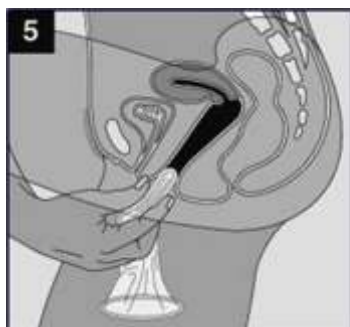


4. **Choose a comfortable position** – raise one leg, sit or lie down. **See picture 4.**

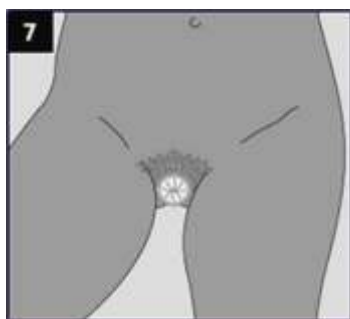
<sup>33</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People* pg. 243-244



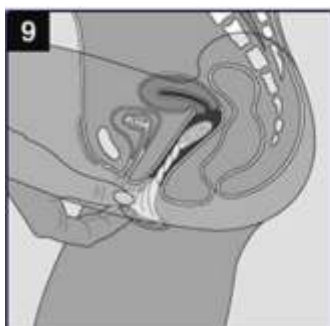
5. With your other hand, spread the lips open and **gently insert the inner ring into the vagina**. Place your index finger inside the condom, and **push the inner ring up as far as it will go**. Make sure the outer ring is outside the vagina and the condom is not twisted. **See pictures 5 and 6.**



6. The condom is now in place – see picture 7. When you are ready to have sex, **guide the penis inside the condom**. Be sure the penis does not go to the side of the condom and make sure it stays inside the condom during sex. **See picture 8.**



7. To remove the condom after sex, **squeeze and twist the outer ring** to keep the semen inside the pouch. **See picture 9.** Then gently pull the condom out of the vagina. Throw it away in a rubbish bin or pit toilet. Do not flush it down the toilet.



**Reference:** <http://www.ripnroll.com/femalecondoms.htm>

Female condoms are not difficult to use and may require some practice to get used to. Women should practice putting the condom in and removing it prior to using it for the first time during sexual intercourse. If someone has difficulties, they can ask for advice and assistance at a family planning clinic.

**Remember to offer the participants, including young participants the name and contact details of the nearest service provider (youth friendly health facilities, healthcare services, family planning services, NGOs, social services, counsellors etc.) that will be able to provide assistance regarding condom use. Give out referral slips and refer participants to relevant service providers.**



# Exercise 17: The Oversized Pumpkin: Cancer Awareness

## PURPOSE

This exercise seeks to explain the basic facts about different types of cancer, particularly cervical cancer, breast cancer and prostate cancer. The exercise also aims to explain the benefits of early diagnosis in treatment and prevention.

Time Required: 30 minutes



## Other Requirements

- Picture of Gertrude and the vegetable garden
- Cross-section diagram of the female reproductive system

Make sure you have read through the basics of cervical cancer, breast cancer and prostate cancer, so that you can use this information in the discussion

## OBJECTIVES

By the end of this exercise, participants will be able to:

- ✓ Understand the basics related to cancer with emphasis on cervical cancer, breast cancer and prostate cancer, and benefits of early detection.
- ✓ Understand primary prevention of cervical cancer, including screening, abstinence, vaccination and being faithful to one sexual partner

## METHOD

1. Explain that you are going to read a story and ask some questions about it. Ask the participants to listen carefully. Read the story about the Oversized Pumpkin.
2. Using the cross-section diagram of the female reproductive system, show participants where the cervix is located.
3. Ask participants to identify when things started to go wrong. Ask the following questions:
  - a. Did things start to go wrong when Gertrude planted the seeds?
  - b. What about when the pumpkin started to grow?
  - c. Did things take a turn for the worse when Gertrude went away for a few weeks? Why was this?
  - d. Could Gertrude have prevented this from happening? What could she have done?

## PROCESSING

1. Explain to the participants that the vegetable garden is like a person's body. It has many different parts and all these parts work together, and keep us healthy.
2. However, there is a disease called cancer.
3. Cancer occurs when normal cells of the body behave differently and start growing and growing and growing.
4. Ask the participants to highlight the different types of cancers that they know (cervical, breast, prostate, liver, lung etc.)
5. Explain that most cancers can be treated if diagnosed early. Just like Gertrude could have treated the pumpkin if she had found the beetles earlier.
6. If cancer is left untreated it can take over the whole body, just like the pumpkin took over the vegetable patch.
7. There is a type of cancer that only affects women– it is called cervical cancer. It is when cells on the cervix continue to grow.
8. If cancer is detected early, it can be treated easily; just like Gertrude could have saved the pumpkin if she had spotted the beetles early. Ask participants: **How could Gertrude have saved the pumpkin?**
7. It is suggested that women, at least once every three years, allow a medical practitioner to perform an inspection of their cervix. This is a process cervical screening which can be done through either VIAC or Pap smear.
8. Explain what VIAC stands for and the process followed during VIAC. Discuss where VIAC can be accessed. Explain the Pap-smear test and discuss where and how it can be accessed.
9. An HPV vaccine is now available and can be administered to girls from 10 years.



## The Oversized Pumpkin

Gertrude is Samson, Admire and Tatenda's grandmother. She often visits the family and when she does she loves to take some fresh vegetables with her, to share. These vegetables are grown in her own vegetable garden in the small patch of land behind her house. She has many different types; spinach, corn, carrots, beetroot, sweet potatoes, onions lettuce, potatoes and butternut. The one thing she does not grow however, is pumpkin. Can you think why? Let me tell you the story...

The morning promised a wonderful day ahead. The rain during the night had left a garden that was fresh looking and sweet smelling. It just invited someone to come and plant, and Gertrude was going to accept that invitation. She headed out to the garden with all her equipment in hand, a hoe, a small trowel, a large fork for turning the soil and, of course lots of seeds. Gertrude planned her garden well and looked after it. After all, much of her daily food came from this garden. If she did not look after it, she would not be as healthy as she was. She weeded and watered and planted and trimmed and pruned and composted and mulched and supported and harvested.

"Mmm, let's see", she said to herself, "Carrots at the front where there is more drainage, and onions over there. Potatoes far away from the onions – they don't like growing near one another. Maize I will put at the back, against the wall so that they don't shade the other plants. What about the pumpkin? Where shall I put that? I know, over there where there is lots of space for it to grow."

Soon, given the warm weather, the rain, and of course Gertrude's care and attention, the garden soon began to flourish. Fresh vegetables were on her dinner table and the tables of her neighbours every night. She was particularly pleased with her pumpkin, and looking forward to harvesting that – it was her favourite. Green shoots soon appeared and the creepers from the plant quickly established themselves.

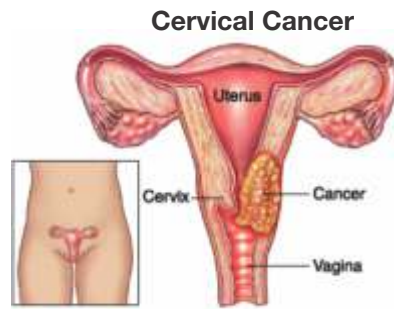
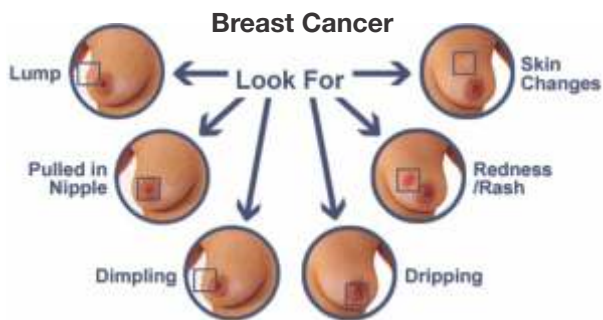
A few flowers soon indicated that there was going to be a number of pumpkins, but instead only one pumpkin seemed to appear. It was round and smooth, just as it should be. And it grew, and grew, larger and larger. Gertrude, in her garden each day, did not pay too much attention to it. After all pumpkins are known to take up lots of space, and it was her favourite. However, one evening, after returning from a visit to family for a few weeks, she took a walk into her garden and noticed that her beetroot plants had disappeared.

The following morning, she went out to take care of this and realized that her peas and beans were also "under attack". The beetroot plants were still there, but were withered and dry. The pumpkin leaves had shaded them and prevented the sun getting to them. The pumpkin had also grown up the supports Gertrude had placed for the peas and beans and, as a result, the pods for the peas and beans were small and withered. The tendrils of the pumpkin had also made their way into the rows of spinach leaving them looking wilted. "My goodness", she thought, "I have lost all of my vegetables, but at least I still have the pumpkin".

In contrast, the pumpkin itself looked wonderful. It was big and fat and round, and by the looks of things promised to provide enough pumpkin for Gertrude and all her neighbours. But there was something wrong. "Sniff! Sniff!" Gertrude tilted her head and tried to find out where the smell was coming from. "Sniff! Sniff!" As she bent over the beautiful, round, fat pumpkin, the smell grew stronger and stronger. And it was not a nice, warm, rich healthy smell of a vegetable garden; it was a terrible, rotten smell.

Gertrude turned the pumpkin over, and there, a round brown hole, with beetles crawling in and out told the full story. Taking a spade and whacking the pumpkin revealed the awful truth; the pumpkin had been eaten from the inside out. Gertrude was very disappointed. She looked over her ruined garden, no beetroot, no peas and beans, withered spinach and now no pumpkin. There was nothing left to take to her family and friends.

And from that day on Gertrude never grew pumpkin in her garden again.



**Remember to offer the participants, including young participants the name and contact details of the nearest service provider offering cancer screening services and information regarding cancers of the reproductive system. Give out referral slips and refer participants to relevant service providers.**

### **FACILITATOR'S INFORMATION**

Cancer is a condition where one's body cells grow out of control and form lumps of tissue known as tumours. There are many different types of cancer and they are named after the organ from which it begins. If it remains untreated it can spread throughout the body. It is relatively easy to treat if it is diagnosed early and there are some basic steps that can be taken to reduce risk of cancer.

#### **Basic Information On Cervical Cancer**

Cervical cancer is caused by the Human Papilloma Virus which is transmitted mainly through sexual contact and most people are infected with HPV shortly after the onset of sexual activity. If cervical cancer is found early there is a 100% survival rate.

#### **Who Is at Risk of Getting Cervical Cancer?**

Your risk increases if:

- You started having sex at an early age
- You have had multiple sexual partners
- Your sexual partner has had multiple sexual partners
- Smokers (Tobacco use)
- You have other STIs
- Your diet is low on fruits and vegetables
- You have used oral contraceptive pills for a long time
- Immune suppression (for example, HIV-infected individuals are at higher risk of HPV infection and are infected by a broader range of HPV types)

#### **Signs of cervical cancer**

Symptoms of cervical cancer tend to appear only after the cancer has reached an advanced stage and may include:

- Abnormal bleeding or spotting from your uterus (Periods last longer than usual and periods are heavier than usual)
- back, leg or pelvic pain
- fatigue, weight loss, loss of appetite;
- vaginal discomfort or odorous discharge; and
- a single swollen leg

#### **How do you guard against cervical cancer?**

- Abstain from sexual intercourse
- Delay your first sexual intercourse
- Reduce the number of sexual partners
- Promotion and provision of condoms for those already engaged in sexual activity;

- Go for regular cervical cancer screening, VIAC – to check on the health of your cervix
- Stop smoking
- Circumcised men are less likely to pass on the HPV to their partner

### **Cervical Cancer Screening and Treatment**

The Zimbabwe Ministry of Health and Child Care has an established cervical cancer prevention programme that offers Visual Inspection using Acetic Acid and Cervicography (VIAC) screening and treatment at several of the nation's major hospitals.

**The VIAC procedure** - VIAC begins by swabbing the cervix with a vinegar-like solution of dilute acetic acid. If abnormal cells are present, the vinegar-like solution turns the abnormal cells white. Next, a camera is used to photograph the cervix. The photo helps identify the presence of abnormal cells. If abnormal cells are identified, the person can receive treatment immediately or can be referred for further examinations and treatment.

**Pap Smear** is another method of diagnosing cancer early and is available in some health facilities.

**The HPV vaccine** targets girls before they become sexually active in order to prevent acquisition of the human papillomavirus, a sexually transmitted infection.

*Adapted from WHO Fact sheet: Human Papilloma Virus (HPV) and Cervical Cancer June 2016 [available online at] <http://www.who.int/mediacentre/factsheets/fs380/en/> accessed 23/04/17*

### **Breast Cancer<sup>34</sup>**

Breast cancer occurs when normal breast tissue cells behave differently and start growing abnormally. Some warning signs of breast cancer are;

- New lump in the breast or underarm (armpit).
- Thickening or swelling of part of the breast.
- Irritation or dimpling of breast skin.
- Redness or flaky skin in the nipple area or the breast.
- Pulling in of the nipple or pain in the nipple area.
- Nipple discharge other than breast milk, including blood.
- Any change in the size or the shape of the breast.
- Pain in any area of the breast

To reduce the risk of getting breast cancer; eat healthy, exercise regularly, avoid taking alcohol, avoid exposure to chemicals that can cause cancer, and breastfeed any children you may have.

Women and men are encouraged to for regular breast examination (mammogram) at the health facility.

### **Prostate Cancer<sup>35</sup>**

The prostate is a walnut small shaped gland found in men. The prostate gland surrounds the neck of the bladder and the beginning of the urethra. The bladder stores urine whilst the urethra is the tube that drains urine from the bladder through the penis. Cancer which starts in the prostate gland is referred to as prostate cancer or put simply cancer of the prostate.

<sup>34</sup> Centre for Disease Control. Breast Cancer basic information [available online at] [https://www.cdc.gov/cancer/breast/basic\\_info/symptoms.htm](https://www.cdc.gov/cancer/breast/basic_info/symptoms.htm) accessed 23/04/17

<sup>35</sup> Prostate Cancer Foundation. Prostate Cancer Symptoms [available online at] <https://www.pcf.org/c/prostate-cancer-symptoms/> accessed 23/04/17

Prostate cancer does not have early symptoms and the latter symptoms may include;

- ➔ A need to urinate frequently, especially at night; sometimes urgently
- ➔ Difficulty starting or holding back urination
- ➔ Weak, dribbling, or interrupted flow of urine
- ➔ Painful or burning urination
- ➔ Difficulty in having an erection
- ➔ A decrease in the amount of fluid ejaculated
- ➔ Painful ejaculation
- ➔ Blood in the urine or semen
- ➔ Pain or stiffness in the lower back, hips, pelvis, or thighs

To reduce the risk of getting prostate cancer: exercise more to maintain a healthy weight, maintain healthy diet, avoid smoking and drinking alcohol, and seek medical treatment for stress, high blood pressure, diabetes, high cholesterol, and depression.

**It is important to note that most cancers do not have early signs and symptoms therefore it is necessary for people to focus more on behaviours that reduce the risk of getting the cancers.**



# Exercise 18: Sexual and Gender Based Violence (SGBV)



This exercise explores Sexual and Gender Based Violence (SGBV), and enables participants to reflect on acts perpetrated against a person's will based on gender norms and unequal power relations. SGBV entails threats or violence and coercion. Such violence can be physical, emotional, psychological and sexual in nature. The activities in this exercise examine various forms of touching and violence and enables participants to think about what to do if they or someone they know experiences violence, as well as how to report cases of violence.

## Activity 18.1: Sexual and Gender-Based Violence

### PURPOSE

This activity gives participants an understanding of the different forms of Sexual and Gender-Based Violence. It gives participants the platform to discuss the contributing factors to SGBV, consequences of SGBV and the steps to reporting an SGBV case.

### OBJECTIVES

By the end of the activity the participants will:

- Know the different facets of sexual and gender based violence (SGBV)
- Be able to act together to address SGBV within the household and community
- Identify channels for reporting SGBV cases

Time Required: 60 minutes



### METHOD AND PROCESSING

1. Ask participants what the term 'sexual and gender based violence' (SGBV) means. Participants should provide examples of SGBV.
2. Define the term "gender" by explaining that gender is how society tells us men and women should act and behave, and roles and positions that men and women can have in the society.
3. Depending on the number of participants, determine the number of groups to act out or discuss the different types of SGBV.

Point out that SGBV can be done in a number of ways including:

- a. physical (hurts the body)
  - b. emotional (hurt feelings)
  - c. sexual (sexual abuse)
4. Also point out that violence is not necessarily doing something, but it might also be withholding or NOT doing

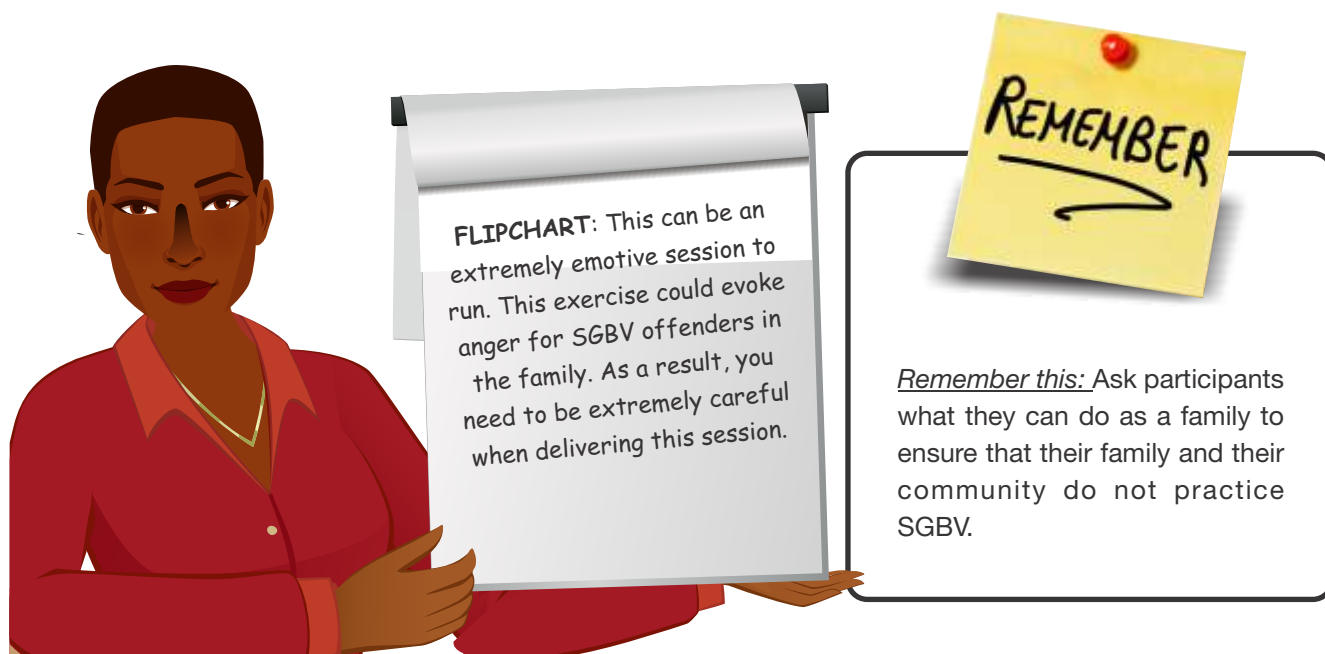
something.

5. Engage in a discussion with participants on the causes of sexual and gender based violence in families and communities. These may include societal / gender norms on sexual rights, denial of conjugal rights, views of manhood, 'lobola' or bride price, sexual exploitation of children, and poverty, etc.
6. Ask how the victims suffer as a result of violence (e.g. physical violence might result in bruises and cuts and broken bones, emotional violence might result in depression and low self-esteem, etc.). Discuss how SGBV affects the family. Highlight other possible consequences of SGBV such as unintended pregnancy, STIs, HIV, suicide, homicide, divorce, etc.
7. Read the story "Violence" and ask participants to identify the forms of violence in the story and what they would do if they were Tanaka and Sihle. Make sure the group decides that the incident should be reported, and state why it should be reported and to whom?

**Answer: Forms of violence in the story include sexual, physical and emotional. The emotional violence occurred when Mr. Moyo offered the children money and asked them to keep the incident a secret. The threat and risk of being raped pose emotional violence and trauma.**

Point out that many cases of SGBV are covered up (hidden), and families and communities hardly speak out to protect the victim.

8. Ask the participants what they can do to start speaking out against SGBV in the household and community. Separate this into two categories: How to support the victims and How to prevent or discourage abuse.



It is important that any form of violence **MUST** be dealt with and reported to responsible authorities (e.g., the Police Victim Friendly Unit and SGBV clinics). In the event of sexual abuse victims may access a package of services including PEP, STI screening and treatment, pregnancy testing and other referrals (**refer to the SGBV service-flow process**).



Remember to offer participants the contact details of the nearest ZRP-Victim Friendly Unit, health care providers, social services, counsellor etc. Encourage participants to report any cases of sexual and gender based violence. Give out referral slips to the household members and refer them to relevant service providers.

## Violence

Tanaka and his sister Sihle are sent by their mother to get some cooking oil from their neighbour, Mrs Moyo. They usually go to Mrs Moyo's house to play with her children. Upon arrival they are told that Mrs Moyo has gone to the shops, and her husband, Mr. Moyo offers them fruits while they wait for her. As they are eating the fruits, Mr. Moyo starts rubbing Sihle's thighs. Tanaka tries to stop Mr. Moyo but he slaps him on the cheek while he tries to remove Sihle's clothes. Sihle falls on the ground and Mr. Moyo forces himself on her but she manages to fight back. In the process her dress is torn and Mr. Moyo angrily pushes Sihle out of the room. Just before they leave the house, Mr. Moyo offers Tanaka and Sihle some money and asks them not to tell anyone about what happened and keep it a secret.

*Source: Adapted from Population Council Zambia, 2013. Adolescent Girls Empowerment Program (AGEP): Health and Life Skills Curriculum*

## Activity 18.2: Good, Confusing, and Bad Touches<sup>37</sup>



<sup>37</sup> Population Council Zambia, 2013. Adolescent Girls Empowerment Program (AGEP): Health and Life Skills Curriculum. Pages 216 – 238

## PURPOSE

This activity enables parents and children to understand good, confusing and bad touches and understand that some victims of sexual abuse are assaulted by family members, relatives or friends.

## OBJECTIVES

By the end of the activity participants will be able to

- Understand different types of physical contact.
- Differentiate between a 'good touch', 'a bad touch' and 'confusing touch'.

**Time Required: 15 minutes**



## Other requirements

- Flipcharts and markers

**NB:** The activity applies to both boys and girls.

## METHOD

1. Ask: What is a touch? Let participants give examples of touches.
2. Ask one participant to demonstrate examples of touches on themselves.
3. Draw three columns on a chalkboard or flipchart and label them; Good touches, Confusing touches and Bad touches.
4. Ask: What are some examples of good touches, confusing touches, and bad touches?
5. Write the participants' examples of the kinds of touches into their corresponding category on the table as illustrated in the table, 'Kinds of Touches'.
6. Ask participants to highlight the touches that may be "culturally acceptable" but bad, for example, '*kutamba chiramu*'. Discuss how these touches may lead to violence, both physical and sexual.

**Explain:** Some of these touches could be good touches or bad touches depending on the context and intent of the touch, and the relationship between the two people. If someone touches you sexually without your consent, it is a bad touch.

Sexual exploitation usually happens gradually. It starts with a good touch, goes to a confusing touch and into a bad touch. It also usually involves tricks, threats, or treats. Most often it involves a person known to the exploited, even though it also happens with strangers. Many times it can involve a pact of secrecy and it can affect both boys and girls.

## Examples of different types of touches

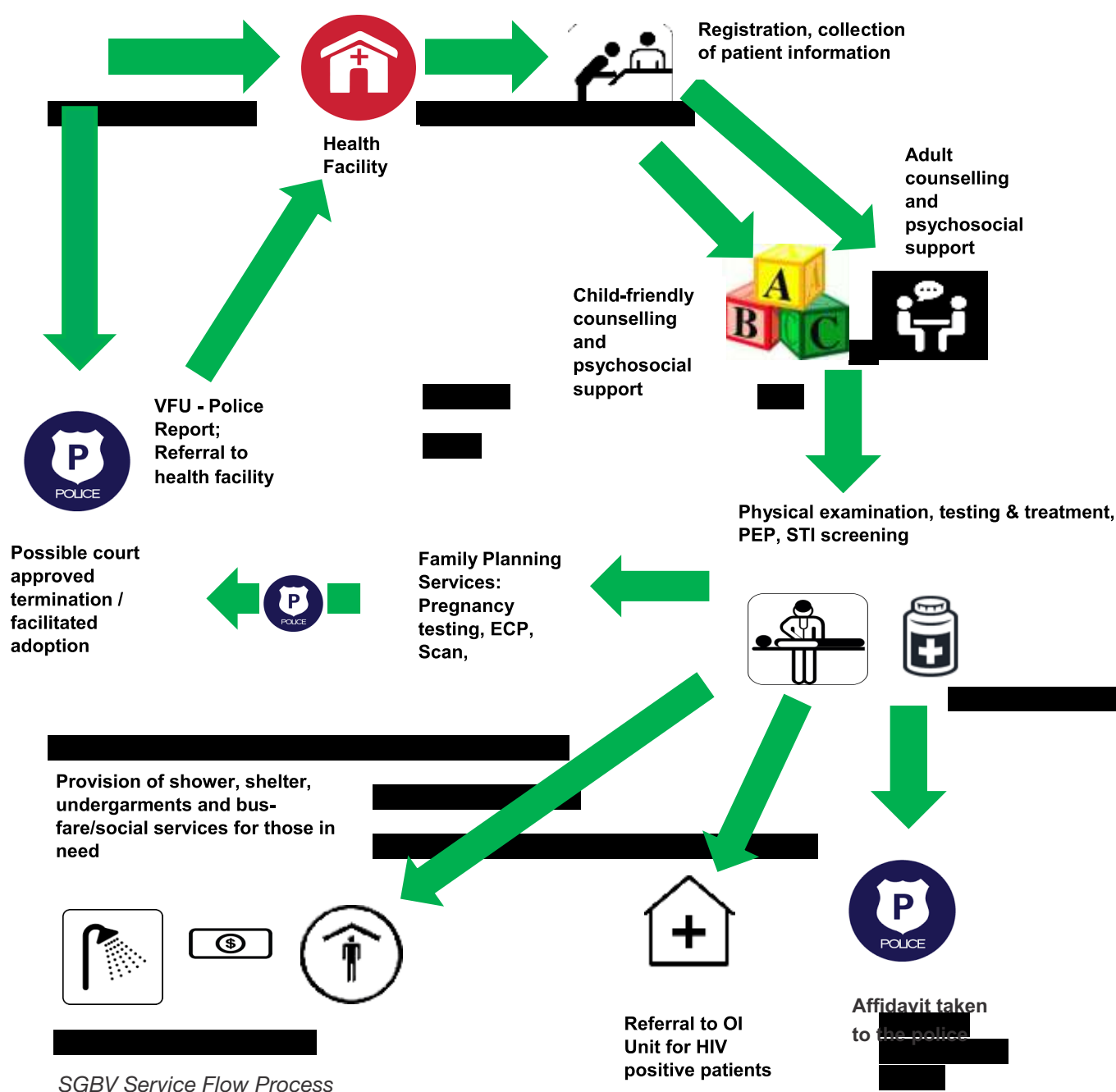
Good touches	Confusing touches	Bad touches
Hugging	Kissing	Kicking
Holding hands	Tickling	Biting
Hair brushing	Handshake with a pinch	Punching
A pat on the back	Backrubs	A pat on buttocks
A doctor's examination		Slapping
Kissing		Pinching
Tickling		Kissing

**Key Message:** Not all touches are good – if you experience a bad touch, tell someone about it and address the problem before it develops into something more serious.

### Explain:

- It is important for parents and children to openly talk about inappropriate touches. A bad touch should be reported regardless of who the perpetrator is; whether a parent, guardian, teacher, or trusted relative as soon as possible because these touches do not normally end there – they can develop into actions such as forced sex. All bad touches should be taken seriously by families and communities.
- In situations where bad touches occur, it is important for parents / caregivers of children to seek child-friendly services and ensure that children receive counselling and support.
- Girls and boys have the right to say 'NO' to anyone who wants to touch them without their consent even if that person is a peer, boyfriend / girlfriend, parent or relative.

### SGBV Service-Flow Process<sup>38</sup>



<sup>38</sup> Check with MoHCC / UNFPA and partners regarding the SGBV flow chart

## FACILITATOR'S INFORMATION

### Consequences of SGBV<sup>39</sup>

Consequences of Violence against Women and Girls include:

Physical Consequences	Emotional Consequences	Social Consequences	Economic Consequences
<ul style="list-style-type: none"> <li>· Injuries</li> <li>· Chronic or recurring pain</li> <li>· Digestive problems</li> <li>· Limited mobility</li> <li>· Unwanted pregnancies</li> <li>· Sexually transmitted infections (STIs)</li> <li>· Increased tobacco, alcohol and drug use</li> <li>· General poor health and even death</li> </ul>	<ul style="list-style-type: none"> <li>· Low self-esteem</li> <li>· Anxiety and depression</li> <li>· Fear, post-traumatic stress, and panic attacks</li> <li>· Learned helplessness and despair</li> <li>· Identification with the aggressor</li> <li>· Victims vent their frustrations on others</li> <li>· Emotional suffering, including withdrawal, loneliness and even suicide</li> <li>· Mistrust of others</li> <li>· Inability to concentrate</li> </ul>	<ul style="list-style-type: none"> <li>· Short and long term social isolation</li> <li>· Rejection and social stigma</li> <li>· Divorce and broken families</li> <li>· Psychological scars</li> <li>· Increased dependence on the aggressors for economic security</li> <li>· Victims accept violence as an alternative means of conflict resolution and communication</li> </ul>	<ul style="list-style-type: none"> <li>· Loss of income</li> <li>· Loss of jobs</li> <li>· Loss of skills building opportunities</li> <li>· Increased poverty</li> <li>· Impaired judgement over managing money</li> <li>· Inability to provide for dependents</li> </ul>

<sup>39</sup> Adapted from Plan International (2016) *Living free from Gender-Based Violence. In Girls Champions of Change: Curriculum for Gender Equality and Girls Rights*. Working, UK: Plan International pg. 33; and Minnesota Advocates for Human Rights (2003) *Causes and Effects of Gender-Based Violence*

### **Guidelines related to assisting survivors of rape and SGBV.**

Survivors of rape and sexual abuse are encouraged to seek health care as quickly as possible.

People that have been sexually violated should visit any service provider closest to them (these include health facilities (clinic or hospital), ZRP Victim Friendly Unit, Legal services). These have been provided with guidelines of providing this services which include the following:

- No decision should be made without the informed consent of the survivor.
- Discussions with client/ survivors should be conducted in private settings, preferably with a person of the same-sex as the survivor (where possible).
- Being a good listener, and being non-judgemental.
- Being patient and not pressing for information the survivor does not want to share.
- Asking only relevant questions.
- Avoiding the survivor having to repeat her story in multiple interviews.
- Refraining from laughing showing disrespect, disbelief or sympathy.
- Never blaming the survivor.
- Prioritising the survivor and staff safety and security at all times.
- Always observing the guiding principles of Confidentiality, Safety, Respect and Dignity.

By law, all incidents of rape and sexual abuse of children must be reported to the police. However, rape treatment can be initiated before informing the police. So you can ask for treatment before having to report the rape to the police. According to the law, nurses can now treat survivors and are authorised to fill out the medical affidavit. Priorities for referrals are:

#### **1. Health care**

- Female survivors will get emergency contraceptives within 72 hours of incident.
- Post Exposure Prophylaxis (PEP) for HIV within 3 days of incident.
- STI Prophylaxis within 5 days of incident.
- Termination of pregnancy in the event of pregnancy after sexual abuse. This termination is done after authority is granted by a magistrate
- Survivors of sexual violence can access services at a hospital or clinic nearest to them.

#### **2. Psychosocial support**

- It's never too late to seek emotional and psychosocial support.
- Helps adult survivor to make decision about reporting to the police.
- Helps survivor to move on.
- Involvement of the Department of Social welfare in cases involving children.
- Cases can be referred for community based counsellors for long term support.
- Assists in finding safe shelter for the survivor.

#### **3. Legal/Justice AID**

- Victim Friendly Units – ZRP have been trained on appropriate interaction and treatment of survivors of SGBV.
- Department of social services is called in for cases involving children and vulnerable adults as probation officers.
- Cases of sexual violence can be tried before a victim friendly court.

Legal aid service organisations can:

- 1 Help survivors through the court process.
- 2 Assist in claiming civil remedies such as damages
- 3 Assist in obtaining protection orders
- 4 Assist minors and other incapacitated persons to assert their rights
- 5 Monitor the court process

# Exercise 19: Child Marriage<sup>40</sup>

## PURPOSE

This exercise seeks to explore drivers and consequences of child marriage and how child marriage can be stopped. Child marriage is a form of sexual and gender based violence, and a violation of human rights. Any marriage of a child under the age of 18 years is illegal, and a violation of the Constitution of Zimbabwe.

Time Required: 30 minutes



## OBJECTIVES

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

- Identify causes and consequences of child marriage;
- List the human rights violations related to child marriage;
- Explore ways to end child marriage.



## Other Requirements

- Flipchart paper
- Marker pens

## METHOD

1. Ask participants to call out the first word that comes to their mind when they hear the word 'marriage.' Write these on a piece of flipchart paper. Then ask them what they notice about the words written on the flipchart paper.
2. Tell them that this exercise is about child marriage.
3. Ask them what the term 'child marriage' means. Use their responses to come up with the following definition of child marriage:  
**Child marriage is any marriage of a person under the age of 18.**
4. Read Alice's story below and generate discussion by asking the questions that follow.

### Agnes' Story

Three months ago, my parents sat me down and told me I was no longer their responsibility. They wanted me to move out and start a life of my own. When a stranger paid a bride price to my parents, things moved faster than I expected and I had no say in the matter. I didn't choose this life and I'm not happy here. I want to escape but I am afraid my parents won't take me back. Sometimes it is hard to defy our parents because it is disrespectful, but we can't continue to allow them to make choices that are bad for us. It was my wish to finish school and become a nurse but I guess that will never happen because my husband won't allow me to further my studies. Now instead of going to school, I spend the whole day doing chores -- washing dishes, cleaning and cooking. My husband expects me to fall pregnant as soon as possible so that I prove my fertility and be respected as a wife and in-law in a family. **Agnes, 17 years old**

- Did Agnes want to get married?
- Why did she get married, if she did not want to?
- How does she feel about her marriage? Why?
- How does she feel about her future? Why?
- What do you think about her situation?

Source: Maseko, Nomsa (2014). *Zambian child bride: 'I was forced to marry a stranger'* BBC News, Chibombo, Zambia. Available at <http://www.bbc.com/news/world-africa-28401068> in UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People* pg. 333

<sup>40</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People* pg. 384

5. Tell the participants to brainstorm all the consequences of child marriage. Ask them for their ideas and write the ones that are immediate consequences under the heading 'Immediate consequences'. Answers may include: Stop going to school, unprotected sexual intercourse, rape, relationship problems and being unhappy (or miserable).
6. For each immediate consequence, ask them: what are the consequences of this (e.g., stop going to school)? If they name one that leads to further consequences (such as lack of job qualifications), after writing it down, ask: And what will happen later because of that? (e.g., unemployment, poverty, dependence on husband).

They may include the consequences listed below (use the ones they give you, you do not need to get all of these answers, but make sure the most significant ones are mentioned):

- Consequences of not going to school: lack of qualifications for work; unemployment; less money for family/greater poverty; financial dependence on husband; unable to leave marriage.
  - Consequences of unprotected sexual intercourse or rape: early pregnancy; STIs and/or HIV; problems when giving birth; fistula (tears between the vagina and the bladder or the rectum; death of the young mother; death of the foetus or baby.
  - Consequences of having relationship problems: fights and arguments; beatings; injuries; rape or sexual abuse; divorce; single-parenthood.
  - Consequences of feeling unhappy or miserable: depression; wanting to commit suicide; running away; living on the street; turning to sex work to earn money.
7. Then ask the participants the following questions:
    - Looking at all of these consequences - what is your opinion of child marriage?
    - What does the community say about child marriage?
    - What does the Zimbabwean constitution say about child marriage? Build on their responses and tell them that the Constitutional Court made a ruling which states that:

'With effect from 20 January 2016, no person male, or female, may enter into any marriage, including an unregistered customary law union or any other union including one arising out of religion or religious rite, before attaining the age of eighteen (18) years'.<sup>41</sup>

8. Ask participants to suggest practical ways to stop child marriage in their communities. Possible answers; stop traditional and religious practices that support child marriage, girls' empowerment, law enforcement etc.

**Remember to offer participants the contact details of the nearest ZRP-Victim Friendly Unit, health care providers, social services, counsellor etc. Emphasise that child marriage is illegal, and household members should report any cases of child marriages to the local authorities. Give out referral slips to the household members and refer them to relevant service providers.**

<sup>41</sup> <http://www.kanokangalawfirm.net/landmark-ruling-on-child-marriages-in-zimbabwe/>



## FACILITATOR'S INFORMATION: CHILD MARRIAGE

### Causes of child marriage<sup>42</sup>

The causes of, and risks for, child marriage follow a cycle of harmful causes and effects. Gender inequality – and related violation of girls' rights – drives child marriage. The effects of child marriage, in turn, further entrench gender inequalities and denial of girls' rights. There is thus considerable overlap between the harmful impact and the causes of child marriage.

Factors contributing to child marriage include the following:

- ✓ Geographic location: Girls from rural areas are more likely to be married as children than their urban counterparts.
- ✓ Poverty: Those married before the age of 18 are more likely to live in poorer households and those married later are more likely to live in richer households.
- ✓ Low educational attainment: Child brides are less educated than women married after the age of 18 and more likely not to attain more than secondary education.
- ✓ Isolation: Child brides often have fewer social connections than girls who marry later.

Socio-economic, cultural and religious factors influence gender inequality and norms that perpetuate child marriage.

Some examples of these factors include:

- ➔ Poverty, and the economy of marriage (such as bride price and dowry - the potential financial gain (through for example bride price) or cost (through dowry) effect the age that families want to marry girls.
- ➔ Norms that devalue girls and see them as a burden - girls' lack of education and decision-making power relative to boys are two indications of their lower social status. This inequality is worsened by child marriage, especially when girls are married to older spouses.
- ➔ Girls' sexuality -child marriage is linked with girls' sexuality. In many situations, girls may be forced or choose to marry because they had (or are suspected of having) sex, or because they have gotten pregnant. Often, parents believe that protecting the honour and purity of a young girl once she reaches puberty is an important task, and child marriage is viewed as the most effective way of shielding daughters from undesirable romantic relationships, sex or pregnancy outside marriage.
- ➔ Gender-based violence and sexual harassment - girls who experience sexual assault may be forced to marry their rapist as a result of norms that believe that marriage is the only route to repairing "family honour." Such pressures may be further exacerbated if the girl becomes pregnant from the rape.
- ➔ Norms of masculinity - in some communities, child brides demonstrate a man's status. These norms promote and normalize older men marrying young girls.
- ➔ Traditional and religious norms and beliefs - each community has a system of social arrangements, customs and religious beliefs and practices that influence the timing and nature of marriage. For example, initiation ceremonies and traditional rituals shape the timing and determine reasons for child marriage.
- ➔ System of patriarchy - cutting across the community norms and practices listed above, the system of patriarchy reinforces the rights of men to make decisions for and control the bodies of women and girls. Norms linked to patriarchal values, and the resulting gender inequalities it perpetuates, underpin many of the contributing causes of child marriage.

<sup>42</sup> Plan International (2016) *Living Free from Child Marriage. In Girls Champions of Change: Curriculum for Gender Equality and Girls Rights.* Working, UK: Plan International pg.9



## Effects of child marriage on rights of girls<sup>43</sup>

HUMAN RIGHT	Effect
<b>Education</b>	Child marriage often means the end of education for girls. This denies girls the education they need for their personal development, their preparation for adulthood, and their ability to contribute to the family and community.
<b>Income and Economic Well Being</b>	Child marriage limits girls' access to the skills needed to earn income for themselves, and contribute to their families and their communities.
<b>Health</b>	<p><b>HIV and AIDS:</b> Once married, girls may feel powerless to refuse sex. They mostly find it difficult to insist on safer sex practices, including condom use as their husbands are usually older and more sexually experienced. This makes the girls especially vulnerable to HIV.</p> <p><b>Unwanted pregnancy:</b> Married girls are often under pressure to become pregnant immediately or soon after marriage, although they know little about sex or reproduction. A pregnancy too early in life before a girl's body is fully mature is a major risk to mother and baby.</p>
<b>Life</b>	<p><b>Death during childbirth:</b> Complications of pregnancy and childbirth are the main causes of death among adolescent girls (15-19 years old) in developing countries.</p> <p><b>Survival of infants:</b> Babies born to a mother who is under 20, are more likely to die within their first weeks of life than babies born to a mother in her 20's.</p>
<b>Safety and Protection</b>	<b>Violence:</b> Rape resulting in pregnancy is a risk factor for girls being forced into child marriage. Girls married before 18 are more likely to report being beaten by their husbands and forced to have sex ('marital rape') than girls who marry later.
<b>Development, Empowerment and Self-Esteem</b>	<p><b>Social isolation:</b> Marriage often causes girls to be socially isolated, bringing unwanted separation from their friends and family. This further limits girls' access to information and key resources.</p> <p><b>Development and empowerment:</b> Child marriage robs girls of their childhood, and the opportunity to develop and realize their vision for their own lives and well-being. Linked to this, child marriage cuts girls off from the support to develop the resources and experiences of their own power within, and isolates girls from other peers and the related sense of solidarity that contributes to girls' power with others to realize their goals.</p>

<sup>43</sup> Plan International (2016) *Living Free from Child Marriage. In Girls Champions of Change: Curriculum for Gender Equality and Girls Rights. Working, UK: Plan International* pg. 36

## Exercise 20: Improving Maternal and Child Health

### PURPOSE

The exercise aims to illustrate ways in which maternal, newborn and child health can be improved through use of maternal and child health services. It enables participants to understand the importance seeking modern maternal and child health care services, or integrated health services, in order to improve maternal and child health outcomes.

### OBJECTIVES

By the end of this exercise, participants will:

- Understand the importance of seeking modern maternal and child health care services, particularly antenatal care (ANC), institutional delivery, skilled birth attendant, postnatal care (PNC) and immunisation.
- Understand obstetric fistula, its causes and how it can be treated.

**Time Required: 45 minutes**



### Other Requirements

- Card with Fungisai's story
- Baby health cards pictures

### METHOD

1. Read "Fungisai's story: Scenario 1" and generate a discussion based on the following questions.

#### Fungisai's story: Scenario 1

It is late afternoon, and Fungisai begins experiencing labour pains. She decides to wait for her husband to accompany her to the health facility. When her husband Nqabutho arrives at home towards sunset he rushes her to Mrs Chanakira, a traditional birth attendant in the community. Mrs Chanakira attends to Fungisai during the birthing process in an unhygienic room and uses unsterilized equipment while Fungisai bleeds heavily. Mrs Chanakira tells Fungisai to confess her sins to enable the smooth delivery of the baby. Unable to stop the bleeding, Mrs Chanakira advises Nqabutho that his wife should be taken to a hospital but unfortunately Fungisai and the baby die.

#### Discussion questions:

- a) What do you think motivated Fungisai and Nqabutho's to consult Mrs Chanakira, the traditional birth attendant and not the health facility?
- b) What socio-cultural and religious beliefs or practices promote non-use of modern health care services?
- c) How could Fungisai and her baby's death have been prevented?

2. Read "Fungisai's story: Scenario 2" and generate a discussion based on the following questions.

#### Fungisai's story: Scenario 2

It is late afternoon, and Fungisai begins experiencing labour pains. She decides to wait for her husband Nqabutho to accompany her to the health facility. When he arrives at home towards sunset he rushes her in the direction of the health facility. Along the way, they meet Mrs Gumbukai who suggests that they go and see Mrs Chanakira, an esteemed traditional birth attendant in the community as it is getting dark. They arrive at Mrs Chanakira's home where she prepares Fungisai for the birthing process. After some time in labour with increasing complications, Mrs Chanakira recognises that she can no longer handle the complications and reluctantly refers Fungisai to a local clinic. It is now night time and so Fungisai's husband has to look for transportation to take his wife to the clinic. Unfortunately, he cannot access a vehicle or call for an ambulance and he resorts to using an ox-drawn cart, which takes a long time to arrive at the clinic.

When they arrive at the clinic, the only two nurses available are attending to the women who had booked for delivery earlier and had stayed at the maternity waiting home. Fungisai has to wait for some time before she is served, and she learns that her child is in a breech position. She has to be referred to a District hospital, and

fortunately, an ambulance was available to take her there. However, due to prolonged labour at the traditional birth attendant's house, Fungisai develops "obstetric fistula" (a hole between the vagina and the rectum). This means that she is now incontinent of faeces. Fungisai suffers and feels ashamed even though it is not her fault that she no longer has control over her rectal system. She is rejected by her husband and close family due to her foul smell. Fungisai never registered for ANC when she was pregnant and so she did not know about the maternity waiting home.

#### Discussion question

- a) Why is it important for women to register early for ANC and delivering at a health facility with a skilled birth attendant?
- b) What causes obstetric fistula?
- c) What are some of the health and social consequences of obstetric fistula?

(refer to Facilitator's notes, where necessary)

- 3. Show participants the child health cards (Girls and Boys), and ask if they have ever seen them.
- 4. Read the story of Rudo and Tendai and follow the discussion questions.

#### The story of Rudo and Tendai

Rudo and Tendai are neighbours and they both had their first child around the same time. Tendai exclusively breastfed her child for six months whereas Rudo practiced mixed feeding for her son. Tendai always took her child to the clinic for routine immunisation and weighing, and followed instructions on infant and young child feeding from the health workers. On the other hand, Rudo did not take her son for immunisation and never received any instruction on child feeding and nutrition. There was a measles outbreak when the children were about three years old, and unfortunately Rudo's son died.

Discussion questions:

- a) What do you think Rudo could have done to prevent her son's death?
- b) Why do you think Rudo failed to exclusively breast feed her child and have the child immunised?
- c) What are the reasons why children in communities are not immunised? (Explore; socio-cultural and religious reasons, fears and misconceptions etc.).
- d) What actions should families and communities take to ensure that children are properly fed and immunised?

**Highlight the importance of immunising children at a health facility and following the immunisation schedule.**



***Remember this:** Encourage pregnant women to register early for ANC and deliver at a health facility as well as seek post-delivery care. Encourage participants to visit health facilities to familiarise themselves with the ANC services available, e.g. equipment / testing services, staff capacity and regularity of these services.*

*Inform participants that maternal death is a notifiable event (has to be reported) within 48 hours of its occurrence.*

**All suspected maternal and neonatal deaths must be reported to the health facility. As a BCF, you have a responsibility to identify any such cases within your community and report them as soon as possible. Remember to offer participants referral slips and refer them to relevant services providers that offer maternal, newborn and child health services.**

## FACILITATOR'S INFORMATION

### Advantages of delivering at a health facility <sup>44</sup>

These include:

- a. Being attended to by a skilled health worker
- b. Close monitoring of labour progress
- c. Management of complications e.g. breech delivery
- d. Postpartum care e.g. management of postpartum haemorrhaging
- e. Neonatal care e.g. vaccinations, care of preterm babies

### Obstetric Fistula <sup>45</sup>

Obstetric fistula is a childbearing injury that is usually caused by several days of obstructed labour, without timely medical intervention - typically a Caesarean section - to relieve the pressure. Unattended obstructed labour can last for up to six or seven days, although the foetus usually dies after two or three days. During the prolonged labour, the soft tissues of the pelvis are compressed between the descending baby's head and the mother's pelvic bone. The lack of blood flow causes tissue to die, creating a hole between the mother's vagina and bladder (known as a vesico vaginal fistula), or between the vagina and rectum (causing a recto vaginal fistula) or both. The result is a leaking of urine or faeces or both.

The consequences of fistula are often life shattering: In most cases, the baby dies and the woman is left with chronic incontinence (involuntary leakage of urine or faeces or both), unless she undergoes reconstructive surgery. Because of her inability to control her flow of urine or faeces, she is often abandoned or neglected by her husband and family and ostracized by her community. Without treatment, her prospects for work and family life are greatly diminished, and she is often left to rely on charity.

### Causes of fistula

Fistula occurs when emergency obstetric care is not available to women who develop complications during childbirth. Poverty, malnutrition, poor health services, child marriage and gender discrimination are interlinked root causes of obstetric fistula. Poverty is the main social risk factor because it is associated with child marriage and malnutrition and because poverty reduces a woman's chances of getting timely obstetric care. Because of their low status in many communities, women often lack the power to choose when to start bearing children or where to give birth. Childbearing before the pelvis is fully developed, as well as malnutrition, small stature and general poor health, are contributing physiological factors to obstructed labour. Older women who have delivered many children are at risk as well.

### How can fistula be prevented?

Making family planning available to all who want to use it would reduce maternal disability and death. Complementing that with skilled attendance at all births and emergency obstetric care for those women who develop complications during delivery would prevent fistula.

Addressing social issues that contribute to the problem - such as early pregnancy, girls' education, poverty and women's empowerment - are important areas of intervention as well.

### How can fistula be treated?

- Reconstructive surgery can mend the injury. Two weeks or more of post-operative care is needed to ensure a successful outcome. Counselling and support are also important to address emotional damage and facilitate social reintegration.
- When surgery cannot correct the problem, women undergo a procedure called a urostomy, and they wear a bag to collect their urine. If the surgery is successful, women can resume full and productive lives. They can usually have more children, but caesarean sections are recommended to prevent a recurrence of fistula.

<sup>44</sup> Scott H and Dairo A (2015) "Maternal Death Surveillance and Response in East and Southern Africa" *Journal of Obstetrics and Gynaecology Canada* 2015;37(10):915-921

<sup>45</sup> Adapted from German Foundation for World Population (DSW), 2006 "Sexual and Reproductive Health Training Manual for Young People" pg. 65

Most fistula sufferers are either unaware that treatment is available or cannot access or afford it. In addition, treatment capacity in most areas where fistula is common cannot meet the demand. **The key to ending fistula is preventing it from occurring so this backlog of cases will not continue to grow.**

## Immunisation

Immunisation of children against vaccine-preventable diseases is one of the vital interventions to prevent child morbidity and mortality. It prevents death of children from life threatening illnesses such as diphtheria, tuberculosis, polio, pneumonia, meningitis, Haemophilus influenzae type B, hepatitis B, tetanus, pertussis (whooping cough), measles, rubella and rotavirus. World Health Organization recommends all children be vaccinated against the above-mentioned diseases.

### Vaccine Preventable Illnesses

Vaccine	Illness	Description of Illness and Consequence of Not Vaccinating
BCG	Tuberculosis (TB)	A disease that typically attacks the lungs. If not treated properly, TB infection can be fatal.
Pentavalent (including DPT)	Diphtheria	A serious disease caused by a potent bacterial toxin. It causes a thick coating in the back of the nose or throat that makes it hard to breathe or swallow. It can be deadly.
Pentavalent (including DPT)	Hepatitis B	A serious infection that affects the liver. It leads to chronic liver disease and puts people at high risk of death from cirrhosis and cancer of liver.
Pentavalent (including DPT)	Haemophilus influenza type B (Hib)	Causes acute respiratory infections, meningitis and other serious diseases almost exclusively in children under the age of 5.
Measles Vaccine	Measles	A highly contagious respiratory disease caused by a virus. Measles causes fever, runny nose, cough and rashes all over the body.
Rubella Vaccine	Rubella	Children whose mothers have rubella during the early stages of pregnancy often contract congenital rubella syndrome (CRS). Children with CRS are born with lifelong disabilities and are at risk for other developmental problems such as congenital heart disease and mental retardation.
Pentavalent (including DPT)	Pertussis	(Whooping cough) A highly contagious respiratory disease, which produces violent, uncontrollable coughing which often makes it hard to breathe. Pertussis most commonly affects infants and young children and can be fatal, especially in babies less than 1 year of age.
Pneumococcal Vaccine	Pneumococcal disease	Causes pneumonia, meningitis, or blood infection. In its worst forms, pneumococcal disease kills one in three people who contract it. Pneumonia is one of the leading causes of child death around the world.

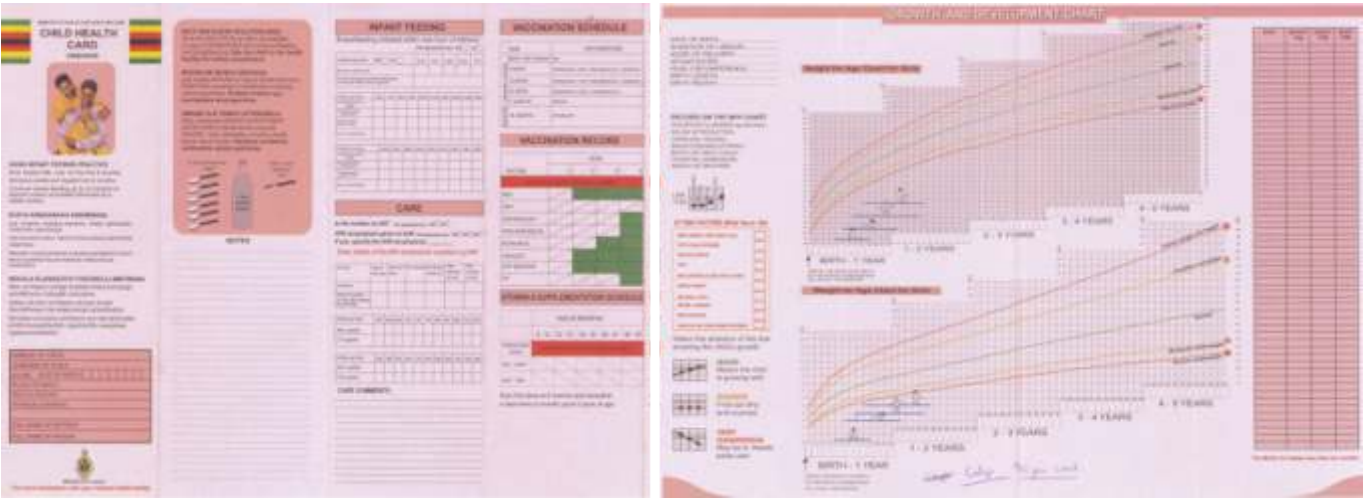
Polio Vaccine	Poliomyelitis (Polio)	Mainly affects children under five years old. Infections can lead to irreversible paralysis.
Rotavirus Vaccine	Rotavirus	The leading cause of severe diarrhoea in infants and young children. Globally, diarrhoea causes more than half a million deaths each year in children under 5.
Pentavalent (including DPT)	Tetanus	Mothers and their newborn contract tetanus, an extremely deadly disease, when deliveries happen in unhygienic conditions – especially in remote and areas without access to health facilities. Tetanus can be easily prevented by tetanus vaccines, hygienic delivery and good cord care practices.
Human Papilloma Virus (HPV) Vaccine	Cervical cancer	A leading cause of death and suffering among women. Cervical cancer is a growing problem increasingly affecting younger women in Zimbabwe and other countries. HPV vaccine to be administered to girls from 10 years of age onwards.

\*\*\* Measles and Rubella vaccines are usually administered together as Measles-Rubella (MR) Vaccine



# Child Health Cards

For girls



For boys



## Exercise 21: Livelihood and Resilience Building



### PURPOSE

Livelihood and resilience building are vital aspects of empowering households in all aspects of life. Securing a means of livelihood for the household is an important step in addressing other related social issues, including poverty as one of the key drivers of HIV and AIDS, STIs, SGBV. This exercise seeks to empower households to explore initiatives that enhance livelihood and build their resilience.

### OBJECTIVES

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

- Explore ways of securing their own livelihood
- Identify potential means of livelihood for themselves

**Time Required: 45 minutes**



Preparation: Gather information on local organisations and charities that help vulnerable families with capital or ideas for projects for their financial independence and livelihood.

### METHOD AND PROCESSING

1. Read Vimbai's story to the participants.
2. Ask the participants the following questions:
  - o What do they think would have happened to Vimbai if she had not begun her chicken rearing project?
  - o Do you know any girls who were in a similar situation? How did their stories turn out?
  - o What could these girls have done to change their situation?
3. Engage participants in a discussion on the availability of projects to promote their financial independence and livelihood.
4. Refer them to local organisations and institutions that provide financial aid and also advice on small-medium enterprises (SMEs) and skills development.



### Vimbai's Story

Vimbai comes from a poor family. Vimbai's parents have always struggled to provide for Vimbai and her three siblings. In spite of marrying a child under the age of 18 being illegal in Zimbabwe, Vimbai's sister Mazvita was traditionally married off to an older man at 16 because the family needed some money. Vimbai is afraid that the same thing will happen to her, since she recently turned 16, and she will not be able to finish school and pursue her career dreams. Vimbai's parents have already informed her that she will be married off to a local business man.

Vimbai confides in Mai Norman, a local BCF, who advises her about an organisation in the area that supports girls and young women at risk. The organisation pays school fees and empowers girls and young women with income-generating and livelihood skills. Vimbai receives \$500 capital and starts her own small poultry-rearing project while she pursues her education.

With the income from selling chickens, Vimbai is able to complete her A-level education and support her siblings.

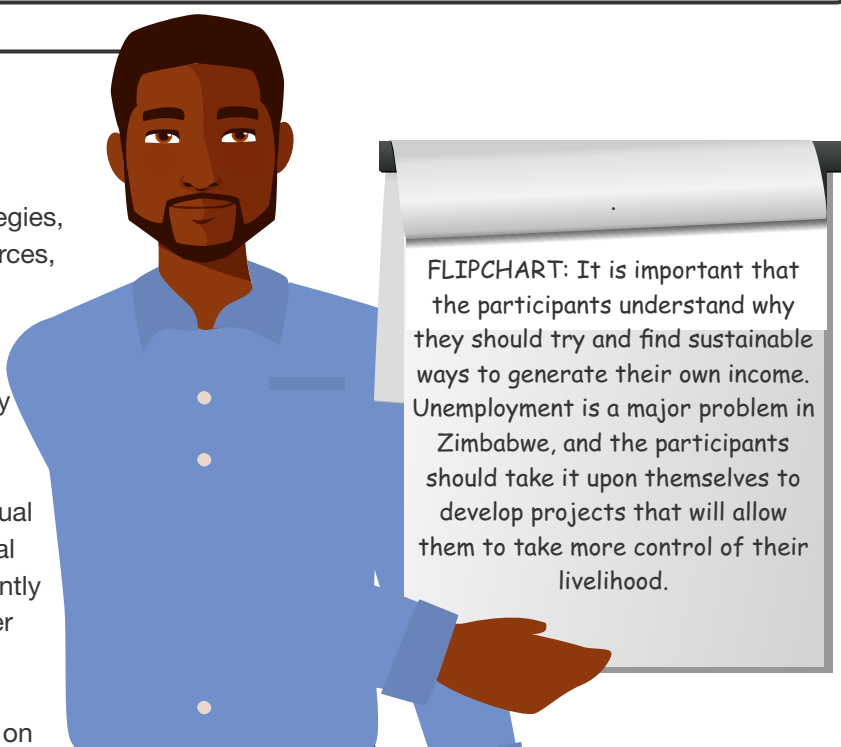
### FACILITATOR'S INFORMATION

A livelihood is a means of making a living and resilience is developing positive coping strategies, which are based on available skills and resources, to face, manage and recover from difficult circumstances.

Poverty and financial dependence are directly linked to harmful practices such as wife pledging, wife inheritance, and poverty. All of these practices negatively impact a girl's sexual and reproductive health, as well as her general well-being. Financial independence significantly reduces a girl's vulnerability and increases her chances of staying healthy.

Make sure that participants have information on local organisations and charities that are assisting vulnerable groups such as child headed families, orphans and vulnerable children (OVCs), the disabled people, and women with funds and training for projects to ensure sustainable livelihoods. Some of the livelihood project are:

- o Sewing and embroidery
- o Chicken rearing
- o Micro-credit



**FLIPCHART:** It is important that the participants understand why they should try and find sustainable ways to generate their own income. Unemployment is a major problem in Zimbabwe, and the participants should take it upon themselves to develop projects that will allow them to take more control of their livelihood.

**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGO, church, ZRP, social services, counsellor, BEAM etc.) that will be able to assist them if they need more help or have more questions.**

#### Section Four: Resources

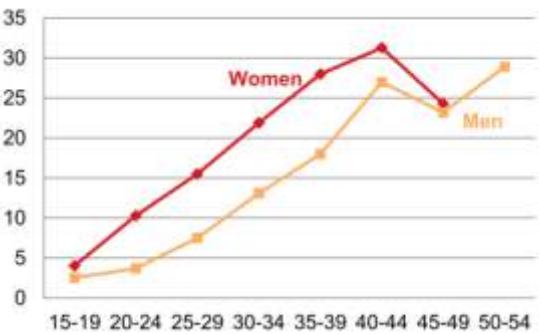
As a Behaviour Change Facilitator, there is need to conduct a community mapping exercise and identify the available services offered in your community. This will help when you want to refer participants to access services. You can include other services offered in your community that are not mentioned in the table below.

Services	Service Provider and Contact Details
Antiretroviral Therapy (ART)	
Social Welfare Services - Department of Social Welfare - Charity organisations including Children's Homes - Child line etc.	
Family Planning and Contraception	
Sexual and Gender Based Violence - PEP - STI screening, HIV testing - Victim Friendly Unit - Legal Aid - SGBV clinic etc	
Post Exposure Prophylaxis (PEP)	
HIV Testing Services	
Pregnancy and Antenatal Support	
Maternity Waiting Homes	
Nutrition	
Health	
Education	
Legal Aid	
Electricity	
Fuel	
Transportation	
Water	

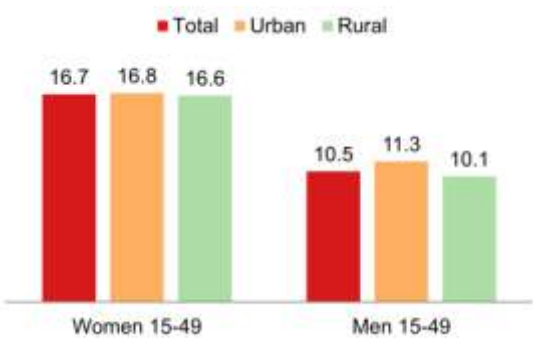
**HIV Prevalence: Data from the 2015-16 Zimbabwe Demographic and Health Survey (ZDHS)**

According to the 2015-16 ZDHS, HIV prevalence among women and men, age 15-49 is 13.8%. Prevalence is higher among women (16.7%) than men (10.5%).

**HIV Prevalence by Age**

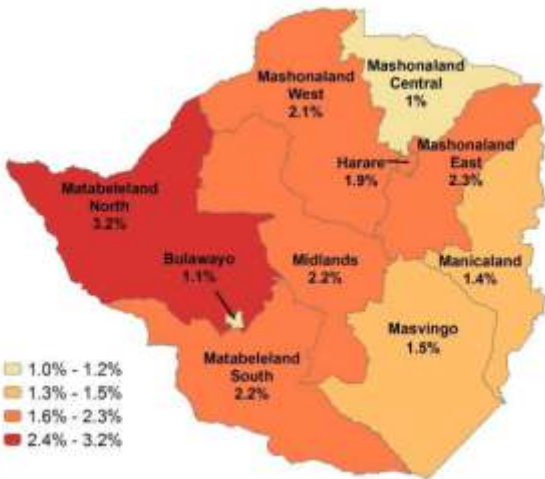


**HIV Prevalence by Residence and Sex**



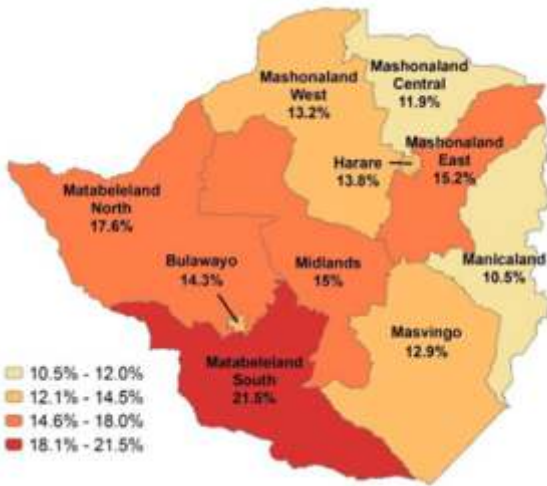
From the 15-19-year age group to the 20-24 year age group HIV prevalence increases from 4.0% to 10.3% among women and from 2.5% to 3.7 among men. There is very little difference between the urban and rural prevalence among women.

**HIV Prevalence Among Children by Province**



Matabeleland has the highest prevalence among Children. In this province, 3.3% of girls age 0-14 And 3.2% of boys age 0-14 are living with HIV.

**HIV Prevalence Among Adults by Province**



By province, among women and men age 15-49, HIV prevalence ranges from 10.5% in Manicaland to 21.5% in Matabeleland South.

## Reference Documents

- National Health Strategy for Zimbabwe 2016-2020
- The Zimbabwe National Family Planning Strategy (ZNFPS) 2016-2020
- Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2015-2020
- National Adolescent and Youth Sexual and Reproductive Health (ASRH) Strategy II: 2016-2020
- Zimbabwe National Gender Based Violence Strategy 2012-2015
- Standard National Adolescent and Youth Sexual and Reproductive Health (ASRH) Training Manual 2016 Edition
- Zimbabwe Demographic Health Survey 2015
- National Adolescent Fertility Study Technical Report 2016
- National Guidelines on Clinical Adolescent and Youth Friendly Sexual and Reproductive Health Services Provision (YFSP) 2016 Edition
- Training module to compliment the National Adolescent Sexual and Reproductive Health (ASRH) Training Manual for Service Providers
- Zimbabwe Reproductive, Maternal, Newborn, Child, Adolescent Health, and Nutrition Strategy (2017-2021)
- Zimbabwe Maternal and Neonatal Health Strategy 2017-2021
- National Guidelines on Key Interventions to Improve Perinatal and Neonatal Health Outcomes in Zimbabwe
- Zimbabwe National Child Survival Strategy (2016-2020)
- The Zimbabwe Cervical Cancer Prevention and Control Strategy (ZCCPCS) 2016-2020
- Community Systems Strengthening Framework for Health in Zimbabwe 2017
- Population Council Zambia. Adolescent Girls Empowerment Program (AGEP): Health and Life Skills Curriculum (2013)
- German Foundation for World Population (DSW). Sexual and Reproductive Health Training Manual for Young People (2006)
- National AIDS Commission of Malawi (2007) Guidelines for Conducting Community Dialogue, A Community Engagement Tool for Sustainable HIV and AIDS Behaviour Change
- EGPAF (2012) Addressing the Social and Behavioural Barriers to PMTCT of HIV Through Community Dialogue, An Implementer's Guide
- Plan International. Champions of Change Modules
- SAFAIDS Behaviour Change Manuals for Adolescents
- Tuneme.org- Website resource for adolescents

# **Section Four:**

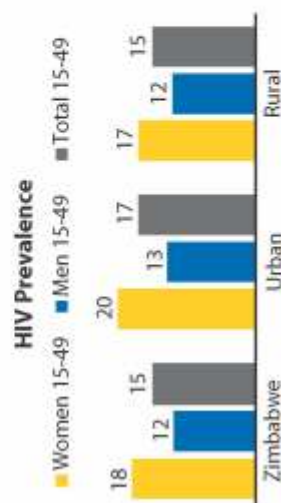
## **Resources**

People and Places	Address and Contact Number	Services Available
ART		
Child Care		
Contraception		
Education		
Electricity		
Family Planning		
Fuel		
GBV and Domestic Violence		
HCT		
Health		
Legal Aid		
Nutrition		
PEP		
Transportation		
Water		
Pregnancy and ante-natal support		

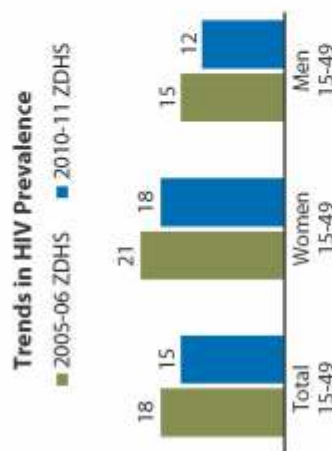


# HIV Prevalence: Data from the 2010-11 Zimbabwe Demographic and Health Survey

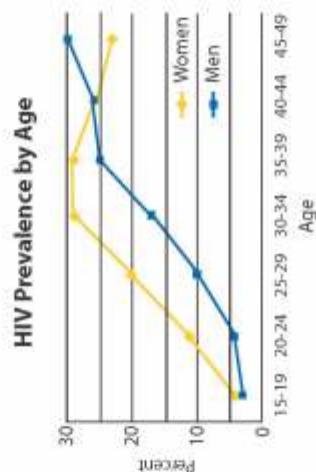
The 2010-11 Zimbabwe Demographic and Health Survey (ZDHS) included HIV testing of 7,313 women age 15-49 and 6,584 men age 15-54. According to the survey, 15% of Zimbabweans age 15-49 are HIV-positive.



Overall, 18% of women and 12% of men are HIV-positive. HIV prevalence is slightly higher in urban areas than in rural areas.



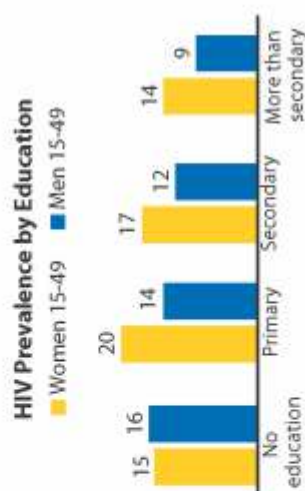
There has been a slight decrease in Zimbabwe's HIV prevalence since the estimate published in the 2005-06 ZDHS.



Women become infected at younger ages than men. Prevalence for both women and men increases with age until it peaks at ages 30-39 for women (29%) and at age 45-49 for men (30%).



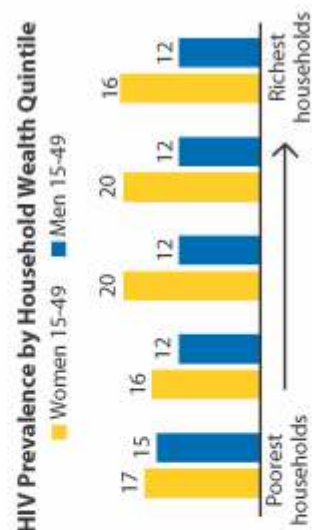
HIV prevalence is highest in Matabeleland South where over 1 in 5 adults age 15-49 are HIV-positive. HIV prevalence is lowest in Harare (13%).



There is no clear relationship between educational level and HIV prevalence among women; however, among men, HIV prevalence decreases as education increases.

71% of women and 51% of men who tested HIV-positive in the 2010-11 ZDHS had been tested previously for HIV and received the results of that test.

Overall, 34% of women and 21% of men had been tested for HIV and received the results in the past year.



There is no clear relationship between wealth and HIV prevalence among women or men.



### But I have already had unprotected sex with my partner before?

Many people don't know that DISCORDANCE is possible. Discordance means that one partner in a relationship is HIV positive, while the other partner is still HIV negative. This is possible even if the couple have had unprotected sex before. The box below explains why

Imagine you have unprotected sex with someone who got infected with HIV 6 months ago. This person will not have the highest concentration of HIV in their blood and you may actually not get HIV immediately.

**BUT:** If you continue to have unprotected sex with this partner, you might eventually get infected. Therefore

- you need to protect yourself, even if you had unprotected sex before
- you should find out your status as a couple

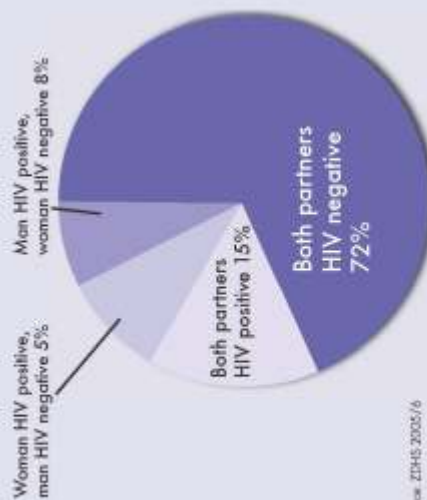
### What can I do?

- Talk about HIV risk with your partner.
- If you are currently not in a relationship, know your HIV status and before starting a new relationship know your partner's HIV status. It's wise to go for an HIV test together!
- Discuss how you and your partner will prevent HIV. These are your options:
  - Abstain from sex until you have been tested for HIV.
  - Be faithful to each other. (If one or both of you are HIV positive you also need to use condoms every time you have sex)
  - Use male or female condoms. Remember, condoms are effective when used correctly and used all the time.

### Q: But I already have more than one wife?

A: This is common but it is never too late to take action. You can talk to your wives or husband and together go for HIV testing. Consider your risks and make a commitment to prevent HIV.

In Zimbabwe, 1 out of 7 couples are discordant.



Source: ZIMHS 2005/6

### Do you need more information?

If you would like to know more, visit your nearest health facility or call the National Aids Council Office nearest to you.

NAC Head Office	04-791170
Harare:	04-708070
Bulawayo:	09-884077
Manicaland:	020-64324
Midlands:	054-220084
Mashonaland West:	067-22741
Mashonaland East:	079-22008
Mashonaland Central:	011878935
Matibeleland North:	09-882943
Matibeleland South:	084-22631
Masvingo:	039-262097



**ONE partner**  
is the **right choice**



Find out more in this pamphlet.



## What is HIV?

HIV, Human Immunodeficiency Virus, is the virus that causes AIDS. The virus attacks the defense system of the body and slowly makes an infected person sicker and sicker until they have AIDS.

## What is AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome. AIDS is the name for a group of sicknesses caused by HIV. AIDS usually develops some years after a person is infected with HIV.

## Can AIDS be cured?

No. There is no cure for AIDS.

## How does a person get HIV?

HIV is found in body fluids such as blood and sexual fluids (semen in men and vaginal fluids in women). It is also found in breast milk. HIV is mainly spread by:

- Sex (80 to 90 %): You can get HIV from having unprotected sex with a person who is infected with HIV. This is the main way of HIV transmission in Zimbabwe!
- Mothers to babies (10 to 20 %): women with HIV can pass on the virus to their babies during birth and through breast feeding.
- Infected blood (1 %): a person can get HIV from the infected blood of another person. This can happen when

receiving a blood transfusion, contact of open wounds with infected blood or even through injection needles used on an infected person before. In Zimbabwe blood used in hospitals is thoroughly screened for HIV and other infections before it is given to a patient. If the test is HIV positive it is not used for transfusions.

## HIV is NOT spread by:

- donating blood
- sharing cooking utensils
- using public toilets
- sharing a room with an infected person
- touching or caring for an infected person
- eating freezits
- mosquitoes
- coughing and sneezing
- witchcraft

## Can one partner be infected and the other not?

Yes, this is not uncommon. It is estimated that in 1 out of 7 couples in Zimbabwe, one partner is infected and the other not. Partners who talk about HIV and get tested together can, as a couple and, as the parents of their children, keep healthy and protected.

## Are some people at greater risk of getting HIV than others? Yes!

- Persons who have more than one sexual partner over the same period of time (for example a partner outside their marriage).
- Young people who start sex early with older sexually experienced partners who are likely to have been exposed to infection.
- Those who start a sexual relationship or get married without using condoms and without knowing their HIV status.

## Are you personally at risk of having or getting HIV?

Only YOU can answer this question! Think about behaviors which may place you at risk:

- Have you ever had unprotected sex?
- Have you had sex with many partners?
- Is it possible that you have ever had sex with a partner who is infected with HIV?
- Have you ever had a sexually transmitted disease? Do you have a sexually transmitted disease now?
- Has any of your past or current sex partners had sex with other persons?

If you answered YES to any one of the above questions, you have been exposed to risk.

## How can you protect yourself from getting HIV?

- Acknowledge that
  - AIDS is a serious problem in your community
  - Your or your partner's behaviour may expose you to HIV risk
  - Learn about the ways that HIV is spread and use this information to avoid infection.
- Reduce your personal risk:
  - Delay having sexual intercourse.
  - Before starting a sexual relationship, know your HIV status, go for an HIV test and insist on knowing the HIV status of your partner.
  - Remain faithful to one partner who is faithful to you.
  - Use condoms consistently.
  - Talk to your sexual partner about HIV.
- Take action!
  - Talk about HIV testing with your partner.
  - Get tested for HIV and find out the result.
  - Use the information to plan for your future and your family's future.
  - Be a role model, but do not point fingers at others.
  - Help others to understand about HIV and AIDS. Talk to your parents, your friends and your children
  - Accept, love and care for People Living With HIV.

## How Do You Score

- 1 Fact
- Nonsense – there can be high HIV infection risk in a relationship if one partner was infected before that relationship or in a sexual relation outside the relationship.
- 2
- Nonsense – HIV infection rates in young women are high and infection rates in men above 25 years of age are also high – both among the married and unmarried.
- 3
- 4 Fact
- 5 Fact
- Nonsense - HIV is present in the blood of an infected person
- 6
- Nonsense - HIV can be passed from an infected mother to her unborn baby
- 7
- 8 Fact
- 9 Nonsense - There is no cure for AIDS
- 10 Fact
- 11 Fact
- Nonsense - You cannot get HIV by sharing a toilet seat with an HIV infected person
- 12
- 13 Fact
- 14 Fact – HIV prevalence in men above 30 years is 6 times higher than in men younger than 24 years
- 15 Fact

## HIV and AIDS Facts or Nonsense Let's Face it!

Read the following statements and place a tick in the Fact or Nonsense box. Match your answers against the score sheet on the back page. What was your score?

0-7 correct = Check your facts again and look for further information

8-13 correct = OK, you know some of the facts but you still need more information

14-18 correct = Good, but keep checking your facts

19-22 correct = Well done, keep searching about HIV and AIDS

23-26 correct = Excellent! Share your information with others

16 Nonsense - HIV cannot be contracted by simply touching an infected person

17 Fact

18 Nonsense - There is no cure for AIDS. This belief is very dangerous

19 Fact

20 Fact – for couples it is considered useful to go for testing together.

21 Fact

22 Fact

23 Fact

24 Nonsense - Some STDs do not have symptoms

25 Nonsense. Mosquitoes do not spread HIV. It is spread through sex with an infected person, when infected blood enters the bloodstream or from an infected pregnant woman to her child during pregnancy, delivery or breastfeeding.

26 Nonsense – in 1 out of 7 couples in Zimbabwe one partner is HIV positive and the other HIV negative. In 1 out of 7 couples both partners are HIV positive. Therefore condom use in marriage is an important way to prevent HIV transmission. Most couples in Zimbabwe do not know their HIV status yet. All couples can reduce their HIV risk by using condoms consistently during the window period of 3 months, going for an HIV test and then remaining faithful to each other.



### Is the risk worth it?

Studies have shown that some young women have sex with experienced partners and get infected at a young age. As this leaflet shows, some young women do this because they don't understand the risk of such relations. But there may also be some other reasons for it. Ask yourself:

- why do young women get involved in relationships that could turn out to be risky?
- are there advantages?
- what are the real challenges of such relations?

There may be short-term benefits like cash, cell phones, fashionable clothes, riding in fancy cars. BUT consider:

- the life-long condition of infection and/or illness,
- the risk to infect your life long partner when you decide to settle down,
- the risk to infect your future children.

### Is the risk worth it?

It is believed that some women get infected with HIV, because they are too shy to ask their older partner for an HIV test before having sex or before marriage.

### What do you think?

### Make the best choice for your life

Now that you know what puts you at risk, you can do something about it.

#### YOU CAN:

- decide not to have sex until you are older and feel ready to make informed decisions.
- avoid sex with several partners.
- if you are currently not in a relationship, know your HIV status before starting a new relationship (getting tested for HIV as a couple before and during marriage is the wise choice).
- discuss how you and your partner will prevent HIV.
- make a commitment to be faithful to each other;
- use male or female condoms; remember: condoms are effective when used correctly and used all the time.



**HIV & I**  
What's new?



#### Do you need more information?

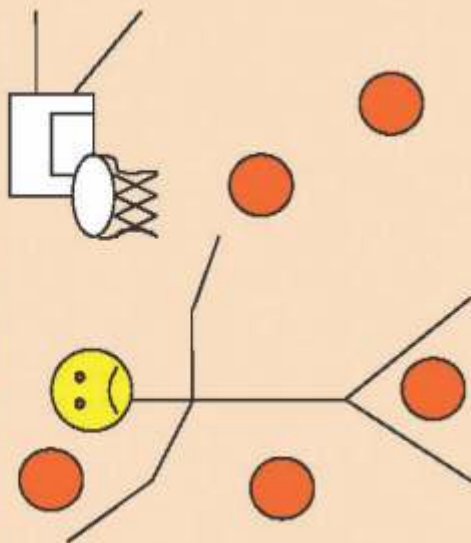
If you would like to know more, visit your nearest health facility or call the National Aids Council Office nearest to you.

NAC Head Office	04-791171
Harare:	04-708070
Bulawayo:	09-884077
Manicaland:	020-64324
Midlands:	054-220084
Mashonaland West:	067-22741
Mashonaland East:	079-22008
Mashonaland Central:	011878935
Matabeleland North:	09-882943
Matabeleland South:	084-22631
Masvingo:	039-262097

Find out in this pamphlet about your risk and how you can avoid HIV infection.



## So how many balls are you juggling all over the court?



### To reduce your risk, consider adopting values like:

- Value yourself, keep your body healthy.
- Don't have sex when you are too young, make sure the first time you have sex it is with someone you care about and who really cares about you.
- Avoiding getting into situations which would make it easy to be pressurized into having sex when you don't want to
- Remember that you are not obliged to have sex with an older man just because he asks you
- Be content with who you are and value self-reliance
- Know your rights and claim them when they are violated

### Benefits of adopting these values:

- You lower the risk of becoming infected with HIV yourself as a student, for your future infant and your future partner.
- You lower your chances of becoming infected with STIs other than HIV
- You avoid teenage pregnancies
- You will focus more on your school work

## What can I do?

### Consider advantages of waiting to start having sex:

- If you don't have sex your chances of becoming HIV infected are very very low. Even if you have already had sex, you can stop having sex and reduce your risk. If you have already had sex you should be tested for HIV.
- If you are already infected, you need to seek medical advice and may need treatment. Remember if you have sex with someone who is negative you could also infect them.
- Waiting until you are older will allow you to have sex on your terms and not those of your more experienced and possibly infected older partners
- As you get older you will feel more comfortable discussing issues relating to sex with a potential partner. You should discuss HIV testing before you get to the point of having sex with someone. It is important to know your status and the status of your partner before you have sex with them, or before you get married or have a child
- HIV prevention does not end when you get married. In order for you to remain safe as a couple you both have to commit to being faithful to each other. Couples can test for HIV together before they get married.
- So, remember waiting till you have sex will enable you to finish your studies without distractions and allow you enough time to prepare for your future.

### So, share with a friend that:

- Be content with who you are and don't think that having access to lovely gifts and presents is worth the price you may have to pay for it. A cell phone lasts for a few years, HIV lasts forever.
- Choose friends who share the same values as you and avoid peer pressure to behave in ways you don't feel comfortable with
- True love waits: you will enjoy sex more if you have it with someone who you really love and who really loves you. Wait until you are sure that what you have is real
- Meanwhile, concentrate on your goals and have a happy future
- Enjoy your youth; don't spoil it since the risk is not worth it after all

Do you need more information? Visit your nearest health facility or call a National AIDS Council office.

# Is the risk worth it?

HIV prevention information for young people in school





ZIMBABWE AIDS PREVENTION AND SUPPORT ORGANISATION

