



# Let's Chat!

**PARENT CHILD COMMUNICATION ON  
SEXUAL AND REPRODUCTIVE HEALTH**



**Health  
Development Fund**

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





DECEMBER 2017

# CONTENTS

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ACKNOWLEDGEMENTS.....	1
PREFACE.....	3
INTRODUCTION.....	4

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<b>UNIT 1: YOU, YOUR FAMILY AND YOUR CULTURE.....</b>	<b>10</b>
SESSION 1: Trust.....	12
SESSION 2: Language.....	13
SESSION 3: Understanding My Values and Culture.....	16
SESSION 4: Families and Knowing Yourself.....	18
Families (Adolescents only).....	18
Knowing Yourself (Parents only).....	20
SESSION 5: Engaging in Conversation About SRHR.....	22

---

<b>UNIT 2: HUMAN AND SEXUAL DEVELOPMENT.....</b>	<b>25</b>
SESSION 1: Understanding Sexual Health.....	26
Understanding Sexual Health (Adolescents).....	26
Understanding Sexual Health (Parents).....	28
SESSION 2: Understanding Sexual Development.....	31
Understanding Sexual Development (Adolescents 10-13 years).....	31
Understanding Sexual Development (Adolescents 14-15 and 16-19 years).....	34
Understanding Sexual Development (Parents).....	35

---

<b>UNIT 3: REPRODUCTIVE HEALTH.....</b>	<b>38</b>
SESSION 1: How Pregnancy Happens.....	39
How Pregnancy Happens (Adolescents).....	39
How Pregnancy Happens (Parents).....	40
SESSION 2: Abstinence and Family Planning and Contraception.....	42
Abstinence (Adolescents 10-13 years).....	43
Abstinence and Family Planning and Contraception.....	43
(Adolescents 14-15 and 16-19).....	43
Abstinence and Family Planning and Contraception (Parents only).....	45
SESSION 3: Talking about pregnancy.....	53

---

<b>UNIT 4: RELATIONSHIPS.....</b>	<b>55</b>
SESSION 1: Decision-making.....	56
Decision-making (Adolescents).....	56
Decision-making (Parents only).....	57
SESSION 2: Communication.....	59
Communication (Adolescents).....	59
Communication (Parents).....	61
SESSION 3 Sex: A decision for Two.....	65
Sex: A decision for two - Adolescents 14-15 and 16-19 years.....	65
Sex: A decision for two - Parents.....	65

<b>UNIT 5: ALCOHOL AND SUBSTANCE ABUSE.....</b>	<b>67</b>
SESSION 1: Alcohol and Substance Abuse.....	69
SESSION 2: Ending alcohol and substance abuse.....	71
<b>UNIT 6: STIs, HIV AND AIDS.....</b>	<b>73</b>
SESSION 1: Sexually Transmitted Infections (STIs).....	74
SESSION 2: Basics on HIV and AIDS.....	80
<b>UNIT 7: HIV TESTING SERVICES (HTS), DISCLOSURE, STIGMA AND DISCRIMINATION.....</b>	<b>86</b>
SESSION 1: HIV Testing Services (HTS).....	87
SESSION 2: HIV Treatment.....	91
SESSION 3: Disclosure.....	94
SESSION 4: HIV and Stigma and Discrimination.....	96
<b>UNIT 8: SEXUAL AND GENDER BASED VIOLENCE (SGBV).....</b>	<b>99</b>
SESSION 1: Good, Confusing, and Bad Touches.....	100
SESSION 2: Sexual and Gender-Based Violence.....	102
SESSION 3: What Should They Do?.....	104
<b>UNIT 9: CULTURAL AND TRADITIONAL PRACTICES.....</b>	<b>109</b>
SESSION 1: Cultural Practices.....	110
SESSION 2: Child Marriage.....	112
SESSION 3: Other Harmful Practices.....	117
<b>UNIT 10: CONFLICTS.....</b>	<b>120</b>
SESSION 1: Conflict Resolution - Part 1.....	121
Conflict Resolution: Part 1 (All Adolescents).....	121
Conflict Resolution: Part 1 (Parents).....	123
SESSION 2: Conflict resolution - Part 2.....	124
Conflict Resolution: Part 2 (All Adolescents).....	124
Conflict resolution: Part 2 (Parents).....	125
SESSION 3: Laws.....	126
Laws (Adolescents) .....	126
Laws (Parents).....	126
<b>UNIT 11: TALKING TOGETHER.....</b>	<b>129</b>
SESSION 1: Conversations in families.....	130
SESSION 2: Conversations within families.....	131
<b>HANDOUTS.....</b>	<b>133</b>

# ACRONYMS

ActionIEHDC	Action Institute of Environment, Health and Development Communication
ADRA Zim	Adventist Development Relief Agency Zimbabwe
AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretrovirals
CAMFED	Campaign for Female Education
FGM	Female Genital Mutilation
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
ICPD	International Conference on Population and Development
NAC	National AIDS Council
NASRH	National Adolescent Sexual and Reproductive Health
NGO	Non Governmental Organisation
PCC	Parent Child Communication
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SAYWHAT	Students and Youths Working on Reproductive Health Action Team
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
YPNSRHHA	Young People's Network on Sexual Reproductive Health HIV and AIDS
ZNFPC	Zimbabwe National Family Planning Council

# ACKNOWLEDGEMENTS

The Ministry of Health and Child Care, National AIDS Council, Zimbabwe National Family Planning Council on behalf of the Government of Zimbabwe would like to extend gratitude to stakeholders, implementing partner organizations, community cadres and consultants who worked tirelessly in developing and updating the Parent Child Communication on Sexual and Reproductive Health facilitators manual.

The following individuals and organisations provided technical support and took part in the process of reviewing, updating and development of this manual:

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Amon Mpofo, NAC	Silibile Mpofo, NAC	Victor Makaza, NAC
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Raymond Yekeye, NAC	Tonderai Mabamba, NAC	Francis Magureyi, NAC
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Jacqueline Kabongo, M-CARE	Dagmar Hanisch, UNFPA	Tamisayi Chinhengo, UNFPA
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Ministry of Women Affairs and Youth (MoWAY)  
National AIDS Council (NAC)  
Zimbabwe National Family Planning Council (ZNFPC)

## **Implementing Partners:**

Family AIDS Caring Trust (FACT)  
World Vision Zimbabwe (WVZ)  
Zimbabwe AIDS Prevention and Support Organisation (ZAPSO)  
Zimbabwe Community Health Intervention Research - Behaviour Change (ZiCHIRe BC)

Development and production of this manual was supported through the Health Development Fund (2016-2020) comprised of the following Donors:

Government of Canada, Ireland, Norway, Sweden, United Kingdom, European Union and GAVI

*Disclaimer:* The views expressed in this publication do not necessarily reflect the views of the MOHCC, NAC, ZNFPC or the United Nations Population Fund (UNFPA) and the HDF donors.

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# PREFACE

Ministry of Health and Child Care (MoHCC), Ministry of Women Affairs and Youth (MoWAY), 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. A component of this programme encapsulated in this manual concentrates on enhancing parent to child communication on sexual and reproductive health and rights and sexual gender based violence (SGBV) at family and community level.

The methodology brings parents and adolescents together through facilitating group meetings. These group meetings provide an environment for open dialogue and communication on issues around SRHR and SGBV and a social support network within their own community.

Adolescents and parents both benefit when PCC about sexuality is open and honest. There are both immediate and long-term improvements in SRH for the adolescent and relational benefits for the family unit. These benefits extend beyond the family environment to the community as a whole by providing for healthier more stable family units and individuals.

While it is recognised that changing an individual's behaviour remains the responsibility of that individual, creating an environment that supports and encourages positive behaviour change requires effort and commitment from a multitude of players. The Community Health Workers (CHWs) as mentors in the PCC groups are key agents in this endeavour. However, the group members are also key contributors to building change in their own and their fellow group members' lives. Providing information and education is only one component of influencing change of an individual's behaviour.

The mentors, working with the support and under the guidance of implementing partner organisations, are aware of this limitation and as a result will draw on the expertise and skills of other organisations located within their communities. These organisations, 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, Club members who require information beyond the expertise of the mentor will be referred to these organisations for services.

Working together, these organisations and CBWs will strive to improve parent to child communication on sexual and reproductive health and rights and sexual and gender based violence at the family and community level. In that vein, we would like to thank individuals and organisations that have contributed in any way to the development of this guide.

This manual is an updated version of the January 2015 version and will be used as part of the demand generation tools for community health systems as of 2018.



# INTRODUCTION

The Parent-Child-Communication package consists of the Training Manual and the Facilitator Guide which will greatly assist parents and community leaders, under the Community Approach, to spearhead and support the sexual and reproductive health (SRH) status of adolescents. It seeks to address challenges that many parents face in discussing with young people about relationships, development and sex. The package therefore equips parents and adolescents with adequate information and tools to engage in dialogue and communicate issues around SRH. It also empowers parents on how to encourage and support their adolescents in accessing sexual and reproductive health and rights (SRHR) services. The clinical adolescent and youth-friendly sexual and reproductive health services include:

- HIV Testing Services - HIV testing, voluntary medical male circumcision (VMMC) etc.
- STI Screening, prevention and treatment
- Cancer screening, including HPV Vaccine
- Family planning with a focus on contraceptives and condoms
- Safe motherhood - pregnancy testing, antenatal care (ANC), prevention of mother-to-child transmission of HIV (PMTCT), institutional delivery, postnatal care (PNC), and nutrition
- Sexuality Education and Counselling
- Sexual and gender-based violence (SGBV)

## Programme Rationale

Adolescents and parents both benefit when Parent-Child Communication (PCC) about sexuality is open and honest. There are both immediate and long-term improvements in sexual and reproductive health for the adolescent and relational benefits for both the parent and the adolescent. These benefits extend beyond the family environment to the community as a whole by providing for healthier, more stable family units and individuals. This manual positions the parent as the entry point for parent-child communication on Sexual and Reproductive Health and Rights (SRHR).

## Programme Goal

Improved parent to child communication on sexual and reproductive health and rights and sexual and gender based violence (SGBV) at family and community level.

## Program Objectives

- ➔ To increase parents' and adolescents' knowledge about sexual and reproductive health and rights (SRHR) and sexual and gender based violence (SGBV) that will form the basis from which they can have conversations.
- ➔ To improve the ability of parents and adolescents to begin and maintain SRHR conversations with each other.
- ➔ To reduce parents' and adolescents' concerns about home-based SRHR conversations.

## Schedule

This programme is designed to be covered in seven units, with 90 minutes of group time per day, as follows:

Unit 1:	You, Your Family, and Your Culture
Unit 2:	Human and Sexual Development
Unit 3:	Relationships
Unit 4:	Reproductive Health
Unit 5:	Alcohol and Substance Abuse
Unit 5:	STIs, HIV and AIDS
Unit 6:	HIV Testing Services, Disclosure, and Stigma and Discrimination
Unit 7:	Sexual and Gender Based Violence (SGBV)
Unit 8:	Harmful Cultural Practices
Unit 9:	Conflicts
Unit 10:	Talking Together

## Participants

This programme is designed to be family-based. At least, one adolescent or young adult and one parent from a family must attend. In the case of child-led families, the child may decide together with the facilitator which group it is best for them to attend based on their family needs.

This programme has these key defined tracks:

Young adolescents	<b>(10 – 13 years)</b>
Middle adolescents	<b>(14 – 15 years)</b>
Older adolescents	<b>(16 – 19 years)</b>
Parents	

By separating the adolescent participants into three age groups, conversations are able to be targeted more appropriately to the specific development of the adolescents. While some of the content is consistent across all age groups, the younger and older adolescent groups have some needs that are distinct from each other, given the wide age range. The middle adolescent group draws content and processes from both the older and the younger group as appropriate. If adolescents who are 13 or 16 years old are joining the group, the facilitator and the parents may decide together which age group is most appropriate for their developmental stage. The young adult group uses the same materials as the older adolescent group. The difference will be in the content of the conversations. The parent handouts for each day also separately address the needs of young adults.

The parent programme is inclusive for parents and / or guardians with adolescents between ages 10 and 24. Many parent / guardian participants will have more than one child in this age range, which is why parents are included as one group.

When there are not enough adolescents for three groups, you may choose to split them up differently. It is important to note that young adolescents (10 – 13) should not be in a group with older adolescents (16 – 19). Any group should not have more than a three-year age spread. Each adolescent group should have between 10 and 20 participants, which will mean the parent group will be two to three times as large because parents representing all adolescent age groups will be present.

Adolescents may repeat the programme three times – one time in each age group. Parents also benefit from repeating the programme because they will be focused on different children and at different ages and with different needs each time. Coming to the programme with new needs and new feelings will give them a new perspective on the content. They can also act as mentors, supporting parents who are going through the programme for the first time.

**NOTE:** Exception should be considered in the classification of adolescents and parents in certain circumstances. For instance, adolescents who are already pregnant may require additional information to that given to members of their cohort and some adolescents are already parents so they have to be treated as such.

Included in this manual is a parent-child communication assessment (**Handout 1 and 2**). If the facilitators are able to give it to the parents and the adolescents before the first day and again after the last day, it will provide them with information and guidance for the effectiveness of the programme.

## Facilitators

The facilitators are very important to the success of this programme. Participants will learn from the facilitator how to talk about SRHR topics easily and without fear or stigma. This skill will create a conducive environment that allows participants to express their feelings and have in-depth conversations about SRHR during the sessions and at home.

It is important to begin each session with a welcoming environment. This sets the tone for the remainder of your time together. In addition to modelling comfort with the content, facilitators will build trust within the group as they get to know the participants. This is critical to an environment that is supportive of open conversation. Therefore, it is important that each small group has a leader who will stay with them through all of the discussions, both separate and combined. Number of groups will determine the required number of facilitators for each session / exercise. Facilitators should have a pre-training briefing before and a debriefing after every session in order to speak the same message, deal with concerns and issues, and address questions in the same way.

It is useful for the leaders to have a mix of both men and women. Participants should appreciate that both men and women are able to talk about SRHR in the home rather than assuming all conversation must be directed to either the mother or the father. It is also useful for the facilitators to be parents themselves, with children who are adolescents or older. Facilitating from a space of personal parenting experience increases participant respect of the programme.

Additionally, facilitators should ideally be...

- Comfortable talking about SRHR
- Knowledgeable about SRHR
- At ease saying when they do not know the correct answer to a question and do know where to find answers
- Attentive listeners
- Respected by the community
- Maintain confidentiality

- Able to volunteer their time to the programme

Facilitators are not expected to be counsellors, but it is important for them to listen and watch the participants and know when to reach out and offer additional support. Some participants, both adolescents and parents, may remember or think about painful experiences during the programme. Facilitators should reach out to these participants and offer resources for counselling or other kinds of help as they are needed. When necessary, facilitators should refer participants to the nearest health centre or health worker for assistance. The list of some service providers whose contact details are to be completed by the facilitator for their specific area, is given in **Hand-out 27**.

### **Supplies and Space**

Every effort has been made to ensure that the only necessary supplies are included in these materials. There are times when taking notes of participants' brainstorming is beneficial, but it is not necessary.

You will need to have one space large enough for all four groups to meet. The units require four individual spaces for the four individual groups.

### **Information about Children Under 10**

This programme is designed to work well with adolescents (10 – 19 years). Children who are younger than 10 years are not developmentally prepared to attend. However, parent participants may have questions about their younger children that come up during the programme. If there is time and the facilitator feels it is appropriate, the group may choose to discuss younger children at some points during the programme. Parents begin providing information to their children about what it means to be physically healthy as soon as they are born. By cleaning the babies, touching them gently, and talking to them, parents teach babies what it means to feel good and be accepted in their bodies.

Toddlers learn, for the first time, about the differences between their bodies and other people's bodies. Learning how to be gentle with other people and to listen to them when they say they are hurt is a critical part of being a sensitive adolescent and adult. The lessons that babies, toddlers, and children learn from their parents also influence how they will interact with others later on in life.

Other important lessons for babies and young children are the names of all of their body parts, including their genitals, and to know that they are able to talk about their bodies freely with their parents, but not with other children or with adults other than doctors. Children need to feel comfortable exploring their bodies in private. Children also need to know about puberty, so that they are prepared for it when it begins. Girls can be very scared when they begin menstruating if they don't know about it. Boys can be very scared when they get an erection or experience ejaculation for the first time if they don't know about it.

Parents may feel uncomfortable talking with their children about their bodies and other things that they think of as sexual in nature. However, if conversations about these parts of growing up start when the children are younger, both parents and children may feel more comfortable having them. Starting younger allows the parents to become more comfortable and more practised at the conversations by the time the

child starts puberty and has deeper questions and concerns.

For further information on the development of the children and some tips on communicating with them, refer to **Hand-outs 25 and 26**.

### **Information about Children Who are HIV Positive**

For parents with HIV positive children, the matter of disclosure is very important (Handout 17 Kudzi's Story). Children need to know why they are taking medicine from the age of six. Understanding the importance of their medications, as well as a growing understanding of what being HIV positive means about other physical choices, is critical to HIV positive children's healthy development, sexually and in other ways too.

### **Note to Facilitators**

You should be aware that the activities, ice breakers and sitting arrangements are just a guide. They are determined by the prevailing conditions at venues where discussions will take place. This sets the tone for the remainder of your time together. Participants can start the day with an appropriate opening reading or song which is connected with the topic of the day. Participants should also have a discussion on the homework given in previous meeting and/or recap on lessons learnt in the previous meeting.

### **Setting group norms**

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- ➔ Note that some participants may not be able to read or write. Quickly identify such participants so that you avoid embarrassing them or making them uncomfortable. You can ask participants to express themselves through drawing and ask them to explain their drawings to you or the group later should there be need.
  - ➔ You will maintain confidentiality. Although you cannot guarantee that each member will not tell someone about events and discussions, encourage participants to uphold confidentiality among group members. However, you can assure the participants that YOU will maintain their confidentiality. This means that you are not allowed to tell anyone what the participants share with you. If you make this promise make sure that you keep it, as the participants will trust you. The participants will share details with you that may sometimes be considered embarrassing or sensitive, and it is essential that you earn their trust and continue to earn it by never divulging anything that the participants do not specifically ask you to share with the rest of the group or anyone else.
-

# UNIT 1: YOU, YOUR FAMILY AND YOUR CULTURE



# UNIT 1: YOU, YOUR FAMILY AND YOUR CULTURE

## Rationale

The goal of this programme is to encourage and support increased levels of communication between parents and adolescents in the home on sexual and reproductive health and rights (SRHR). Beginning conversations on SRHR can be difficult. There is need to build trust between parents and children, and reduce stigma around family-based conversations on SRHR. This unit creates a platform for understanding the adolescents at various stages of development, their rights and values, and the importance of family and culture. By the end of the unit intergenerational conversations about SRHR would have begun in a small way.

### Early Adolescence 10 - 13 years:

Younger adolescents engage with their parents from the perspective of a child and are more open to parental input and guidance. When intergenerational, family based conversations about sexual and reproductive health and rights (SRHR) begin in the early years, they are more likely to continue throughout adolescence. This benefits both parents and adolescents. Therefore, engaging younger adolescents so that they feel family communication about sexual and reproductive health and rights is both useful and accessible as it will have long-term positive outcomes.

**Late Adolescence 16 - 19 years:** Older adolescents may be sexually active themselves and are likely to have friends who are sexually active. The need for information and conversations about sexual and reproductive health and rights (SRHR) increases dramatically among this age group. Understanding their own needs for information and assistance and their parents' capacity to fulfil those needs allows older adolescents to have additional means of support.

### Middle Adolescence 14 - 15 years:

Adolescents in this age group have developed and grown from children, but they may not yet be fully engaged in a culture of sexual engagement. Nevertheless, many adolescents in this age group are interested in the sexuality that exists in popular culture and on the Internet. If conversations about sexual and reproductive health and rights (SRHR) have not begun by this age, the adolescents may have developed a bias against that dialogue. Overcoming that barrier is critical for parents to support their adolescents as they face increasingly complex sexual issues, both as individuals and within their peer groups.

**Parents / Guardians:** Parents / Guardians are their children's first and primary sexuality educators, but they are often left without guidance on how to effectively engage with their children and adolescents on the topic. This series of lessons on parents and sexual and reproductive health and rights (SRHR) is designed to expand broadly, which is followed by an invitation to parents to consider what they can do to increase communication with their adolescents. Additional information to give to parents on Handout 3

## Objectives

- To define sexual and reproductive health and rights.
- To raise awareness on the importance of family communication on SRHR and SGBV between parents and adolescents.

- To empower parents and adolescents to develop trust and skills that enable them to engage in conversations about SRHR and SGBV.
- To identify the values and culture that influence communication, behaviours and practices.

## UNIT PLAN

<b>Activities:</b>	100 minutes
Introduction icebreaker: (Split session)	10 minutes
PCC Assessment Questionnaire	10 minutes
Session 1: Trust (Split session)	10 minutes
Session 2: Language (Split session)	20 minutes
Session 3: Understanding my values and culture (Split session)	20 minutes
Session 4: Families and knowing yourself (Split session)	15 minutes
Session 5: Engaging in conversation about SRHR (Combined)	15 minutes

**Materials needed:** Flipchart paper, marker pens, scissors, tape and or glue

**Note to Facilitators: Separate the Parents/Guardians from the Adolescents before doing the introduction icebreaker activity**

### Introduction icebreaker



**10 minutes**

There are two alternate activities to use here. The first option is for groups who know each other. If your participants all know each other's names, use the first icebreaker. If some of your group members know each other's names, or if they are mostly unfamiliar with each other, use the second icebreaker. Regardless of which approach you choose, the goal is for it to be a fun and lively process.

#### ***If your group knows each other: (Ice breaker 1)***

1. This is a game to get people to have fun and explore different ways to communicate.
2. Stand in a circle and have the participants count off around the circle. Ask the even numbered participants to turn to their right and the odd numbered participants to turn to their left. The circle should be in pairs now. If there is an odd number of participants, you can participate. If everyone has a partner, you can stand back and watch.
3. Let the participants know that they will be trying to describe something using only their hands - no talking!
4. Ask the even numbered participants to describe their favourite activity using only their hands. After two minutes, see if the odd numbered participants can guess the activity.
5. Switch and have the odd numbered participants describe their favourite activity using only their hands and the even numbered participants guess.
6. Have all of the participants turn to the inside of the circle again, make eye contact with someone across the circle, and point at them. That is their new partner.
7. Have the new partners move to stand face to face with each other and choose who goes first. This partner should describe their favourite person using only their hands. See if the other person can guess who the favourite person is.



- Switch.
- Stand in a circle again and ask if anyone would like to share what it felt like to try and have a conversation using only their hands.

### **If your group is new to each other: (Ice breaker 2)**

- This is a game to help everyone learn each other's names. Stand in a circle.
- Say your name and something to remember you by that starts with the same first letter as your name. This can be your favourite colour, a description of your personality, or a plant or animal you are drawn to.  
*For example:*
  - My name is Fadzai, you can remember me by calling me Free spirit.
  - My name is Sithabile, my favourite plant is a Sunflower
- Ask each participant to do the same, going around the circle. Let participants know that they need to listen to what everyone says.
- Once each person has said their name and something to go with it, explain to the participants that you are going to play a game. You are going to go around in a circle again, and rather than the person saying their own name and associated word, everyone else is going to say it for them.
- Go around once slowly. Then go around again a few times, faster each time, seeing how fast you can get around the circle, saying everyone's name. It is helpful to clap a steady beat as you do this, saying one syllable per clapped beat. This allows you to increase the pace of the beat to increase the speed of the names. Invite participants to clap with you.

### **PCC Assessment**



**10 minutes**

Distribute the PCC Assessment Questionnaire - Handout 1 (for adolescents) and Handout 2 (for parents) and allow time for the participants to fill in.

## **SESSION 1: Trust**

### **Split Session (Parents only and Adolescents only)**



**10 minutes**

This activity encourages the participants to develop trust amongst themselves so that conversations about emotional topics will be easier to have.

### **Procedure**

- Ask participants if they are nervous talking about SRHR with the group. It is likely that most of your participants will say "Yes", some will remain silent, and a few might say "No".
- Let the participants know that many people have difficulty talking about SRHR, and so if they are feeling that way, they are very normal.
- Tell the participants that if you all agree on a few things; everyone will have an easier time talking about SRHR.
- Ask participants to share what they think would make talking about SRHR easier for them. Some examples to include, being kind, not laughing at anyone, there are no bad or wrong questions, someone may ask a question that is not about them, and more. You can include items that the participants do not include. If you have access to a way to write this list for all of the participants to

- see, like on a chalkboard, that is nice, but it is not required.
5. It is important to include confidentiality in this list. This means that when someone shares a personal or a private story during discussions, no one will share that story outside the discussions.
  6. In order to agree with your listed items, ask all of the participants to stand. Ask them to think of a traditional blessing of agreement (African proverb) or other words that could be said here to indicate agreement like:

*Chara chimwe hachitswanye inda.  
Umunwe wohodwa ausoze ubulale impukhane.  
(Speak out or your problems are not known or solved)*

## SESSION 2: Language

**Split Session (Parents only and Adolescents only)**



**20 minutes**

This activity is designed to get your participants engaged and a little more comfortable with the language of sexual and reproductive health and rights. Use the poster file (providing visual aids) to support you in this activity. If you will be meeting in the same space, you might hang these posters on the wall during class time, but this is not necessary.

### Procedure

1. Ask participants if they know what they are in the discussions to talk about. Give them a little time to consider their answers. If they seem to know the answer, but are embarrassed, reassure them that it is okay to say the words that they are thinking.

2. Tell participants that you will be talking about sexual and reproductive health and rights over the next few PCC meetings. Before you can do that, let them know that you need to talk about what each of those words means and what they mean about each other.

3. Hold up the included poster that says Health

Ask participants to provide a definition for what they understand health to be. Refer to **Handout 4**.

After several suggestions, you may offer this definition: *“Being free from illness, injury, or deep emotional pain.”*

4. Next hold up the poster that says Rights.

Ask for participant definitions.

Provide this definition: *“Something every person should have, regardless of who they are, where they live, or anything else.”*

Ask participants for examples of things that would be a right. *Some answers may include: food, housing, love, etc.*

- 
5. Now hold up the poster that says Sexuality.

Ask the participants if they can think of examples of things that have to do with sexuality. The younger adolescents may be very hesitant to provide examples, but it is important that you give them the opportunity. You can list the following items, giving time in between your contributions in case they have thought of ones themselves:

*Being a boy or a girl, kissing, getting married, and having sex. There are many other possible things to include here!*

- 
6. Hold up the two posters that say Sexuality and Health. Ask participants if they can think of ways that a person might be sexually healthy versus being sexually unhealthy. These examples can include things like being sexually healthy means that one does not have a disease, infection or illness associated with sexual behaviour. On the other hand, a sexually unhealthy person indicates that one has a disease, infection or illness associated with sexual behaviour.

***If the participants do not include these examples, you may say them.***

- 
7. Hold up the two posters that say Sexuality and Rights. Ask participants for some examples of rights that are about sexuality. *Poster - Sexuality Rights*

***These examples can include things like:***

- a. You have the right to information and education
- b. You have a right to the safety of the sexual body.
- c. You have a right to access health care
- d. You have the right to make free and responsible reproductive choices.
- e. You have the right to equality and to be free from all forms of discrimination
- f. You have the right to privately and confidentially make your own decisions about your sexual and reproductive life and to have these decisions respected.
- g. You have the right to health care and health protection
- h. You have the right to decide whether or not to have children
- i. You have a right to sexual and reproduction information based on scientific inquiry.
- j. Everyone has the right to access SRH services.
- k. You have the right to freely associate sexually

***If the participants do not include these examples, you may say them. However, it is not necessary to include all the examples in the discussion.***

***Note that some of these rights are not applicable to the younger adolescents due to limitations imposed by the Constitution and legislation in Zimbabwe.***

For other rights selected from the Zimbabwe Constitution, refer to **Hand-out 22**.

- 
8. Hold up the poster that says Reproductive.

Ask for participant definitions.

“It refers to the well-being of the reproductive system of individuals which

make it possible for them to have a satisfying and safe sex life with freedom to decide whether or not to have children and how often to do so”.

Emphasise that it is about reproduction.

9. Hold up the two posters that say Reproductive and Health

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

- 
10. Ask participants if they can think of ways that a person might be reproductively healthy versus being reproductively unhealthy.

Let them know that these things are not only about whether someone has a baby, but also about the physical health of their bodies and the emotional health of their choices around having babies. These examples can include things like:

*“Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence.*

*For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (World Health Organization, 2006)*

***If the participants do not include these examples, you may say them.***

- 
11. Now hold up the two posters that say Reproductive and Rights. Ask participants for some examples of rights that are about reproduction. These examples can include things like:

- a. You have the right to access SRH services.
- b. You have the right to life and this should not be put at risk by pregnancy and child birth.
- c. You have the right to freedom to control your own sexual and reproductive life.
- d. You have the right to freedom of thought or expression
- e. You have the right to protect your health, including using condoms and delaying sexual initiation.
- f. You have the right to sexual pleasure.
- g. Right to have safe and satisfying sexual relationship.
- h. You have the right to sexual privacy
- i. You have the right to emotional sexual expression.
- j. You have the right to choose whether or not to marry, and whether or not to found and plan a family.
- k. Sexual and Reproductive health rights are human rights.
- l. Adolescents have a right to participate in decision making that affect their sexual and reproductive rights

- 
12. Hold up the poster that says Responsibility. Ask participants what they think it might mean about sexuality and reproduction. Be aware that some of the questions may not be appropriate for some age group, particularly 10 -15 years. Lead a discussion based on the following question:
- What kinds of responsibility does a boy have to a girl he wants to have sex with?
  - What kinds of responsibility does an adolescent who is HIV positive have to the person they want to have sex with?
  - What kinds of responsibilities does an adolescent or a young adult have to future children?
  - What kinds of responsibility does a parent have to talk with their adolescents and young adults about sex and reproduction?
  - What responsibility does an adolescent have toward protecting their SRH rights? Possible answers may include participation in issues that affect their SRHR, taking responsibility for the consequences of their actions, and advocating for better services.
  - What responsibility does a parent / guardian have to protect his / her adolescent's SRH rights?
  - What responsibility does the community have to a child or adolescent living with HIV?

Note to Facilitators: At this time, it would be ideal to have an energizer. You can ask your group to come up with suggestions for this.

## SESSION 3: Understanding My Values<sup>1</sup> and Culture

**Split Session (Parents only and Adolescents only)**

**20 minutes**



This activity will help participants explore the influence of family, culture, religion and friends on their values as well as identify which influences are disregarded and why. It also examines how they decide on personal

### **Procedure: All Adolescents**

- Tell the participants that in this activity they are going to discuss the values they learned from their families, culture, religion, and friends about sex and gender. Read the instructions on the fact sheet below. Ask the participants if they have any questions and give clarity where necessary.
- Ask participants to individually reflect on differences between males and females.
- After a few minutes, ask a few people to share what they learned from their family about the differences between males and females. Then ask who learned something different. Make notes on two or three different values that different participants learned.

**Note to the facilitator:** If many say that they learned that there is no difference between males and females, ask them how many of them have parents / guardians who both do equal amounts of housework. Ask them what message

<sup>1</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People*; pp 33-35

they get about the difference between males and females if they see that their parents don't do equal amounts of housework. *Note that actions speak louder than words.*

4. Then ask the following questions:
  - How many of you got the same message about differences between males and females from your family, culture, religion and friends?
  - Is that also your personal value about the differences between males and females? If not, why not?
  - How many of you got a different message?
  - How did you decide which message to make your personal value?
5. Repeat the same process (steps 2 and 3) for when it is okay to start having sex
6. Then ask the following questions:
  - Were there any topics that your family, culture, religion or friends did not teach you anything about? If so, which ones? Why do you think this is so?
  - Does family, culture, religion or friends have the most influence on your values? Why?
  - Do you share all of your family's values? Why or why not?
  - What about your cultural values? What about your religious values? Your friend's values?
  - Who decides what your personal values are? (Only you do.)
7. Ask participants to summarize what they learned from the activity. Add any of the following points that are not mentioned.

- ➔ **Each one of us is influenced by the values of our family, culture, religion, and friends.**
- ➔ **Sometimes we learn different values from different sources. We need to decide for ourselves what our personal values are.**

## FACTSHEET: WHAT DID YOUR FAMILY, CULTURE, RELIGION AND FRIENDS TEACH YOU ABOUT...?

Think about what you learned from your family, culture, religion and friends about the following topics. Write down or draw a picture showing what they taught you. Do the same if you did not learn anything about the topic from the source (family, culture, religion and friends). Remember that sometimes we learn from people's behaviour, not just their words.

1. What did you learn about differences between males and females from your:
  - Family:
  - Culture:
  - Religion:
  - Friends:
2. What did you learn about when it is okay to start having sex from your:
  - Family:
  - Culture:
  - Religion:
  - Friends:

## Procedure: Parents

1. Tell the participants that in this activity they are going to discuss their family, cultural and religious values about sex and gender.
2. Ask participants to individually reflect on the differences between males and females.
3. After a few minutes or when they have finished, call their attention back to the front. Ask a few people to share what their values about the differences between males and females. Then ask who has different values. Make notes on two or three different values that different participants give.

**Note to the facilitator: If many say that there is no difference between males and females, ask them how many of them as parents do equal amounts of housework. Ask them if they get their female and male adolescents to do equal amounts of work and/or similar chores.**

4. Ask participants; based on your values when is it okay for your adolescent to start having sex?
5. Then ask the following questions:
  - When you were an adolescent, were there any topics that your (a) family, (b) culture, (c) religion or (d) friends did not teach you about? If so, which ones? Why do you think this is so?
  - Does family, culture, religion or friends have the most influence on your values? Why?
  - What family values do you share with your adolescents? Why or why not?
  - What about your cultural and religious values?
  - Who should decide your adolescents' values?
6. Ask participants to summarize what they learned from the activity. Add any of the following points that are not mentioned.
  - ➔ **Each one of us is influenced by the values of our family, culture, religion, and friends.**
  - ➔ **Sometimes we learn different values from different sources.**
  - ➔ **Allow your adolescents to decide for themselves what their personal values are.**

# SESSION 4: Families and Knowing Yourself

**Families (Adolescents only)**

**15 minutes**



This is the time to begin to address concerns about family communication on SRHR.

## Procedure:

1. Tell the participants that in a few minutes the parents and all of the adolescents will be coming together to talk about SRHR.
2. Ask the participants if any of them have ever talked with their parents about SRHR? If anyone says “YES”, and feels comfortable talking about it, ask them how the topic came up. Did they bring it up or did their parents? Did they think it was a good, bad, or a neutral experience? You can allow two to three participants to share their stories if they want to.
3. Ask the participants why it is important for adolescents about their age to talk with their parents about SRHR. Listen carefully to their answers. If they do not include these answers, you may include them in the conversation:

*To provide knowledge to the children, to provide emotional support, to help children understand themselves better, to answer questions, to help figure things out. There are many other potential answers.*

**Note to Facilitators: Separate the adolescents into different groups according to age for this part of the session. Recognise the difficulties that adolescents of different gender may have in discussing sexual and reproductive issues. Therefore, you can create gender specific sub-groups within the age groups but do your best to ensure that at least they are able to discuss freely.**

4. In their age groups, ask the participants to each turn to a neighbour so that everyone has a partner. Ask them to brainstorm in pairs three ways that they could ask their parents, aunts, or uncles about the following questions:

### Early Adolescence (10 – 13 years)

- a) Dad why do I have an erection when I wake up in the morning?
- b) Is it true that if I start menstruating then I can have sex?
- c) At school I buy lunch and pay bus fare for my girlfriend but she doesn't want to kiss or hug me. Why can't she kiss or hug me to say thank you?

### Middle Adolescence (14 – 15 years)

- a) I have not had sex but I dream about girls and when I wake up I find out that I have this sticky white stuff. Is there something wrong with my body?
- b) My friends advise me to have sex with my boyfriend as a way of not losing him to others. Should I go ahead and have sex with him?
- c) I experience pain when passing out urine and produce a smelly yellowish stuff? What is going on with me?

### Late Adolescence (16 – 19 years)

- a) I had unprotected sex with an old married man and I think I am pregnant what should I do?
- b) My boyfriend is pushing me to have sex, so what should I do?
- c) My girlfriend demands that we have anal sex, what should I do?

5. After a few minutes ask each pair to share one of the ways to begin a conversation with their parents.



- Let participants know that it is time to gather with the large group (including parents) to continue the conversations. Move with them into the large group space.

### Knowing Yourself (Parents only)

15 minutes



Parents can grow from considering the two topics that will be raised in this activity: why conversations about SRHR are important and the mind-set that will allow them to talk lovingly and effectively with their adolescents about SRHR.

### Procedure

- Ask participants why they believe parent/ child conversations about SRHR are important. Listen carefully to their answers. If they do not include these answers, you may include them in the conversation:

- *To provide knowledge,*
- *To provide emotional support,*
- *To help children understand themselves, and*
- *To help figure things out.*

- Tell parents that in order to have these very important conversations about SRHR, parents need to provide an environment that is open and where the children and adolescents feel comfortable coming to the parent with questions.

- Hold up or hang the **Know Yourself** poster included from the printed materials.

- Read the first poster **Know Yourself**.

Ask the participants if they can think of why it might be important for parents to have a deep understanding of themselves in order to have good conversations with their adolescents about SRHR. If they are not mentioned by the participants, be sure to say the following:

- Parents' sexual histories influence how they talk with their children. However, the children and adolescents have different experiences than the parents, and so need different kinds of conversations than the parents needed.*
- Parents have hopes, fears, and expectations about adolescents in general and their children specifically. Knowing what those all are helps parents think more carefully about whether they accurately apply to their adolescents.*

- Read the second poster **It's not about you**. Ask participants if they can think of why it is important for parents to remember that conversations about SRHR are not about themselves, but about their adolescents.

### ***If they are not mentioned by the participants, be sure to say the following:***

- Adolescents are having a deeper understanding of sex and sexuality for the first time – and that can feel both very exciting and very scary and lots of other feelings too. When you interrupt your adolescent's internal experience by*

*talking about yourself – or by directing the conversation based on what you want to say – you aren't able to pay attention to what they are really feeling and so may miss important things.*

- b. *Most adolescents have a good idea of how their parents feel about SRHR, and so they don't need to hear those things again. Most parents, however, haven't heard much about how their adolescents feel about SRHR, and so it is the parents' turn to listen and learn about their children.*
- c. *Adolescents are in a state of development – so their thoughts and feelings about SRHR are changing rapidly compared to the parents' thoughts and feelings about SRHR, and keeping up with that evolution takes time and attention.*
- d. Read **Hand-out 6** about **Ruvimbo and the Forest** to support the above points and discuss.

- 
6. Read the Let your child or teen lead the way poster. Ask participants if they can think of why it is important for children and adolescents to lead the way in conversations about SRHR. If they are not mentioned by the participants, be sure to say the following:

- ➔ *Parents may have incorrect perceptions about what conflicts or hurdles adolescents are facing and so may not raise the correct topics.*
- ➔ *Adolescents will be unlikely to listen to their parents talk about a topic if they aren't ready, even if it is one that is relevant in their lives.*

7. Read the **You can do it** poster.

Ask participants if they can think of why it is important for them to feel confident that they can have difficult SRHR conversations with their adolescents. If they are not mentioned by the participants, be sure to say the following:

- a. *Losing faith in yourself and your ability to talk with your adolescent will ensure that you won't have conversations.*
- b. *Adolescents listen to their parents, even when they pretend not to. Your opinion does matter and does have an influence.*

8. Let participants know that it is time to gather with the large group (including all adolescents) to continue the conversations. Move with them into the large group space.

# SESSION 5: Engaging in Conversation About SRHR

**Combined Session - All**

**15 minutes**



The second half of the first day gathers all four groups together to begin an intergenerational conversation that will continue during the final discussion. It is important for all of the participants in this programme to first of all agree that parent-child conversations about sexual and reproductive health and rights (SRHR) are important in order for them to increase those conversations in their home environments. This activity will help to lower the stigma of engaging in conversation about SRHR in intergenerational environments and get parents and adolescents to begin intergenerational conversations about SRHR in a small way.

## Procedure

1. Tell participants that you are all here to learn about sexual and reproductive health and rights. Let them know that they have all done very similar activities in separate groups so that they know what those words mean, and that now you're going to start talking together as a whole. Acknowledge that conversations between parents and adolescents can feel difficult at first, but that working on them together helps make things easier in the long run.
2. Ask the participants to find a partner, any partner, and then to form two circles so that they are facing their partner - the inside circle facing outwards and the outside person facing inwards. Tell them each person will each take one minute to answer this question: Why did you join this programme? Tell the inside circle to answer the question first, then after one-minute call time, and the other person should answer.
3. After one more minute, call the group to stop. Tell the inside circle to remain still and the outside circle to move two people to the left. Everyone will have a new partner now.  
  
Ask the participants to repeat the question process with this new partner, telling them why they joined this programme with one minute for each to answer.
4. Ask the outside circle to move two people to the left again. Ask the new pairs to each take one minute to discuss the following question: *What do you hope you will learn from these discussions?*
5. Ask the outside circle to move two people to the left again. Ask the new pairs to each take one minute to discuss the following question: *What do you hope your other family members who are here with you will learn from these discussions?*
6. Ask the group to expand into one large circle again. Invite anyone who wants to share what they learned from talking in their pairs, either about themselves or about their partners.
7. Participants may return to their regular places.

**Note to facilitator: Tell the participants that the day has come to an end. Each day will wrap-up with a homework assignment for the family. Every group will get the same assignment.**

**Ask participants to sing an appropriate song to end sessions.**

**Homework:** Talk about the courting practices that were common when the parents were adolescents and to compare with the courting practices that adolescents now use.



**Remember to offer the participants 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 if they need more help or have more questions. Give referral slips and refer people to relevant service providers as needed.**

# UNIT 2: HUMAN AND SEXUAL DEVELOPMENT



# UNIT 2: HUMAN AND SEXUAL DEVELOPMENT



## Rationale

Healthy sexuality is described in many ways with a focus on the physical body. However, sexuality is more than just about the body. The emotional and social aspects of sexuality must also be tended to in order for a person to experience full sexual health. Through an understanding of healthy sexuality, the normal development of sexuality can be pinned down and discussed more thoroughly. Understanding human and sexual development is important to adolescents and young people contextualizing the space that they are growing and developing in. It is critical for parents to be able to support them throughout the development process.

**Early Adolescence (10 - 13 years):** The youngest adolescents are experiencing the emergence of puberty in themselves and seeing it emerge in their friends and peers. This physical development shows the approach of adulthood and can be emotional for young people, especially if they have concerns about the pace of development and normality.

**Middle Adolescence (14 - 15 years):** Adolescents in the middle of the teen years are neither children nor adults. They are in the middle of that unique cognitive transition and need some information from both the younger and the older set.

**Late Adolescence (16 - 19 years):** The older adolescents have, for the most part, completed puberty and are focused on the emotional and psychological transition of adolescence into adulthood. Providing them with the knowledge and skills for how to make that transition thoughtfully and gracefully allows them a firm footing on which to begin adulthood.

**Parents / Guardians:** Understanding human development is integral for parents to be able to support their children and adolescents throughout the process. Access to resources that support full sexual health in the body and heart are critical for parents / guardians to have so they can provide access to their children and adolescents as the resources become needed.

**Note to Facilitator:** Additional information to give parents on Human and Sexual Development on **Handout 7**.

## Objectives

- ➔ To expand participants' understanding of sexual health, including what it is, how to achieve it, and why it is important.
- ➔ To understand the pathway of human sexuality through the adolescent years.

## Learning outcomes

- ➔ After completing this session, participants will be able to:
- ➔ Define sexual health

- ➔ Name three things that contribute to sexual health
- ➔ Name physical, emotional and sexual changes that happen during adolescence
- ➔ Identify where they are on the adolescent developmental pathway

## UNIT PLAN

### Activities:

Icebreaker: (Split session)	<b>95 minutes</b> 10 minutes
Session 1: Understanding sexual health (Split session)	40 minutes
Session 2: Understanding sexual development (Split session)	40 minutes
Closing	5 minutes

**Materials needed:** Flipchart paper, marker pens, tape and scissors or Glue

**Note to Facilitators: Separate the Parents/Caregivers from the Adolescents before doing the introduction icebreaker activity**

## SESSION 1: Understanding Sexual Health

### Understanding Sexual Health (Adolescents)

#### Introduction icebreaker

**10 minutes**



Ask participants to start with an appropriate opening song. Invite participants to share how their family homework conversations went.

- Did the conversations take place?
- What were the challenges?
- What were the lessons?

#### Session

**40 minutes**



In unit 1, participants discussed the realities of sexual and reproductive health and rights. This activity focuses on what healthy versus unhealthy sexuality and reproduction is and how to work towards it.

#### Procedure

1. Tell participants that the first step to understanding sexual health is to define the ways in which the word 'sex' is used. Ask for examples of what people are referring to when they say sex. Try to check if their examples include both sexual contact and a person's biological make-up. Tell participants that people are often unclear when they say 'sex' exactly what kind of sexual contact they are referring to. Tell the participants that you are going to say a list of sexual activities. Ask them to raise their hands if a peer and / or older friend told them that he / she had done that activity, if they would consider the friend to have had sex.

As you read the list, include the definitions so that all the participants know what you are referring to (**Poster and Hand-out 8 on Sexual Patterns and Behaviours**).

- a. Attraction
  - b. Having sexual feelings
  - c. Kissing
  - d. Kissing and touching over clothing
  - e. Touching genitals under clothing to orgasm
  - f. Genital stimulation without clothing
  - g. Masturbation
  - h. Oral sex
  - i. Vaginal sex
  - j. Anal sex
- 

2. Lead a discussion with the following questions:
    - a) Was everyone in agreement about whether a sexual act should be considered “sex”?
    - b) Why do you think there was agreement or disagreement?
    - c) How does one’s definition of “sex” have anything to do with whether someone is a virgin or not?
- 

3. Tell participants that you are going to go over the same list of activities on the poster **Sexual Patterns and Behaviours** again and talk about which ones can result in pregnancy.

Ask the participants to raise their hand if they think that the activity you read can result in pregnancy. Once the participants have given their answers, reiterate that the correct answer is: **only vaginal sex can result in pregnancy.**

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4. Tell the participants you are going to go over the same list of activities one last time to discuss which ones can result in sexually transmitted infection (STI) transmission, including HIV transmission. Tell participants that the activities range from no-risk to low-risk to high-risk. They should raise their hands according to the degree of risk they believe the activity has: high above their head for high-risk activities, about head height for low-risk, and down for no-risk. The first four activities are no-risk. Touching genitals under clothes to orgasm is low-risk for some STIs like herpes. However, touching genitals under clothes does not pose a risk for HIV transmission. Oral sex is low-risk for all STIs. Vaginal sex and anal sex are both high-risk for all STIs and HIV transmission.
- 

5. Tell participants that now that they understand the many ways that sex is understood, they need to learn about healthy sexuality. Read the World Health Organization’s definition of sexual health from the poster on Sexual Health. If you have a space that allows for it, hang this definition on the wall for the remainder of the sessions.

*“Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be*



*respected, protected and fulfilled.” (World Health Organization, 2006)*

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6. Tell participants that what this means is that sexual health is not just about your body being healthy. It is also about making choices about your body that you want and feel good about. Sexual health is every single person’s right that no one should take away.

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  7. Ask participants if there is anything in this definition of sexual health that is new to them or that they find interesting or surprising.

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  8. Point out to participants that sex has a potential impact on people in the following three ways:
    - a. Physical (the person’s body)
    - b. Emotional (the person’s feelings)
    - c. Social (the person’s friends and family)

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  9. Split your group into three small groups based on age (10 – 13; 14 – 15; and 16 – 19). Assign each group one of the three ways (physical, emotional and social) that sex can impact someone. Ask each group to make a list of the ways that having sex impacts a person of their age in that way. Give them five to ten minutes to make their list.

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  10. Ask each group to present their list to the whole group.

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  11. After each group presents, invite the entire group into a discussion of how a person can achieve sexual health in that way.
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**Hand-out 9 How to achieve Sexual Health. Some actions to consider are:**

- a. **Physical:** using a condom every time you have sex, getting tested for STIs and HIV, talking with your partner about what you would do if an unplanned pregnancy happened.
- b. **Emotional:** making the decision to have sex based on what you want rather than on what your partner wants, telling your partner what you want and don’t want before you start to be sexual with them, knowing that you can say “No” to any kind of sexual contact at any time even if you have said “Yes” before, listening to what your partner wants and respecting their boundaries.
- c. **Social:** associating with people that you want to and feel comfortable with, feeling confident with yourself, not hesitating to behave in a way that you feel is right, being yourself and not succumbing to peer pressure influence.

## Understanding Sexual Health (Parents)

### Icebreaker:

10 minutes



1. Participants can open with an appropriate song.
2. Ask each participant to complete the following sentence: “When I went home after we met for the first session, I thought about...”
3. Ask each participant to raise their hand if they talked with their adolescent about the first session. If they did, invite them to share what was said.
  - What were the challenges?
  - What were the lessons?

- What went on well or not well?
- Would you do it again?

## Session

40 minutes 

In unit1, participants discussed the realities of sexual and reproductive health and rights. This activity focuses on what healthy versus unhealthy sexuality and reproduction is and how to work towards it.

## Procedure

1. Tell participants that the first step to understanding sexual health is to understand the ways that the word 'sex' is used. Ask for examples of what people are referring to when they say "SEX". Be sure that this list includes both sexual contact and a person's biological gender. Tell participants that people are often unclear when they say 'sex' exactly what kind of sexual contact they are referring to. Tell the participants that you are going to say a list of sexual activities. Ask them to raise their hands if they believe doing that activity means someone has had sex. As you read the list, include the definitions so that all the participants know what you are referring to.
  - a. Kissing
  - b. Kissing and touching over clothing
  - c. Having sexual feelings
  - d. Masturbation
  - e. Touching genitals under clothing to orgasm
  - f. Vaginal sex
  - g. Anal sex
2. Lead a discussion with the following questions:
  - a. Was everyone in agreement about whether a sexual act should be considered "sex"?
  - b. Why do you think there was agreement or disagreement?
  - c. Do you think your adolescent would agree or disagree with you about what activities are considered "sex"? Would you feel comfortable talking about this subject with your adolescent?
3. Remind parents that only vaginal sex can result in pregnancy.
4. Ask participants which sexual activities can result in sexually transmitted infection (STI) transmission, including HIV. Tell participants that the activities range from no-risk to low-risk to high-risk. They should raise their hands according to the degree of risk they believe the activity has: high above their head for high-risk activities, about head height for low-risk, and down for no-risk. The first four activities are no-risk. Touching genitals under clothes to orgasm is low-risk for some STIs like herpes. However, touching genitals under clothes does not pose a risk for HIV transmission. Oral sex is low-risk for all STIs. Vaginal sex and anal sex are both high-risk for all STIs and HIV transmission.
5. Tell participants that now that they understand the many ways that sex is understood, they need to learn about healthy sexuality.
6. Ask participants to raise their hand if their adolescent's sexual health is one of

the reasons that they decided to join these workshops. For those who raised their hands, ask them to share in one sentence what aspects of sexual health were on their minds when they decided to join.

7. Read the World Health Organization's definition of sexual health from the included poster. If you have a space that allows for it, hang this definition on the wall for the remainder of the sessions.

*“Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (World Health Organization, 2006)*

8. Ask participants to consider whether or not they had a sexually healthy adolescence themselves. Participants may share if they want to, but no one is required to.
9. Tell participants that many parents who believe they had a sexually unhealthy adolescence try to make sure that their adolescents do not repeat their choices. Parents who believe they had a sexually healthy adolescence often try and get their adolescents to make the same choices. It is important for parents to understand their own history so they can understand what their impulse might be. However, it is critical for parents to remember that their adolescent's emerging sexual development is not about the parent, it is about the adolescent. Poster on Boy and Girl body changes at puberty.
10. Point out to participants that sex has potential physical, emotional, and social impacts on adolescents of different ages in different ways.
11. Split your group into three small groups of parents and assign each group an age range: young adolescent (10 - 13), middle adolescent (14 - 15), and older adolescent (16 - 19). You can make the groups randomly or you can have parents join the group they feel most drawn to talking about or you can have the parents join a group they have a child in. Ask each group to make a list of the ways that engaging in sexual contact (although not necessarily having sex) impacts a person of their age in that way. They must at least consider both the positives and the negatives. Give them five to ten minutes to make their list. Handout 14 on STIs.
12. Ask each group to present their list to the whole group.
13. After each group presents, invite the large group to consider what kinds of resources a parent would need to support adolescents in that age range if they were to have sexual contact or are sexually active.
14. After all of the groups have presented, provide a list of resources.

**Handout 27: list of SRH service providers**– this will include resources for both physical health like access to condom and hormonal birth control pill and

emotional health like counselling.

## SESSION 2: Understanding Sexual Development

### Understanding Sexual Development (Adolescents 10-13 years)

#### Early Adolescence (10 – 13 years)

40 minutes



Sexual health is not only a general idea, it is also specific to a person's age and developmental stage.

This activity focuses in depth on early adolescents' specific developmental stage.

#### Procedure

1. Discuss with participants that there are a number of changes that happen to girls' and boys' bodies during puberty, which is approximately the age that they are right now. Tell them that these changes happen at different times for different people, but that they usually start at a certain age.
2. Ask the participants to come up with a list of the changes that happen for a girl during puberty.

Be sure that the following are all listed:

- a. Breasts grow
- b. Pubic hair and other body hair grows
- c. Growth spurt
- d. Menstruation

Use **Handout 10 Boy and Girl changes at puberty** and **Hand-out 13 Adolescent psychological and social development** as a guide.

3. Ask the participants to list the changes that happen for a boy during puberty. Be sure that the following are all listed:
  - a. Growth of the scrotum, testes, and penis
  - b. Change of voice
  - c. Facial hair, pubic hair, and other body hair grows
  - d. Growth spurt
  - e. Body shape changes – broadening of shoulders

Use **Hand-out 10 Boy and Girl changes at puberty** and **Handout 13 Adolescent psychological and social development** as a guide.

4. Read the following story about 'Something Else'

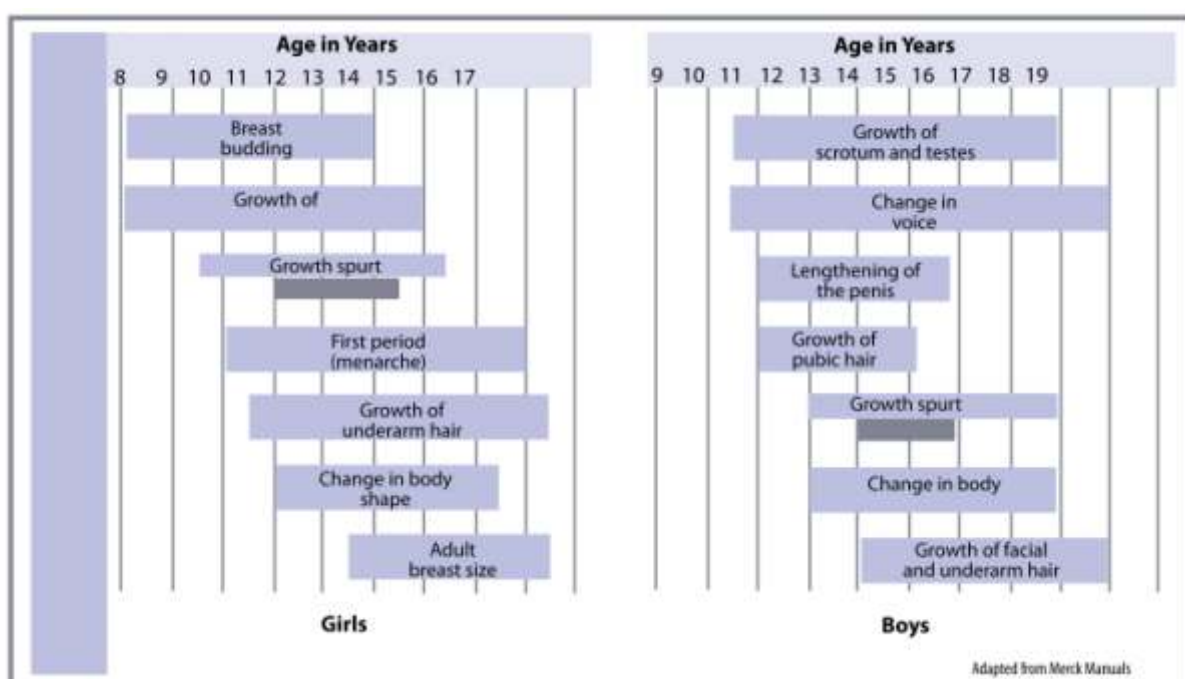
*'Something Else is a little creature who lives all alone on a hill because he has no friends, he is different from others. When he tries to play with the other creatures or eat his food with them or say 'Hi' as they do, they say 'Sorry, you are*

*not like us. You're Something Else. You don't belong'.*

Ask the participants how they would feel if they were Something Else.

Based on the story 'Something Else', lead a discussion by asking what kind of differences exists between young boys and girls as they grow up and how these differences affect them.

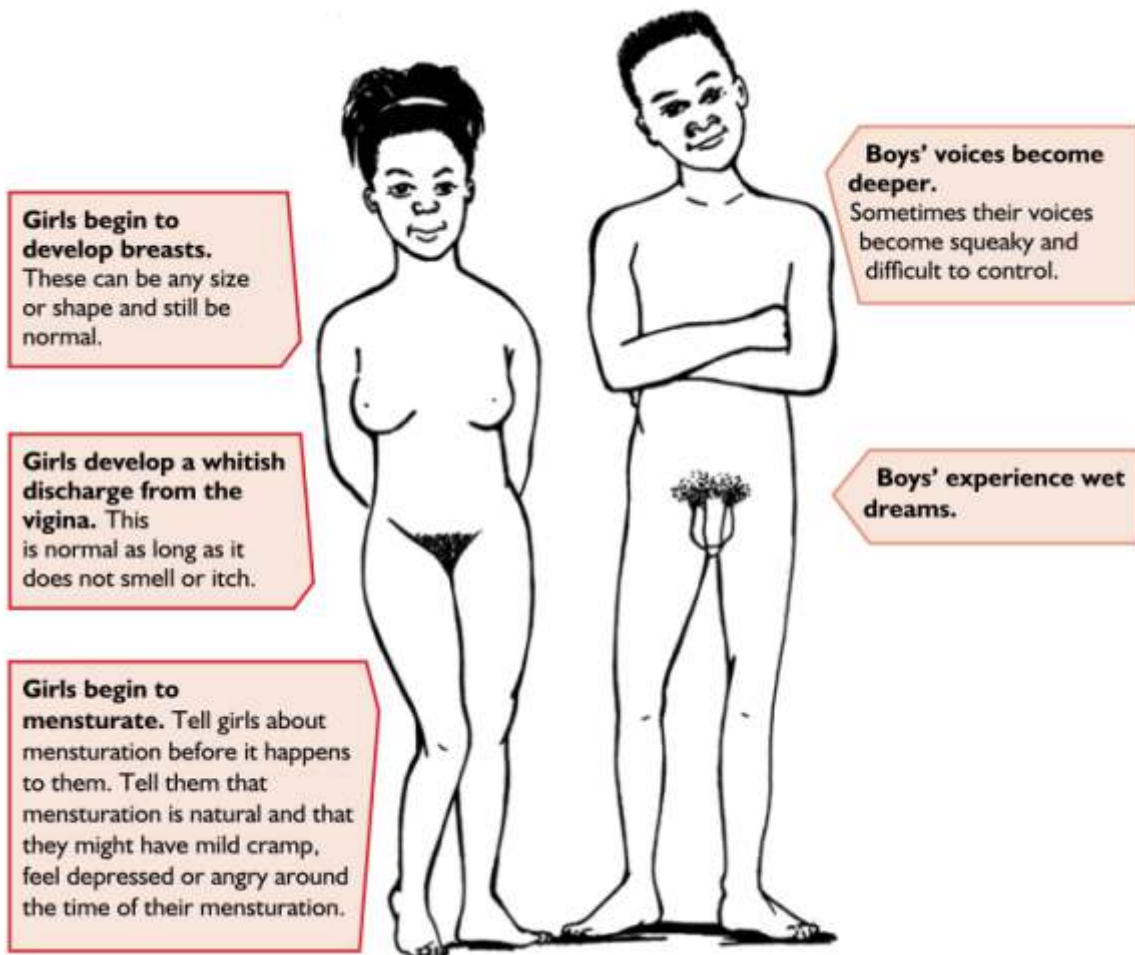
**Note to Facilitator:** Explain that there may be delays in reaching puberty in both girls and boys living with HIV. Adolescents who acquired HIV perinatally may have additional sexual and reproductive health concerns due to HIV related complications such as slow skeletal growth and delayed sexual maturation. They may also experience strong feelings of frustration, depression and anger due to how they look or feel different from other peers who are HIV negative.<sup>2</sup>



## Puberty

- ➔ As children grow up they will experience changes in their bodies and their emotions.
- ➔ These changes can happen at any time between the ages of 11 and 16. For children living with HIV, the changes can delay due to a number of reasons that include side effects of some ARVs they will be taking.
- ➔ Puberty changes happen at different times for the different children.
- ➔ Children need help to understand these changes about puberty.

<sup>2</sup> *Adolescent and Young People Living with HIV: Training Module to Complement the National ASRH Training Manual for Service Providers, pg. 16*



**Note to Facilitator:** Be sure to highlight that a girl who has undergone these changes can fall pregnant and a boy can make a girl/woman pregnant.

**NOTE:** Refer to facilitator notes for information on menstruation, wet dreams and spontaneous erections.

**FACILITATORS INFORMATION:**

**MENSTRUATION<sup>3</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.

<sup>3</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People*; pg. 68-69

## **WET DREAMS** <sup>4</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.

## **SPONTANEOUS ERECTIONS** <sup>5</sup>

Spontaneous erections are erections that happen suddenly for no reason. It is common for adolescent boys to get sudden erections, even when their penises have not been touched and they feel no sexual excitement.

Adolescent boys can have erections (20 or more times a day) because of high or changing level of testosterone in their bodies. Spontaneous erections go away by themselves if they are not touched. Boys and men often wake up in the morning with erections. These are thought to be due to having a full bladder.

## **Understanding Sexual Development (Adolescents 14-15 and 16-19 years)**

### **Session**

**40 minutes**



**Note to facilitator: Split the 14-15 year adolescents and the 16-19 year adolescents.**

Sexual health is not only a general idea, it is also specific to a person's age and developmental stage. This activity focuses in more depth on middle and late adolescents' specific place in life.

### **Procedure**

1. For 14-15year olds: Ask participants to listen to **Handout 11 Female adult story part 1 and 2**  
  
For 16-19 year olds: Ask participants to listen to Handout 11 **Female adult story part 1, 2 and 3**
2. After listening to the story, lead a discussion with the following questions:
  - a. Was there anything the author wrote about that you have experienced?
  - b. Was there anything the author wrote about that surprised you?
  - c. What do you think might come next in this author's sexual story?
3. While it is nice if your group is cohesive enough for the participants to feel comfortable sharing which parts of the story they identified with, don't press them if they seem uncomfortable. They are likely to be more comfortable opening up about what surprised them. The same is true for the second story.

<sup>4</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People*; pg. 73-74

<sup>5</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People*; pg. 74

4. For 14-15 year olds: Ask participants to listen to **Handout 12 Male adult story part 1 and 2**

For 16-19 year olds: Ask participants to listen to **Handout 12 Male adult story part 1, 2 and 3**

5. After listening to the story, lead a discussion with the following questions:
  - a. Was there anything the author wrote about that you have experienced?
  - b. Was there anything the author wrote about that surprised you?
  - c. What do you think might come next in this author's sexual story?
6. **For 14-15 year olds:** After you have read and discussed both stories, tell participants that every person develops at their own individual pace. This is probably obvious to them because some people go through puberty earlier or later than others. This is especially obvious because different people grow taller at certain times, women's bodies grow breasts and hips, and men's voices get deeper. Tell the participants that in addition to these physical things happening at different times, people decide to begin being sexual at different times. Each person should be true to their own development and not feel pressured by what sexual activities someone else is doing.

**For 16-19 years olds:** After you have read and discussed both stories, tell participants that every person develops at their own individual pace. This was probably obvious to them when they and their peers were all going through puberty. (Check for agreement here. If they need to have their memories jogged, ask if some people grew taller much faster than others.) Even though it is less obvious now that most people are finished with puberty, sexual development continues to happen at different times for different people. Each person should be true to their own development and not feel pressured by what sexual activities someone else is doing.

7. Also tell participants that having sexual feelings is a normal part of being human. Sexual feelings themselves are not bad or wrong. What can be bad and wrong or good and healthy about sexual feelings is how you act on them or don't act on them. Handout 13: Adolescent psychological and social development.

## Understanding Sexual Development (Parents)

**Parents Only**

**40 minutes**



Sexual health is not only a general idea, it is also specific to a person's age and developmental stage. This activity focuses in more depth on that pathway.

### Procedure

1. Ask participants to listen to the Female adult story, Handout 11.
2. After listening to the story, lead a discussion with the following questions:
  - a. Was there anything the author wrote about that surprised you?
  - b. If you were this young woman's parent, how would you feel about her experience?



- c. What do you think might come next in this author's sexual story?
3. Ask participants to listen to another **Male adult story part, Handout 12.**
4. After listening to the story, lead a discussion with the following questions:
  - a. Was there anything the author wrote about that surprised you?
  - b. If you were this young man's parent, how would you feel about his experience?
  - c. What do you think might come next in this author's sexual story?
5. Tell the participants that adolescents develop on their own timelines, both in terms of physical development and when they become sexually active. The different rates of change are normal and should be accepted by the parents. **Hand-out 13, Adolescent psychological and social development.**
6. Show parents the included posters of typical physical development and typical sexual activities in Zimbabwe. Handout 10, Boy and Girl changes at puberty.
7. Include the poster of pubertal development from the session with early adolescents. Refer to **Handout 13 on Adolescent Psychological and Social Development.**

**Note to Facilitator:** Talk about delays in reaching puberty that can happen to both girls and boys living with HIV. Adolescents who acquired HIV prenatally may have SRH concerns due to HIV related complications such as slow skeletal growth and delayed sexual maturation. This may also have an impact on psychosocial development, resulting in strong feelings of frustration, anger, and depression because they look or feel different from their HIV-negative peers.<sup>6</sup>

Tell participants that their day is coming to an end. Tell them their assignment and ask participants to sing an appropriate closing song.

**ASSIGNMENT: Tell parents to share with other parents / caregivers what they have learnt based on the following questions. Did you learn any new things about sexual health and adolescent development? What did you already know about adolescent development?**

**Tell parents / caregivers to ask their adolescents the same questions at home and encourage their adolescents to talk.**



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

<sup>6</sup> *Adolescent and Young People Living with HIV: Training Module to Complement the National ASRH Training Manual for Service Providers.* pg. 16

# UNIT 3: REPRODUCTIVE HEALTH



# UNIT 3: REPRODUCTIVE HEALTH



## Rationale

Reproductive health issues are critical for young people. The term “reproductive health” in a broad sense refers to the health and well-being of women and men in terms of sexuality, pregnancy, birth, and related conditions, infections and illnesses. Good parent-to-child communication leads to informed abstinence, informed choices on relationships and safer sexual practices among adolescents. Through understanding reproductive health issues, young people are able to cope with reproductive health risks and consequences.

### Early Adolescence 10-13 years:

Adolescents at this stage are beginning to experience THE changes in their reproductive systems that occur with puberty. Boys begin to experience wet dreams and girls may begin menstruation during this time. This signals that the body is now ready to create children, and that the adolescent must now take reproductive decisions into account. It is important that they are given a basis of understanding what these changes mean for their reproductive health and how to make decisions that best serve their own health.

**Late Adolescence 16-19 years:** This stage is often accompanied by advanced sexual experimenting, and as such has a greater risk of resulting in negative reproductive outcomes for the adolescents, including early pregnancy and exposure to STIs and HIV. It is important to stress the need for safe sex and the long-term and short-term consequences of making bad decisions regarding their reproductive health.

**Middle Adolescence 14-15 years:** Many adolescents at this stage have already experienced the changes in their reproductive systems, or are at the tail end of these shifts. This is the time when many adolescents are experimenting sexually, and it is important that they know the consequences of their actions, and what they can do to prevent undesirable outcomes. Adolescents at this stage must be educated about the processes of pregnancy and the consequences of unprotected sex.

**Parents/Caregivers:** Navigating reproductive health can be a tricky endeavour for parents, especially within more conservative households. Parents are, however, their children’s first point of reference for many issues relating to their health and maturation. It is essential that parents understand the issues that their adolescents are facing and have open communication channels with their children to allow adolescents to express what they are going through and to gain support from their parents.

**Note to Facilitator:** A 'mature minor' is a child under 18 years who is pregnant or already a parent. You may encounter situations where an adolescent is a mature minor. Stress the information that is appropriate to both the adolescent's age group and their status as a parent. It is at the discretion of the BCF to decide which group the minor should join.

## Objectives

### Adolescents

- ➔ To increase awareness on how pregnancy happens and improve knowledge on

- ➔ how to prevent unintended pregnancy including contraceptive use.
- ➔ To foster communication with parents on issues relating to reproductive health.
- ➔ To identify different forms of contraception and where they can access it.

### Parents

- ➔ To encourage parents to communicate with adolescents about issues relating to their reproductive health.
- ➔ To improve knowledge in parents on how they can help their adolescents to prevent unintended pregnancy.

## UNIT PLAN

### Activities:

Icebreaker (Split session)	<b>90 minutes</b>
Session 1: How Pregnancy Happens (Split Session)	10 minutes
Session 2: Adolescents, Abstinence and Contraception (Split Session)	30 minutes
Session 3: Talking about Pregnancy (Combined Session)	30 minutes
	20 minutes

### Icebreaker

**10 minutes**



It is important to begin each session with a welcoming environment. This sets the tone for the remainder of your time together, which helps when discussing topics that may be uncomfortable for the adolescents and their parents. Ask the adolescents and parents to relate how they fared in their conversations at home after the last session.

Areas of importance include:

- What challenges did they face?
- What lessons did they learn?
- What went well, and what did not?

## SESSION 1: How Pregnancy Happens

### Split Session - Parents and Adolescents

#### How Pregnancy Happens (Adolescents)

**30 minutes**



This exercise provides adolescents with information on how pregnancy happens and allows them to reflect on what would happen to their dreams if they were to become parents.

### Procedure

1. Ask participants to close their eyes where they are seated. Tell them to think about their hopes, dreams and plans for the future. Speaking slowly and pausing for a long time between questions, ask:
  - ➔ What do you hope will happen in the next few years?
  - ➔ What are you dreaming about?
  - ➔ What are your plans for the future?

After at least a minute (don't rush them) say: There's been a change in your circumstances. If you are a girl, you just found out that you are pregnant. If you are a boy, you just found out that your girlfriend is pregnant and you are going to be a father. What will happen now?

- 
2. After about 30 seconds, then tell them to open their eyes. Ask them:
    - ➔ If this happens to you now, what will happen to your hopes, dreams and plans?
    - ➔ Do you want to get pregnant now? Why or why not?
    - ➔ What responsibility do boys have for their children if they get a girl pregnant?

**Note to Facilitator:** Make sure it comes up that we have a moral obligation to care for our own children. According to the Constitution of Zimbabwe, parents also have a legal obligation to provide for their children. The Maintenance Act Chapter 5:09 further makes it possible for the mother to take the father (or the father's family if he is a minor) to court to get child support money. DNA tests can ascertain paternity. DNA testing is available in major cities.

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3. Tell participants that they are now going to learn about how a woman gets pregnant. Refer to the facilitators notes on how pregnancy happens.

- 
4. Ask participants: How do adolescents prevent pregnancy after unprotected sex? Dispel all of the myths that they have heard. (Myths: Jumping up and down after sex to push sperms out, taking strong black tea, douching with Coca Cola after sex).

- 
5. Is there ANYTHING you can do in those three days after unprotected sex that could help prevent pregnancy? (Answer: You can take emergency contraception within 72 hours). Probing questions: Have you ever heard of emergency contraception? The 'morning after' pill? There is NO other way to prevent unintended pregnancy after unprotected sex besides using emergency contraception. Refer to the facilitators notes on Emergency contraception

## How Pregnancy Happens (Parents)

### Procedure

30 minutes



1. Ask participants to close their eyes where they are seated. Tell them to think about their hopes and dreams for their children. (don't rush them give them at least a minute).
2. With their eyes still closed, say: Your adolescent daughter tells you that she is pregnant or your son tells you that he has impregnated a girl and is going to be a parent. (Ask them to think about this for a while)
3. Then after about 30 seconds, then tell them to open their eyes. Ask them:

If this happens to your child what would you do?  
What would be your responsibilities as a parent to your daughter or son?

4. Ask participants: How can you communicate with your adolescent about how pregnancy happens and the consequences of adolescent pregnancy? Refer to the facilitators' notes on How Pregnancy Happens.
5. Ask them if they have heard of any ways to prevent pregnancy after unprotected sex. Dispel all the myths that they have heard.
6. Ask the participants: Is there *ANYTHING* you can do to help your adolescent prevent pregnancy after having unprotected sex? (Answer: She can take emergency contraception within 72 hours). Probing questions: Have you ever heard of emergency contraception the 'morning after' pill? There is NO other way to prevent unintended pregnancy after unprotected sex besides using emergency contraception. Refer to the facilitators notes on Emergency contraception.

**Note to facilitator:** Emphasize that emergency contraception is the only method that one can use to help prevent an unintended pregnancy after sex. Emergency contraception is a special dose of concentrated oral contraceptive pills that are meant to be taken within 3 days (72 hours) of unprotected sex. The sooner emergency contraceptive is taken after the unprotected sex, the more effective it is in preventing pregnancy.

7. Emphasise that abandonment, fear, not supporting or chasing away a pregnant adolescent may lead to unsafe abortion practices among adolescents.

**Note: Unsafe abortion (back-door abortion) is illegal in Zimbabwe. However, if such abortion is carried out and somehow goes wrong, it is advisable to seek medical help.**

8. Also explain that if a couple or sexual partners had unprotected vaginal sex but the man pulls out of the vagina before ejaculating, there is still a chance the woman can become pregnant. The reason is that a small amount of fluid comes out of the penis before ejaculation. This is called pre-ejaculate or pre-cum and it may have sperm in it.

## **FACILITATOR'S INFORMATION**

### **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>7</sup>

Induced abortion is illegal in Zimbabwe. The Termination of Pregnancy Act (Chapter 15:10) states that, 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

<sup>7</sup> Adapted from German Foundation for World Population (DSW), 2006 "Sexual and Reproductive Health Training Manual for Young People" pg. 65

(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>8</sup>

### How Pregnancy Happens

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. 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 fertilisation. When the fertilised egg reaches the uterus, it attaches itself to the lining. This is called implantation. Once implantation has happened, the woman is pregnant.

If a man and a woman have unprotected sex, but the man does not ejaculate, some of his sperm (that may be contained in the pre-ejaculate fluid) may still enter the vagina and cause pregnancy. The pre-ejaculate is the small amount of clear fluid that comes out of the penis before ejaculation.

## MOST IMPORTANT INFORMATION ABOUT EMERGENCY CONTRACEPTION

- Emergency contraception must be taken within 3 days of unprotected sex.
- You should take it as soon as possible after unprotected sex. The sooner you take it, the better it works.
- Emergency contraception is available in health facilities and pharmacies, and adolescent and young people can access them from their youth-friendly sexual and reproductive health service providers.
- Emergency contraception is for emergencies and should not be used as a regular family planning method.
- Emergency contraception does not protect you from STIs and HIV.
- If a woman takes emergency contraception and then has sex again without using another kind of contraception or her method fails, she can still get pregnant. If she still doesn't want to get pregnant, she needs to take emergency contraceptive pills again.

## SESSION 2: Abstinence and Family Planning and Contraception<sup>9</sup>

### Split Session

**Note to Facilitator: Separate the adolescents age 10-13 from the other two groups and have the following sub-exercise.**

<sup>8</sup> Termination of Pregnancy Act [Chapter 15:10] Available at <http://www.parl.zim.gov.zw/acts-list/termination-of-pregnancy-act-15-10>  
<sup>9</sup> German Foundation for World Population (DSW), 2006. *Sexual and Reproductive Health Training Manual for Young People*. Pages 122 - 152

## Abstinence (Adolescents 10-13 years)

### Procedure

30 minutes



1. Reflect on earlier conversations on boys and girl undergoing body changes at puberty and the possibility of falling pregnant.
2. Remind them that going through puberty means that girls and boys should know how to relate to each other in healthy ways, because irresponsible sexual behaviour may lead to pregnancy, and/or STIs and HIV
3. Ask participants what abstinence is and discuss the benefits of abstinence. Abstinence means completely avoiding vaginal, oral, or anal sexually intercourse. It is 100% effective in preventing pregnancy and STIs including HIV.
4. Ask participants what the disadvantages of early sexual debut are.
5. Ask participants to identify the negative impacts that early pregnancy has on girls.

## Abstinence and Family Planning and Contraception (Adolescents 14-15 and 16-19)

Although middle adolescents (14-15 years) should learn about contraception, emphasis should be placed on abstinence as the most effective form of preventing pregnancy.

### Procedure

30 minutes



1. Ask participants to name different methods of preventing pregnancy they know of and what they might have heard about them.
2. Guide participants in a discussion of the various modern contraceptive methods available to them, and which ones would be most suitable for adolescents including those living with HIV and discuss why.
3. Dispel any myths regarding contraceptives and reiterate that abstinence, use of modern contraceptives, and correct and consistent use of short term methods such as condoms and the pill are the only ways to prevent pregnancy.
4. **For 16 - 19 year olds:** Have participants go through Handouts 6 and 7 on how to use the Male and Female condoms.
5. Take any questions regarding condom use that participants might have.
6. Ask participants: What challenges do young people face in accessing and using contraceptives and how can these challenges be overcome?
7. Emphasise that only abstinence is 100% effective in preventing pregnancy and contracting STIs including HIV. Condoms reduce the risk of contracting STIs/HIV and unintended pregnancies. Also emphasise dual contraception for adolescents including those living with HIV.



Delaying sexual debut and limiting the number of sexual partners can also reduce the risk of contracting HPV, which causes cervical cancer. **Girls can also access the HPV vaccine from the age of 10 to prevent cervical cancer. It is advisable to access the vaccine before sexual debut as that is when the protection is optimum.**

## Abstinence and Family Planning and Contraception (Parents only)

### Procedure

30 minutes



1. Tell participants that you are going to talk about issues related to adolescents deciding or not deciding to have sex, and the implications for contraception. Encourage them to think about how they can assist adolescents who are sexually active to prevent pregnancy. Ask participants to highlight ways in which adolescents can prevent pregnancy.
2. Ask participants to express their concerns about their children becoming sexually active.
3. Ask which contraceptive methods they might consider suitable for adolescents who are sexually active, including those living with HIV. Why?
4. Guide participants in a discussion of the various contraceptive methods available, their advantages and disadvantages.  
  
Also explain to parents that some female adolescents who experience cramping during menstruation may be advised to use combined oral contraceptive pills to ease the pain.
5. Ask participants: What are some the challenges adolescents face in talking about contraceptives? How can you effectively communicate with your adolescent about contraception and preventing pregnancy? What challenges do you think you might face?
6. Dispel any myths and reiterate that abstinence, use of contraceptives, and correct and consistent use of short term methods such as the condom and pill are the only ways to prevent pregnancy.
7. Discuss where adolescents can access contraceptives and the challenges they face in accessing these services.

**Note to facilitator:** Encourage parents to talk to their children about contraception so that they can make informed decisions.

### FACILITATOR'S INFORMATION

#### Disadvantages of early sexual debut<sup>10,11</sup>

- Risk of STIs and HIV
- Greater risk for not using contraception
- Risk of having multiple partners
- Pregnancy
- Risk of cervical cancer among the girls
- Increased chances of SGBV

<sup>10</sup> Ma, Q., Ono-Kihara, M., Cong, L., Xu, G., Pan, X., Zamani, S., Ravari, S., Zhang, D., Homma, T. and Kihara, M. (2009). Early initiation of sexual activity: a risk factor for sexually transmitted diseases, HIV infection, and unwanted pregnancy among university students in China. *BMC Public Health*, 9(1).

<sup>11</sup> Baumgartner, J., Waszak Geary, C., Tucker, H. and Wedderburn, M. (2009). The Influence of Early Sexual Debut and Sexual Violence on Adolescent Pregnancy: A Matched Case-Control Study in Jamaica. *International Perspectives on Sexual and Reproductive Health*, 35(01), pp.021-028.

## **Consequences of Early Pregnancy**

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.

### **Psycho-Social Consequences**

- 
- ➔ 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, 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. 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.

### **Contraceptives**

A contraceptive is a drug or device used to prevent pregnancy. There are many different contraceptive methods – but only the condom can prevent pregnancy as well as HIV or STIs. In this Unit, we will focus on pregnancy prevention.

Most contraceptive methods are reversible; that is a woman will be able to become pregnant again after she has stopped using the method. Some methods, such as surgical sterilization, are permanent, meaning a woman cannot become pregnant ever again or a man cannot make a woman pregnant again. In this Unit we shall discuss a range of contraceptive methods. Even though not all methods may be available where you are (or recommended for young people), it is important that you know about them and how they work. Contraceptive methods are frequently referred to by the way in which they prevent pregnancy:

- Barrier methods
- Intrauterine methods
- Hormonal methods
- Non Hormonal
- Surgical (permanent) methods
- Natural methods
- Emergency contraception

## Advantages and Disadvantages of Selected Contraceptive Methods<sup>12</sup>

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</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 polyurethane (plastic)</li> </ul>

Group	Type	Definition	How it Works	Effectiveness	Advantages	Disadvantages	Side effects
					<ul style="list-style-type: none"> <li>cycle</li> <li>Protects against STIs/HIV and pregnancy</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> <li>No systemic medication involved</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 provider for measurement</li> </ul>	<ul style="list-style-type: none"> <li>Allergies to rubber</li> <li>Can promote urinary tract 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</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>

Group	Type	Definition	How it Works	Effectiveness	Advantages	Disadvantages	Side effects
Oral contraceptives	Pills Combined Oral Contraceptives (COC) Progestogen Only Pill (POP)	These are hormonal pills women take daily by mouth to prevent pregnancy	<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>	99.9% (COC)  99.5% (POP)	<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>
Injectable	Depo-Provera® Noristerate®	Injectable Contraceptive that contains hormone similar to that in the woman's	<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</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</li> </ul>	<ul style="list-style-type: none"> <li>Requires qualified persons for injection</li> <li>Needs medical supervision</li> <li>Delays return to</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>

Group	Type	Definition	How it Works	Effectiveness	Advantages	Disadvantages	Side effects
		body	inner lining of the womb from thickening in preparation for pregnancy		<ul style="list-style-type: none"> <li>• use Reversible</li> </ul>	<ul style="list-style-type: none"> <li>• fertility Lack of period</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%	<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>
	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</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>



Group	Type	Definition	How it Works	Effectiveness	Advantages	Disadvantages	Side effects
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>womb from thickening in preparation for pregnancy</li> <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>

# SESSION 3: Talking about pregnancy

**Combined Session: ALL**

**15 minutes**



This session sets a platform for the parents and adolescents to openly talk about pregnancy and contraceptive use. This activity will help to reduce barriers in conversation that often exist between parents and their adolescents when discussing reproductive health matters. It facilitates conversation on how to navigate reproductive issues.

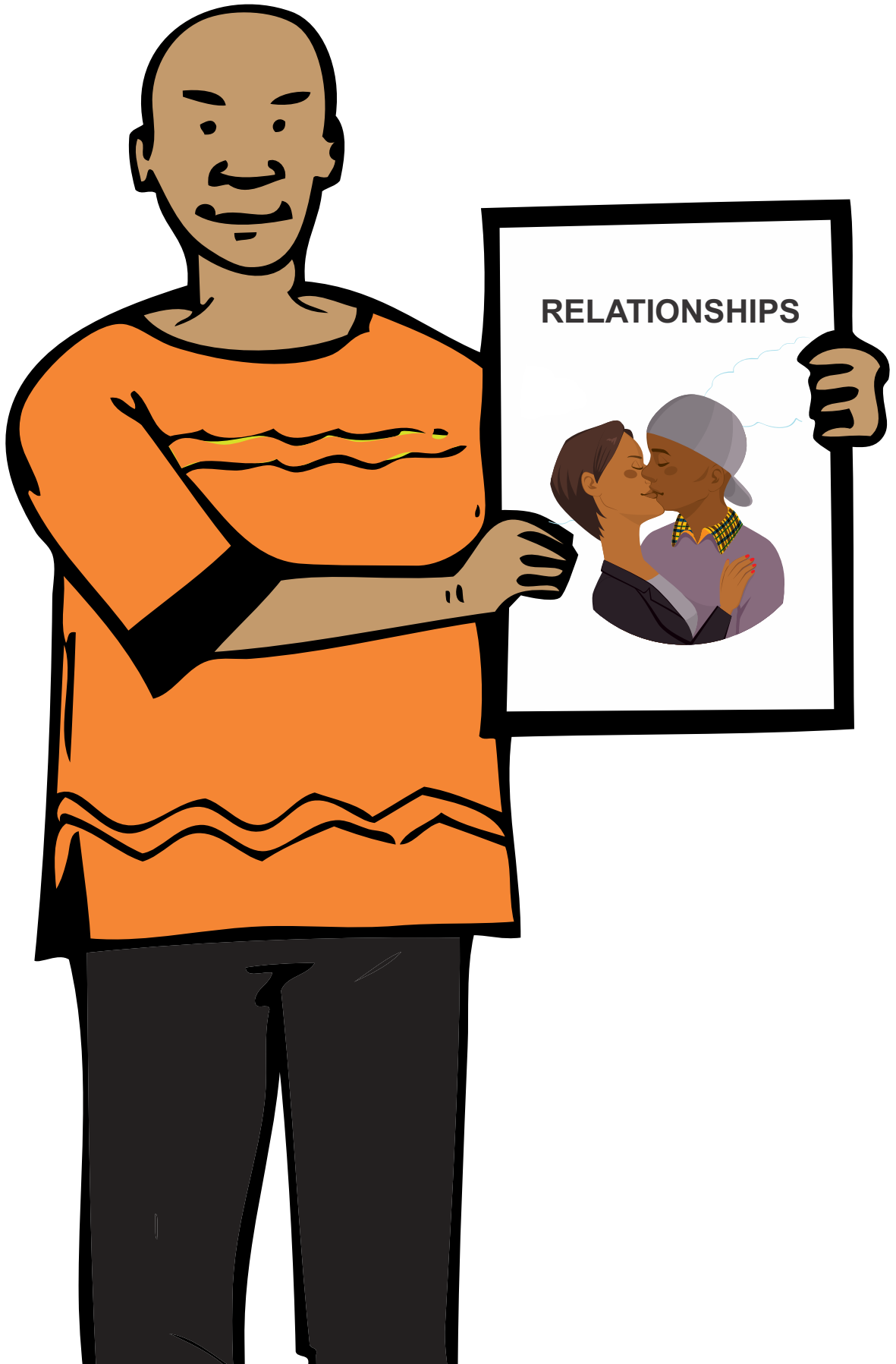
## **Procedure**

1. Ask participants to reflect on what they learnt in their different groups regarding prevention pregnancy. What was common?
2. Ask the adolescents to share their expectations in terms of parents supporting them in preventing pregnancy.
3. Encourage parents and adolescents to continue talking about pregnancy prevention.



**Remember to offer the participants 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 if they need more help or have more questions. Give referral slips and refer people to relevant service providers as needed.**

# UNIT 4: RELATIONSHIPS



# UNIT 4: RELATIONSHIPS



## Rationale

Understanding what one wants and needs from a relationship is a complex process of introspection that requires teasing out other people's beliefs and input until all that remains is your own. Adolescents of all ages need support to fully immerse themselves in this process. Once a young person has come to understand what they want, they need to communicate that to their family, friends, and partners. The need for conversation and negotiation around sexual activities ranging from holding hands and a first kiss through sexual intercourse within the context of a relationship is important for all adolescents to learn. In order to fulfil their sexual rights, these decisions must be made by each adolescent without force or coercion from anyone. Parents can learn to support their children in that process by listening and providing guidance. Allowing an adolescent space to talk about relationships and sexual decisions, and make decisions is an important part of enabling their growth and empowering them.

**Early Adolescence 10-13 years:** Younger adolescents are in transition, and this transition carries with it changes in how they relate to their parents, family and peers. This is the time when adolescents begin to relate more with their peers and generally spend more time with other adolescents, and less with their parents. Many adolescents begin to develop romantic affection for the opposite sex, which may lead to confusion and needs understanding from parents. Adolescents need support and understanding from their parents to enable them to make the right decisions with regard to their sexuality and relationships.

**Middle Adolescence 14-15 years:** Adolescents at this stage have begun to explore their relationships with the opposite sex and their peers to a greater degree. Some may even be sexually active. The middle part of adolescence is usually where parents and their children begin to have conflicts, as the adolescent tries to reconcile growing up and becoming more independent with adhering by their parents' rules. Communication about sexuality and decision-making is vital to empower adolescents to make the right choices for their lives.

**Late Adolescence 16-19 years:** Adolescents in this stage often solidify their relationships with their peers, as well as gain a deeper understanding of their own interests and beliefs. This can present potential conflict between parents and children, as adolescents may stray from their parents' wishes regarding their beliefs. Many adolescents at this stage have had to make sexual decisions. Some of them may know peers who have made bad sexual decisions, and will need education on how and why the decisions they make at this stage will impact the rest of their lives

## Objectives

### Adolescents

- To identify types of relationships that adolescents engage in.
- To know how to make sexual decisions.
- To know how to assertively communicate a sexual decision.
- To have negotiation skills that can be drawn on to support conflict resolution with partners, friends, and family.

## Parents

- ➔ To appreciate the types of relationships that adolescents engage in.
- ➔ To know how to help their adolescents as they make a sexual decision.
- ➔ To know how to support their adolescents in assertively communicating a sexual decision.

## Learning Outcomes:

After completing this session, participants will be able to:

- ➔ Identify different types of relationships that adolescents engage in
- ➔ Identify three elements to consider when making sexual decisions
- ➔ For parents, to identify three perspectives for their adolescents' to consider when making sexual decisions as well as steps to help adolescents when making decisions
- ➔ Define aggressive, assertive and passive forms of communication

# UNIT PLAN

## Activities:

Icebreaker: (Split session)	<b>90 minutes</b> 10 minutes
Session 1: Decision making (Split session)	20 minutes
Session 2: Communication (Split session)	25 minutes
Session 3: Sex: A decision for two (Split session)	35 minutes

## Icebreaker:

**10 minutes**



Begin the day by asking participants to sing an appropriate song. Invite participants to share how their family homework conversations went.

# SESSION 1: Decision-making

## Decision-making (Adolescents)

**20 minutes**



This activity introduces the participants to relationships and decision-making as a conscious, thoughtful process. Approaching relationships and sexuality in this way, rather than going with whatever happens, supports healthy relationships and reduces sexual risk.

## Procedure

1. Tell participants that you are going to start today by talking about relationships and decision-making.
2. Ask participants the different kinds of relationships they have and what is important in those relationships. Discuss the different activities that occur within each kind of relationship. Encourage the participants to cite possible positive and negative consequences in each kind of relationship.
3. Ask participants to share examples of difficult decisions they had to make and

why the decision was difficult. If the volunteers do not include these details, say that decisions are sometimes hard because:

- a. you don't know what you want,
  - b. other people want you to do something you don't want to do, or
  - c. none of the available options feel like good options.
4. Ask the 10 – 15 year olds to role play scenarios where they have to make difficult decisions.
  5. Continue the exercise with adolescents 16 – 19 years. Highlight that without informed decision-making in a relationship, sexual activity is risky. The first step to sexual activity is knowing exactly what kind of sexual activity you want. If you don't know what you want – you're not ready to be sexual.
  6. Tell participants that there are three elements to consider when making a decision about sexual activity:
    - a. **What level of physical contact would feel good to you** both emotionally that day, without taking anyone else's opinions into account, including your parents, your friends, and your partner? (Your answers can change on different days!)
    - b. **What level of physical contact would feel good to your partner** both physically and emotionally that day? This is not something you can guess at – you have to communicate with your partner because otherwise you can't know what they want. (Their answers can change on different days!)
    - c. The risks associated with the sexual contact that both you and your partner want to have. **Do you have the appropriate tools i.e. knowledge, decision making skills, contraceptives, ability to communicate with your partner etc.) at hand to reduce sexual risks?** If you do not have a condom, then you are not ready. Refer to Handout 5, Easy as ABC.
  7. Discussion questions:
    - a. Do you think it is important to make a decision about sexual activity without taking other people's opinions into account? Why?
    - b. Do you think it is important to ask your partner and find out what kind(s) of sexual activities they want to have? Why?
    - c. Would you feel comfortable asking your partner what sexual activities they are interested in? Why or why not?
    - d. Would you feel comfortable talking about your HIV status with your partner? Why or why not? Read **Hand-out 17 Kudzi's Story** and discuss.

### Decision-making (Parents only)

20 minutes



This activity is designed to strengthen parents' views of their adolescents' decision-making processes something to support, but not do for them.

### Procedure

1. Tell participants that you are going to start today by talking about decision-making. Ask participants to raise their hands if they feel their own adolescent sexual decision-making was done with full information and resources. Ask participants to raise their hands if they feel their own adolescent sexual decision-making needed additional support to happen in a way that was effective and good for them, physically and emotionally.

2. Lead a discussion with the following questions:
  - a. How did you make decisions about sex when you were an adolescent?
  - b. Who influenced your decision-making around sexual issues when you were an adolescent?
  - c. Who and what were the positive and negative influences in your lives? How can you replicate the positive things to influence your adolescent's decision making?
  - d. Who should influence your adolescent's decision making related to sex?
  - e. What can you do as parents to communicate effectively with your adolescents on matters and decisions related to sex?

**Note to facilitator:** Explain to participants that support in decision making related to sex is not about encouraging adolescents to have sex but rather to make responsible choices and decisions, including abstinence and preventing pregnancy etc.

3. Ask participants for examples of things that can complicate a difficult sexual decision. If the volunteers do not include these details, say that decisions are sometimes hard because:
  - a. you don't know what you want,
  - b. other people want you to do something you don't want to do, or
  - c. none of the available options feel like good options.
4. Tell participants that their adolescents are learning about three elements to consider when making a sexual decision:
  - a. **What level of physical contact would feel good to them**, both physically and emotionally that day, without taking anyone else's opinions into account, including their parents, their friends, and their partner. (Their answers can change on different days!)
  - b. **What level of physical contact would feel good to their partner** both physically and emotionally that day? This is not something they can guess at - they have to communicate with their partner because otherwise they can't know what their partner wants. (Their partner's answers can change on different days!)
  - c. **What risks are associated with the sexual contact** that both they and their partner want to have? Do they have the appropriate tools at hand to reduce sexual risks? If they do not have a condom, are they able to get one?
5. Discussion questions:
  - a. Why do you think it is important for your adolescents to consider each of these three points?
  - b. How do these three points relate to a person's sexual and reproductive rights?
  - c. As parents when do you think it is appropriate for your children to exercise their sexual and reproductive rights?
  - d. If you do not agree with your adolescents' sexual decisions, how do you resolve this?
6. Ask parents to share what they consider their role, as parents, to be as their adolescents consider these three sexual decision-making points. If the participants do not refer to it in their conversation, refer to posters from the first day. Their role is to let their adolescent lead the way while they follow and support.

# SESSION 2: Communication

**Communication (Adolescents)**

**20 minutes**



After making a decision about sexual contact, the next step is to communicate that decision with a partner. This short activity outlines the differences between aggressive, assertive, and passive communication styles.

## **Procedure**

1. In the first activity, you will ask three different participants for something in different ways. What you ask for is dependent on the context of your environment, and can include that they move to another location in the space or to give you their cell phone or a pencil or something else entirely. Decide what you are going to ask of them ahead of time. You should make the same request all three times so that it's easier for participants to compare the experience. It might be helpful for you to rehearse this part of the lesson with a friend or colleague before the lesson starts.
2. Tell participants that you are going to demonstrate three different ways of asking for something. Do this in the following ways:
  - a. State your request as a demand from the first participant. You should be loud and commanding. While not out-right mean, your request should leave no room for argument. For example, "Give me your pencil right now, I want to use it!" (This is the aggressive approach.)
  - b. Turning to the second participant, state your request as much like a question as possible. You should be soft-spoken and include many caveats, like noting that the participant doesn't have to comply with your request if they don't want to. It's best if it is initially unclear what you are even asking for. For example, "If it's not too much to ask, can I use your pencil? If you cannot, then it's okay." (This is the passive approach.)
  - c. Turning to the third participant, ask for what you want of them in clearly defined and spoken terms. Do not apologise. Do not demand. Clearly state what it is you need them to do. For example, "May I please use your pencil, I need to write something?" (This is the assertive approach.)
3. The participants will likely be taken aback by your three approaches, especially if you made them different enough from each other. If they start talking about it, let them talk for a few minutes. Be sure that the following points are talked about:
  - a. What was different about the three approaches?
  - b. How did the different approaches feel to the participants you were talking to?
  - c. Did they know what you wanted?
  - d. Did they want to do what you asked?
4. Put names to the three approaches that you used:
  - a. The first was an aggressive approach, which involves being demanding and not caring about the other person's feelings. This approach often makes people want to argue with you or leave because they don't want to be around you.
  - b. The second was a passive approach, which involves not being clear about your feelings. This approach often confuses people because they can't figure out



- what you want.
- c. The third approach was assertive, which involves clearly stating what you need without being oppressive in your delivery. People are more likely to happily provide what you need when you approach them in this way.
5. Ask participants to raise their hands if they have ever been approached by a friend in an aggressive way. Ask them how they felt. Repeat the two questions with passive and assertive.
  6. Tell participants that after making a decision about sexual contact, communicating that information to your partner in an assertive way is important. Tell participants that the next activity is going to provide them with an example that they should consider in light of your conversations about decision-making and communication.
  7. Ask participants to get into pairs (if you have an odd number of participants, you can have one group of three). Tell participants that they are going to practise communication in the three different forms so that they can experience what they feel like.

Each person should practise each kind of request, and their partner should continue the conversation for a few exchanges to get the feel for the conversation. The partner who is not role-playing a particular kind of communication should respond as themselves. Tell the partners to begin with the aggressive request. After all participants have had a chance to be the aggressive communicator, tell the pairs to move on to role-playing passive communication. After the passive communication role-plays have finished, move on to the assertive communication role-plays. You may find that the participants benefit from hearing the descriptions of the different communication styles as you instruct them to begin their role-plays.

- a. **Aggressive request:** “The least you could do is have sex with me and don’t you refuse girl you owe me. Damn it — you have been accepting money and gifts from me!”
  - b. **Passive request:** “I want to come to visit you at your place? That is, if you feel it’s fine with you?”
  - c. **Assertive request:** “Will you please come to my place today, I need your company?”
8. After participants have completed their role-plays, lead a short whole group discussion with the following questions:
    - a. What did it feel like when you were communicating in:
      - an aggressive way?
      - a passive way?
      - an assertive way?
    - b. How do you think that these different communication styles would work if you were talking about sex? What would be the upsides and the downsides of each communication style?

**Note to facilitator:** Point out that the communication skills they learn in this session, are not only useful in sexual situations but can be applied in everyday settings, e.g. asking someone to do a chore, asking a classmate for help with the homework task, asking an older person for advice, or even better giving an older person advice.

## Communication (Parents)

20 minutes



After making a decision about sexual contact, the next step is to communicate that decision with a partner. This short activity outlines the differences between aggressive, assertive, and passive communication styles.

### Procedure

1. In the first activity, you will ask three different participants for something in different ways. What you ask for is dependent on the context of your environment, and can include that they move to another location in the space or to give you their cell phone or a pencil or something else entirely. Decide what you are going to ask of them ahead of time. You should make the same request all three times so that it's easier for participants to compare the experience. It might be helpful for you to rehearse this part of the lesson with a friend or colleague before the lesson starts.
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  - a. What was different about the three approaches?
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4. Put names to the three approaches that you used:
  - a. The first was an aggressive approach, which involves being demanding and not caring about the other person's feelings. This approach often makes people want to argue with you or leave because they don't want to be around you.
  - b. The second was a passive approach, which involves not being clear

about your feelings. This approach often confuses people because they can't figure out what you want.

- c. The third approach was assertive, which involves clearly stating what you need without being oppressive in your delivery. People are more likely to happily provide what you need when you approach them in this way.
5. Ask participants to raise their hands if they have ever seen a parent approach their child or adolescent in an aggressive way. Ask how they felt watching the exchange and whether the parent was able to get their point across. Ask if they thought the adolescent would be more or less likely to come to the parent for support after the interaction. Repeat the three questions with passive and assertive.
6. Tell participants that communicating with their adolescents in an assertive way is often the most effective way to support their behaviour.
7. Ask participants to get into pairs (if you have an odd number of participants, you can have one group of three). Tell participants that they are going to practise communication in the three different forms so that they can experience what they feel like.

Each person should practise each kind of request, and their partner should continue the conversation for a few exchanges to get the feel of the conversation. The partner who is not role-playing a particular kind of communication should respond as themselves. Tell the partners to begin with the aggressive request. After all participants have had a chance to be the aggressive communicator, tell the pairs to move on to role-playing passive communication. After the passive communication role-plays have finished, move on to the assertive communication role-plays. You may find that the participants benefit from hearing the descriptions of the different communication styles as you instruct them to begin their role-plays.

- a. **Aggressive request:** "The least you could do is have sex with me and don't you refuse girl you owe me. Damn it — you have been accepting money and gifts from me!"
  - b. **Passive request:** "I want to come to visit you at your place? That is, if you feel it's fine with you?"
  - c. **Assertive request:** "Will you please come to my place today, I need your company?"
8. After participants have completed their role-plays, lead a short whole group discussion with the following questions:
    - a. What did it feel like when you were communicating in:
      - an aggressive way?
      - a passive way?
      - an assertive way?
    - b. How do you think that these different communication styles would work if you were actually talking with your adolescent? What would be the upsides and the downsides of each communication style?

**Note to facilitator:** Point out that the communication skills they learn in this session, are not only useful in sexual situations but can be applied in everyday settings, e.g. asking someone to do a chore, asking a classmate for help with the homework task, asking an older person for advice, or even better giving an older person advice.

## Communication (Parents)

20 minutes



After making a decision about sexual contact, the next step is to communicate that decision with a partner. This short activity outlines the differences between aggressive, assertive, and passive communication styles.

### Procedure

1. In the first activity, you will ask three different participants for something in different ways. What you ask for is dependent on the context of your environment, and can include that they move to another location in the space or to give you their cell phone or a pencil or something else entirely. Decide what you are going to ask of them ahead of time. You should make the same request all three times so that it's easier for participants to compare the experience. It might be helpful for you to rehearse this part of the lesson with a friend or colleague before the lesson starts.
2. Tell participants that you are going to demonstrate three different ways of asking for something. Do this in the following ways:
  - a. State your request as a demand from the first participant. You should be loud and commanding. While not out-right mean, your request should leave no room for argument. For example, "Give me your pencil right now, I want to use it!" (This is the aggressive approach.)
  - b. Turning to the second participant, state your request as much like a question as possible. You should be soft-spoken and include many caveats, like noting that the participant doesn't have to comply with your request if they don't want to. It's best if it is initially unclear what you are even asking for. For example, "If it's not too much to ask, can I use your pencil? If you cannot, then it's okay." (This is the passive approach.)
  - c. Turning to the third participant, ask for what you want of them in clearly defined and spoken terms. Do not apologise. Do not demand. Clearly state what it is you need them to do. For example, "May I please use your pencil, I need to write something?" (This is the assertive approach).
3. The participants will likely be taken aback by your three approaches, especially if you made them different enough from each other. If they start talking about it, let them talk for a few minutes. Be sure that the following points are talked about:
  - a. What was different about the three approaches?
  - b. How did the different approaches feel to the participants you were talking to?
  - c. Did they know what you wanted?
  - d. Did they want to do what you asked?
4. Put names to the three approaches that you used:
  - a. The first was an aggressive approach, which involves being demanding and not caring about the other person's feelings. This approach often

makes people want to argue with you or leave because they don't want to be around you.

- b. The second was a passive approach, which involves not being clear about your feelings. This approach often confuses people because they can't figure out what you want.
  - c. The third approach was assertive, which involves clearly stating what you need without being oppressive in your delivery. People are more likely to happily provide what you need when you approach them in this way.
5. Ask participants to raise their hands if they have ever seen a parent approach their child or adolescent in an aggressive way. Ask how they felt watching the exchange and whether the parent was able to get their point across. Ask if they thought the adolescent would be more or less likely to come to the parent for support after the interaction. Repeat the three questions with passive and assertive.
  6. Tell participants that communicating with their adolescents in an assertive way is often the most effective way to support their behaviour.
  7. Ask participants to get into pairs (if you have an odd number of participants, you can have one group of three). Tell participants that they are going to practise communication in the three different forms so that they can experience what they feel like.

Each person should practise each kind of request, and their partner should continue the conversation for a few exchanges to get the feel of the conversation. The partner who is not role-playing a particular kind of communication should respond as themselves. Tell the partners to begin with the aggressive request. After all participants have had a chance to be the aggressive communicator, tell the pairs to move on to role-playing passive communication. After the passive communication role-plays have finished, move on to the assertive communication role-plays. You may find that the participants benefit from hearing the descriptions of the different communication styles as you instruct them to begin their role-plays.

- a. **Aggressive request:** "The least you could do is have sex with me and don't you refuse girl you owe me. Damn it — you have been accepting money and gifts from me!"
  - b. **Passive request:** "I want to come to visit you at your place? That is, if you feel it's fine with you?"
  - c. **Assertive request:** "Will you please come to my place today, I need your company?"
8. After participants have completed their role-plays, lead a short whole group discussion with the following questions:
    - a. What did it feel like when you were communicating in:
      - an aggressive way?
      - a passive way?
      - an assertive way?
    - b. How do you think that these different communication styles would work if you were actually talking with your adolescent? What would be the upsides and the downsides of each communication style?

# SESSION 3 Sex: A decision for Two

## Sex: A decision for two - Adolescents 14-15 and 16-19 years

### Procedure

35 minutes



1. Explain that this lesson explores why the idea that “sex is a decision for two” is often not realized in real life.
2. Distribute the Handout 16: Sexual Behaviour Attitude Survey. Divide participants into mixed groups of males and females and ask them to try to reach group consensus on each item and write their answers on separate pieces of paper. After a few minutes have the groups present their points to the larger group and discuss.
3. Distribute Handout 18 Sex: A Decision for Two — the Scenario and Handout 19 Sex: A Decision for Two — the Analysis. Read Hand-out 18 yourself, or get two participants to read it aloud as the group reads along. Ask participants to go through the Analysis (Handout 19 Sex: A Decision for Two — the Analysis) in their groups and have groups complete it on paper.
4. Ask participants to return to the whole group. Discuss the Analysis briefly.
5. Then ask the participants to quickly write all the ways they can help prevent date rape.
6. List the brainstorming from each group on the board/flip chart.

### Discussion Questions:

- a. Do you think that understanding how date rape happens will help prevent it? Why or why not?
- b. What skills would females need to express themselves more clearly in sexual situations?
- c. What skills would males need to be more sensitive of their partners' real feelings?
- d. What issues does a couple need to deal with in order to avoid getting into risky situations?

## Sex: A decision for two - Parents

### Procedure

35 minutes



1. Explain that this lesson explores why the idea that “sex is a decision for two” is often not realised in real life.
2. Distribute **Handout 16 Sexual Behaviour Attitude Survey**. Divide participants into separate groups of males and females and ask them to try to reach group consensus on each item and write their answers on a piece of paper. After a few minutes, have the groups present their points to the larger group and discuss.
3. If participants are not already in small groups of four or five each, divide them

now. Distribute **Handout 18 Sex: A Decision for Two** — the Scenario and **Handout 20 Sex: A Decision for Two — the Analysis for Parents**.

4. Read **Hand-out 18** yourself, or get two participants to read it aloud as the group reads along. Ask participants to go through the Analysis (**Handout 20 Sex: A Decision for Two — the Analysis**) in their groups and have groups complete it on paper.
5. Ask participants to return to the whole group. Discuss the Analysis briefly.
6. Then ask the participants to quickly write all the ways they can help prevent their adolescents from date rape.

**Discussion Questions:**

- a. Do you think that understanding how date rape happens will help prevent it? Why or why not?
- b. What skills would females need to express themselves more clearly in sexual situations?
- c. What skills would males need to be more sensitive of their partners' real feelings?
- d. How can you assist your children from getting into sexually charged situations and effectively deal with the situations?

**ASSIGNMENT: Pick a relationship from a book, television show, radio show, bible, history, or cultural story. Make sure that everyone in the family has the same understanding of the relationship by taking turns to describe it. Talk about whether each person thinks it was a healthy relationship and what made it that way.**



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



## UNIT 5: ALCOHOL AND SUBSTANCE ABUSE

### Rationale

Exposure to alcohol and substance abuse during adolescence is often associated with poor conduct and outcomes including risky sexual behaviours, increased dependence on substances, STIs, HIV infection, unintended pregnancy, and crime etc. Therefore, reducing or delaying exposure to alcohol and substance use may prevent a wide range of health and social problems. During adolescence, the adolescents may experiment with alcohol and illicit substances. Hence awareness, education and parent-child communication around alcohol and substance abuse should begin early.



### **Adolescence (10 - 19 years):**

Adolescence is a period of experimentation, and therefore adolescents may be at risk of alcohol and substance abuse. In experimenting with alcohol and substances, the adolescent may become dependent on them as well as make poor decisions and judgements resulting in poor conduct and poor health outcomes. Hence there is need to raise awareness and educate adolescents to be responsible as well as avoid alcohol and substance abuse.

**Parents / Guardians:** Parents often worry about the long-term consequences that alcohol and substance abuse may have on their adolescents. During adolescence, parents / guardians need to positively influence their children on decisions and choices about alcohol and substance use. Therefore, parent-child conversations about alcohol and substance use should start early to prevent adolescents from experimenting with alcohol or substances. Starting communication early and opening up lines of communication enable parents and adolescents to talk about alcohol and substance use and abuse.

### **Objectives**

- To identify the common alcohol and substances abused by adolescents, and reasons for abusing alcohol and substances
- To understand how alcohol and substance abuse increase the risk of STIs, HIV infection, unintended pregnancy, dependence on substances, and poor conduct
- To facilitate conversation between parents and adolescents on alcohol and substance abuse

**Materials needed:** Flipchart paper, marker pens, tape and scissors or glue

## UNIT PLAN

### **Activity**

Icebreaker

Session 1: Alcohol and substance abuse (Split session)

Session 2: Ending alcohol and substance abuse (ALL)

**90 minutes**

10 minutes

50 minutes

30 minutes

**Note to facilitator:** separate the adolescents from the parents before taking them through the introduction steps.

### **Icebreaker**

**10 minutes**



It is important to begin each session with a welcoming environment. This sets the tone for the remainder of your time together, which helps when discussing topics that may be uncomfortable for the adolescents and their parents. Ask the adolescents and parents to relate how they fared in their conversations at home after the last session. Areas of importance include:

- What challenges did they face?
- What lessons did they learn?
- What went well, and what did not?

# SESSION 1: Alcohol and Substance Abuse

**Split session (Parents only and Split Adolescents)**

**50 minutes**



**Note to facilitator:** Separate parents from adolescents. Have two groups for adolescents: 10-14 year-old adolescents and 15-19 year-old adolescents for this session

## **Procedure**

1. Explain to the participants that they are going to explore ways alcohol and substance abuse affect lives and health of adolescents and adults in the community. Often, adolescents find themselves under enormous pressure to conform to peer pressure and the desire to please others. This may include the pressure to engage in alcohol and substance abuse, and have sex.
2. Ask participants to define alcohol and substance abuse.
3. Ask participants to highlight the substances and types of alcohol widely used and abused by adolescents in the community.
4. Ask a volunteer to read the following stories.

**Jonathan is 19 years old.** He says: I met this beautiful girl in a bar and we started chatting and drinking together. She was getting drunk and she sat on my lap and she started kissing me and I could not stop because I did not want my friends to think I was not man enough. After kissing for some time, she asked if we could leave and go somewhere private. I was so drunk that when she asked to have sex, we did so without a condom. I did not have the courage to insist on condom use. It all happened so fast. I only realized what I had done when I was sober but it was already too late. I am scared I might have been infected with HIV because I had sex with a stranger without a condom.

**Netsai is 17 years old.** She says: Here in my community, we have a lot of small bars. Every weekend we just go and hang around there and drink and take drugs. And of course, guys will come and buy alcohol and drugs for us and then entertain us. They always expect sex from us because they are spending their money on us. Okay, we feel obligated. We have to go and have sex with them because they are spending their money on us. When we don't want sex, they sometimes get violent. One time, a guy got really violent. He was furious, telling me - "What did you expect after spending all of my money?" He ended up beating me. My face was really messed up and my eye was swollen. I use condoms with some guys and sometimes I do not, especially when I get a good offer, or with a guy that I like a lot. I wish I could negotiate for safer sex but I feel no one would really like me if I said 'no', because I am not that beautiful.

5. Then ask the participants the following questions.
  - What is Jonathan doing that is putting him at risk? (Answers: getting drunk/drinking alcohol, having unprotected, casual sex) What is he at risk of?

- (STIs, HIV, getting a girl pregnant)
  - What is Netsai doing that is putting her at risk? (Answers: getting drunk/drinking alcohol, having sex in exchange for drinks, not using condoms consistently, having multiple sex partners) What is she at risk of? (STIs, HIV, getting pregnant, losing her reputation, violence, rape)
  - Are these situations common in your community? Why or why not? What do others think?
6. Based in the two stories, ask participants what are the risks and risky behaviours associated with alcohol and substance abuse (refer to the notes in the facilitator's information text box).
  7. Ask:
    - In what way does parents' alcohol and substance abuse affect adolescents' behaviours and decisions on alcohol and substance use?
    - In what way does media (television, music, social media) affect adolescents' behaviours and decisions on alcohol and substance use?
    - In what way does your community reinforce alcohol and substance abuse?
  8. Based on the stories of Jonathan and Netsai, what lessons can parents and children learn on communicating with each other about making decisions regarding alcohol and substance use and abuse?

**For parents:** Explain that talking with children about alcohol and substance use can help children to be more open, express their feelings and share their thoughts and decisions related to alcohol and substance use.

**For adolescents:** Explain that openly talking about alcohol and substance use with parents can help clarify any confusion they might have and avoid risks associated with alcohol and substance abuse.

9. Ask participants to briefly summarise what they learnt.

### **FACILITATOR'S INFORMATION**

**Physical risks:** Having no fear and doing risky things, accidents, driving drunk and crashing, crossing the road without looking, falling over, ripping clothing, passing out in the street, accepting a ride with a stranger or someone who is drunk, getting beaten up.

**Sexual risks:** Having unprotected /unsafe sex/not using a condom, making wrong or bad decisions about sex, feeling sexual desire, having sex with someone you wouldn't normally sleep with, having sex in exchange for drinks, being raped or forced to have sex, raping someone else.

**Social risks:** Doing embarrassing things (like peeing in your pants, defecating unexpectedly, sleeping anywhere, or singing and dancing in a drunk way), becoming violent or abusive, fighting with friends or strangers, breaking your relationships, committing crimes, getting in trouble with police or parents, going somewhere with someone you don't know; not studying when you

should and failing a test (dropping out of school); losing your values or breaking your own rules.

**Financial risks:** Losing a cell phone, school bag, purse or wallet or other valuables, gambling, spending money on alcohol or drugs that should be spent on something more important.

**Physical effects:** Nausea and vomiting or throwing up, crying, having a hangover, addiction, alcohol poisoning, drowning in your own vomit, passing out, not remembering what happened; over a long time, liver disease and other health problems; taking an overdose; death.

## SESSION 2: Ending alcohol and substance abuse

**ALL**

**30 minutes**



### Procedure

1. Divide participants into three or four groups (mix parents and children). Tell participants that they are going to do a five-minute role play to demonstrate how alcohol and substance abuse affect adolescents, families and the community as well as come up with a song / jingle to discourage alcohol and substance abuse. Give them 10 minutes to prepare their role play and song.
2. After 10 minutes ask the groups to present their role plays to the whole group.
3. Ask participants to come up with ways to improve communication among adolescents and parents, around alcohol and substance abuse.

**Note to Facilitator:** Emphasise the importance of open communication between parents and children around alcohol and substance use and abuse.

**Homework:** Tell participants to have a conversation around reasons for alcohol and substance use among adolescents and parents. Each family should come up with ways to address some of the reasons leading to alcohol and substance abuse.

# UNIT 6: STIs, HIV AND AIDS



# UNIT 6: STIs, HIV AND AIDS<sup>13,14</sup>



## Rationale

To learn about STI and HIV transmission and prevention.

**Early Adolescence 10-13 years:** Many adolescents begin to develop romantic affection, and hence the need to improve parents and guardians' understanding of adolescent developmental changes. Adolescents need support and understanding from their parents and guardians to enable them to make the right decisions with regards to making correct sexual reproductive health choices including prevention of HIV and early diagnosis and treatment of STIs

**Late Adolescence 16-19 years:** Adolescents in this stage often solidify their relationships with their peers, as well as gain a deeper understanding of their own interests and beliefs. Some of them may know peers who have made bad sexual decisions and some will have made bad choices themselves. This age group needs education on how and why the decisions they make at this stage will impact the rest of their lives. Communication about risky behaviours associated with HIV and AIDS and STIs is vital to empower adolescents to make the right choices for their lives.

**Middle Adolescence 14-15 years:** Adolescents at this stage have begun to explore their relationships with the opposite sex and their peers to a greater degree. Some may even be sexually active. There is therefore need for this age group to have knowledge on HIV transmission and be aware of STIs, the signs and symptoms and how they can be prevented. Communication about risky behaviours associated with HIV and AIDS and STIs is vital to empower adolescents to make the right choices for their lives. It is imperative for adolescents to know the importance of HIV testing and treatment, and early diagnosis and treatment of STIs.

**Parents / Caregivers:** Parents need to understand the importance of communicating about HIV and AIDS with their adolescents. Adolescents need correct information on HIV and STI transmission, prevention and treatment to empower them to make the right choices for their lives. Parents also have the responsibility to address myths and misconceptions about HIV and AIDS, STIs and VMMC.

## Objectives

- To know how STIs and HIV are transmitted and prevented.
- To explain the relationship between STIs and HIV.
- To identify prevention strategies of STIs and HIV.

**Materials needed:** Flipchart paper, marker pens, tape and scissors or glue

## UNIT PLAN

### Activity

Icebreaker  
Session 1: STIs (Split session)

**90 minutes**

10 minutes  
40 minutes

<sup>13</sup> UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People*; Manual p.259 - 317  
<sup>14</sup> UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People*; p. 265 - 274

Session 2: Basics on HIV and AIDS (Combined session) 40 minutes

**Note to facilitator:** separate the adolescents from the parents before taking them through the introduction steps.

### Icebreaker

10 minutes



It is important to begin each session with a welcoming environment. This sets the tone for the remainder of your time together, which helps when discussing topics that may be uncomfortable for the adolescents and their parents. Ask the adolescents and parents to relate how they fared in their conversations at home after the last session. Areas of importance include:

- What challenges did they face?
- What lessons did they learn?
- What went well, and what did not?

## SESSION 1: Sexually Transmitted Infections (STIs)

**Split session (Parents only and Split Adolescents)**

40 minutes



**Note to facilitator:** Separate parents from adolescents. Have two groups for adolescents: 10-14 year-old adolescents and 15-19 year-old adolescents for this session.

### Procedure

1. Ask participants what STIs are and how they can be transmitted. Use Handout 14 on STIs and Facilitator's Information on the Basic Facts About STIs, to guide the discussion particularly steps 1-4.
2. 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).
3. Ask the group to list the STIs they know and 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.*

4. Conduct the True or False activity with the participants. Give out pieces of paper with the written statements to volunteers. Ask the volunteers to read out the statements and state whether they are true or false. Use the Facilitator's answer key to guide the discussion and correct any misconceptions.

### Exercise: True or False Statements

- ▶ You won't get an STI if you only have oral sex.
- ▶ Only people who have lots of sex partners get STIs.
- ▶ You can get an STI from a toilet seat.
- ▶ Many STIs can be transmitted to babies during pregnancy or birth.
- ▶ You can have an STI even if you do not have any signs or symptoms.
- ▶ Some 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.
- ▶ Women have more noticeable signs and symptoms of STIs than men.
- ▶ STIs caused by viruses cannot be cured.
- ▶ Passing urine after sex protects you from STIs.
- ▶ If you have an STI, you are at greater risk of getting HIV and of spreading HIV to your partners.
- ▶ STIs cannot lead to cancer.
- ▶ STIs that are not treated can result in problems getting pregnant.

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5. Ask participants what other things they have heard about STIs that they think may be wrong. Discuss these and any other questions or comments that they have.

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6. **For 15 – 19 year olds:** Ask the participants:
- Why do think it is important to tell your partner if you have an STI?
  - How can you tell your partner?
  - How can you overcome the challenges in communicating?

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7. Ask participants: What should people who think they may have an STI do?

**Make sure the key points on Handout 14 are highlighted in the discussion. Also use the Facilitator's Information on Basic facts about STI's to guide your discussion.**

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8. Ask the participants if they have any questions, comments or concerns and respond to them.

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9. Ask participants to summarize what they learned from the activity. Add any of the following points that are not mentioned.

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## 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 half of all cases, 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>15</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.

<sup>15</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People* pg. 273-274

**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.

# SESSION 2: Basics on HIV and AIDS

**Combined session: ALL**

**45 minutes**



**Materials needed:** Paper, pens, at least 2 containers or hats

## **Procedure:**

1. Tell participants that they are going to talk about HIV and AIDS and ways in which HIV can be transmitted, prevented and treated.
2. Write the following statements on slips of paper (without the answers) and fold them up.
3. Separate participants into three groups (parents only; 10-15 year olds; 16-19 year olds - If these groups are still too large separate them further) and ask them to assign a member of the group to take notes for them.
4. Pass the containers around and have each group pick one statement until all the statements have been picked.
5. Ask each of the groups to discuss the answers (true or false) for the statements they picked.
6. After ten minutes ask the groups to present their answers (this activity should be done quickly). Make sure you know all of the correct answers and the reasons for them by reading the facilitator's information. If you are unsure, you can get a co-facilitator who is experienced in the field of HIV to assist you.

**Use the facilitator's information on Transmission, Prevention and Treatment HIV to guide the discussion and clarify any misconceptions, particularly relating to VMMC, condom use, PMTCT etc.**

**Note to Facilitator:** Highlight to the participants especially adolescents that, pulling the penis out before the man ejaculates (withdrawal method) does not protect the boy or the girl from HIV. The pre-ejaculate (the fluid that comes out of the penis before a man ejaculates) may have HIV in it (if he is HIV-positive). The man will also have contact with the woman's vaginal fluids, which may have HIV in it (if she is HIV-positive).

## **Statements about HIV transmission:**

- A person can get HIV if they have sex without using a condom. (True)
- A person can get HIV by using needles or razors that were used by someone else. (True)
- A person can get HIV from a mosquito that bit someone with HIV before. (False)
- An HIV-positive woman who is pregnant (and not on treatment) can pass HIV to her baby. (True)
- An HIV-positive woman who breastfeeds (and is not on treatment) can pass HIV to the baby. (True)
- HIV can be transmitted through witchcraft. (False)

- ▶ I can get HIV by being around people who are HIV-positive. (False)
- ▶ Condoms can spread HIV. (False)
- ▶ A person with a sexually transmitted infection can get infected with HIV more easily. (True)
- ▶ If you have HIV, you will know you have it. (False)
- ▶ If you have HIV, you can get infected with HIV again (re-infection). (True)

### Statements about prevention and treatment of HIV:

- ▶ Not having sexual intercourse is one way to protect yourself from HIV. (True)
- ▶ Using contraceptive injections is one way to protect yourself from HIV. (False)
- ▶ Always using condoms correctly with sex partners greatly reduces your risk of getting HIV. (True)
- ▶ Pulling the penis out before the man ejaculates is one way to protect yourself from HIV. (False)
- ▶ Having sex only with your regular partner whom you know their HIV status will reduce your chances of contracting HIV. (False)
- ▶ If a person is not in a high-risk group, they don't need to worry about getting HIV. (False)
- ▶ A person doesn't need to worry about getting HIV because there is now a cure. (False)
- ▶ There is a vaccine to prevent HIV infection. (False)
- ▶ A pregnant woman who is HIV-positive can take medicines (ARVs) to protect her baby from HIV. (True)
- ▶ If a person and their partner both have HIV, they don't need to use condoms. (False)
- ▶ Having unprotected sex with a person who looks healthy and fit is safe. (False)
- ▶ Getting circumcised will fully protect a man from HIV. (False)
- ▶ An HIV-positive woman who is on treatment can have a baby who is HIV negative. (True)

## FACILITATOR'S INFORMATION

### Transmission and Prevention 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 or during accidents).

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 with HIV by 60%. In Zimbabwe VMMC is done through either the surgical method or the non-surgical method. 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 drug use;
- ▶ 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.

### **Voluntary Medical Male Circumcision (VMMC)**

Voluntary Medical Male circumcision is the complete removal of the skin covering the head of the penis (foreskin).

#### **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

### **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 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 service provider (healthcare services, NGO, church, ZRP, social services, counsellor, etc.) that will be able to assist them if they need more help or have more questions. Give referral slips and refer people to relevant service providers as needed.**

# UNIT 7: HIV TESTING SERVICES (HTS), DISCLOSURE, STIGMA AND DISCRIMINATION



# UNIT 7: HIV TESTING SERVICES (HTS), DISCLOSURE, STIGMA AND DISCRIMINATION

## Rationale

To strengthen communication between parents and adolescents on the importance of HIV testing for everyone as well as utilisation of HIV Testing Services (HTS). This enables families to address stigma and discrimination associated with HIV, and facilitate disclosure.

### Early Adolescence 10-13 years:

Adolescents at this stage are more exposed to information about HIV and AIDS from their schools and peers. Some adolescents may actually be HIV-positive but not aware of their status. Adolescents need support and understanding from their parents and guardians about HIV testing and what positive and negative test results entail. This will enable them to cope better with their status if they are positive and also make right decisions about relationships and disclosure.

### Late Adolescence 16-19 years:

Adolescents in this stage may have peers who made bad sexual decisions and some will have made bad choices themselves that led to contracting HIV and/or STIs. This age group needs education on how and why the decisions they make at this stage will impact the rest of their lives. Communication about HIV testing, what positive and negative test results entail, and the importance of disclosure is vital to empower adolescents to make the right choices for their lives and that of their partners.

### Middle Adolescence 14-15 years:

Adolescents at this stage have begun to explore their relationships with the opposite sex and their peers to a greater degree. Some may even be sexually active. There is therefore need for this age group to have knowledge on HIV testing. Communication about HIV testing, what positive and negative test results entail, and the importance of disclosure is vital to empower adolescents to make the right choices for their lives.

### Parents / Caregivers:

Parents need to understand the importance of communicating about HIV and AIDS with their adolescents. Adolescents need to know why they have been taking medicine from their parents/caregivers to avoid misinformation from other sources. Understanding the importance of their medications, as well as a growing understanding of what being HIV positive means about other physical choices, is critical to HIV positive adolescents' healthy development, sexually and in other ways too. Parents also need to emphasise the importance of HIV testing and disclosure to empower their adolescents to make the right choices for their lives.

## Objectives

- To understand the importance and benefits of knowing one's HIV status and accessing HIV testing services (HTS)
- To be able to identify HTS providers in their community
- To understand the importance of adherence to ART
- To understand the importance of disclosure

- To understand how stigma and discrimination can affect disclosure

## UNIT PLAN

### Activities

Icebreaker	5 minutes
Session 1: HIV Testing Services (Combined session)	20 minutes
Session 2: HIV Treatment (Combined session)	20 minutes
Session 3: Disclosure (Combined session)	30 minutes
Session 4: Stigma and discrimination (Combined session)	15 minutes

**90 minutes**

### Icebreaker

**5 minutes**



It is important to begin each session with a welcoming environment. This sets the tone for the remainder of your time together, which helps when discussing topics that may be uncomfortable for the adolescents and their parents. Ask the adolescents and parents to relate how they fared in their conversations at home after the last session and if the assignment was done. Areas of importance include:

- What challenges did they face?
- What lessons did they learn?
- What went well, and what did not?

## SESSION 1: HIV Testing Services (HTS)

**Combined Session - ALL**

**30 minutes**



### Procedure

As you conduct this session refer to the Facilitator's Information below to guide the discussion.

1. Ask participants what they know about HIV Testing Services (HTS).

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 HIV services include testing, counselling, antiretroviral therapy (ART), care and support, prevention of mother-to-child transmission of HIV (PMTCT), and voluntary medical male circumcision.

2. Ask participants to highlight the importance and benefits of HIV testing. Write their answers on a flipchart.
3. Ask participants to identify HTS providers in their community, and the benefits of accessing those services.
4. Lead a discussion on how HIV testing can be done and the eligibility criteria for accessing HIV testing services. **The age of consent for HIV testing in Zimbabwe is 16 years. Adolescents below the age of 16 require parental consent.**
5. Ask participants to highlight some of the challenges that they think adolescents may face in accessing and utilizing HTS services.

6. Ask participants to highlight services or information that adolescents living with HIV would require under HTS and the challenges that they may face in accessing services. (Services may include: Viral load testing, ART, VMMC, home-based care and psychosocial support, prevention and treatment of opportunistic infections, condom promotion)

## **FACILITATOR'S INFORMATION**

### **Benefits of HIV Testing for:**

#### **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

#### **The Couple:**

- Supports safer relationship
- Know 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

#### **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

#### **Children, Adolescents**

- To facilitate early knowledge of HIV status.
- To improve 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 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 Services process for all clients/patients attending health facilities.
- Community-based HIV testing services
- 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 HTS**



- 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

## HTS gives you access to the following:



### FACILITATOR 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. When HIV enters the body, the body starts to make antibodies right away to fight the virus. The test can usually find these antibodies in the blood 2 to 8 weeks later, but it may take as long as three months for the body to make enough of them to show up in a test. In very rare cases, it can take up to 6 months. For this reason, if the HIV test is done during the first 3 months after possible exposure to HIV and is negative, a second test needs to be done more than 3 months after the possible exposure to HIV.

**What is the window period?** The window period is the time between infection and when the body has produced enough antibodies for the test to find them. During this time, if a person with HIV gets tested, the results may not be accurate. They may get what is called a 'false negative' result. A false negative result means the test is negative, but the person actually has HIV and is positive. To avoid false negative results, it is recommended that a person get tested three months after they may have been exposed to HIV.

**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

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

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 half an hour or less. When the results are given, the counsellor talks to them about their results, no matter what their status is. If the test is positive, the counsellor provides the necessary counsel and information and encourages the person to seek HIV services. 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:

- Because it is a good thing to know
- Before having sexual intercourse with a new partner;
- Before marriage;
- Before stopping use of condoms with a partner;
- Before getting pregnant;
- Because they put themselves at risk by having sex without a condom;
- Because they have repeated infections;
- 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;
- To be able to get care and treatment and protect their partners if they are positive.<sup>17</sup>

## SESSION 2: HIV Treatment

**Combined Session: ALL**

**20 minutes**



### Procedure

1. Ask participants to share what they know about antiretroviral therapy (ART).
2. Using the Facilitator's Information below, discuss ART, its benefits and the importance of adherence. Emphasise that it is important to support adolescents living with HIV in order to ensure they adhere to treatment.

<sup>17</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People*; pp.289-295



3. Ask participants to share what they know about PrEP and PEP.
4. Inform participants about pre-exposure prophylaxis (PrEP) and post exposure prophylaxis (PEP) and how they can be accessed.

## **FACILITATOR'S INFORMATION**

### **Antiretroviral Treatment**

**Antiretroviral drugs (ARVs)** are the drugs used to treat HIV. Because HIV is a retrovirus, drugs used against HIV are called antiretroviral.

**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**. All of the drugs may be in one pill to make it easier for the person to take it.

**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 which greatly reduces the amount of HIV in the body fluids (the viral load). 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.

- ART prevents HIV from making copies of itself, which greatly reduces the amount of HIV in the body fluids (the viral load).
- When there are few HIV in the blood, HIV can no longer effectively attack the immune system. It also makes it less likely that the person will transmit HIV to others.
- ART 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 the doctor says.
- If a person has side effects from ART, they should see their health care provider or visit their nearest clinic. They should not stop taking the medications unless told to by doctor or nurse.
- Patients on ART are encouraged to go for viral load monitoring on their prescribed dates.

**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:**

- ➔ Lack of information and non-disclosure;
- ➔ Not understanding of the importance of adherence;
- ➔ Forgetting to take their medication due to busy schedules, other commitments or other reasons;

- ➔ Concealing medicines (e.g., partners, other household members, friends, boarding school);
- ➔ Experiencing side effects to ART drugs (e.g., rashes, diarrhoea, or jaundice);
- ➔ Lack of treatment supporter;
- ➔ Poor provider-client relationship;
- ➔ Pill fatigue;
- ➔ Depression;
- ➔ Substance misuse;
- ➔ Stopping taking ART because they feel better;

### Post Exposure Prophylaxis (PEP)

Post Exposure Prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse.<sup>18</sup> If you have been potentially exposed to HIV, through rape, unprotected sex or accidental exposure to contaminated sharp instruments you need to follow the following process:

- a. Go to your nearest service provider within 72 hours of exposure
- b. Get tested for HIV
- c. If you are HIV negative you will be given PEP medication
- d. Take this medication as prescribed.

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

### Pre-Exposure Prophylaxis (PrEP)

PrEP is an HIV prevention method in which people who do not have HIV infection take antiretroviral drugs (ARVs) daily to reduce their risk of becoming infected. PrEP prevents HIV from making copies of itself in your body after you have been exposed and thus preventing HIV from establishing an infection and making you sick.

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

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

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 instructed during the period of substantial risk.

#### For one to be on PrEP there is need for:

- a. An HIV test result which is negative
- b. Clinical screening for acute HIV infection
- c. HIV risk assessment (using a screening tool)
- d. Adherence counselling

#### Note to Facilitator: Remind participants that:

- PrEP reduces the risk of HIV by 90% if taken daily and correctly as prescribed.

<sup>18</sup> WHO (2017) HIV/AIDS: Post Exposure Prophylaxis Available at <http://www.who.int/hiv/topics/prophylaxis/en/> accessed on 29/06/17

- PrEP does NOT prevent STIs, pregnancy, or protect you from HIV after exposure.
- PrEP is not for everyone, but for those who are at substantial risk of HIV infection.

## SESSION 3: Disclosure

**Note to Facilitator: The first part of this session is Combined for ALL Adolescents and Parents**

### Procedure

**30 minutes**



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 they will role play different scenarios.
  - a. **Suppose a 17-year-old adolescent discovers that he / she is HIV-positive and has to make the decision to tell his / her partner about it.** Ask for a volunteer adolescent to role play this scenario. After the role play, ask participants to highlight the challenges associated with disclosing HIV status to a partner (also include challenges faced by married couples).
  - b. **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 to role play with an adolescent how this disclosure could take place. Ask participants what possible challenges / dilemmas parents / caregivers may face in disclosing the child's HIV status.
  - c. **Suppose a parent is living with HIV and is thinking about telling his / her children.** Ask volunteers to role play the disclosure process that could take place in the household. Discuss the fears and challenges the parent may have in disclosing.

- d. Suppose a 14-year-old adolescent discovers that he / she was born with HIV and wants to tell his / friend. Ask two adolescents to role play this scenario and ask participants to discuss the positive and negative effects of such kind of disclosure.
4. Facilitate a discussion to identify ways to address challenges associated with disclosure. Also discuss how parents and adolescents can support each other on disclosure.
5. 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

## **FACILITATORS INFORMATION**

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

- ▶ Allows children to cope better with HIV
- ▶ Increases self-esteem among children and adolescents
- ▶ Helps children adhere to treatment
- ▶ Helps adolescents make informed decisions when contemplating sexual intercourse with a partner
- ▶ Children and caregivers psychologically adjust to living with HIV
- ▶ Works towards reducing stigma, discrimination, and myths and misconceptions regarding HIV
- ▶ Family-centred disclosure builds trust in relationships and improves healthy communication between parents and children

### **NB. Children who are disclosed to tend to adhere better to treatment**

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

- ▶ Depression
- ▶ Development of self-stigma for looking sick
- ▶ Development of inappropriate actions, like refusal to take drugs
- ▶ Discover HIV status from wrong sources
- ▶ Loss of confidence and trust in parents
- ▶ Poor child parent relationship, communication etc.
- ▶ Confusion resulting from unclear messages
- ▶ Reasons parent or guardians may fear to disclose.
- ▶ Self-blame and guilt
- ▶ Concern about breach of confidentiality

**Note to facilitator:** Encourage young people to attend support groups for improved life skills training for developing resilience, coping skills, self-worth and self-esteem. Parents should ensure that support is available for pre-disclosure and post-disclosure. Link participants with relevant service providers and psycho-social support groups in your area.

<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.

# SESSION 4: HIV and Stigma and Discrimination

**Combined session: ALL**

**15 minutes**



## **Procedure**

1. Ask the participants to explain what they understand by “stigma” and “discrimination”.
2. Discuss how stigma and discrimination can affect disclosure?
3. Discuss stigma and discrimination experienced by adolescents living with HIV.
4. Ask the participants what they can do to reduce stigma within their homes, and in the community.<sup>20</sup>

## **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 bore hole, not allowed to play with other children or share their food).

### **Stigmatisation is a process:**

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

### **Remember this**

- Stigma and discrimination result in great suffering. People get hurt!
- HIV stigma 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.
- Stigma isolates people, and that supportive family and community do not practice stigma.

Tell participants that the day's programme has come to an end and tell them their homework assignment. Get participants to sing an appropriate song to close the session.

**ASSIGNMENT: As a family have a discussion on anyone you have seen stigmatized and what action you could take to correct this.**

<sup>20</sup> Demand Generation Home Visit Guide pp.66-68



**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGO, 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 referral slips and refer people to relevant service providers as needed.**

# UNIT 8: SEXUAL AND GENDER BASED VIOLENCE (SGBV)



# UNIT 8: SEXUAL AND GENDER BASED VIOLENCE (SGBV)

## Rationale

The unit introduces participants to sexual and gender based violence and enables them to discuss societal and gender norms that perpetuate such violence.

**Early Adolescence (10 – 13 years):** The youngest adolescents are experiencing puberty in themselves and in their friends and peers and at the same time getting exposed to some traditions within their community, including labia elongation and traditional male circumcision. This physical development coupled with the need to understand cultural practices can be emotional and confusing for young people, especially if they have concerns about the traditions they are supposed to follow.

**Middle Adolescence (14 – 15 years):** Adolescents in the middle of the teen years are neither children nor adults. This age group is often exposed to various traditions which include child marriage, virginity testing and male circumcision. They are beginning to understand sexual violence but most are still not able to distinguish between good and bad touches.

**Late Adolescence (16 – 19 years):** The older adolescents have, for the most part, completed puberty and are focused on the emotional and psychological transition of adolescence into adulthood. Providing them with the knowledge on the different traditional practices and how they affect their lives and that of their families is important. Although the age of sexual consent in Zimbabwe is 16 years and legal age for marriage is 18 years, this age group still need to understand the consequences of sexual and gender based violence, including child marriage.

**Parents / Caregivers:** Parents / Caregivers are often unaware of their children's sexual lives to the extent of not knowing how their children are being violated. At times they are the perpetrators of the violation. Therefore, this series offers parents some basic information on the different touches and they are classified as good, confusing and bad. The lessons also cover SGBV causes and consequences and also seek to identify ways in which parents can help their children overcome harmful cultural practices, such as child marriage.

## Objectives

### Adolescents

- To expand participants' understanding of good and bad touches and how this may lead to SGBV.
- To identify the different types of SGBV, services available for SGBV victims, and pathways for reporting and dealing with SGBV.

### Parents

- To expand participants' understanding of good and bad touches and how this may lead to SGBV.
- To identify different types of SGBV and available resources for adolescents and parents / caregivers dealing with SGBV in their community.



# UNIT PLAN

## Activities:

Icebreaker: (Split session)	90 minutes
Session 1: Good, Confusing and Bad Touches (Split session)	10 minutes
Session 2: Sexual and Gender Based Violence (Split session)	10 minutes
Session 3: What should we do? (All)	30 minutes
	40 minutes

**Materials needed:** Flipchart paper, marker pens, tape and scissors or Glue

**Note to Facilitators: Separate the Parents/Caregivers from the Adolescents before doing the introduction icebreaker activity**

## Icebreaker:

10 minutes



Begin the day by asking participants to sing an appropriate song. Invite participants to share how their family homework conversations went.

## SESSION 1: Good, Confusing, and Bad Touches<sup>21</sup>

**Split Session – Split Adolescents and Parents / Caregivers 10 minutes**



### Procedure

1. Ask: What is a touch? Let participants give examples of touches.
2. Ask a few participants 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 chiramū'. 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 intent of the touch. If a touch is intended to lead to sexual activities, 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, 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.

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.

<sup>21</sup> Population Council Zambia, 2013. Adolescent Girls Empowerment Program (AGEP): Health and Life Skills Curriculum. Pages 216 - 238. Also adapted from Plan International (2016) Champions of Change

Most often, 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.

## KINDS 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

- For 10-15 year olds:** You have the right to say 'NO' to anyone who touches you without your consent or in ways that you are not comfortable with. You have the right to say 'NO' even if that person is a peer, partner (boyfriend / girlfriend), parent or relative. It is important to report the bad touches to 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. Reporting helps to protect yourselves and others.
- For 16-19 year olds:** It is important to know how to get out of an exploitative situation. You have the right to say 'NO' to anyone who touches you without your consent or in ways that you are not comfortable with. You have the right to say 'NO' even if that person is a peer, partner (boyfriend / girlfriend), parent or relative.
- For parents / caregivers:** Sexual exploitation is never the adolescent's fault. When adolescents report a sexual exploitation, parents should listen and act on the matter immediately. Talking about personal safety and sexual exploitation should be an on-going process and should be done in a way that the adolescent can feel safe and relaxed.

# SESSION 2: Sexual and Gender-Based Violence

**Split Session (Parents only and Adolescents only)**

**30 minutes**



Preparation: Familiarise yourself with the laws related to violence in Zimbabwe, including the laws on rape, age of consent for sex, sexual harassment and violence (including forced sex) between intimate partners, including in marriage.

## Procedure

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1. Ask participants what the term 'sexual and gender based violence' (SGBV) means. Participants should provide examples of SGBV.

*Sexual and gender-based violence (SGBV) refers to any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. It encompasses threats of violence and coercion. It can be physical, emotional, psychological, or sexual in nature, and can take the form of a denial of resources or access to services. It inflicts harm on women, girls, men and boys (UNHCR 2017).*

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2. Define the term "gender" by explaining that gender is how society tells us men and women should act and behave and the roles and positions that men and women can have in the society.
- 

3. Get the participants into groups and ask them to role play the different types of sexual and gender violence.

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.<sup>22</sup>
- 

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
- 

<sup>22</sup> MWAGCD Zimbabwe National Gender Based Violence Strategy (2012-2015)

## FACILITATOR'S INFORMATION

### Consequences of SGBV<sup>23</sup>

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 dependants</li> </ul>

<sup>23</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*

# SESSION 3: What Should They Do?

Combined session: ALL

35 minutes



## Preparation

Find out where in your community people can get help if they experience different types of violence, including rape, sexual harassment, child sexual abuse and intimate partner violence. These might include clinics or other government agencies, like child protection agencies, and NGOs.

## Procedure

1. Tell participants that in this activity, they are going to think about what a person who experiences violence can do about it. **Divide them into four groups (10-13 year olds, 14-15 year olds, 16-19 year olds and parents / caregivers)** and assign each group one of the following scenarios as follows:  
Group 1 (10-13 years): Agnes and her teacher  
Group 2 (14-15 years): Danai and her husband  
Group 3 (16-19 years): Gift and Sekai  
Group 4 (parents / caregivers): Brenda and her father, and Tanaka and Sihle  
Each group should have a note-taker to capture the key points / conversation.
2. Read the instructions to the participants and ask if they have any questions. Circulate among the groups while they are working to assist them as needed.  
**Group Instructions:**
  - Read the scenario assigned to your group.
  - Imagine that the main person in your scenario has confided in you and asked for advice on what to do.
  - List the options and their possible consequences.
  - Discuss the options and decide what you would advise the person to do.
  - Prepare to share your options, the consequences, your decision and the reasons for your decision with the rest of the group.

**Agnes and her teacher:** Agnes is studying catering at a technical and vocational training institute. One day her business skills teacher asked her to see him after school. When she went to see him, he started asking her personal questions. She was confused about why he called her in. When he started touching her, it became clear that he was expecting her to have sex with him. She pushed him away. Then he reminded her that she needed to pass the up-coming examination to get her certificate. Angry, she grabbed her bag and ran out the door. Now she is worried that she is going to fail. What should Agnes do?

**Brenda and her father:** Brenda starts crying after her father leaves her room. She feels like she always does when he comes into her room and molests her - she wants to die. He has been doing this since she was only nine. She hates it and feels so dirty and disgusted with herself when he leaves. He often tells her that if she tells anyone, he will kick her out of the house. Brenda has thought about telling her mother, or running away, or even killing herself, but she has always been too scared to do anything. Now she feels like she has to do something. What should Brenda do?

**Tanaka and Sihle:**<sup>24</sup> 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.

**Gift and Sekai:** Gift wonders all the way home what he should do. Sekai forced him to have sex with her even though he had told her over and over again that he didn't want to. She said it was his fault for kissing and touching her and getting her so turned on. She said that he must want it too since he had an erection. She insulted him and said he wasn't a man. Now he feels like he doesn't love her anymore. Instead, he feels hurt, used and betrayed. He wonders who will believe that he did not want to have sex with his beautiful girlfriend. What should Gift do?

**Danai and her husband:** Danai was just 15 when her parents forced her to marry Nkosana, who was 35 years old. She didn't know him and didn't want to get married. She wanted to finish school, but no one listened to her: she was married. Now she stays at home, cooking and doing housework all day. When Nkosana comes home, she gives him his supper and tries to please him. But so often, like tonight, he is already angry. He starts insulting her and gets angrier. When she tries to say something, he hits her. Now he is sleeping in the next room. She is in the bathroom, looking in the mirror. Her right eye is swollen and turning blue. What should Danai do?

3. After 10 minutes, ask each group to present their responses. If the group does not explain their reason for choosing the option that they chose, ask them: Why did you choose that option?

4. Generate a discussion based on the following:

- Very often when a person is abused or experiences violence, they suffer in silence. Ask participants why this is so.

**Probing questions:** What are some of the things that they might be afraid of? (Answers: May be blamed for abuse; afraid of stigma; think they are at fault; nowhere to go; dependent on the abuser; afraid of losing support; abuser might harm them more; may not be believed; face rejection; don't know how to tell someone.)

Emphasise that the abused person is never to blame.

- Is it different for girls and women than for boys and men who experience violence? (Answer: Because of gender roles, it can be even more difficult for boys and men to cope with violence, especially sexual violence, because they are expected to be strong, to always want sex, and not to become victims of sexual abuse or violence.)

<sup>24</sup> Adapted from Population Council Zambia, 2013. *Adolescent Girls Empowerment Program (AGEP): Health and Life Skills Curriculum*

- Why is it a good idea to speak up and get help in these situations?  
**Probing questions:** What will happen if we do not? Do we have to accept violence in our lives?

Tell participants that it can be very difficult to tell others about what is happening or has happened. However, if it is a situation that is on-going, the person will continue to suffer. They need to take action to get help and get out of the violent situation as soon as they feel able to do so.

4. Ask participants what they can do as children / parents to ensure that their family and their community do not practice SGBV.

Point out that many cases of SGBV are covered up (hidden), and families and communities hardly speak out to protect the victim. 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). SGBV victims may access a package of services including PEP, STI screening and treatment, pregnancy testing and other referrals.

**Note to Facilitator: This can be an extremely emotive session to run. This exercise could evoke anger for SGBV offenders in the household / community. As a result, you need to be extremely careful when delivering this session.**



**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGO, 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 referral slips and refer people to relevant service providers as needed.**

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

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 same-sex staff (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 is 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:

- Help survivors through the court process.
- Assist in obtaining protection orders
- Assist minors and other incapacitated persons to assert their rights
- Monitor the court process

**Note to Facilitator:** Emphasize, if necessary, that rape is never the fault of the victim. It is always the fault of the perpetrator – the person who raped or abused. All crimes are the fault of the person who commits them, not the fault of the victim. If someone steals something from you, we don't say it is your fault that they stole it. We cannot hold the victim responsible for someone else's criminal choices and actions.





UNIT 9:  
CULTURAL  
AND  
TRADITIONAL  
PRACTICES

# UNIT 9: CULTURAL AND TRADITIONAL PRACTICES<sup>25</sup>

## Rationale

This unit will invite mutual understanding of culture and religion as well as how some traditional and religious practices violate human rights and have negative influence on sexual and reproductive health and rights. It enables participants to critically examine child marriage and its consequences on girls. It empowers participants to explore ways to stop child marriage.

**Early Adolescence (10 – 13 years):** The youngest adolescents are experiencing puberty in themselves and seeing it in their friends and peers and at the same time getting exposed to some traditions within their community, such as labia elongation and traditional male circumcision. This physical development coupled with the need to understand cultural practices can be emotional and confusing for young people, especially if they have concerns about the traditions they are supposed to follow.

**Middle Adolescence (14 – 15 years):** Adolescents in the middle of the teen years are neither children nor adults. This age group is often exposed to various traditions which include child marriage, virginity testing and male circumcision.

**Late Adolescence (16 – 19 years):** The older adolescents have, for the most part, completed puberty and are focused on the emotional and psychological transition of adolescence into adulthood. Providing them with the knowledge on the different traditional practices and how they affect their lives and that of their families is important. Although the age of sexual consent in Zimbabwe is 16 years and legal age for marriage is 18 years, this age group still need to understand the consequences of child marriage.

**Parents / Caregivers:** Parents / Caregivers are often unaware of their children's sexual lives to the extent of not knowing how their children are being violated. At times they are the ones who initiate the harmful practice such as a child marriage. Therefore, this series offers parents important knowledge on consequences of child marriages and also seeks to identify ways in which parents can help their children overcome the harmful cultural practices.

## Objectives

- To identify different culture, traditional and religious practices that affect sexual and reproductive health and rights (SRHR)
- To identify positive and negative cultural, traditional and religious practices related to SRHR, and those practices that contribute to child marriage.
- To enable participants to prevent harmful practices including child marriage.

<sup>25</sup> UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People*; p. 389 - 406

# UNIT PLAN

## Activities:

Icebreaker: (Split session)  
Session 1: Cultural Practices (Split session)  
Session 2: Child marriage (ALL)  
Section 3: Other practices (ALL)

**90 minutes**

10 minutes  
30 minutes  
30 minutes  
20 minutes

## Icebreaker

**10 minutes**



Ask participants to re-cap on previous lesson on SGBV.

# SESSION 1: Cultural Practices

## Split Sessions

### Cultural Practices (Adolescents only)

**30 minutes**



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

*“Culture is a way of life, especially the general customs and beliefs, of a particular group of people at a particular time and place”.*

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 dowry (lobola) payments to be done in November.

## Procedure

1. Ask participants to name traditional and cultural practices related to sexual and reproductive health, and relationships. Make a list of these traditional and cultural practices on a flip chart, and you may add the following, if they are not mentioned: Initiation ceremonies, labia elongation, traditional male circumcision, child marriage, virginity testing, cleansing rituals, girl / wife pledging, lobola or bride price, etc.
2. Ask participants which traditions and cultural practices are deemed good or appropriate in today's society. `Why do you think this?
3. Ask participants to identify four common traditional and religious practices in their area. Separate participants into two groups and assign two common practices per group.

4. Each group should answer the following questions:
  - a. What are the perceived benefits of the practices to individuals, family and community?
  - b. What are the negative effects of the practices to individuals, family and community?
5. Bring the groups together and ask each group to share the key points from their discussions.
6. After all the presentations have been made explain that some of these traditional / cultural and religious practices can contribute to SGBV and also violate the rights of women and girls.
7. Ask them: Of those practices which ones should be Kept, Changed or Stopped. What should be done to change or stop these practices?

### Cultural Practices (Parents only)

30 minutes



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

*“Culture is a way of life, especially the general customs and beliefs, of a particular group of people at a particular time and place”.*

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 dowry (*lobola*) payments to be done in November.

### Procedure

1. Ask participants to name traditional and cultural practices related to sexual and reproductive health, and relationships. Make a list of these traditional and cultural practices on a flip chart, and you may add the following, if they are not mentioned: Initiation ceremonies, labia elongation, traditional male circumcision, child marriage, dry sex, virginity testing, cleansing rituals, polygamy, wife inheritance, girl / wife pledging, lobola or bride price, etc.
2. Ask participants which traditions and cultural practices are deemed good or appropriate in today's society. `Why do you think this?
3. Ask participants to identify four common traditional and religious practices in their area. Separate participants into two groups and assign two common practices per group.
4. Each group should answer the following questions:
  - a. What are the perceived benefits of the practices to individuals, family and community?

- b. What are the negative effects of the practices to individuals, family and community?
5. Bring the groups together and ask each group to share the key points from their discussions.
6. After all the presentations have been made explain that some of these traditional / cultural and religious practices can contribute to SGBV and also violate the rights of women and girls.
7. Ask them: Of those practices which ones should be Kept, Changed or Stopped. What should be done to change or stop these practices?
8. Ask parents what they can do to protect your children from the harmful traditional and religious practices?

## SESSION 2: Child Marriage

**Combined Session - ALL**

**30 minutes**



This session critically examines child marriage, and enables participants to understand the consequences of child marriage and how it can be stopped.

Child marriage is a form of sexual and gender based violence as well as a violation of human rights. It is any marriage, whether under civil, religious or customary law, and with or without formal registration-where either one or both spouses are children under the age of 18.<sup>26</sup>

### Procedure

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 observe about the words written on the flipchart paper.
2. 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.

3. Read Alice's story and generate discussion by asking the questions after the story:

#### **Agnes' Story**<sup>27</sup>

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

<sup>26</sup> Plan International. *Champions of Change, Module 9, pg. 5*

<sup>27</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education (CSE) Manual for Out of School Young People*; p. 314

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, 16 years old**

- Did Alice 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?
4. Ask participants what are the consequences of child marriage. Answers may include: Stop going to school, unprotected sexual intercourse, rape, relationship problems and being unhappy (or miserable).
  5. Ask participants if there are any perceived positive consequences? (Whatever the perceived consequences may be, for example being part of a more financially secure family or getting better nutrition, emphasize that child marriage is illegal and violates the rights of children.
  6. For each consequence, ask them: what are the further 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).
  7. Then ask the participants the following questions:
    - Looking at the negative consequences of child marriage, what can be done to prevent child marriages in families and in the community?
    - For all adolescents: Ask what are your rights related to marriage? (Answer: You have the right to marry when you are legally old enough; you have the right to choose your partner; no one can force you to marry.)
    - For parents / caregivers only: As parents how do you empower your children and other parents to end 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>28</sup>

8. Emphasize that child marriage is a violation of human rights and the Constitution of Zimbabwe. Child marriage has many serious consequences for

<sup>28</sup> <http://www.kanokangalawfirm.net/landmark-ruling-on-child-marriages-in-zimbabwe/>

the girl, including unfinished education, early pregnancy, health problems such as STIs, HIV, difficulties during birth that result in fistulas, death of the young mother and/or foetus or baby, intimate partner violence, divorce, financial dependence on husband, and poverty

## **FACILITATOR'S INFORMATION**

### **Causes of child marriage<sup>29</sup>**

The causes and effects of child marriage follow a cycle. Poverty can lead to child marriage and child marriage can lead to poverty. Gender inequality and the violation of girls' rights drives child marriage. The effects of child marriage, in turn, further entrench gender inequalities and denial of girls' rights. Therefore, there is an overlap between the causes and effects 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 early marriage, especially when girls are married to older spouses.
- ➔ Girls' sexuality - early 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 early 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.

<sup>29</sup> Plan International. *Champions of Change. Module 9. "Living free from child marriage"* pg.9

- ➔ 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, where men hold the power - 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.

### How does child marriage violate girls' rights?<sup>30</sup>

Marriage under the age of 18 is a rights violation in and of itself, and at the same time it created barriers to multiple human right, including:

- ✓ Right to marry and establish a family (and to make this decision)
- ✓ Right to education
- ✓ Right to life
- ✓ Right to freedom of expression
- ✓ Right to development and the highest attainable standard of health
- ✓ Right to sexual and reproductive health and rights
- ✓ Right to equality
- ✓ Right to participation in decisions that affect one's life



<sup>30</sup> Plan International. *Champion of Change. Module 9. "Living free from child marriage"* pg.6



## Harmful effects of child marriage<sup>31</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 early 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>31</sup> Plan International. *Champions of Change. Module 9. "Living free from child marriage"* pg. 36

## SESSION 3: Other Harmful Practices

Combined: ALL

20 minutes



### Procedure

1. Get all the participants in one group.
2. Ask one volunteer to read Siya's story and facilitate a discussion based on the questions below.

*Siyamukele ('Siya') is an adolescent widow aged 16 who comes from a poor family. She was pledged (kuzvarira) to an older man when she was 6 years old. Siya knew that she would join her 'husband' at some point in her life. Siya became rebellious and considered the tradition of girl pledging unfair since she had her own dreams of her future and the kind of man she would want to marry. At 14, she was forced to undergo a virginity test. To mark the results of the virginity test, she was given a white cloth with holes punched in it. To avoid embarrassment and shame to the family name, Siya's parents concealed that she was not a virgin and asked the man she had been pledged to marry to immediately take her. Unfortunately, a few months after she turned 15 this older man passed away since he had battled with illness for quite some time. After the funeral Siya went for an HIV test, and discovered she was HIV positive. She was later inherited her late husband's brother because the family felt she needed to bear children for the family. However, her late husband's brother could not make her pregnant and the family requested that she sleeps with the other brother for her to fall pregnant.*

### Discussion questions: (See answer key for questions 1 - 4)

- a. Discuss the types of marriage that Siya experienced (i.e. what are these practices called)?
- b. How do you think Siya felt about her situation?
- c. What are the risks posed by the situation, to Siya and her in-laws?
- d. How can other girls be protected from being in Siya's position?

### Answer key:

- a. Wife pledging (*kuzvarira*), wife inheritance (*kugarwa nhaka*), *kumutsa mapfihwa* (literally means restoring hearth stones; the act where a widower or widow accepts a replacement wife or husband)
  - b. Sad, angry, uprooted, vulnerable, etc.
  - c. Poverty; polygamy; HIV infection, sexual and gender based violence etc.
  - d. Keep girls in school long enough for them to complete their education so that they can own their own livelihood, not pledging the girl child, discourage early sexual debut; discourage early marriage; do away with harmful traditional and cultural practices etc.
3. Encourage parents and adolescents to explore ways to stop harmful cultural practices and explore ways of making this happen.

**Note to facilitator:** Make sure to highlight as many harmful religious and traditional practices in Siya's story as the participants can identify, e.g. virginity testing.



**Remember to offer the participants the name and contact details of the nearest service provider (healthcare services, NGO, 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 referral slips and refer people to relevant service providers as needed.**



UNIT 10:  
CONFLICTS

# UNIT 10: CONFLICTS

## Rationale

This unit seeks to empower participants with conflict resolution skills and enables them to handle conflict. It guides adolescents on how to approach both the theoretical and the practical dynamics associated with managing and responding to relationship conflict. It also addresses the legal restrictions and rights Zimbabwean adolescents will confront and the potential legal ramifications of sexual decision-making.

**Early Adolescence (10 - 13 years):** Most young adolescents are still considering their future sexual activities rather than engaging with them. By beginning to consider and practise conflict resolution skills with friends and family at this age, they will be better prepared for future romantic and sexual conflicts. Young adolescents need guidance on how to approach both the theoretical and the practical dynamics associated with managing and responding to relationship conflicts. This session also addresses the legal restrictions and rights Zimbabwean adolescents will confront in the immediate and long-term future. Sexual decision-making is incomplete if it does not take into account potential legal ramifications.

**Late Adolescence (16 - 19):** Older adolescents may be engaging sexually, or their peers are. Providing concrete support for negotiating the inevitable conflicts that older adolescents experience helps to smooth those experiences and provide for better eventual outcomes. Topics like sexual initiation and condom use are no longer theoretical, but are now very real to these young people. Family dynamics may continue to be contentious as older adolescents exert their independence. This session also addresses the legal restrictions and rights Zimbabwean adolescents will confront in the immediate and long-term future. Sexual decision-making is incomplete if it does not take into account potential legal ramifications. Additional information to give to parents on Hand-out 21

**Middle Adolescence (14 - 15 years):** Adolescents in the middle of their developmental pathway are emerging into sexual and romantic relationships and start to develop their conflict resolution skillset. These adolescents need guidance on how to approach both the theoretical and the practical dynamics associated with managing and responding to relationship conflicts. Emerging sexual and romantic interests may also increase the conflicts felt between adolescents and parents, and so addressing the family dynamics is also important. This session also addresses the legal restrictions and rights Zimbabwean adolescents will confront in the immediate and long-term future. Sexual decision-making is incomplete if it does not take into account potential legal ramifications.

**Parents / caregivers:** Conflict management and resolution is a responsibility that falls primarily with the parents. As the adults in the relationship, they have a responsibility to care for their children and teenagers. This responsibility includes resolving conflicts in a way that allows them to continue to parent and care for their children after the conflict is resolved. Maintaining a caring, trusting relationship is crucial to this process. Understanding the legal structure is also important for parents to support their adolescents in the sexual decision-making process.

## Objectives

- To enable participants to understand conflict resolution and the layer model of conflict resolution, and how to use it in their families.
- To deepen understanding of the self and their sexual needs.
- To understand the rights and laws associated with sexual activity and reproduction in Zimbabwe.

## UNIT PLAN

### Activities:

Icebreaker

Session 1: Conflict Resolution Part 1 (Split sessions)

Session 2: Conflict Resolution Part 2 (Split sessions)

Session 3: Laws (Split sessions)

**80 minutes**

10 minutes

25 minutes

25 minutes

20 minutes

### Introduction icebreaker

**10 minutes**



Invite participants to share how their family homework conversations went.

### Conflict game

Ask participants to stand in pairs facing each other, and put their arms straight out in front of them to shoulder level. Tell them to touch palms with the other person and push as hard as they can against each other so that they stand in a way that is safe.

Once they have pushed for at least two minutes, tell them suddenly to stop pushing. Ask them how much of a relief it was to stop pushing.

Tell them that this is what happens when we are in conflict with someone. Each of us try to 'push' our message home.

## SESSION 1: Conflict Resolution - Part 1

### Conflict Resolution: Part 1 (All Adolescents)

**25 minutes**



Conflict resolution is both a theoretical and a concrete process. Part one of conflict resolution introduces theoretical and practical ideas for approaching conflicts.

### Procedure

1. Ask participants to define conflict.  
(A serious disagreement or argument)
2. Ask participants to define resolution.  
(A solution or a decision that ends a conflict; the act of solving or ending a problem or difficulty)
3. Ask participants to define conflict resolution. (Ways people work towards the peaceful resolution of disagreements).

4. Ask participants to arrange themselves in pairs. If you have an uneven number, you can have one group of three. Each person in the pair should:
  - a. Describe one time you had a conflict.
  - b. How did you resolve the conflict?
  - c. What did you do to make it a peaceful conflict resolution? If it was not peaceful what could you have done?
5. Ask each pair to find another pair to sit with for groups of four. Invite the pairs to share with their small groups the steps they felt were helpful in conflict resolution. Each group should come away with two to three suggestions of ways to facilitate conflict resolution.
6. Invite each group of four to share conflict resolution approaches.
7. Tell participants that you are going to introduce them to a theoretical model of conflict resolution called the onion model. Show participants the **Onion Model Poster**.
8. Tell participants that identifying your own and other people's positions in a conflict situation allows for a deeper understanding of how to approach the problem peacefully and increases the likelihood that the conflict can come to a resolution that each person can be supportive of.



9. Point to the outside layers of the model and tell participants that what we want is only the outside layer of a conflict. For example, a teenage boy may want to have sex, but that is only the very outside issue.
10. Point to the middle layers of the model and tell participants that the reasons someone wants something are not always immediately clear. For example, a boy may want to have sex to prove that he is a man because of cultural beliefs of masculinity; a girl may want to have sex to prove that she loves her boyfriend.

11. Point to the inner layers of the model and tell participants that what we need is often different from what we want. In our example, it may be that the boy needs companionship and friendship. He may also need physical touch, like hugs and kisses. What he needs may be very different from what he wants. A need is something that most humans require to be content with and fulfilled in life. Some examples of needs include food, shelter, companionship, and love. There are other needs, but these are some of the most general ones.
12. Ask participants to give their own examples for each of the three layers of the Onion Model.

Acknowledge that sometimes it is difficult to understand the difference between what someone wants and what they need. But it is important, in a conflict, for both people to consider what they want and what they need as different. If one person has a want that is in conflict from the other person's need, it is the need that must be answered, not the want.

13. Lead a short discussion with the following questions:
  - a. Would considering this model have provided for more effective communication in the conflict example that you shared with your partner earlier? Why or why not?
  - b. How can you use this model in future conflicts?
  - c. Would you be willing to consider the three levels of your approach to a specific conflict in the future? Why or why not?
  - d. Would you be willing to consider the three levels of another person's approach to a specific conflict in the future?  
Your friends, parents, or romantic or sexual partners? Why or why not?

### **Conflict Resolution: Part 1 (Parents)**

Conflict resolution is both a theoretical and a concrete process. Part one of conflict resolution introduces theoretical and practical ideas for approaching conflicts.

#### **Procedure**

**25 minutes**



1. Ask the participants to brainstorm conflicts that are common for parents and adolescents. At least some of the conflicts should relate to sexual and dating activities. Gather five to ten conflicts.
2. Divide participants into groups of three to four participants. Give each group one of the brainstormed conflict examples.
3. Ask each group to read over their example and to define each of the three conflict layers for each of the people in their example. Give groups ten minutes for this process.
4. Invite each group to present their conflict example to the large group and then to outline the positions, interests, and needs of each person involved.
5. Lead a discussion with the following questions:



- a. Was this process easy or hard? Why?
  - b. How did you start thinking about the wants, reasons, and needs of each of the different people in your conflict example?
  - c. Do you think your relationships with your children and adolescents would be happier if you could talk about wants, reasons, and needs?
6. Invite each group of four to share conflict resolution approaches.
  7. Tell participants that you are going to introduce them to a theoretical model of conflict resolution called the onion model. Show participants the **Onion Model Poster**.
  8. Tell participants that identifying your own and your adolescents' positions in a conflict situation allows for a deeper understanding of how to approach the problem peacefully and increases the likelihood that the conflict can come to a resolution that each person can be supportive of.
  9. Point to the outside layers of the model and tell participants that what we tell people we want is the outside layer of the conflict process. Tell participants that this can be a very specific thing. For example: (Facilitators...suggest a family-based example that parents may experience in their relationships.)
  10. Point to the middle layers of the model and tell participants that the reasons why we want say what we want are not always immediately apparent to the people we are talking with. For example: (Please take the examples from 9 and include an example interest for each.)
  11. Point to the inner layers of the model and tell participants that what we need is somewhat different from what we say we want and why we say those things. Needs are usually more general – they are not necessarily about the specific example but are about the whole of the relationship or physical or emotional health. For example: (Please take the examples from 9 and include an example need for each.)

## SESSION 2: Conflict resolution - Part 2

### Conflict Resolution: Part 2 (All Adolescents)

25 minutes



This activity invites participants to develop insight into real-world examples of conflict to increase their insights into the process.

### Procedure

1. Ask the participants to brainstorm conflicts that are common for adolescents. Some of the suggestions may be conflicts that adolescents have with other adolescents, and some of them may be conflicts that adolescents have with parents. Gather five to ten conflicts.
2. Divide participants into groups of three to four participants. Give each group one of the brainstormed conflict examples.

3. Ask each group to read over their example and to define each of the three conflict layers for each of the people in their example. Give groups ten minutes for this process.
4. Invite each group to present their conflict example to the large group and then to outline the positions, interests, and needs of each person involved in the conflict example.
5. Lead a discussion with the following questions:
  - a. Was this process easy or hard? Why?
  - b. What are the wants, reasons, and needs of each of the different people in your conflict example?
  - c. Do you think your relationships with your friends and boyfriends / girlfriends would be healthier if you could talk about wants, reasons, and needs?
  - d. Do you think your relationships with your parents / guardians would be healthier if you could talk about wants, reasons, and needs?
6. Lead a short discussion with the following questions:
  - a. Would using the Onion Model improve communication and conflict resolution? Why or why not?
  - b. How can you use this model in your own conflict resolution?

### **Conflict resolution: Part 2 (Parents)**

**(25 minutes)**



This activity invites participants to develop insight into real-world examples of conflict to increase their insights into the process.

### **Procedure**

1. Ask the participants to brainstorm conflicts that are common for parents and adolescents. At least some of the conflicts should relate to sexual and dating activities. Gather five to ten conflicts.
2. Divide participants into groups of three to four participants. Give each group one of the brainstormed conflict examples.
3. Ask each group to read over their example and to define each of the three conflict layers for each of the people in their example. Give groups ten minutes for this process.
4. Invite each group to present their conflict example to the large group and then to outline the positions, interests, and needs of each person involved.
5. Lead a discussion with the following questions:
  - a. Was this process easy or hard? Why?
  - b. What are the wants, reasons, and needs of each of the different people in your conflict example?
  - c. Do you think your relationships with your children and adolescents would be healthier if you could talk about wants, reasons, and needs?

6. Lead a short discussion with the following questions:
  - a. Would using the Onion Model improve communication and conflict resolution? Why or why not?
  - b. How can you use this model in your own conflict resolution

## SESSION 3: Laws

### Laws (Adolescents)

20 minutes



Understanding what (if any) legal repercussions may result from sexual activity is a critical piece of the decision-making process. Parents need to be aware of the potential impact of laws on their adolescents' sexual activities. This activity will inform participants of the laws, including adolescent rights.

### Procedure

1. Tell participants that understanding the laws about sexuality that apply to them is important for them to make wise decisions about sexual activity and to know when and where they are able to reach out for help when they need it.
2. Invite participants to brainstorm all of the laws that they know about in Zimbabwe that may affect adolescent sexuality. Invite them to brainstorm without correcting them or letting others in the group correct them. This process will allow the participants to consider the different issues at hand.
3. If you have a blackboard or other way to take notes, writing the participants' ideas so that everyone can see them is nice, but it is not required.
4. After the participants have named the laws that they are aware of, use the included Hand-out to correct any misconceptions that they have. If they have not addressed any of the laws included in the Hand-out, name and describe those laws here. **Hand-out 22 - Selected National Laws, Policies and Strategies.**
5. After the laws have been discussed, ask the following questions:

Do you feel that there are laws that should be introduced that are not currently in place to support sexual and reproductive health and rights of adolescents? What should be included in those laws?

### Laws (Parents)

20 minutes



Understanding what (if any) legal repercussions may result from sexual activity is a critical piece of the decision-making process. Participants need to be aware of the potential impact of laws on adolescents' sexual activities. This activity will inform participants of the laws, including adolescent rights.

### Procedure

1. Tell participants that understanding the laws about sexuality that apply to them is important for them to make wise decisions about sexual activity and to know when and where they are able to reach out for help when they need it.

2. Invite participants to brainstorm all of the laws that they know about in Zimbabwe that may affect adolescent sexuality. Invite them to brainstorm without correcting them or letting others in the group correct them.  
This process will allow the participants to consider the different issues at hand.
3. If you have a blackboard or other way to take notes, writing the participants' ideas so that everyone can see them is nice, but it is not required.
4. After the participants have named the laws that they are aware of, use the included Hand-out to correct any misconceptions that they have. If they have not addressed any of the laws included in the Hand-out, name and describe those laws here. **Hand-out 22 - Selected National Laws, Policies and Strategies.**
5. After the laws have been discussed, ask the following questions:  
Do you feel that there are laws that should be introduced that are not currently in place to support sexual and reproductive health and rights of adolescents?  
What should be included in those laws?

**Note to Facilitator:** Tell participants the day is coming to an end and their homework is to share with their family the biggest conflict they've had with their friends (parents should share too!). How was it resolved? Did everyone feel good about it or were there hard feelings afterwards? What lessons did you learn from this conflict?

Participants will sing an appropriate closing song which is connected with the topic of the day. Each group can have its own song, or they can be repeated across groups.



**Remember to offer the participants 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 if they need more help or have more questions. Give referral slips and refer people to relevant service providers as needed.**



UNIT II:  
TALKING  
TOGETHER

# UNIT 11: TALKING TOGETHER

## Rationale

The overarching goals of this programme are to support increased levels of sexual and reproductive health and rights (SRHR) conversations in the home and enable parents and children to develop a plan of action. Bringing participants together to experience those conversations in a concrete, guided fashion allows for the conversations to happen more naturally after the programme is complete and the participants are at home, away from leader support and guidance.

**Early Adolescence (10 - 13 years):** Most young adolescents are still considering their future sexual activities rather than engaging with them. During the early adolescent years, parents and families can greatly influence the growth and development of their children. By beginning discussing SRHR issues with family at this age, they will be better prepared for future experiences.

**Late Adolescence (16 - 19 years):** Older adolescents may be engaging sexually, or their peers are. Their sexual thoughts and decisions often reflect increasing maturity due to the advanced cognitive development and sometimes moral development. However, parents still need to have separate, more thorough discussions to ensure their children have vital SRHR information.

**Middle Adolescence (14 - 15 years):** Most Middle Adolescence are interested in more intimate relationships and experimentation. Parental and societal concerns regarding premature sexual activity include unplanned pregnancy, sexually transmitted infections (STIs), sexual abuse, and potential emotional consequences of sexual behaviours. The pressures upon this age group, from peers and also the media may actually offer one of the most effective pathways to opening an ongoing dialogue about sex and sexuality, not a single talk or lecture in the home

## Objectives

- To support conversion of the programme content into lived experiences in the home.
- To have at least one engaging, inter-familial conversation about SRHR.

## Learning Outcomes

- After completing this session, participants will be able to:
- Describe three different approaches to opening a conversation about SRHR within their family.
- Identify one SRHR topic that they have had a conversation about within their family and one SRHR topic that they would like to have a conversation about within their family.

# UNIT PLAN

## Activities:

Icebreaker

Session 1: Conversations between families

Session 2: Conversations within families

PCC Assessment Questionnaire

## 80 minutes

10 minutes

40 minutes

30 minutes

10 minutes

### Icebreaker

10 minutes

Participants will sing an appropriate closing song which is connected with the topic of the day. Each group can have its own song, or they can be repeated across groups. Invite participants to share how their family homework conversations went. Because the entire group is participating, only a few people will have time to share. Be sure that at least one parent and one adolescent shares. **Additional information to give to parents on Handout 28**

## SESSION 1: Conversations in families

Combined session: ALL

40 minutes



Beginning intergenerational conversations about SRHR can be more difficult with family members than with non-family members. This activity is preparing participants to engage in the more difficult intra-familial conversations in the next activity. It may be important during this activity to remind parents that one of their primary goals in conversations with adolescents is to let the adolescents lead the way.

This activity is a great time for them to practise that. It may be useful during this activity to remind parents that one of their primary goals in conversations with adolescents is to let the adolescents lead the way.

### Procedure

1. Tell participants that you are going to begin by asking them to get into groups that do not include anyone else in their family. Ideally each group should have at least one parent and at least two adolescents, and not more than four people in the group. You may choose to assign groups or you can allow participants to organize themselves into groups.
2. Once the groups are arranged, ask each group to share among them how they felt completing the family discussion homework assigned during the programme. Each person should have about two minutes to share.
3. After ten minutes, ask the groups to brainstorm at least five conversations around SRHR topics that they think would be most critical for families to have. Give them about ten minutes for this brainstorming.
4. Ask each group to pick one of their brainstormed topics to focus on, and to discuss the following questions about their topic area / critical conversation:
  - a. How would you like to be approached about this topic?
  - b. How would you most likely approach someone else about this topic?
  - c. Would parents and adolescents want to be approached in different ways? Why?
5. Ask each group to share to the large group:
  - a. Their chosen topic.
  - b. One good result that could come from parent-adolescent conversation about their chosen topic.

6. After the groups have discussed the questions above, let them come up with suggestions on how to initiate or open a conversation on a selected SRHR topic with a parent or a child.
7. Ask the groups to thank their group members for the conversation and give each other one encouraging comment about talking with their family about SRHR.

## SESSION 2: Conversations within families

**Combined session: ALL**

**30 minutes**



The activity is the one that the programme has been building towards, but even with so much preparation, it can still be difficult for families to talk together.

### Procedure

1. Ask participants to form family groups
2. Begin by acknowledging that some participants may be excited about this part of the process while others are nervous, worried, or even more hesitant to take this step. Tell the participants that these feelings, as well as a range of feelings, are all normal.
3. Ask participants to share with their families the parting encouraging words they were given from the group they just left.
4. Ask adolescents and parents to all share two or three of the topics that their previous group brainstormed as important for families to talk about
5. Let participants know that the goal for the next twenty minutes is to come up with a family plan for conversations about SRHR. Give each family a copy of the Handout 24 Family Plan for Conversations.
6. It may be useful for the facilitator to walk between groups during this activity to help families answer these questions honestly and to build a positive family commitment statement.
7. When there is about ten minutes left, let participants know that it is time for closing. If there is no time for the families to complete this handout, encourage them to take it home and complete it there.

**Note to facilitator:** Thank the participants for participating in the programme and ask them to complete the following sentence: “The most important thing I will take with me from this programme is ..... Participants will sing an appropriate closing song which is connected with the topic of the day. Each group can have its own song, or they can be repeated across group.

### PCC Assessment

**10 minutes**

Distribute the PCC Assessment Questionnaire – Handout 1 (for adolescents) and Handout 2 (for parents) and give participants enough time to fill in.





**HANDOUTS**

# HANDOUTS



## Handout 1

### Pre/Post Parent-Child Communication Assessment Questionnaire: Adolescents

**This is a Monitoring and Evaluation tool to be administered to participants when you start and again when you complete the PCC workshop meetings**

1. Do you feel free talking with your parents about sexuality? A. Yes, very free. B. I feel somewhat comfortable. C. I do not feel very comfortable. D. I feel quite uncomfortable.

2. When was the most recent time you talked with your parents about sexuality? A. Within the last week. B. Within the last month. C. It has been more than a month. D. I have never spoken with my parents or adolescents about sexuality.

3. List sexuality issues you would like to discuss with your parent(s) / guardian(s)?

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4. List sexuality issues you wouldn't like to discuss with your parent(s) / guardian(s)?

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5. Would you like to talk with your parents about sexuality more often? A. Yes, I would like to. B. I don't know. C. No, I do not want to.

6. If you were going to give advice to another adolescent about how to talk with their parents about sexuality, what advice would you give them?

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## Handout 2

### Pre/Post Parent-Child Communication Assessment Questionnaire: Parents

**This is a Monitoring and Evaluation tool to be administered to participants when you start and again when you complete the PCC workshop meetings**

1. Do you feel free talking with your children and adolescents about sexuality? A. Yes, very free. B. I feel somewhat comfortable. C. I do not feel very comfortable. D. I feel quite uncomfortable.
2. When was the most recent time you talked with your children and adolescents about sexuality? A. Within the last week. B. Within the last month. C. It has been more than a month. D. I have never spoken with my children or adolescents about sexuality.
3. Would you like to talk with your children and adolescents about sexuality more often? A. Yes, I would like to. B. I don't know. C. No, I do not want to.

4. List sexuality issues you would like to discuss with your child(ren)?

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5. List sexuality issues you wouldn't like to discuss with your child(ren)?

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6. If you were going to give advice to another parent about how to talk with their children and adolescents about sexuality, what advice would you give them?

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## Handout 3

### **You, Your Family, and Your Culture**

Younger adolescents are more engaged with their parents from the perspective of a child than middle or older adolescents, and so are more open to parental input and guidance. When intergenerational, family conversations about sexual and reproductive health and rights (SRHR) begin in the early years, it is more likely to continue on throughout adolescence. This benefits both parents and adolescents. Therefore, engaging younger adolescents in ways where they feel that family communication about sexual and reproductive health and rights is both useful and accessible will have long-term positive outcomes.

Adolescents in the middle adolescent age group have begun or even completed puberty, but they may not yet be engaging in sexual activities. Nevertheless, many adolescents in this age group are interested in the culture of sexuality that exists in popular culture and on the Internet. If conversations about sexual and reproductive health and rights (SRHR) have not begun by this age, the adolescents may have developed a bias against talking with their parents. Overcoming that barrier is critical for parents to support their adolescents as they face increasingly complex sexual issues, both as individuals and within their peer groups.

Older adolescents may be sexually active themselves and are likely to have friends who are sexually active. The need for information and conversations about sexual and reproductive health and rights (SRHR) increases dramatically among this age group. Understanding their own needs for information and support and their parents' capacity to fulfil those needs allows older adolescents to have additional means of support.

Young adults may be living away from their parents, and may even be married, with or without children. However, young adults still often go to their parents for advice and information, and increasing that communication is useful for healthy decision-making and family planning.

Parents are their children's first and primary sexuality educators, but they are often left without guidance on how to effectively engage with their children and adolescents on the topic. Having the confidence to have conversations about SRHR is important!



## Handout 4

### **Sexuality**

Sexuality is an expression of who we are as human beings. Sexuality includes all the feelings, thoughts, and behaviours of being male or female, being attractive, and being in love, as well as being in relationships that include intimacy and physical sexual activity.

### **Reproductive Health**

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

### **Sexual Rights**

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

### **Reproductive Rights**

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

The “rights of couples and individuals, to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so” were first recognised as a human rights issue at the International Conference on Human Rights in Teheran in 1968.

*Source: Standard National Adolescent Sexual Reproductive Health (ASRH) Training Manual for Service Providers 2012.*



## Handout 5

### Easy as ABC

This chart includes some of the things a person needs to know, have and be able to do if s/he is to Abstain, Be Faithful, or Use Condoms effectively. Use this list to supplement ideas generated in small groups.

<b>ABSTAIN</b>	<b>BE FAITHFUL</b>	<b>USE CONDOMS</b>
1. YOU NEED TO KNOW...		
2. YOU NEED TO HAVE...		
3. YOU NEED TO BE ABLE TO...		



## Handout 5

<b>ABSTAIN</b>	<b>BE FAITHFUL</b>	<b>USE CONDOMS</b>
1. YOU NEED TO KNOW...		
<ul style="list-style-type: none"><li>• What abstinence means to you</li><li>• What it means to your partner</li><li>• How long you plan to abstain</li><li>• What your values are</li><li>• What you won't do</li><li>• What you will do</li><li>• How to avoid going beyond the limits you set</li><li>• About your partners' past practice of abstinence</li><li>• What is (or is not) a turn on for you</li></ul>	<ul style="list-style-type: none"><li>• What you and your partner mean by being faithful</li><li>• What you and your partner mean by cheating</li><li>• About your partner's past sexual relationships and risky behaviours</li><li>• How much you can trust your partner</li><li>• How long you expect to stay together with your partner</li><li>• Whether you or your partner already has a sexually transmitted infection</li><li>• Where you can get tested for HIV and other STIs</li><li>• That if you have vaginal intercourse, and do not want a pregnancy, you also need contraception</li></ul>	<ul style="list-style-type: none"><li>• What they are</li><li>• How effective they are</li><li>• The variety of condoms available</li><li>• If you or your partner are allergic to latex</li><li>• Where to get them</li><li>• How to get to a place that provides or sells them</li><li>• When (and how) to talk about them with a partner</li><li>• That they need to be used consistently</li><li>• How to use them correctly</li><li>• What to do if they leak or break</li></ul>



## Handout 5

<b>ABSTAIN</b>	<b>BE FAITHFUL</b>	<b>USE CONDOMS</b>
2. YOU NEED TO HAVE...		
<ul style="list-style-type: none"><li>• Clear reasons for practicing abstinence</li><li>• Strong commitment</li><li>• A partner who will respect your decisions and agree to abstain</li><li>• Ability to say no</li><li>• Back-up plan if you change your mind</li></ul>	<ul style="list-style-type: none"><li>• A partner who is trustworthy, honest and also committed to being faithful</li><li>• The same definition of being faithful as your partner</li><li>• Rules that you both agree upon</li><li>• A discussion if outside sexual activity has occurred or will soon</li><li>• A plan on how to protect your partner if outside sexual activity happens</li><li>• An infection-free partner</li><li>• Contraception if you are having vaginal intercourse, and want to avoid pregnancy</li></ul>	<ul style="list-style-type: none"><li>• A place nearby where you can get them</li><li>• Money to buy them</li><li>• A commitment with your partner to use them consistently</li><li>• Condoms always available at the right times</li><li>• Water-based lubricant</li></ul>





## Handout 5

<b>ABSTAIN</b>	<b>BE FAITHFUL</b>	<b>USE CONDOMS</b>
3. YOU NEED TO BE ABLE TO...		
<ul style="list-style-type: none"><li>• Communicate assertively</li><li>• Get to testing site if necessary</li><li>• Exercise self-control</li><li>• Be faithful in the relationship</li><li>• Trust yourself</li><li>• Be honest with each other if your decision changes</li></ul>	<ul style="list-style-type: none"><li>• Get tested if necessary</li><li>• Get contraception</li><li>• Communicate honestly and clearly your definitions and expectations</li><li>• Be trustworthy in your partner's absence</li><li>• Plan for the possibility of pregnancy if you don't use contraception</li><li>• Exercise self-control</li><li>• Be honest if your pledge of faithfulness is broken or your decision changes</li></ul>	<ul style="list-style-type: none"><li>• Talk about using condoms with your partner</li><li>• Get them</li><li>• Remember to use them</li><li>• Use them every time</li><li>• Put them on correctly</li><li>• Not have intercourse if you have no condom available</li><li>• Get emergency contraception if the condom leaks or breaks</li></ul>



## Handout 6

### Ruvimbo and the Forest

Once there was a young girl named Ruvimbo. She lived in a beautiful house in the Eastern Highlands close to the forest with her father, mother and little sister. One day when Ruvimbo was nine years old, she decided to go exploring in the forest behind the house. This was the first time for her to go into the forest alone.

Ruvimbo ventured to the edge of her house, turning her head this way and that way, trying to see through the trees without actually going into them. She imagined how it would be cooler in there, under the shade. Ruvimbo reached out her hand and stretched it as far into the shade as she could. She admired the beautiful shadows of the trees on her skin and pretended that her fingertips indeed felt cooler than her shoulders, still out in the sun. Ruvimbo heard a beautiful bird call from deep within the shadows and she looked, trying to catch sight of this amazing bird that must be so much more colourful and interesting of any bird that flew over the sun-filled lawn. Suddenly something bright and fast rushed out between the trees, and Ruvimbo was sure it was the same bird she had heard calling.

She started to run after it, to see the colours more clearly, but she stopped a few feet into the forest. Now that she was all the way under the forest shade, it really was much cooler. Under her feet, Ruvimbo felt the leaves and the twigs crunching. Stooping down, she sifted through the debris and smelled something that was a bit like the compost pile in the corner of her own yard...but this was a much richer, much deeper, much older smell. Ruvimbo sat down. Then she lay down and closed her eyes. She stayed there, breathing in the smells and feeling the sun and shade move back and forth over her closed. After some time, Ruvimbo walked back to her house. The afternoon sun felt harsh after the coolness of the forest. Inside, Ruvimbo ran to her mother, excited to share what had happened.

“Mama, I went into the forest alone! I heard birds, and I think I even saw one!” “Oh, that’s wonderful, dear!” said her mother. “You know, when I was about your age, I went into the forest alone for the first time too. Ah, it was nice to go into the cool forest for the first time. The bird that you heard was probably an African hawk eagle. They’re hard to find, but one day when I was a little girl I fell down a hill and found their nest. I’ll show you where the hill is – but you can’t go down there because it’s too steep and you’ll fall. You should also be careful if you sit or lay down on the ground, because there are snakes around. I found all of the different kinds of snakes when I was a girl and so I can tell you about each of them and what they look like and whether they’re poisonous or not. Oh, and you should be careful and not eat the plants you find in the forest. I tried many of them when I was a girl, and while some of them are very good, it can be very hard to tell them apart from the ones that make you sick and I don’t want you getting sick. What else did you do in the forest?”

“Um, nothing.” Ruvimbo went up to her room, wondering why she had been very excited to tell her mother about her trip to the forest. Her mother had already seen and felt everything she had seen and felt, plus much more.

Source: Adapted from: [www.breakingthehushfactor.com](http://www.breakingthehushfactor.com)



## Handout 7

### Human and Sexual Development

Healthy sexuality is often defined exclusively by the health of the physical body. However, sexuality is far more pervasive than the body. The physical, emotional, and social pieces of sexuality must also be tended to in order for a person to experience full sexual health. Through an understanding of healthy sexuality, the normal development of sexuality can be pinned down and discussed more thoroughly. Understanding human development is integral to young people contextualizing the space that they are growing and developing in.

Young adolescents are experiencing the emergence of puberty in themselves and seeing it emerge in their friends and peers. This physical manifestation of adulthood approaching can be emotional for young people, especially if they have concerns about the pace of development and normality.

Adolescents in the middle of the teen years are neither children nor adults. Puberty may be mostly over, but that only applies to the physical changes that adolescence brings. They are in the middle of a unique cognitive transition that means they respond to conflicts and risks differently depending on whether they are alone, with their peers, or with parents or other adults. These different response systems are part of normal adolescent cognitive development and do not mean that the adolescent is being disrespectful or reckless.

Older adolescents have focused on the emotional and psychological transition from adolescence into adulthood. Providing them with the knowledge and skills for how to make that transition thoughtfully and gracefully allows them a firm footing on which to begin adulthood. Adolescents in this age range may have mostly moved into an adult reaction to conflict and risk or may still be in an adolescent mind set.

Young adults have completed their transition from childhood to adulthood and are now living fully adult lives, whether they are still in school or not. Their decisions about sexuality and relationships have moved on from teenage concerns to longer-term relationships and family planning rather than pregnancy prevention.

Parents need access to information and resources to support their children in achieving and maintaining healthy sexuality.



## Handout 8

### Sexual Patterns and Behaviours

#### Major Sexual Patterns

**Heterosexuality** - Male and female sexual relationships. Individuals who prefer partners of the opposite sex.

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

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

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

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

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

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

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

**Sodomy:** Anal or other copulation-like act between two males. According to the law in Zimbabwe, sodomy refer to any “act involving contact between two males that would be regarded by any reasonable as an indecent act”.

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

**Exhibitionism:** Sexual pleasure from exposing one’s genitals.

**Satyriasis:** Excessive desire for sexual intercourse in men.

**Nymphomania:** Excessive desire for sexual intercourse in women.

**Gerontosexual:** Sexual pleasure from elderly by a young person.

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

**Paedophilia:** Sexual pleasure by having sexual intercourse with children.

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

**Paedarasty:** Sexual pleasure from young boys.

**Zoophilia/Bestiality:** Sexual pleasure from animals.

**Necrophilia:** Sexual pleasure from corpses.

**Urophilia:** Sexual pleasure from urine.

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

**Sadism:** Sexual pleasure from inflicting pain to another person.

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

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

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

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

*Source: Standard National Adolescent Sexual Reproductive Health (ASRH) Training Manual for Service Providers 2016 Edition*



## Handout 9

### How to Achieve Sexual Health

**Physical Health:** using a condom every time you have sex, getting tested for STIs and HIV, talking with your partner about what you would do if an unplanned pregnancy happened

**Emotional health:** making the decision to have sex based on what you want rather than on what your partner wants, telling your partner what you want and don't want before you start to be sexual with them, knowing that you can say no to any kind of sexual contact at any time even if you have said yes before, listening to what your partner wants and respecting their boundaries

**Social Health:** associating with people that you want to and feel comfortable with, feeling confident with yourself, not hesitating to behave in a way that you feel is right, being yourself and not succumbing to peer pressure influence.



## Handout 10

### Boy and Girl Changes at Puberty

CHANGES DURING ADOLESCENCE		
BOYS	GIRLS	BOTH
<b>PHYSICAL CHANGES</b>		
May have temporary breast growth	Breasts develop	Genitals get bigger
First ejaculation; Wet dreams, also called nocturnal emissions	First ovulation and menstruation	Hair grows on body, in armpits and on genitals
Gain in muscular strength	Increase in vaginal & cervical secretions	Become taller and gain weight
Shoulders broaden and chest gets wider	Fat tissue increases	Voice changes
Growth of facial hair	Hips, thighs & bottom widen	Skin becomes oilier; may get pimples and acne
Voice breaks	Proportionate growth in the reproductive organs	Sweat glands develop; Increased sweating leading to stronger body odour
Proportionate growth in the reproductive organs		Wet dreams
		Rapid growth both in height and weight
		Skin problems such as pimples/acne
<b>EMOTIONAL CHANGES</b>		
		Moods change quickly
		Try to know and understand yourself
		Sensitivity to self-image
		Start feeling sexual attraction

		Rebellious tendencies
		Develop own values
		Concerned about being normal and fitting in
<b>SOCIAL CHANGES</b>		Start having romantic relationships
		Become part of peer groups
		Try to look and behave like your peer group
		Experience peer pressure
		Become more independent from parents and family
		Become closer to friends

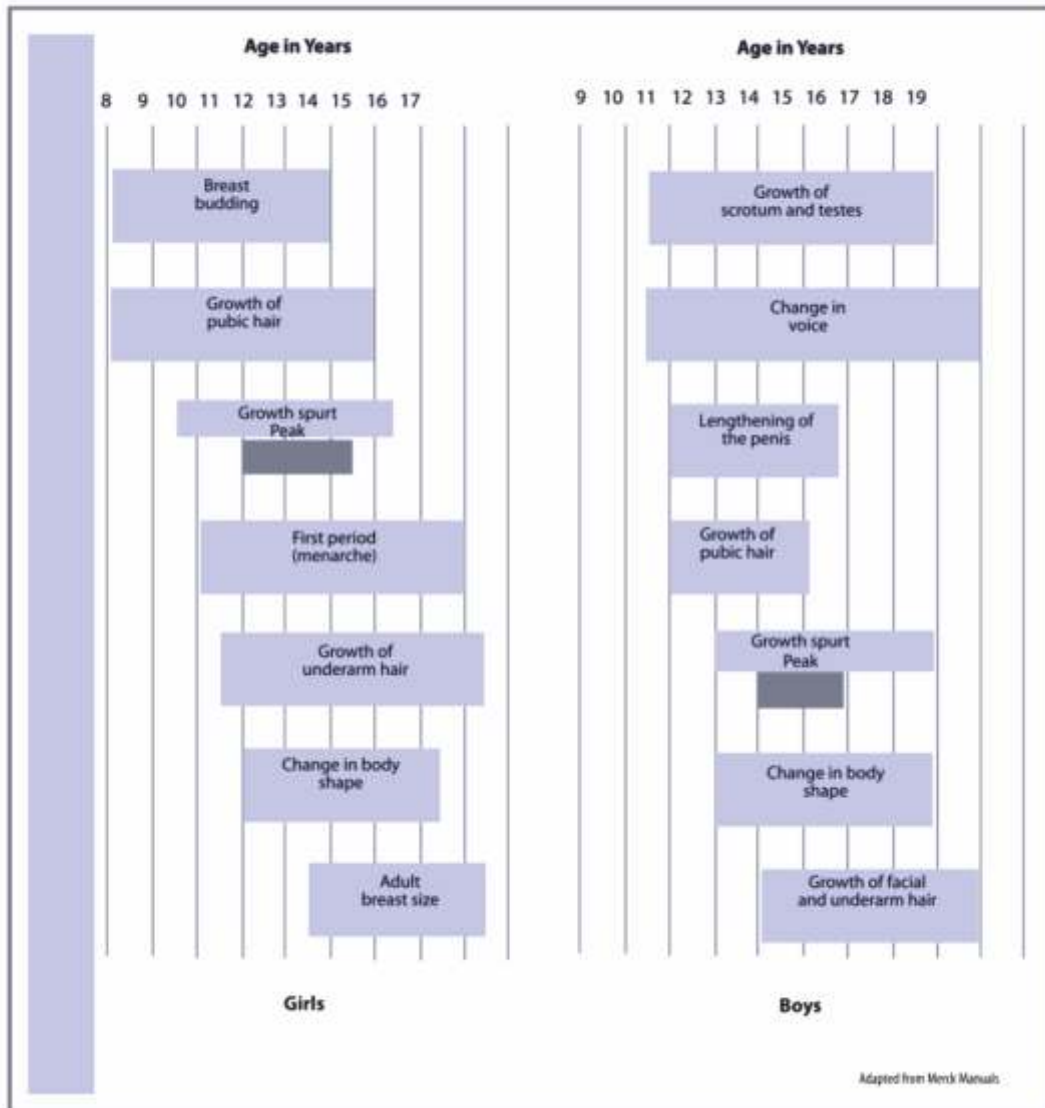
**A girl who has undergone the physical changes can fall pregnant.**

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

*Source: Adapted from UNFPA (2016) Comprehensive Sexuality Education Manual for Out of School Young People and Standard National Adolescent Sexual Reproductive Health (ASRH) Training Manual for Service Providers 2016.*



## Boy and Girl Body Changes at Puberty





## Handout 11

### Female Adult Story

**1.** I grew up in a rural set up and only moved to town when I was 18 to do my first year training as a teacher. You know what, when I was at primary school, around 9 years old, I always admired older girls with breasts in the upper grades and wondered if I would also one day get there. At 9 I was very free to move around my home, at times without clothes and I had no problems with it but when I was eleven things changed for me. It was when my breasts started to bud. I didn't understand what was happening. I became concerned even with the clothes I put on. I didn't want to put on clothes that would shape my breasts. My aunt one time told me to sweep the breasts using a small broom she gave me so that they would disappear but it didn't work. Surely I had to stay with the changes that had started to surface. During this period I also started to grow pubic hair and all this brought more confusion to me.

I remember one day this boy called Langton approached me and I felt something towards him but still I didn't know what it was. I was attracted to him and this was very exciting to me but also brewed questions I had no answers to. My behaviour continued changing towards people especially those of the opposite sex. I also could not dress even in front of my mother and sisters. I think this is the time I needed help from my parents and elderly family members to help me make healthy and informed choices about my sexual life. Unfortunately, things happened and no one was there to tell me what all these changes meant and what I was supposed to do except my sister. As time went on, one day I just woke up with my pants red with blood. I was 12 years then and that's when I had my first period. This was not hurting but I was shocked.

I couldn't even get out of the blankets. Fortunately, my sister gave an ear when I finally broke the news to her. She provided me with a piece of cloth to use as a pad. She explained to me that what had happened to me was normal but I discovered that she also had learnt about it through experience and friends. From that day I was so concerned and my main worry was what if this happened when at school, how would people look at me. At times the thought of being at this stage would make me happy knowing that I am now a grown up but at times I would be scared talking to boys thinking this would end up badly with them forcing me to have sex leading to pregnancy.

**2.** My sister told me that once one starts menstruating, playing with boys was dangerous and I got more scared. While feelings towards males were rising, I also battled with controlling them. This was a very confusing phase in my life. I remember one day when I was going home this boy in my class, Langton followed me. As we were moving down through the forest he hugged and kissed me. I can't really explain how I felt. There was this electric feeling which I couldn't understand. I was attracted to this boy but couldn't respond to his advances, I was confused. When I got home I thought a lot about him and couldn't sleep. Could this be love? I wondered. The next day I told my close friend Siphon about the incident. She laughed it off and told me to understand them and also to be able to deal with them for a healthy sexual life.

that she actually had a boyfriend and told me that they always kissed and hugged and ended there. I wondered how possible that was. This actually left me with questions because I thought such things wouldn't just end there. One day they would end up having sex and who knows what would end up with a pregnancy and then expulsion from school. I managed to deal with my feelings and never had sex with Langton.

At 15 things changed our relationship grew and got very exciting. I was now grown up and issues of enlarging breasts, menstruation, and pubic hair we no longer issues to me. I would walk with my boyfriend on our way back home from school as we stayed in the same area. I however didn't want my parents to know, to me they were too strict. On weekends I would sneak out from home and tell my mother that I was going to fetch firewood yet in the true sense I would be going to meet my boyfriend. It was all exciting. This behaviour went on and on but when I went to college the relationship went stronger. I told no one about my relationship, even my sister. Everything I did was done secretly. Langton and I went to the same teacher training college soon after high school. We both moved to a college at an urban set up.

**3.** At college life changed and we learnt lot from students from different corners of the country. There was freedom at last and generally those without boyfriends were looked down upon and this time I became comfortable with my relationship with Langton. I was now grown up, nice hips and very concerned about my dressing and how I looked. At times Langton was so jealous that some other guys were also attracted to me. As time went on it became impossible to resist having sex with him. I remember the day, he picked me from my hostel and sneaked me into his. Because we didn't protect, I fell pregnant. I was 19 then and we were both in our second year at college. My parents couldn't swallow the news, they were very disappointed but because my boyfriend didn't deny the pregnancy, they gave me the support I needed but unfortunately I had to drop out of college to take care of the baby. Raising the baby was a challenge as we both were not working. Dropping a year behind affected my studies so much. I however went back to college when my daughter was one-year-old and managed to complete my course. Right now my husband and I are teachers. My growing up taught me a number of lessons that there are some things that happen to our bodies that we cannot avoid but we need hel



## Handout 12

### Male Adult Story

**1.** I grew up with my mum and dad in a mine set where everyone knew each other. My father was a pastor in the mine and a well-respected man. We grew up going to church every Saturday. On Sundays we would go swimming with friends at the nearest swimming pool with male and female friends, we loved that. At 10, if I can remember well, I was in Grade 6, and I just felt a change in my body and my eye for the girls changed. I got attracted to girls and did no longer want them to see me naked. Since then I realised that I was changing. I had always wanted to grow to be a big boy and knew the time had come. I started to change even the way I spoke and walked. I wanted people to realise that I was now a man. I was so close to my parents especially my mum but at times I would even challenge her. As from 11 years, more changes took place in me that included voice changes and growing of pubic hair. My worst surprise was the wet dreams. This experience really confused me as I didn't know what it meant. My luck was that I was so close to my father so I managed to share with him and that gave us an opportunity to discuss this and other changes that were taking place in me.

**2.** Even though my father discussed some of these growing up issues with me all that happened around me needed more answers than what I was being told. Friends said this and that, relatives and so on and I had to come up with conclusions on my own. At 15 I grew stronger sexual feelings that I felt would affect my school work. I had friends who were always trying out things. Some experimented with drugs, having sex with their girlfriends, some experimented with masturbation, and all this piled on me. A lot was happening around and to belong to the group you had to do as everyone did. I had my first sexual encounter at 16, under the influence of alcohol and I can't really recall what took place on the day. I always regret that day. To my friends that was being a real man but I had hoped for an organised and well thought-out first sexual experience. It was tough for me because I had my father's position in the community to protect, a pastor. Lucky the sexual act didn't result in a pregnancy. At a point I forgot about my father's expectations and flowed with the group's decisions. In the process I had more than one girlfriend at a time. I liked seeing girls fighting over me, it was fun. My bedroom became a no go area as I kept romantic magazines, photos, etc. that I didn't want my parents to lay their hands on.

**3.** At 19 my behaviour changed for the better. My experiences with girls was about to affect my education so I reflected deeply. I felt the pressure of girls on me and couldn't cope. One day my father sat down with me and we had a lengthy man to man talk. It is when I thought deeply about my future and decided to choose one girlfriend from the huge list I had. Because of her experiences with me the relationship didn't last long. There was a time when I stayed without a girlfriend just to collect my thoughts and that time I stopped even partying and did my school work. The break gave me direction and the girlfriend I finally settled for at 20 who later became my wife, whom I am proud of. The journey was really tough with a lot of lessons. All my experiences taught me that life can be miserable if one doesn't set him or herself goals in life. Some of my friends became fathers at 19 and never completed their education. At least I completed my education, got a job, and I am able to take care of my family that I love so much.



### Adolescent Psychological and Social Development

#### Characteristic Behaviours of Adolescence

Developmental Stage	Early Adolescence (10 to 13 years old)	Middle Adolescence (14 to 16 years old)	Late Adolescence (17 to 19 years old)
	<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>
Independence	<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>• Moves away from parent and toward 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>
Cognitive Development	<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 of 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>
Peer Group	<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>
Body Image	<ul style="list-style-type: none"> <li>• Is preoccupied with physical changes</li> </ul>	<ul style="list-style-type: none"> <li>• Is less concerned about body image than before</li> </ul>	<ul style="list-style-type: none"> <li>• Is usually comfortable with body image</li> </ul>

	<ul style="list-style-type: none"> <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 more interested in looking attractive</li> </ul>	<ul style="list-style-type: none"> <li>• Accepts personal Appearance</li> </ul>
Sexuality	<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 inside or outside of marriage</li> </ul>	<ul style="list-style-type: none"> <li>• Begins to develop serious intimate relationships that replace group relationships as primary relationships</li> </ul>



## Handout 14

### Sexually Transmitted Infections

Sexually transmitted infections (STIs) are infections that are spread from person to person by sexual contact. To avoid contracting an STI people should:

- Know about STIs and what their signs are.
- Not engage in sexual activity – the only 100% effective way to prevent contracting an STI.
- Avoid sexual activity that involves genital contact or fluid exchange. Hugging, kissing, cuddling, touching, fantasy, and using your hands are all safe practises.
- Use condoms
- Limit the person they have sex with to one faithful partner
- Talk to their partner to find out if he or she has ever had an STI, and ask about being tested before having sex.

<b>TYPE OF STI</b>	<b>SYMPTOMS (when they occur)</b>	<b>TREATMENT</b>
Syphilis	A single firm, round, small and painless sore that appears at the spot where syphilis entered the body. If not treated, rough, reddish brown spots appear both on the palms of the hands and the bottom of the feet, there is fever, swollen lymph glands, sore throat, patch hair loss, headaches, weight loss, muscle aches and fatigue. If still not treated it can damage the body and cause death.	Injection(s) administered by a doctor. There are no home remedies or over-the-counter drugs that will cure syphilis.
Herpes	Fever blisters in the genitals, which can disappear within 2 to 4 weeks. If untreated a second crop of sores, flu-like symptoms, fever and swollen glands occur. However, not everyone gets symptoms, while those who do may have several out breaks a year.	Herpes cannot be cured, but it can be treated by a medical practitioner.
Chancroid	Genital sores that rupture into painful ulcers after a few days. Can lead to swollen lymph nodes in the groin.	Can be treated by a medical practitioner. There is no home remedy or over-the-counter drugs that will cure chancroid.

Gonorrhoea	Fever, abdominal pain, pain on urination, and red, tender or itching genitals.	Can be treated by a medical practitioner. There are no home remedies or over-the-counter drugs that will cure gonorrhoea.
Gonorrhoea Trichomonas	Most males don't have symptoms. In females, signs include a grey or greenish-yellow and frothy vaginal discharge, severe itching, redness, swelling and tenderness. Symptoms may last up to several months.	Can be treated by a medical practitioner.
Chlamydia	Unusual vaginal bleeding, penile discharge, fever, pain in the abdomen, burning sensation during urination, painful sexual intercourse.	Can be treated by a medical practitioner.

One of the key issues affecting the sexual health of adolescents is the imbalance of power between the sexes. Women's and girl's relative lack of power over their bodies and their sexual lives, supported and reinforced by their poverty and social and economic inequality, puts them at risk of STIs and HIV. Adolescents find it particularly difficult to protect themselves against unwanted and unsafe sex from older people. Adolescents experience mood swings as a result of hormonal changes. They may feel moody or powerful, take excessive risks or feel suicidal. These mood swings can make adolescents vulnerable to unplanned behaviour and risks, including in their sexual behaviour.

**If you think you may have an STI seek medical treatment immediately.**





## Handout 15

### Relationships

Understanding what one wants and needs from a relationship is a complex process of introspection that requires teasing out other people's beliefs and input until all that remains is your own. Adolescents of all ages need support to fully immerse themselves in this process. Once a young person has come to understand what they want, they can begin to communicate that to their family, friends, and partners. The need for conversation and negotiation around sexual activities ranging from holding hands and a first kiss through sexual intercourse within the context of marriage is important for all adolescents to learn.

Adolescents of all ages with access to cell phones and the Internet may use this technology to deepen their relationships. Texting, WhatsApp, Facebook, and other ways of using digital media offer new ways to communicate, and so new ways to meet, fall in love, and communicate. This new means of communication can be good and healthy, or it can be problematic, in the same ways that all forms of communication can be these things.

Sexting, or sending sexy pictures through text or other digital media, is illegal and also leaves the participants at risk for social shaming if the picture is sent on to other people. This is an emerging issue in Zimbabwe and needs to be taken seriously by adolescents and parents.

Younger adolescents are usually thinking about their future relationships – although some of the 12 and 13 year olds may have begun small relationships. It is important for this age group to know that they do not need to have sex yet, even if they have started puberty, including menstruating, and even if they look and feel like an adult.

Middle adolescents are more likely to be actively engaging in romantic relationships, which may be sexual or not. Adolescents in this group are more likely to be touching and kissing without having intercourse.

Older adolescents are likely to begin having sexual intercourse. Relationships during this age range may be more serious and longer lasting.

Young adults may be interested in finding someone to marry and have a family with. Relationship decisions are often made with this goal in mind.

Parents can learn to support their children in the decision-making and communication processes by stepping back and listening. Allowing an adolescent, the space to talk about a sexual decision and form their own decisions based on their needs allows for the adolescent to have a deeper commitment to the decision and to stick with it even when they are with peers and partners.



## Handout 16

### Sexual Behaviour Attitude Survey

**Directions:** Please circle the response which most accurately describes your beliefs about each statement.

**1. The penis has a mind of its own. Once aroused it can't be controlled**

Strongly Agree                      Unsure                      Strongly Disagree

**2. Once a girl has sexual intercourse, she can't refuse it in the future.**

Strongly Agree                      Unsure                      Strongly Disagree

**3. A guy isn't a real man if he is a virgin.**

Strongly Agree                      Unsure                      Strongly Disagree

**4. Girls need to be in a relationship if they want to be respected and popular with their friends.**

Strongly Agree                      Unsure                      Strongly Disagree

**5. A guy will stay with a girl only if she has sexual intercourse with him.**

Strongly Agree                      Unsure                      Strongly Disagree

**6. Girls want sex as much as boys, but they have to say no to maintain their reputations.**

Strongly Agree                      Unsure                      Strongly Disagree

**7. A guy has the right to force sex if he gets so excited he can't stop.**

Strongly Agree                      Unsure                      Strongly Disagree

**8. Girls are the ones who decide how far sexual touching will go. They are responsible for setting limits.**

Strongly Agree                      Unsure                      Strongly Disagree

**9. If a guy goes to a girl's house and her parents aren't home - that means she is willing to have sex.**

Strongly Agree                      Unsure                      Strongly Disagree

**10. When a girl says "no she really means "maybe or "yes. Girls want to be persuaded and are expected to struggle a little bit.**

Strongly Agree                      Unsure                      Strongly Disagree



## Handout 17

### **Kudzi's Story**

Kudzi was born with HIV and commenced on ART when she was 14 years old, when she was 19 years, she met Tawanda through her church and they began dating, she knew she needed to inform him of her HIV status but was afraid he would not want to continue their relationship if she did.

She attended her local support group where she asked her peers what she should do. They shared mixed opinions with her. Some said she should tell Tawanda her status and that if he loves her, he will love her anyway and support her. Others said she should wait until they have known each other for longer and by that time, he will be less likely to leave her. Others said she must not tell him at all, in case he doesn't react well.

Kudzi then spoke with her counsellor who informed her of the different options and explained that only she could make the decision but that she would be supported. Kudzi decided she wanted to tell Tawanda and the counsellor taught her simple ways of explaining HIV and the ways HIV is transmitted. The counsellor reminded Kudzi of all the life skills she had learnt, drawing on resilience, coping skills, self-worth and self-esteem so that she was well prepared for the process and was able to respond to either a positive or negative outcome.

The counsellor arranged a follow up appointment for Kudzi so that she could provide post-disclosure counselling and support as soon as possible. She encouraged Kudzi to bring Tawanda to the appointment if he wanted to join her so that she could follow up with additional information and counselling for the couple. The following week, Kudzi phoned the counsellor to inform her that she had disclosed to Tawanda. She explained she had found it extremely difficult and had cried a lot whilst telling him. However, he had held her hand and told her he loved her for who she is and that her status did not change anything. She explained she was extremely relieved and happy and that they would come for counselling together the following week as they both had lots of questions. The counsellor congratulated Kudzi for her courage and confirmed she would see them both the following week.



## Handout 18

### Sex: A Decision for Two — the Scenario

#### 8:00p.m.

“Hurry up, urged Nyasha. “I thought you said Tinashe would meet us downstairs at 8:00 p.m. Thabiso, Nyasha’s roommate, replied, “Yeah, I know. Listen, I forgot to mention - but that guy you know from class is gonna come with us. You remember, he’s a good friend of Tinashe’s. Nyasha felt nervous suddenly. “You mean Craig? You know I think he’s really cute. What do I say? Thabiso answered, “Just act natural. Nyasha nodded, thinking the party was going to be really good with Craig there.

#### 8:15p.m.

At the party, Craig was very attentive to Nyasha. She was thrilled. They started to dance. Nyasha knew she was a terrific dancer and she loved to dance, especially with a guy as cute as Craig. They spent about an hour together, alternating between talking and dancing. Nyasha had a few beers. She could feel her body get looser from the alcohol making her dancing, she felt, even better.

#### 10:30p.m.

A slow song came on and Craig immediately pulled Nyasha close. Nyasha did not feel entirely comfortable dancing in this way, but did not say anything. Instead, she put her hands on his chest in an attempt to keep their bodies from pressing too close. Craig was really enjoying himself. He had noticed Nyasha in class and thought she was attractive. He couldn’t believe his luck. He felt he was acting so cool. He could sense she was responding to it. He decided to kiss Nyasha.

Nyasha was surprised at Craig’s kiss. She was attracted to him, yet felt uncomfortable that he was kissing her in public. She didn’t want him to think that she didn’t like him, so she just tilted her head down to end the kiss. Craig thought to himself, she really likes me. She is snuggling in after the kiss.

#### 11:30p.m.

The dance floor became packed again as the music got fast. Nyasha felt slightly dizzy from the beer and wanted to get some air. Craig was distressed at the mood change. He felt very turned on and wanted to be alone with Nyasha. He said to her, “Want to go outside for some air? It’s pretty stuffy in here. Nyasha looked around for Thabiso but didn’t see her. She said to Craig, “Okay, but just for a little while. She felt very nervous about being with him alone, but she felt silly feeling that way.

#### 11:40p.m.

Once outside, Craig immediately put his arm around Nyasha and began kissing her, thinking how much she wanted to be kissed since she had been dancing so sexy all evening. Nyasha, still unsure about what she wanted, pulled away and began talking about how good her first year in college had been so far. Craig thought she was quite drunk and was very talkative when drunk. So he continued to kiss her. Nyasha again pulled away and stood up saying, “I think I should get going. Let’s find Jill.

#### 12:00a.m.

Craig followed Nyasha into the party. They had found that Thabiso had just left with Tinashe. Craig offered to walk Nyasha to her hostel, thinking he could spend some

more time with her alone. Not wanting to walk home alone, Nyasha agreed.

**2:30a.m.**

Arriving at Nyasha's dark room, Craig asked, "Aren't your roommate home? Nyasha told him she was away. Craig thought to himself, "Nyasha wants to be alone with me too. That's why she brought me back here. Craig said to Nyasha, "Let's go inside then. We don't have to say goodnight out here. Nyasha hesitated. She told Craig that she was very tired and wanted to go to sleep. Craig said, "I won't stay long, and took her key from her hand and opened the door. When Nyasha stood in the hall and said goodnight, Craig laughed. Craig walked past her into the room saying, "Come sit for a while. He motioned to the space next to him on the couch.

Nyasha sat down, still buzzed from the beer, and began to explain once again that she was tired and Craig should stay for only a few minutes. Craig, thinking how sexy Nyasha was, moved over and began to kiss her. He pushed her down onto the bed and began to unbutton her blouse. Nyasha did not respond to his kisses and pushed him away muttering, "No, stop. Craig ignored her, continuing to undress both of them, thinking she really wanted it.

Nyasha stopped saying no and began to cry when Craig began to have intercourse with her.

*Source: © 2012 by The Centre for Family Life Education*



## Handout 19

### All Adolescents

#### Sex: A Decision for Two – the Analysis

1. Identify three times during the scenario when Craig did not respect Nyasha's feelings.

**a.** \_\_\_\_\_

**b.** \_\_\_\_\_

**c.** \_\_\_\_\_

2. Identify three times during the scenario when Nyasha could have made safer decisions.

**a.** \_\_\_\_\_

**b.** \_\_\_\_\_

**c.** \_\_\_\_\_

3. If Craig were sensitive to his partner, what signals would have told him that Nyasha did not want to continue?

**a.** \_\_\_\_\_

**b.** \_\_\_\_\_

4. If Nyasha had been assertive, what things could she have said to make her real feelings clear to Craig?

**a.** \_\_\_\_\_

**b.** \_\_\_\_\_

5. Date rape often proceeds through three stages; identify behaviours in the scenario at each stage.

**a.** Someone enters another's personal space in a public place (kissing, hand on breast or thigh, etc.).

\_\_\_\_\_

**b.** The partner does not assertively stop this intrusion and the aggressor assumes it's okay.

\_\_\_\_\_

**c.** The aggressor gets the couple to a secluded place where the rape takes place.

\_\_\_\_\_

Source: © 2012 by The Centre for Family Life Education



## Handout 20

### Parents Only

#### Sex: A Decision for Two – the Analysis

1. Identify three times during the scenario when Craig did not respect Nyasha's feelings.

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

2. Identify three times during the scenario when Nyasha could have made safer decisions.

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

3. If Craig were sensitive to his partner, what signals would have told him that Nyasha did not want to continue?

- a. \_\_\_\_\_
- b. \_\_\_\_\_

4. If Nyasha had been assertive, what things could she have said to make her real feelings clear to Craig?

- a. \_\_\_\_\_
- b. \_\_\_\_\_

5. Date rape often proceeds through three stages; identify behaviours in the scenario at each stage.

**a.** Someone enters another's personal space in a public place (kissing, hand on breast or thigh, etc.).

\_\_\_\_\_

**b.** The partner does not assertively stop this intrusion and the aggressor assumes it's okay.

\_\_\_\_\_

**c.** The aggressor gets the couple to a secluded place where the rape takes place.

\_\_\_\_\_

6. If Nyasha or Craig were your child, how would you have reacted the following day?

\_\_\_\_\_

\_\_\_\_\_



## Handout 21

### Conflicts

Conflict is the basis of parent-child communication breakdown, and also peer-to-peer issues. Approaching conflict with insight and compassion helps to increase peaceful resolution. Talking about how to approach conflict resolution based on the onion model and examples of how to apply the onion model in real situations are both important. In addition to personal and relationship issues around sexual activities, it is also important to be aware of the legality of sexual activities.

Young adolescents are usually considering their future sexual activities rather than engaging with them. By practising conflict resolution skills with friends and family at this age, participants will be better prepared for future romantic and sexual conflicts.

Middle Adolescence are emerging into sexual and romantic relationships and are at a ripe age to develop their conflict resolution skillset. Emerging sexual and romantic interests may also increase the conflicts felt between adolescents and parents, and so addressing the family dynamics is also important.

Older adolescents may be engaging sexually, or their peers are. Providing concrete support for negotiating the inevitable sexual conflicts that older adolescents experience helps to smooth those experiences and provide for better health outcomes. Topics like sexual initiation and condom use are no longer theoretical, but are now very real to these young people. Family dynamics may continue to be contentious as older adolescents exert their independence.

Young adults are facing the same set of issues that older adolescents are, with increased responsibility and family planning needs.

Parents are primarily responsible for conflict management and resolution between themselves and their children. As the adults in the relationship, they have a duty to care for their children and adolescents. This includes resolving conflicts in a way that allows them to continue to parent and care for their children, after the conflict is resolved. Maintaining a caring, trusting relationship is crucial to this process





## Handout 22

### Selected National Laws, Policies and Strategies

The laws, policies and strategies are reviewed from time to time. Please ensure that you are referring to the most recent version in your discussions.

#### Provisions from Selected Laws

- ❖ The Constitution of Zimbabwe 2013
- ❖ The Children's Protection and Adoption Act
- ❖ The Marriage Act:
  - The Marriage Act precludes boys under 18 years old and girls under 16 from being "capable of contracting a valid marriage." This age of marriage for boys is in conformity with the legal age of majority. Marriage Act; (revised. 1996).
  - Married adolescents are considered adults for the purposes of access to services and information on contraception and STI prevention and are no longer subject to parental/guardian consent requirements for medical treatment. The Centre for Reproductive Law and Policy and the Child and Law Foundation, 'State of Denial: Adolescent Reproductive Rights in Zimbabwe', 2002
- ❖ Domestic Violence Act (Chapter 5:16)
  - Act criminalises harmful traditional or cultural practises such as forced virginity testing, female genital mutilation, pledging of women or girls for purposes of appeasing spirits and child marriage, forced child marriage, forced wife inheritance and sexual intercourse between fathers-in-law and newly married daughters-in-law
- ❖ Sexual Offences Act, 2003 [Chapter 9:21] (Now repealed by section 283 of the Criminal law (Codification and Reform) Act [Chapter 9:23]:
  - Seeks to protect children, adolescents and women from sexual violence, by criminalizing 'extramarital sexual intercourse' with a young person and intellectually handicapped persons
  - Defines statutory rape as a crime where anyone over 15 years of age has extramarital sexual intercourse with anyone under the age of 16 years.
  - It also criminalises the intentional transmission of HIV. The existence of this Act has also led to the development of child or victim friendly courts.
- ❖ Termination of Pregnancy Act (15:30):
  - Permits abortion within limited circumstances.

*Subject to this act, pregnancies may be terminated if: continuation of the pregnancy so endangers the life of the woman concerned or so constitutes a serious threat of permanent impairment of her physical health that the termination of the pregnancy is necessary to ensure her life or physical health, as the case may be; or where there is a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will permanently be seriously handicapped; or where there is a reasonable possibility that the foetus is conceived as a result of unlawful intercourse*

The procedures for obtaining a legal abortion are also outlined and defined by the law:

- For example, in order to effectively carry out the abortion once any of the conditions are met, the medical practitioner requires the permission of the superintendent of the hospital
- Section 10 of the Act also specifies that no person, doctor, nurse or otherwise will be “obliged to participate or assist in the termination of a pregnancy”.

### **Provisions from selected Policies and Strategies**

#### **National Population Policy (1999):**

The policy specifies that:

- Individual rights to choose freely and responsibly the number, spacing and timing of children they want will be fully respected, and
- Underlines the need to recognise the aspirations of women and youth in particular.
- The policy stresses the need to address their health, education and other needs as their reproductive choices and decisions would affect the future of the population growth and other related issues
- It proposes the following key strategies for young people:
  - Strengthen reproductive health education in and out of school; provide counselling services to minimise problems relating to alcohol and drug abuse and reproductive health issues;
  - Advocate for establishment of parent education programmes related to youth problems and parent child communication and
  - Remove obstacles to make reproductive health services easily accessible to all those who are sexually active.

#### **National Reproductive Health Policy:**

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

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

- The strategy represents the second generation results-based strategy that aims to address Sexual and Reproductive Health (SRH) challenges among adolescents and young people between ages of 10-24 years in Zimbabwe.

Ensuring a safer supportive environment can lead to reduction in adolescent pregnancies and their complications, and HIV and STI infections. The strategy identifies four solution pathways that can address the challenges faced by adolescents and lead to a more supportive environment conducive to change in behaviours and inclusive of safer sexual and reproductive practices.

- It expands the provisions of the National Maternal and Newborn Health Road Map (2007 -2015), one of whose objectives is: to increase the availability and utilization of youth friendly Family Planning and HIV prevention services.
- Developed primarily to guide national efforts in providing quality, affordable and appropriate sexual and reproductive health services to young people of Zimbabwe

**Other National Policies and Strategies include:**

- National Gender Policy and Strategy,
- National Reproductive Health Service Delivery Guidelines,
- National Reproductive Health Behaviour Change Communication Strategy,
- National Guidelines on Family Planning,
- 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
- Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III): 2015-2018
- National Health Strategy: 2015-2020
- National HIV and AIDS Behavioural Change Strategy: 2016-2010
- Educational Policy, with respect to teenage pregnancy and life skills programmes,
- National ASRH Strategy II: 2016-2020
- National Guidelines on Clinical Adolescent and Youth Friendly Sexual and Reproductive Health Service Provision (YFSP): 2016 Edition
- National Youth Policy,
- National HIV Policy 1999
- ZIMASSET 2013

*Source: Adapted from the Standard National Adolescent and Youth Sexual and Reproductive Health Training Manual 2016*

**Selected Rights from the Zimbabwe Constitution**

**Section 76 Right to health care**

1. Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services.
2. Every person living with a chronic illness has the right to have access to basic health-care services for the illness
3. No person may be refused emergency medical treatment in any health-care institution.

4. The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in this section.

### **Section 77 Right to food and water**

Every person has the right to –

- a. Safe, clean, and potable water; and
- b. Sufficient food;

And the State must take responsible legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of this right.

### **Section 78 Marriage rights**

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

### **Section 81 Rights of children**

1. Every child, that is to say every boy and girl under the age of eighteen years, has the right—
  - a. To equal treatment before the law, including the right to be heard;
  - b. To be given a name and family name;
  - c. In the case of a child who is—
    - i. Born in Zimbabwe; or
    - ii. Born outside Zimbabwe and is a Zimbabwean citizen by descent; to the prompt provision of a birth certificate;
  - d. To family or parental care, or to appropriate care when removed from the family environment;
  - e. To be protected from economic and sexual exploitation, from child labour, and from maltreatment, neglect or any form of abuse;
  - f. To education, health care services, nutrition and shelter;
  - g. Not to be recruited into a militia force or take part in armed conflict or hostilities;
  - h. Not to be compelled to take part in any political activity; and
    - i. Not to be detained except as a measure of last resort and, if detained—
    - ii. To be detained for the shortest appropriate period;
    - iii. To be kept separately from detained persons over the age of eighteen years; and
    - iv. To be treated in a manner, and kept in conditions, that take account of the child's age.
2. A child's best interests are paramount in every matter concerning the child.
3. Children are entitled to adequate protection by the courts, in particular by the High Court as their upper guardian.

*Source: Constitution of Zimbabwe (Final Draft: 1 February 2013)*

### **SRH Rights**

SRH is not just about health care or information about disease – it is also about rights and choices.

SRH is a human right and is fundamental to human survival and development. Below is a list of the

SRH rights everyone is entitled to:

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

*Source: Standard National Adolescent and Youth Sexual and Reproductive Health Training Manual 2016*



## Handout 23

### Talking Together

The overarching goals of this programme are to support increased levels of sexual and reproductive health and rights (SRHR) conversations in the home. Whether children and adolescents want to have conversations with their parents depends on the child or adolescent in question. Sometimes parents are very unwilling to talk, but the children want to. Other times the parents want to talk and are very open, but the children are unwilling. However, children tend to be more open to conversation than adolescents.

**Young adolescents** may be the most open to SRHR conversations with their parents because they usually are less invested, they are less likely to have secrets about sexual activities to hide, and they usually still consider sexual activity to be something that happens in the future.

**Middle Adolescents** may still be open to conversations with their parents or they might have already shut down.

**Older adolescents** and young adults are usually the most reticent to have conversations with their parents. Because they may have already begun engaging sexually, they can feel the need to hide their activities from their parents. Even if they are not yet sexual, they may feel embarrassed to admit to having intense sexual feelings.

**Parents** set the tone for family-based conversations about SRHR. These conversations benefit from remembering four key elements about parent-child communication:

- Know yourself.
- It's not about you.
- Let your child or teen lead the way.
- You can do it!



## Handout 24

### Family Plan for Conversation

What are reasons why adolescents in this family hesitate to talk about sexual and reproductive health and rights (SRHR)?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

How can the family make it easier for the adolescents in this family to talk about SRHR?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What are reasons why parents in this family hesitate to talk about SRHR?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

How can the family make it easier for parents in this family to talk about SRHR?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Our family commitment to talking about sexual and reproductive health and rights is:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_



## Handout 25

### Tips in dealing with children below the age of 10

These are the most important years of a child's development. Critical brain and personality development occurs in these early years. Here are some things that happen at different stages as your child grows

Baby or infant: from birth to 2 years	Pre-school: Age 3 to 5 years	Primary School: Age 6 to 8 years
Babies cannot talk for you to understand. They make sounds, cry, laugh and coo. This is how they tell you how they feel.	They ask lots of questions! They think you know everything and try to learn about the world from you.	They ask lots of questions! They think you know everything and try to learn about the world from you.
Babies spend most of the time eating, sleeping, and playing.	Your child should start school so that he or she can learn to play with others, make new friends and begin to learn to recognize and write letters.	Your child should start school so that he or she can learn to play with others, make new friends and begin to learn to recognize and write letters.
Most children will start to say words by the time they are two years old.		They run and play a lot. They might also fall, drop things or have other accidents as their eyes and hands do not work well together as yet.
Two year olds love to say "no". This is the earliest stage of decision making.	They run and play a lot. They might also fall, drop things or have other accidents as their eyes and hands do not work well together as yet.	"Let me do it!" Yes, this is when they begin to learn how to do things themselves. They are still young but they can do a lot more without you. At this stage they are:
Babies learn how to trust you when you care for them. This is an important time for bonding.		Spending more time with friends and learning habits from them.
		Reading and writing and can determine what they would like to do or eat.
<b>Two critical ways:</b>		Taking a more active part at home, school, and in their community.
Breastfeeding builds mother-child connection. Plus, breast milk helps to protect babies from getting sick and is the only food or drink they need in their first six months.	"Let me do it!" Yes, this is when they begin to learn how to do things themselves.	Trying to do what they see adults doing. Adults must set good examples.
Talking, reading and playing with them as early as possible, and as often as possible.		Developing the sense of fear and can become afraid; they need you to make them feel safe. You can help by limiting what they see on TV and in books.

Source: Content reproduced from: *What Every Parent Should Know. Communicating With Your Children - Birth to 8 Years.* What Every Parent Should Know Is Produced by The Material Development Working Group of the Coalition for Better Parenting (CBP) with support for project execution by the National Family Planning Board (NFPB). The series is produced with technical and financial support from ©2004 and ©2012 Coalition for Better Parenting.





## Handout 26

### Tips on Communication with your children

Good communication involves building two important skills: how to listen and how to speak. These sound like simple skills that everyone already knows, but often we are not as careful when we speak and listen to our children as we are with other adults. Here are some tips:

When **LISTENING** to your children:

- Pay close attention to what your children tell you. They may take a while or get confused but listen patiently.
- When your children are speaking to you, give them full attention; make eye contact, use words like, “yes” and “oh”, to show your child that you are actively listening.
- Help your children to share their feelings. Ask about the emotion that they are feeling. Ask questions such as: How did that make you feel? How do you feel now?

When **SPEAKING** to your child:

- Your children should be assured of your love through the things that you say and how you say them.
- Speak slowly and calmly when correcting your children.
- Use simple words to explain things to children. Make sure they know what you mean.
- Praise your children a lot – it will make them feel good about themselves. Remember, your actions say a lot to children. Watch your body language – your hand movements, your facial expressions, and other body movements.

### Tips for communicating with your child

This is the most important stage of your children’s life. At this age what you teach them will affect the kind of persons they become. Children can learn TRUST, LOVE, RESPECT, PATIENCE, and HONESTY from how you communicate with them. Be consistent in what you say and do.

#### 1. Example is the Best Teacher

As babies learn to speak, they say the things that adults say. If you curse, they will too. Watch what you say. Read and sing to your children as soon after birth as possible and help them to copy the words and sounds that you make.

#### 2. Talk about Change

Changes can make children feel unsure or afraid. Talk to your young children about changes around them, even before they happen. Talk about changes like moving to a new home or having a new baby.

#### 3. Don’t Use Bad Labels

Children become what people say about them. Do not use negative and insulting labels to describe your children. Describe them as you would like them to be – caring, smart, honest, creative, friendly and so on.

#### **4. Send a Positive Message**

Talk to your children about what they can become or do with hard work. When they fail, be encouraging. Say positive things like, “You can get better. You are smart.” Praise your children when they do well; you will build confidence and self-esteem with your praise.

#### **5. Help your Children to Express their Feelings**

Let your children know that it’s OK to say how they feel about things that happen; it is NOT OK to hurt others because they are angry or upset. Provide opportunities for them to express themselves including drawing, discussion, and sports. If your children cannot express their feelings or hurt others when they do, get help from a counsellor.

#### **6. Be Willing to Change Your Style**

Communication is affected by a lot of things including where, and how it is done, who is doing it and the mood of the people involved. If you find that the way you communicate with your children is not working, try something else. Change what you do and say, how you do and say things, and even where you do them. You may be surprised at the difference these changes make. How you communicate to your children matters, even before your child learns to talk to you. The words, tone of voice and body language (expression on your face, hand and body movements) that you use can teach them how to show respect

*Source: Content reproduced from: What Every Parent Should Know. Communicating with Your Children – Birth to 8 Years. What Every Parent Should Know Is Produced by The Material Development Working Group of the Coalition for Better Parenting (CBP) with support for project execution by the National Family Planning Board (NFPB). The series is produced with technical and financial support from ©2004 and ©2012 Coalition for Better Parenting.*



## Handout 27

### Service provider Contact List<sup>32</sup>

<b>People and Places</b>	<b>Address and Contact Number</b>	<b>Services Available</b>
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		

<sup>32</sup> Adapted from the Hove Visit Guide p.137



## Handout 28

### HOW TO USE A MALE CONDOM<sup>33</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

<sup>33</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People* 242

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. **Tie the condom** to prevent the semen from spilling out. 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.



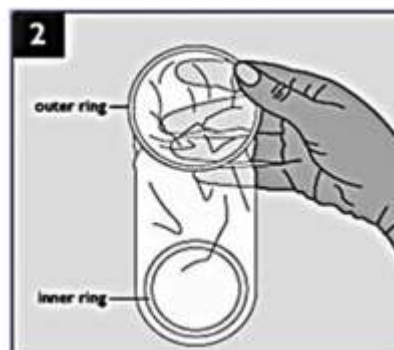
## Handout 29

### HOW TO USE A FEMALE CONDOM<sup>34</sup>

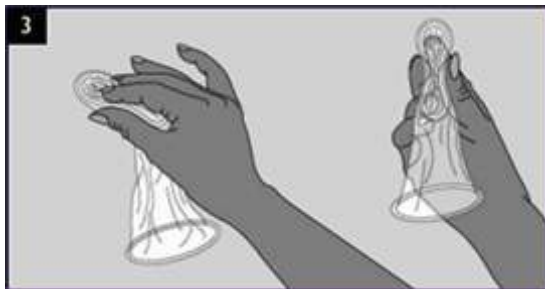
Follow these steps to use a female condom:

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

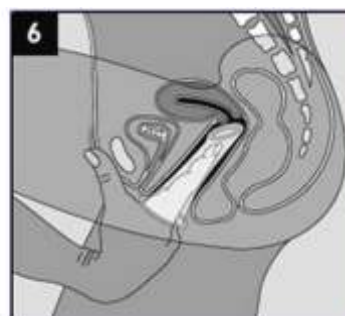
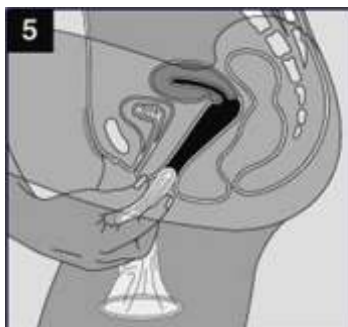


3. Hold the condom with the **open end hanging down** and **squeeze the inner ring at the closed end** with two fingers so it becomes long and narrow or turns into a figure eight. See picture 3.
4. **Choose a comfortable position** – raise one leg, sit or lie down. See picture 4.

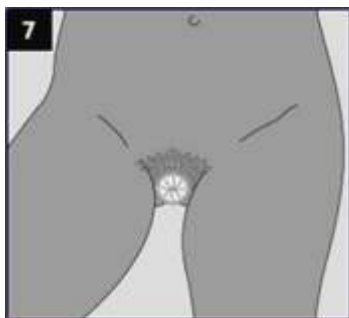


<sup>34</sup> Adapted from UNFPA (2016) *Comprehensive Sexuality Education Manual for Out of School Young People* pg. 243-244

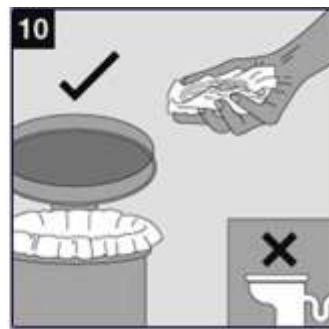
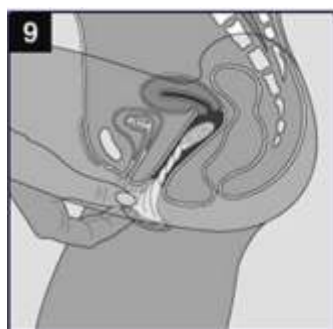
5. With your other hand, spread the lips open and **gently insert the inner ring into the vagina**. Place your index finger inside the condom, and **push the inner ring up as far as it will go**. Make sure the outer ring is outside the vagina and the condom is not twisted. See pictures 5 and 6.



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, but they may take 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. Research has found that women may need to try the female condom up to three times before they become confident and comfortable using it. When first trying to insert the female condom, try a different body position (for example, lying down, crouching, sitting) each time to find the most comfortable one. If someone has difficulties, they can ask for advice and assistance at a family planning clinic.



## Handout 30

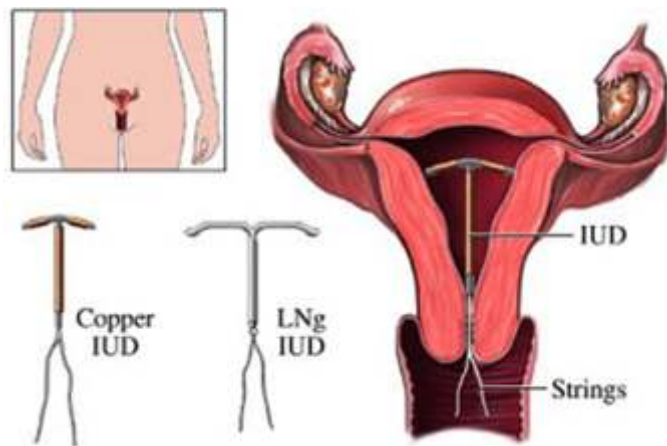
### Family Planning/ Contraceptive Methods

#### Intra-Uterine Contraceptive Device (IUCD)<sup>35</sup>

An IUCD is a plastic, T-shaped device about 3 cm long, generally coated with copper wire. Some IUCDs

also contain the hormone progestin. At the bottom of the IUCD there are strings which hang inside the vagina, but cannot be seen outside.

IUCDs must be inserted and removed by a trained person. They are not recommended for young women who have not yet had children, as there is a risk of infertility, and also for those with multiple or frequently changing sexual partners.



- IUCD is a small 'T' shaped plastic device, which is placed inside a woman's womb to prevent pregnancy for up to ten (10) years.
- It is a non-hormonal method suitable for people with high BP, and diabetes.
- It can be used by a woman who is breast feeding.
- IUCD does not protect against STIs including HIV and AIDS. Hence, you are encouraged to use condoms together with this method

#### Depo-Provera (Injectable)

- Depo-Provera is a short-term hormonal birth control method for preventing pregnancy.
- It is an injectable that prevents pregnancy for up to three (3) months.
- Depo-Provera does not protect against STIs including HIV and AIDS. Hence, you are encouraged to use condoms in conjunction with this method



<sup>35</sup> Population Services Zimbabwe <http://pszim.com/services-2/>



## Jadelle



- Jadelle implants are two small soft rods that are inserted under the skin of a woman's upper arm.
- This is a long term hormonal method for preventing pregnancy for up to five (5) years.
- It can be removed before 5 years if a woman decides to have a child.
- It can be used by a breast feeding mother.
- Jadelle insertion is a quick procedure that does not require surgery.
- Jadelle does not protect against STIs including HIV and AIDS. Hence, you are encouraged to use condoms together with this method

## Emergency Contraceptive



- Emergency Contraception is a hormonal method taken within 72 hours of unprotected sexual intercourse to prevent pregnancy.
- It is used by a woman in situations where:
  - a. She has had unprotected sexual intercourse without any Family Planning method.
  - b. She forgets to use her method correctly.
  - c. A condom burst during sexual intercourse and she is not using any method.
  - d. She is raped and not using any method.
- Remember Emergency Contraception is not to be used as a method of birth control.
- Emergency Contraception does not prevent STIs including HIV and AIDS.

## Contraceptive Pill



The pill is a short-term hormonal method for preventing pregnancy. It is taken orally at the same time every day.

### There are two (2) types of pills:

#### (1) Control Pill (Combined Pill)

- It is not suitable for a woman with medical conditions such as migraine headaches, and High Blood Pressure (BP).
- It can be used by a woman who continues breast feeding after six months from child birth.
- The Control Pill does not protect against STIs including HIV and AIDS. Hence, you are encouraged to use condoms together with this method

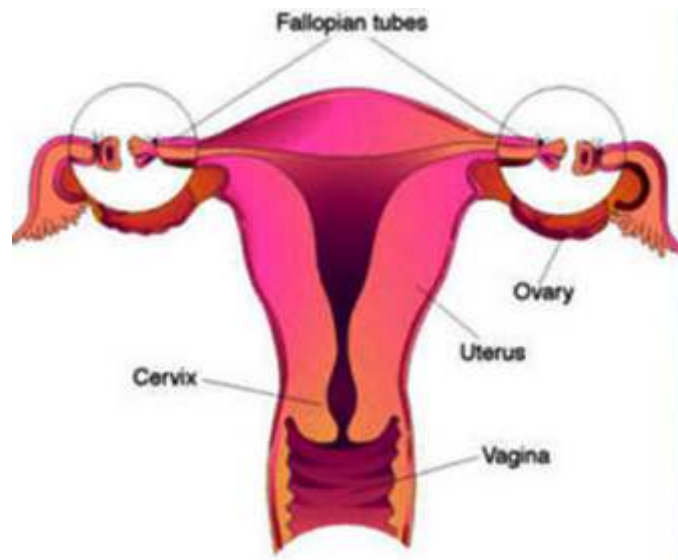
#### (2) Secure Pill (Progesterone pill)

- This is suitable for a mother who is exclusively breast feeding for up to six (6) months from child birth.
- It is suitable for a woman with medical conditions such as diabetes and High Blood pressure (BP).
- The Secure Pill does not protect against STIs including HIV and AIDS. Hence, you are encouraged to use condoms together with this method.

## Permanent methods<sup>36</sup>

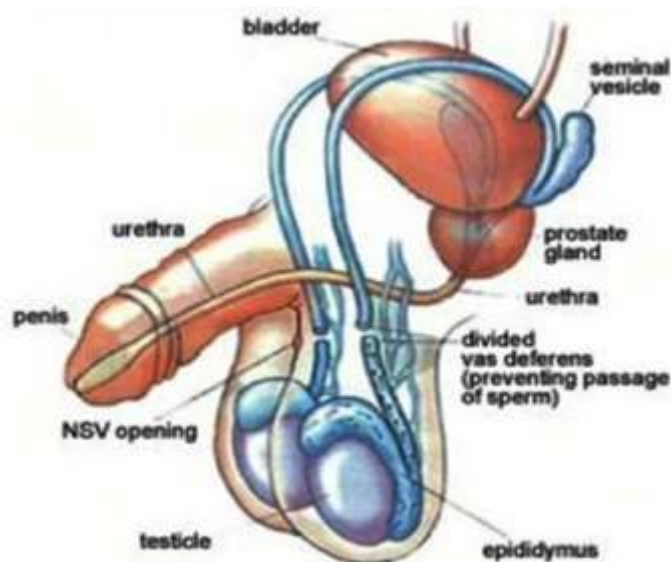
These are sometimes referred to as sterilization or surgical methods. They include Vasectomy for males and Tubal Ligation for females. Once done it is not reversible in developing countries, including those in Africa.

### Tubal ligation (female sterilization)



It is a simple operation in which the fallopian tubes that carry the eggs to the womb are cut and sealed. A trained health worker always performs the operation

### Vasectomy (male sterilization)



It is a simple operation during which the vas deferens, the tubes that carry sperm are cut and closed. A trained health worker must perform the operation without sending one to sleep.

<sup>36</sup> DSW

**The following information about methods that are not suitable for young people is included only in case a participant asks questions about one of these methods. Do not provide information about them to participants if they do not mention them.**

**Fertility Awareness Methods (FAM):** Fertility awareness is based on knowing the signs that a woman is ovulating and therefore fertile and could get pregnant. It uses a combination of different methods to monitor these signs (basal body temperature, cervical mucus, position of the cervix and counting the days). If the methods are used together and correctly, they provide a good way to know the days a woman is fertile. To know how to use these methods correctly, women need to take a class. It is not recommended for young people because of the level of knowledge required. When used correctly, it can be quite effective in preventing pregnancy (although less than some other methods), but it does not protect against STIs or HIV.

**Lactational Amenorrhoea Method (LAM):** Lactational Amenorrhoea can be used during the first six months after birth if the woman is exclusively breastfeeding her baby. Exclusive breastfeeding, which means the baby is getting only breast milk whenever it is hungry, can prevent the ovaries from releasing an egg for up to six months. It does not protect against STIs or HIV.

**Sterilization** is a surgery that makes it almost impossible for a man or a woman to have any more children. Since these operations are permanent, they are only recommended for men or women who are certain that they do not want any more children and not for young people. Vasectomy or sterilization for a man is a simple operation in which the vas deferens are cut and sealed. After a vasectomy, the man will still ejaculate but the semen will not have sperm in it. Tubal ligation or sterilization for a woman is an operation in which the woman's fallopian tubes are cut and sealed. It does not change a woman's ability to have sex or to feel sexual pleasure.

**Withdrawal:** Withdrawal is when a man pulls his penis out of the woman's vagina and away from her genitals before he ejaculates. If no sperm enter the vagina, the woman will not get pregnant. However, the pre-ejaculate may have sperm in it, which theoretically could cause a pregnancy. It is not a good method for young people because it requires self-knowledge and self-control and because it is less effective than other methods. It does not protect against STIs or HIV.

# APPENDIX

## LIST OF SRHR SERVICE PROVIDERS

### Ministry of Health and Child Care

CONTACT PERSON: The Permanent Secretary  
PHYSICAL ADDRESS: 4th Floor, Kaguvi Building, Corner Central Avenue/Fourth Street  
POSTAL ADDRESS: P. O. Box CY1122, Causeway, Harare  
TELEPHONE NUMBER(S): 04 798620 or 04798537-60 Ext 3006  
FAX NUMBER(S): N/A  
MOBILE NUMBER(S): N/A  
EMAIL: ggwinji@mohcc.gov.zw  
WEBSITE: www.mohcc.gov.zw

### Zimbabwe National Family Planning Council

CONTACT PERSON: Executive Director  
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FAX NUMBER(S): 04 620280  
MOBILE NUMBER(S): 0777 796 784  
EMAIL: ed@znfpc.org.zw  
WEBSITE: www.znfpc.org.zw

### Zimbabwe Youth Council

CONTACT PERSON: The Executive Director  
PHYSICAL ADDRESS: 6th Floor, Coal House, Corner Nelson Mandela and Park Street, Harare  
POSTAL ADDRESS: 6th Floor, Coal House, Corner Nelson Mandela and Park Street, Harare  
TELEPHONE NUMBER(S): 04 756177/88  
FAX NUMBER(S): N/A  
MOBILE NUMBER(S): N/A  
EMAIL: youthzim@gmail.com  
WEBSITE: www.zimbabweyouthcouncil.org  
FACEBOOK: www.facebook.com/pages/Zimbabwe-Youth-Council/145270898823238

### Ministry of Primary and Secondary and Education

CONTACT PERSON: Secretary for Primary and Secondary Education  
PHYSICAL ADDRESS: Ambassador House, 14th Floor, Union Avenue, Harare  
POSTAL ADDRESS: P. O. Box CY 121, Causeway, Harare  
TELEPHONE NUMBER(S): +263 4734071/4, 734051/9  
FAX NUMBER(S): +263 4734075  
MOBILE NUMBER(S): N/A  
EMAIL: info@moesac.gov.zw  
WEBSITE: www.mopse.gov.zw/

**National AIDS Council**

CONTACT PERSON: National Youth Coordinator  
PHYSICAL ADDRESS: 100 Central Avenue, Harare  
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MOBILE NUMBER(S): 0772381201  
EMAIL: bnyamwanza@nac.org.zw  
WEBSITE: www.nac.org.zw  
FACEBOOK: www.facebook.com/naczim

**Ministry of Youth, Indigenisation and Economic Empowerment**

CONTACT PERSON: Secretary for Youth, Indigenisation and Economic Empowerment  
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MOBILE NUMBER(S): N/A  
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**Ministry of Higher and Tertiary Education, Science and Technology Development**

CONTACT PERSON: Permanent Secretary  
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POSTAL ADDRESS: P. Bag CY 7732 Causeway  
TELEPHONE NUMBER(S): 263-4-795891-5, 796441-9, 730055-9  
FAX NUMBER(S): 263-4-792109, 728730, 703957  
MOBILE NUMBER(S): N/A  
EMAIL: thesecretary@mhet.ac.zw  
WEBSITE: www.mhet.ac.zw / www.mhet.gov

*You can visit your nearby clinics, hospitals and schools for support and more information on SRH. For further information, visit: [nyddb.zimbabweyouthcouncil.org/asrh/](http://nyddb.zimbabweyouthcouncil.org/asrh/)*

## List of participants who participated in the development process

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Freeman Sibanda	Head Office	
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### United Nation and other Development Partners

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Winnie Farao	CAMFED
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Talent Makoni	ADRA Zim
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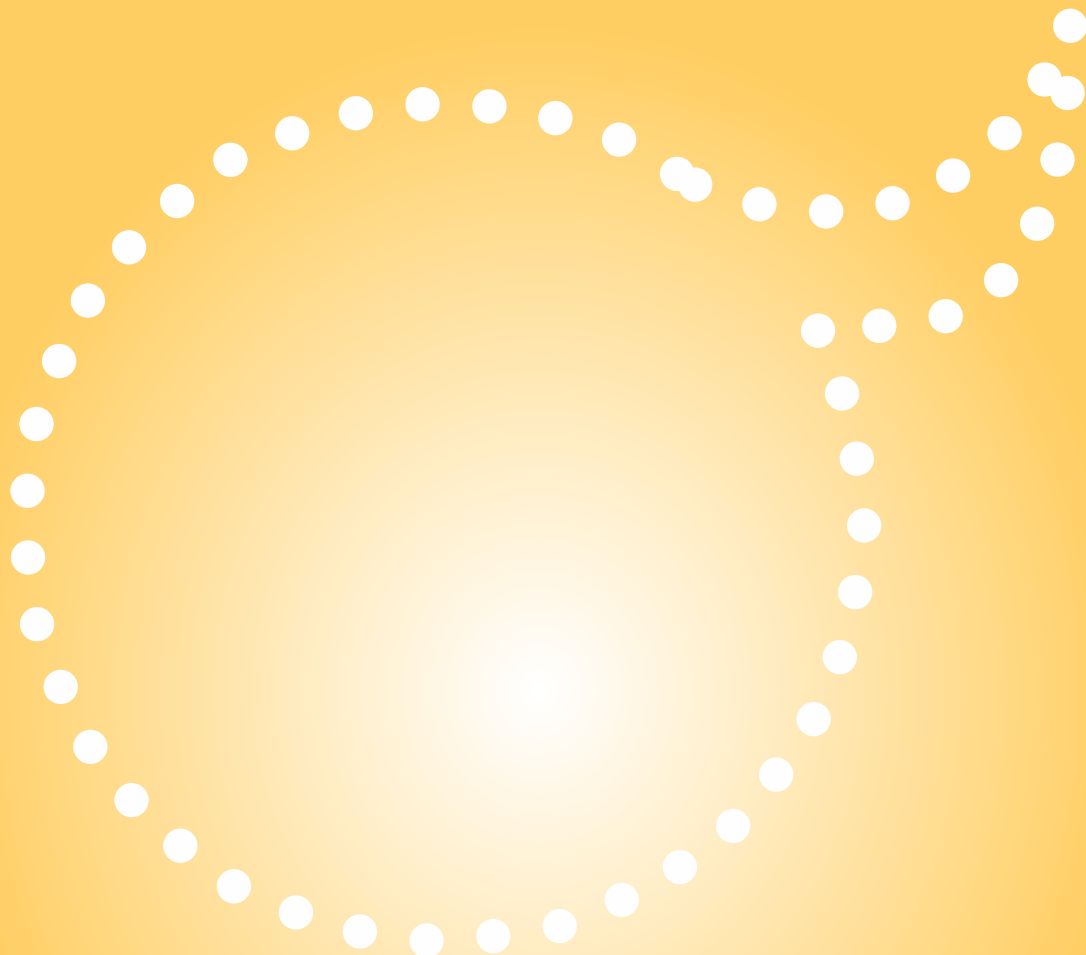
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Pyke Chari	Action IEHDC	Executive Director
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Wilbur Kandiero	Action IEHDC	Graphic Designer/Artist
Dr Karen Rayne	Founder Unhushed	Author, Speaker, Curriculum Writer, Sexuality Educator



## 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 Behavior Change
- EGPAF (2012) Addressing the Social and Behavioral Barriers to PMTCT of HIV Through Community Dialogue, An Implementer's Guide
- Plan International. Champions of Change Modules
- SAFAIDS Behavior Change Manuals for Adolescents
- Tuneme.org- Website resource for adolescents

The material in the manual was researched, updated and piloted by  
M-Care (t/a M-Consulting Group) under contract with UNFPA.  
Design and layout by The Hogo Studios



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Zimbabwe Community Health Intervention Research Project

