SAYWHAT COMPREHENSIVE SRH MANUAL

An Intergrated SRH, Gender and HIV & AIDS Manual

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SAYWHAT
Students and Youth Working on reproductive Health Action Team

Oxfam Australia

About the Students and Youth Working on reproductive Health Action Team (SAYWHAT)

SAYWHAT is an acronym for Students And Youth Working on reproductive Health Action Team. The Students And Youth Working on reproductive Health Action Team (SAYWHAT) is a student membership-based organization whose drive is to address the sexual and reproductive health (SRH) challenges of students in Zimbabwe's tertiary institutions through a rights-based approach.

SAYWHAT was founded by students in 2003 and registered as a trust in 2004. SAYWHAT seeks to provide a platform where students can discuss their SRH concerns and inform relevant advocacy issues. From 2003-2008 SAYWHAT was housed as a program under Community Working Group on Health (CWGH). In 2009 SAYWHAT began operating as a standalone organization guided by its own strategic plan. SAYWHAT envisions a gender-just nation with empowered, healthy and responsible students who enjoy their sexual reproductive health and rights in tertiary institutions. SAYWHAT's mission is to ensure students' participation in information/ knowledge sharing, support provision, networking and advocacy to promote sexual reproductive health and rights in tertiary institutions.

SAYWHAT works with other service providers that seek to mobilize students at Zimbabwe's institutions of higher learning to participate in the promotion of the global targets and goals for a better sexual and reproductive health. Through years of SRH programming, SAYWHAT acknowledges that there is need for increased awareness on issues affecting young people.

Acknowledgements

The students in Zimbabwean tertiary institutions requested for this manual that presents comprehensive information on sexual and reproductive health including HIV and gender. It is because of the their calling that this manual has been made possible.

SAYWHAT would like to thank its members of secretariat and the National Coordinating Committee (NCC) for the effort rendered in the different stages of developing this manual.

Many thanks goes to all those that contributed to the design, preparation, review and pilot testing of the manual with special mention going to Mr. Tayson Mudarikiri for editing the final draft.

At last, the successful outcome of this manual would have not been possible without the financial support from Oxfam Australia.

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Therapy
ARV	Anti Retroviral
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
FGD	Focus Group Discussions
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IUD	Intrauterine Device
MC	Male Circumcision
MTCT	Mother to Child Transmission
SAT	Southern African AIDS Trust
SAYWHAT	Students And Youths Working on reproductive Health Action Team
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infections
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
PEP	Post Exposure Prophylaxis
UNFPA	United Nations Population Fund
ZNFPC	Zimbabwe National Family Planning Council

Glossary

Youth/Student: is anyone who is between the ages of 17-35 years of age and enrolled at a tertiary institution in Zimbabwe (SAYWHAT defination)

Reproductive Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes

Sexual Health: are the behaviours and attitudes that make sexual relationships healthy and enjoyable

SRH Services: These include counselling and testing services, information (family planning, STI prevention and management including HIV), prevention and management of abortion and its complications, contraception, maternal and natal health services, sanitary wear Peer Education: process of undertaking formal or informal knowledge peers

Peer Education: Education whereby the teacher and learner belong to the same peer group. Student peer education empowers students and offers them the opportunity to participate in activities that affect themselves as well as to access information and services related to SRH that they need.

Peer Educator: Is a member of a peer group who takes on the role of teacher or educator. In this context students in tertiary institutions are peer educators.

Introduction to the Manual

Since its inception in 2003, SAYWHAT has trained peer educators to make a difference within their respective tertiary institutions. Sexual Reproductive Health (SRH) is a vast subject with a commensurate body of knowledge. As such institutions have found it challenging to fully equip volunteers with the information that they need. In response to this challenge trainers at SAYWHAT have provided large volumes of assorted texts to prepare and enable peer educators to carry out their work.

Although, largely owing to the ingenuity of trainers, this cumbersome approach has succeeded taking SAYWHAT to where it is today, this manual is set to make this work a lot easier.

The SAYWHAT Comprehensive SRH Manual is a custom made compilation of the existing knowledge on SRH adequately compiled for the needs of youth in Zimbabwe.

Although SAYWHAT, together with many of its partners, may boast of quantity and quality in output of trained peer educators over the years, the organization cannot claim to have standardized such trainings. It has been difficult to account for and track what each and every peer educator is knowledgable about in regards to SRH and its related themes.

This manual will ensure that all volunteers trained by SAYWHAT are provided with the comprehensive information they need regardless of where and when they are trained. In a world where standards are a measure of meaningful success in development interventions, this manual is a milestone in the training programmes of SAYWHAT.

This manual does not come with a training guide and therefore allows room for flexibiilty in training, execution and methodologies. The purpose of the manual is to compile comphrensive information on SRH in a single summarized format such that trainers can reference accurate and precise information in their trainings while using their preferred training methodology. It is noteable, however, that current SAYWHAT methodologies such as Stepping Stones and Aunty Stella have proven useful.

The “Campus Barometer” is one key feature of this manual which can assist with content delivery. The campus barometer serves to ground realities of the subject under discussion, prompting the peer educators to reflect on the challenges faced within their own colleges. The nuggets and facts provided under the campus barometer are based on research undertaken by SAYWHAT at tertiary institutions in Zimbabwe.

With comprehensive information and knowledge students will conquer the battle against SRH challenges!

MODULE ONE:

Sexual and Reproductive Health Rights

Module One: Sexual and Reproductive Health Rights

At the end of this module you should be able to understand:

1. **Definitions of sexual and reproductive health and rights**
2. **Components of sexual and reproductive health**
3. **The SRHR challenges that students and youths face**
4. **Sexual health and related rights**
5. **Reproductive health rights and the rights based approach to reproductive health**
6. **The major drivers of SRHR challenges for students**
7. **The rationale of addressing sexual and reproductive health for students in tertiary institutions**

Campus Barometer

Many students in Zimbabwean colleges face a lot of sexual and reproductive health challenges like unplanned pregnancies, sexual harassment, high rates of STIs and HIV infection because duty bearers do not recognize provision of relevant services to students to address these challenges as a human rights issue.

Introduction

Sexual and Reproductive Health Rights (SRHR) for students remain a priority for college authorities as duty bearers and the students as rights holders (See section on the Rights Based Approach in this module). Through promoting, protecting and fulfilling the students' sexual and reproductive health and rights their vulnerability is reduced. The respect of such SRH rights will ensure provision of essential services that allow for the treatment and management of STIs, prevention of unplanned pregnancies, and the provision of youth friendly SRH services. The rights-based approach offers effective management of sexual and reproductive health needs among students through support provision for treatment and care. The rights-based approach sanctions the necessity to meet the needs of students as an obligation not a privilege.

Towards Defining SRHR

Understanding SRHR requires clear definitions of its individual components – Sex, Sexuality, Sexual Health, Reproductive Health, Sexual Rights and Reproductive Health Rights.

Sex

Sex is the biological definition of an individual i.e. male or female. Sex identity is based on biological characteristics. At birth, boys and girls are identified by their physical anatomy. Boys are identified by a penis, and girls are identified by a vagina. The term sex is also often interchanged with sexual intercourse, the penetration of the penis into the vagina.

Sexuality

Is a total expression of who we are as human beings and encompasses our values, attitudes, behaviours, physical appearance, beliefs, and emotions. Sexuality begins before birth and lasts for an individual's lifetime. The major components of sexuality include sensuality, sexual identity, sexual intimacy, sexual reproduction and sexualisation. The expression of sexuality is influenced by ethical, spiritual, cultural and moral factors. It involves giving and receiving pleasure, as well as enabling reproduction. Sexuality has several component aspects:

Biological Aspects – these include anatomic and physiological 'givens' – the sex organs, hormones, nerves and brain centers. Biological aspects also encompass the concept of instinct, part of the larger reproductive instinct to mate and perpetuate the species.

Psychological Aspects (Body Image) – Sexuality involves gender identity as well as self image and body–image. Positive sexual self-concept is characterized by acceptance of, comfort with, and value of oneself as male and female. These attitudes towards self are informed through interactions with others, presenting less of a façade and more willing to share self, than those with poor self esteem.

Socio-Cultural Aspects – These aspects relate to the concept of gender and sexual identity. These are terms used to describe one's internal sense of masculinity or femininity: the awareness of 'I am male' or 'I am female'.

Sexual Patterns

Sexual patterns are preferences for sharing sexual expressions.

Types of sexual patterns:

Heterosexual – preferring sexual partners of the opposite sex.

Homosexual – preferring sexual partners of the same sex. The term gay is commonly used for men who prefer same sex partners, though it can refer to women as well. Lesbian is a more common term used to describe women who prefer same sex partners.

Bisexual- enjoying sexual partners of both sexes.

Asexual – having little or no sex drive. Though asexual persons are physically male or female neither sex stimulates them sexually. They have no desire for sex.

Celibacy- deliberately abstaining from sexual activity, a choice people make for a variety of reasons. For example, some people may choose celibacy due to certain religious beliefs.

Sexual health

- Sexual health refers to factors that enable individuals to enjoy and control their sexual and reproductive lives, including the quality of their sexual and close relationships.
- Sexual health aims at the enhancement of sexual life and personal relationship, and does not merely consist of counselling and care related to reproduction and sexually transmitted infections.
- It is protection from harmful practices and violence, control over sexual access, sexual enjoyment and useful information on sexuality.
- It represents an aspect of health that is somewhat more in clusive than reproductive health as it includes the enhancement of personal relations, respect for the security of the person and physical integrity of the human body as expressed in human rights documents, as well as the right to make decisions concerning sexuality and reproduction free of discrimination, coercion and violence.

Reproductive Health

- Is a state of physical, mental and social well being and not the mere absence of disease or infirmity in matters related to the reproductive system, its function and processes.
- It pertains to the health implications surrounding reproductive choices and behaviour. It encompasses issues of safe motherhood, maternal and child health, breastfeeding, contraception, sanitary wear and risks of STIs including HIV infections.

REPRODUCTIVE HEALTH ELEMENTS

- **Family Planning (family planning services, counselling, information and education)**
- **Maternal and Child Health and Nutrition (prenatal, safe delivery, postnatal care)**
- **Prevention and management of abortion and its complications**
- **Prevention and management of Reproductive Tract Infections and Sexually Transmitted Infections**
- **Education and Counselling on Sexuality and Sexual Health (Discouragement of Female Genital Mutilation)**
- **Breast and Reproductive Tract Cancers and other Gynaecological Conditions**
- **Men's Reproductive Health**
- **Adolescence and Youth Health (Special attention to certain populations at higher risk or need, such as adolescence, refugees or displaced people, disabled, commercial sex workers)**
- **Violence Against Women and children and effective counselling and treatment**
- **Prevention and treatment of infertility and sexual dysfunction**
- **Gender Based Violence**

REPRODUCTIVE HEALTH RIGHTS WILL GUARANTEE THE FOLLOWING:

- **Satisfying and safe sex life**
- **The ability to have children and the freedom to decide if, when and how often to do so**
- **The right of women and men to be informed and to make choices about their sexuality**
- **The ability to decide when and with whom to have sex**
- **Access to effective methods of protection against HIV infection and pregnancy**
- **Access to services for family planning, treatment of infertility, obstetrics and the prevention and treatment of reproductive tract infections**

Why Address Sexual Health for Students in Tertiary Institutions?

Sexuality has a major influence on what it means to be 'reproductively healthy' and thus should be an integral aspect of reproductive health care for all students. The importance of addressing sexuality has been brought to attention due to the great vulnerability students experience in the face of the HIV pandemic. Through addressing HIV/AIDS in tertiary institutions we have been confronted with the need to address students' sexuality. It is clear that STIs such as HIV cannot be effectively addressed without addressing sexuality in a frank and direct way.

Major Drivers of SRHR Challenges among the Students and Youth Population

Factors that contribute to the prevalence of SRHR problems (cited in Barometer box to the left) include:

- Inadequate access to family planning services, including contraceptives and information
- Abuse of drugs and alcohol
- Inadequate recreational facilities
- Economic hardships
- Abuse of independence and absence of parental guidance
- Negative peer pressure

Reproductive Rights

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

Linked to these are **Sexual rights** which include the human rights of women and men to have control over and decide freely and responsibly on matters related to their sexuality.

CAMPUS BAROMETER: MAJOR SRH CHALLENGES THAT STUDENTS FACE IN COLLEGES

- **Unwanted/Unplanned pregnancies**
- **Illegal abortions**
- **STIs, including HIV**
- **Lack of Access to a wide range of contraception**
- **Limited Access to Antiretroviral Therapy (ART)**
- **Expensive and Inaccessible Sanitary Wear**
- **Lack of Information on SRHR issues**
- **Gender Based Violence and Sexual Harassment**

Reproductive Rights embrace certain human rights recognized in national and international legal and human rights documents. These rights include the right listed in the box below.

Sexual and Reproductive Rights

- **The right of couples and individuals to decide freely and responsibly the number and spacing of their children, and to have information and means to do so**
- **The right to attain the highest standard of sexual and reproductive health**
- **The right to control their fertility**
- **The right to self protection and to be protected against sexually transmitted infections, including HIV**
- **The right to be informed on one's health status and on the health status of one's partner, particularly if infected with STIs, including HIV, in accordance with internationally recognized standards and best practices**
- **The right to have family planning education**
- **The right to make decisions free of discrimination, coercion or violence**
- **The same right of men and women to marry only with their free and full consent**
- **Right to freedom from discrimination (on the basis of sex, gender, marital status, age, race and ethnicity, health status/disability)**
- **Right to freedom from violence against women**
- **The right to choose a sexual partner**
- **The right to decide to be sexually active or not**
- **The right to pursue a satisfying, safe and pleasurable sexual life**
- **The right to seek, receive and impart information related to sexuality**

It is important to note that different countries may put legal limitations to some of these reproductive health rights due to their socio-cultural context/beliefs. For example in Zimbabwe the right to abortion is limited to rape survivors and in cases where the health of a mother is threatened by the pregnancy. Similarly, homosexuality is a crime. In some countries some socio-economic and cultural rights have not been enshrined in the constitutions. This condition makes it difficult for citizens to demand sexual and reproductive health as a right and for such demands to be litigated in a court of law.

The Rights-Based Approach

The Rights-Based Approach is a framework that integrates the norms, principles, standards and goals of the international human rights system into the plans and processes of development.

SOME INTERNATIONAL INSTRUMENTS THAT ENSHRINE SRHR AND WIDER RIGHTS TO EQUALITY, HEALTH, LIFE AND DIGNITY:

International Conference on Population and Development (ICPD) and Programme of Action, 1994 (often known as the Cairo Declaration) - The ICPD PoA was the first and most comprehensive international document to embody concepts of reproductive and sexual health and rights as cornerstone in the enjoyment of basic human rights.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979 - CEDAW is a binding treaty so any countries that have signed up to it are committed to ensure respect for women's and girls' human rights and fundamental freedoms. Although none of these specifically address HIV positive women, HIV positive women have the right not to be discriminated against and therefore are entitled to all the rights that their government has signed up to.

United Nations Special Session on HIV/AIDS: Keeping the Promise: Declaration of Commitment on HIV/AIDS, 2001 (often known as UNGASS) - UNGASS recognizes the importance of empowering women, PMTCT, VCT, the rights of women and sexual and reproductive health, and female controlled methods such as microbicides and the female condom

Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA) Principle, 1994 - The Paris Declaration that outlines the GIPA principle upholds the rights to inclusion and strengthening of organizations of people living with HIV in all decision-making processes that affect their lives.

The international instruments cited above, together with national constitutions and legal provisions, are important in the sense that they prescribe rights to individuals relating to their sexual and reproductive health. The concept of a rights based approach prescribes that there are Duty-Bearers and Rights Holders.

DUTY-BEARERS	A RIGHTS HOLDER
• Respect Rights • Refrain from interfering or violating an individual's ability to enjoy a right • Protect Rights Taking specific measures to prevent violation of people's rights • Fulfill Rights Taking all necessary proactive steps including legislative, budgetary and/or judicial measures towards the full realization and safe enjoyment of the right	• Is entitled to rights • Is entitled to claim rights • Is entitled to hold the duty-bearer accountable • Has a responsibility to respect other rights holders

To ensure that students fully enjoy their sexual and reproductive health there must be "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes". Students should be able to enjoy a satisfying and safe sex life, have the capability to reproduce and the freedom to decide if, when and how often to do so. This requires informed choice and access to safe, effective, affordable and acceptable health-care services.
Effects of ignoring reproductive health concerns include death and disability related to pregnancy and childbirth, sexually transmitted infections, HIV and AIDS, and reproductive tract cancers.

Linking SRH & Rights

SRH was recognized as a human right at the International Conference on Population and Development in 1994. It has since been identified as fundamental to individuals, couples and families and also for social and economic development of communities and nations.

The right to SRH is central to addressing discrimination, gender inequality, HIV/AIDS and poverty. Many of the obstacles to SRH result from failure to uphold rights, including:

- Community based stigma and discrimination
- Gender based norms and attitudes
- Inadequate health and education systems
- Limited access to quality services

Historical, cultural and religious backgrounds have a bearing on SRH.

NECESSARY STEPS IN ADVANCING RIGHTS IN SRH	CHALLENGES IN SRH & RIGHTS
• **Empower women, men and youth to make SRH decisions, free from discrimination, coercion and violence**	• **Inadequate funding for SRH programming and services due to competing priorities**
• **Address gender based violence and ensure there are sensitive and compassionate services and support available**	• **Limited capacity for programmes (including human resources)**
• **Ensure youth are able to receive comprehensive information on sexual and Reproductive**	• **Multiple organizations with poor coordination of efforts**
• **Health including rights**	• **Limited participation of young people particularly young women**
• **Ensure SRH services are not discriminatory and are available and accessible to all people**	• **Lack of sustainability of youth programmes and interventions**
	• **Inadequate review of policies and law – not recognizing SRH as a human rights issue**

RESOURCES

- Sexual and reproductive health and rights, by the International Community of Women Living with HIV/AIDS (ICW) and the Global Coalition on Women and AIDS (GCWA)
- Youth Sexuality and Reproductive Health, A review of literature and youth programmes in Zimbabwe, ZNFPC, 1995.
- Sexuality and Sexual Health, Online Course Module, Engender Health
- Training Manual on Sexual Reproductive Health and Rights and HIV Prevention for Medical Students in Nigeria: University of Ibadan, College of Medicine and UNFPA, 2007
- SAT Training Manual Mainstreaming Gender in HIV and AIDS Work
- The ICDP program of action

MODULE TWO:

Basic Facts on HIV & AIDS

Module Two: Basic Facts on HIV and AIDS

BY THE END OF THIS MODULE YOU SHOULD BE ABLE TO UNDERSTAND:

1. Definitions and key facts on HIV and AIDS
2. How HIV is transmitted
3. Prevention of HIV transmission
4. HIV trends and impact within the country and Zimbabwean tertiary institutions
5. Management of HIV and AIDS

Introduction

The HIV and AIDS pandemic has impacted heavily on young people. Young people aged between 15 and 24 account for 40% of all new HIV infections. About 7,000 young people aged 10 to 24 are infected with HIV every day that is five young people every minute. Every year, about 1.7 million young people in Africa are infected with HIV. Focusing on young people is investing in responses that can curb almost half of the pandemic's impact. In Zimbabwe alone HIV prevalence for those aged between 15 and 24 is at 3.5% for males and 7.5% for females. As students constitutes a significant proportion of the youth, HIV and AIDS impacts on their lives in many ways:

- It increases illness and death
- Lowers life expectancy
- Puts strain on health systems and college budgets
- Reduces attendance and also
- Fuels stigma and discrimination

HIV CAMPUS BAROMETER

HIV Campus Barometer Some of the major Drivers of HIV on Campus are:

- **Age Mixing**
- **Multiple and Concurrent Partnerships**
- **Poverty resulting in transactional sex**
- **High mobility**
- **Low levels of circumcision**
- **Peer pressure, drug and substance abuse**
- **Incorrect and inconsistent use of condoms**

KEY DEFINITIONS AND QUICK FACTS ON HIV AND AIDS

- **HIV is an abbreviation for Human Immunodeficiency Virus. It is the virus that causes AIDS. As with other viruses HIV needs living cells in human beings to replicate. HIV attacks the CD4 cells which are responsible for regulating and coordinating the immune system**
- **AIDS refers to Acquired Immune Deficiency Syndrome which is the last stage of HIV progression. AIDS is a condition of immune deficiency/insufficiency which makes an individual prone to opportunistic infections that takes advantage of the weakened immune system**
- **To know one`s HIV status a clinical HIV test has to be conducted You cannot tell whether someone has HIV by merely looking at them**
- **HIV infection does not mean that one has AIDS, some people with HIV may not develop any AIDS related symptoms for a very long time**

HIV Transmission

- One can contract HIV through blood, body fluids like semen (sperm) or vaginal fluids and breast milk
- During unprotected sexual intercourse with an infected person, HIV can enter a person's bloodstream through the vagina, penis or anus
- The most common means of transmission in Southern Africa and in Zimbabwe are unprotected heterosexual intercourse 92% (Sex between a man and a woman without a condom) and mother to child transmission 7%
- The overall risk of mother-to-child transmission of HIV is about 15 to 25% among seropositive women who do not breastfeed, and between 25 to 45 % among HIV positive women who breastfeed. The risk of transmission is increased if the mother has recently been infected or is already at the AIDS stage
- Casual contact and interaction in public places such as college campus or workplaces, kissing, hugging, toilet seats, mosquitoes and other insect bites, sharing utensils, clothes, tears, and sweat cannot spread HIV

How Can You Prevent HIV?

1. **Changing sexual behaviour** – since HIV is mainly passed on through unprotected sexual intercourse with an infected partner, changing one's sexual behaviour is central in preventing HIV infection. Examples include:

- Abstaining from sex
- Delaying sexual debut, as individuals who indulge in sexual intercourse at an older age (above 23)are most likely to make informed safer sexual choices
- Having one faithful and regularly tested sexual partner
- Using of a condom correctly each time you have sex (either male or female)
- Have non-penetrative sex such as thigh sex, caressing, kissing, massaging and masturbation

Evidence of Behaviour Change (BC) in Prevalence Reduction

Oral sex may be risky if there is an exchange of blood from an HIV-positive person to his or her partner. The virus might enter through damaged skin or mucous membranes around the mouth, bleeding gums or mouth ulcers. Risk is also increased if a man ejaculates in his partner's mouth. Other infections like herpes can also be passed through oral sex.

2. **Treating sexually transmitted infections** – people with ulcerative STIs are at high risk of infection during sex, treating STIs can help prevent HIV infection.

Some STIs like syphilis and chancroid cause sores, which are openings on the skin in and around the genitals. These sores make it easier for HIV to get into the body. Thus, early diagnosis and effective treatment of STIs are an important strategy for preventing HIV transmission.

3. **Taking Post Exposure Prophylaxis (PEP)**

What is PEP?

Post Exposure Prophylaxis (PEP) refers to methods of preventing HIV infection after being exposed to HIV through accidents, rape or any risky event

Quick Facts about PEP

- **It is a short antiretroviral course that is taken for a full month**
- **Report to your nearest health centre (clinic or hospital) as soon as you are exposed**
- **It should be taken within 72 hours of risky exposure. Preferably, PEP must be taken in the first 24 hours of exposure to HIV. The earlier the PEP is taken the more effective it is**
- **PEP can be over 80% effective in preventing HIV infection**
- **You need to prove that you have been put at risk of HIV infection through accidents and or rape. In cases of rape a police report can help however, a police report must not delay rape survivor's access to PEP**

4. **Prevention of mother to child transmission of HIV**
   HIV can pass from the mother to her unborn baby during pregnancy, delivery and can be transmitted to the baby by the mother's breast milk. This is usually called mother to child transmission of HIV (MTCT).

If a pregnant woman does have HIV the doctor assesses if there is need for her to be administered on ART. If she is put on ART it reduces chances of mother to child transmission. In the case of ART not being administered for the mother, ARVs (Nevirapine) will be administered to prevent transmission from the mother to the child. Once the baby is born, the mother needs to consider if replacement feeding—such as using mothers' milk substitutes—is a safe, feasible and an acceptable long term option for her and

the family. If it is not, she needs to exclusively breastfeed the baby until replacement feeding becomes possible. All mothers need access to accurate information, support and counselling when making these choices.

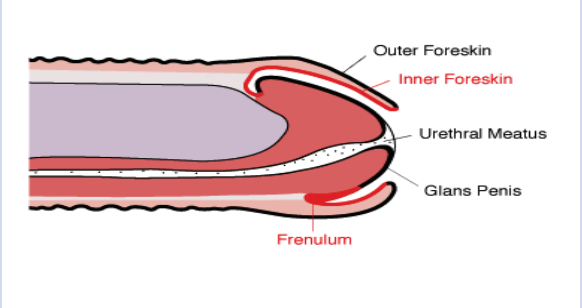
The ARV regimens used to prevent transmission usually contain nevirapine or zidovudine (often know as AZT). Using nevirapine alone is the most usual option for women who come late to pregnancy care, but is not the best option for preventing transmission. In most high income countries the rate of mother to child transmission of HIV has been reduced to less than 1% by using a range of medicines and good care for the mother during pregnancy. HIV positive women intending to get pregnant are advised to do so in consultation with a health care provider in order to reduce the likelihood of the baby becoming infected. Antiretroviral drugs should only be taken under medical supervision.

5. **Using 'universal precautions'** – Universal precautions involve safe practices such as wearing latex gloves when touching blood or body fluids, covering open wounds, cleaning up blood with bleach, and throwing away clothes soaked with blood or body fluids for those caring for AIDS patients.
6. **Male Circumcision** - Male circumcision (MC) which is the surgical removal of the foreskin has recently been identified as a prevention strategy. It reduces men's chances of contracting HIV by 60%.

Biological Explanation: How the foreskin increases infection risk

Diagram below illustrates how the foreskin increases the risk of contracting HIV among men:

Thinly keratinized mucosal layer of inner foreskin is susceptible to minor trauma and abrasion therefore can facilitate entry of pathogens



Area under foreskin is warm, moist environment, suitable for pathogen replication
McCoombe & Short, AIDS 2006 20:1491-1495

Additional Reasons

- More HIV targeted cells (Langerhans and other receptor cells) are more numerous in the foreskin than else where in the human body
- Lack of keratinisation (hardening) of inside mucosal layer of foreskin allows for minor bruises and trauma which facilitates HIV entry
- In-vitro evidence shows foreskin absorbs HIV 9 times more easily than other genital mucosa

HIV Testing
Finding out One's Status

- You cannot find out one's status by merely looking at them. A student or any other person living with HIV might not necessarily present AIDS related symptoms.

- In about a few weeks after infection, the body of an individual with HIV starts producing antibodies. Antibodies are made by an individual's immune system to respond to infection. However, HIV antibodies are not able to fight off the virus. As a result HIV starts to slowly destroy an individual's immune system. Over the years, due to compromised immune system, a person may develop AIDS starting with mild illnesses like skin conditions, then more serious illnesses like TB, thrash etc.
- In Zimbabwe, the common testing procedure establishes the presence of HIV antibodies in a person's blood. If such antibodies are found in a person's blood, it means the individual is HIV positive. HIV positive means an individual has the virus that causes AIDS. If no HIV antibodies are found, the person is considered to be HIV negative. This can be due to different reasons:

1. That the person does not have the virus that causes AIDS in their body at all
2. That the person is currently within the window period - a time when an individual's body has not made enough HIV antibodies for the standard HIV test to detect. The standard window period time ranges from 3weeks to 3 months from the time of infection.

Fact: It is important to note that a person on window period can test HIV negative because the antibodies are not enough to be detectable. However, such a person can pass on HIV – they are actually highly transmissive in this period because HIV will be multiplying faster and the viral load is high.

Counselling and Testing in Zimbabwe is offered in most private and public hospitals including New Start Centers across the country. The service is offered on both provider initiated and voluntary basis.

AIDS

WHO DEFINITION OF AIDS - LISTS THREE MAJOR SIGNS OF AIDS:

- **Severe weight loss – in the early days before science detected AIDS people living with HIV were referred to as having the 'Slimming Disease'**
- **Incessant, bad diarrhoea that goes on for a month or longer**
- **Ongoing fever**

Minor signs include illnesses like cancer, brain infections, bad pneumonia and severe skin rashes.

WHO submits that a doctor should diagnose a person with AIDS if:

- **He/ she tests HIV positive, and**
- **Has one or more of the illnesses and signs common to AIDS**

In cases where HIV testing is unavailable, WHO recommends that AIDS be diagnosed if:

- **2 of the three major signs are present; and**
- **1 of the minor signs of AIDS is present**

HIV PROGESSION

Stage	Explanation
HIV infection	This stage is the starting point where the person gets the virus through sex, blood contact etc.
Window period which ranges from about three weeks to three months	Usually Asymptomatic. At this stage HIV might not be detected using the anti-bodies test
Sero-conversion is a brief period that occurs after two - six weeks and up to a few months	This stage is also called the acute HIV stage as it is synonymous with rapid production of the antibodies and sometimes it is accompanied by flu-like illness.
Asymptomatic HIV which lasts from less than a year to about 10 -15 years	Antibody tests are beginning to show results but there are no apparent symptoms or illness. This is usually referred to as the incubation period.
HIV/AIDS related illness	The intensity of the opportunistic infections increases and they tend to be recurrent and persistent
AIDS	Life threatening illnesses develop and usually the patient dies if the opportunistic infection has become untreatable

In Zimbabwe, a CD4 cell count is done to establish whether an HIV positive individual has developed AIDS. If a person has a CD4 cell count lower than 300, this may be a sign that the person has AIDS. A CD4 count is a test that measures the strength of the immune system.

HIV prevalence indicates the number of people living with HIV in a given population at a given time. **HIV incidence** is the rate at which new HIV infections occur within a population in a specified period of time.

Treatment of HIV and AIDS

HIV cannot be cured although it can be treated. AIDS care and treatment involves:

- Positive Living – nutrition and basic hygiene, disclosure and support mechanisms
- Providing counselling and support
- Using medicines to prevent and treat common infections
- Taking anti-retroviral treatment

For more information on positive living you can refer to the SAYWHAT Positive Living Toolkit

What is HIV Antiretroviral Treatment?

Antiretroviral treatment is the main and commonly known type of treatment for HIV positive individuals. Although it's not a cure, it can stop people from becoming ill for many years. The treatment consists of drugs that have to be taken every day for the rest of a person's life. These drugs are known as antiretrovirals (ARVs). ARVs inhibit the replication of HIV. When antiretroviral drugs are given in combination, HIV replication and immune deterioration can be delayed, and survival and quality of life is improved.

Why is Treatment Important?

Effective HIV/AIDS management requires antiretroviral therapy as a treatment option. Access to antiretroviral therapy ensures that people living with HIV attain the fullest possible physical and mental health for an effective response to the pandemic. ARVs ensure that individuals living with HIV live longer productive lives and reduce stigma and discrimination against people living with HIV and AIDS.

ARV Access Campus Barometer

Many students in Zimbabwe do not have access to ARVs due to some of the following reasons

- **High costs of purchasing drugs**
- **In cases where drugs are provided free of charge in the public hospitals, there are always some hidden costs like transport to hospital, pre ARV commencement tests and proper food costs which students usually find unaffordable**
- **Stigma and discrimination at campus where students feel that others may know and discriminate against them once they find out that they are on ARVs**
- **Limited knowledge and rampant myths about ARVs**

Some Facts on ARVs

- Taking two or more antiretroviral drugs at a time is called combination therapy
- Taking a combination of three or more antiretroviral drugs is sometimes referred to as Highly Active Antiretroviral Therapy (HAART)
- Taking one drug has high chances of developing drug resistance
- Taking two or more antiretroviral drugs at the same time reduces the rate at which resistance would develop, making treatment more effective in the long term

There are more than 20 approved antiretroviral drugs but not all are licensed or available in Zimbabwe.

The choice of drugs to take can depend on a number of factors, including the availability and price of drugs, the number of pills, the side effects of the drugs, the laboratory monitoring requirements and whether there are co-blister packs or fixed dose combinations available. Most people living with HIV in the developing world, including Zimbabwe, still have very limited access to antiretroviral treatment and often only receive treatment for the opportunistic infections that occur as a result of a weakened immune system. Such treatment has only short-term benefits because it does not address the underlying immune deficiency itself.

First and Second Line Therapy

At the beginning of treatment, the combination of drugs that a person is given is called first line therapy. If after a while HIV becomes resistant to this combination, or if side effects are particularly bad, then a change to second line therapy is usually recommended.

Second line therapy will ideally include a minimum of three new drugs, with at least one from a new class, in order to increase the likelihood of treatment success.

Major Considerations Before Administering ARVs

The following considerations must be made before administering ARVs to an individual who is HIV positive:

- HIV counselling and testing and follow-up counselling services to ensure psychological preparedness and adherence to treatment
- Capacity to appropriately manage HIV related illness and opportunistic infections
- A laboratory that provides tests for monitoring treatment
- A continuous supply of antiretroviral drugs and medicines for the treatment of opportunistic infections and other HIV related illnesses
- Need for adequately trained doctors, clinical officers, nurses, laboratory technicians, pharmacists and counsellors

The Groups of Antiretroviral drugs

There are currently five groups of antiretroviral drugs. Each of these groups have a different effect on HIV.

Antiretroviral drug class	Abbreviations	First approved to treat HIV	How they attack HIV
Nucleoside/Nucleotide Reverse Transcriptase Inhibitors	NRTIs, nucleoside analogues, nukes	1987	NRTIs interfere with the action of an HIV protein called reverse transcriptase, which the virus needs to make new copies of itself.
Non-Nucleoside Reverse Transcriptase Inhibitors	NNRTIs, non-nucleosides, non-nukes	1997	NNRTIs also stop HIV from replicating within cells by inhibiting the reverse transcriptase protein
Protease Inhibitors	PIs	1995	PIs inhibit protease, which is another protein involved in the HIV replication process.
Fusion or Entry Inhibitors	F20	2003	Fusion or entry inhibitors prevent HIV from binding to or entering human immune cells
Integrase Inhibitors		2007	Integrase inhibitors interfere with the integrase enzyme, which HIV needs to insert its genetic material into human cells.

NRTIs and NNRTIs are available in most countries. Fusion/entry inhibitors and integrase inhibitors are usually only available in resource-rich countries.

Protease inhibitors are generally less suitable for starting treatment in poor communities due to the cost, number of pills which need to be taken, and the particular side effects caused by protease drugs.

The most common drug combination given to those beginning treatment consists of two NRTIs combined with either an NNRTI or a "boosted" protease inhibitor. Ritonavir (in small doses) is most commonly used as the booster: it enhances the effects of other protease inhibitors so they can be given in lower doses. An example of a common antiretroviral combination is the two NRTIs zidovudine and lamivudine, combined with the NNRTI efavirenz.

HIV and AIDS on Zimbabwean Campuses: What is the Impact?

According to research by SAYWHAT, HIV remains a silent epidemic in tertiary institutions as disclosure and personalization of risk perception remains low. There is sigma towards HIV and most students prefer to live in denial allowing HIV infections to spread amongst some who could have prevented it. The economic hardships and limited government support has left most female students vulnerable to intergenerational, transactional as well as multiple concurrent relationships as a way of survival and meeting their material needs. At the same time, female students tend to have other relationships with male students of their age which are ideal for future marriage. These relationships remain key drivers of HIV.

With access to VCT remaining low in institutions and availability of treatment, support mechanisms and policies non-existent, there are few incentives for students to get tested and know their status. This situation has resulted in the manifestation of AIDS soon after graduating for most students, robbing the country of the needed personnel to propel development.

Orphaned students with no support are also found trapped in the cycle of poverty as they find it difficult to sustain life at college. Most end up in relationships where their sexual right to negotiate for safer sex is compromised because of money and power making them more vulnerable to HIV.

The education sector itself has been facing challenges with lecturers missing classes or dying due to illnesses related to HIV.

In some institutions, HIV education has been prioritized as a response to the HIV epidemic. In such institutions, students are empowered to know how to reduce their risk of contracting HIV as well as how to manage HIV. Such efforts, however, remain challenged by lack of commitment on the part of both the lecturers and the students. In most institutions HIV and AIDS are not examined at all, and where it is examined, the students learn for the purpose of passing exams and very little behaviour change is realized.

Stigma and Discrimination

Fears about family rejection, loss of job, and public shunning impede the effectiveness of HIV and AIDS prevention and care efforts. Stigma and discrimination discourage those who are infected with and affected by HIV and AIDS from seeking needed services because seeking services may reveal their HIV status to their families, workplace colleagues, or community. Ideas about the lifestyles of people living with HIV and AIDS contribute to a sense that HIV and AIDS are problems that affect "others," which may undermine individuals' estimation of their own risk and reduce their motivation to take preventive measures.

Stigma is a perceived negative attribute or attitude that causes someone to devalue or think less of the whole person.

Discrimination refers to the treatment taken toward or against a person of a certain group in consideration based solely status class or category. It involves excluding or restricting members of one group from opportunities that are available to other groups

RESOURCES

HIV and AIDS & Human Rights in Southern Africa: an advocacy Resource Manual by ARASA, 2006.

http://www.avert.org/treatment.htm
http://www.who.int/hiv/topics/arv/en/
http://www.popcouncil.org/hivaids/stigma.html

MODULE THREE:

Gender and SRHR

Module Three: Gender and SRHR

AT THE END OF THIS MODULE YOU WILL BE ABLE TO UNDERSTAND:

1. The definition of gender
2. To differentiate gender from sex
3. How gender imbalances affects access to SRH
4. Impact of gender roles on student's SRHR
5. How to define gender based violence and understand policies and laws that address gender based violence

Introduction

Gender has a bearing on the enjoyment of Sexual and Reproductive Health (SRH) of students in the tertiary institutions. Gender issues have a direct relationship with access to SRH services. Without integrating gender in SRH programing, not much can be achieved in promoting SRH because of the intricate relationship that exists between gender and sexuality.

Gender issues that require focus in tertiary institutions include:

- Acknowledging the disparity of how SRH challenges impact on male and female students
- The empowerment of young women to become assertive and be able to utilize SRH services including safer sex
- Addressing issues of masculinity and how they influence negative behaviours in accessing SRH services
- Ensuring that male and female students actively participate in SRH programing and have equal access to SRH services that meets their needs

Key Points on Gender

- Gender refers to socially ascribed values, norms and opportunities given to men and women, which might change over time, vary within and between cultures. These differences also vary over political and economic settings, and help to determine access to rights, resources and opportunities. Gender constructs often denote unequal power relations (social, economic or political) between men and women
- Gender influences the social, economic and political factors that drive the HIV and AIDS epidemic and many other SRHR challenges
- Gender is often interchanged for 'sex' which refers to biological and physical differences between men and women

Separating Gender from Sex

Sex is the biological definition of an individual i.e. male or female. Sex identity is based on biological characteristics. At birth, boys are identified by their biological make-up like the penis and girls are identified by a vagina.

Gender is the socially constructed roles and responsibilities of men and women within a given culture or location. Gender roles and norms are learnt and can be changed

The table 1 below explores the differences between sex and gender:
Table 1: Sex Vs Gender

Sex	Gender
Biologically defined (e.g. Penis & Vagina)	Socially constructed and learnt
Universal (All women have lactating breasts & all men produce sperms)	Differs within and between cultures
Permanent (one can be a man or woman for the rest of their lives)	Dynamic, changes over time, influenced by a wide range of socio-cultural factors

Gender is a culture-specific construct. There are significant differences in what women and men can or cannot do in one society when compared to another.
Gender Identity - the inner sense of maleness or femaleness.

Sexuality

Sexuality is different from gender, yet linked to it. Sexuality refers to how individuals experience and express themselves as sexual beings.

The following aspects of sexuality should be considered:

- Sexuality is more than sexual behaviour. It is a multidimensional and dynamic concept. An individual's sexuality is influenced by explicit and implicit rules imposed by society. These vary according to gender, age, economic status, ethnicity, religion and education.
- Power has been fundamental to both sexuality and gender. The power underlying any sexual interaction, heterosexual or homosexual, determines how sexuality is expressed and experienced. Power determines whose pleasure is given priority and when, how and with whom sex takes place.
- The power balance in gender relations is unequal in that it favours men. This translates into unequal balance of power in heterosexual interactions. Male pleasure has priority over female pleasure, and men have greater control over when and how sex takes place than women. An understanding of male and female sexual behaviour requires an awareness of how gender and sexuality are constructed through a complex interplay of social, cultural and economic forces that affect the distribution of power

The concepts highlighted above are important in the discussions of HIV and AIDS. Most HIV infections are transmitted through sexual intercourse, and heterosexual intercourse accounts for the largest proportion. Gender and sexuality are, therefore, significant factors in determining the spread of HIV. Gender also has influence on the availability, access and quality of treatment, care and support. In any analysis of the HIV and AIDS situation in Southern Africa, it is crucial to consider gender issues.

Impact of Gender Roles on Students' SRHR

A gender role is defined as a set of perceived behavioural norms associated particularly with males or females, in a given social group or system.
Gender roles have a bearing on the sexual behaviour that young people will display later in their lives. It has been observed that most male students are reluctant to seek medical attention unlike their female counterparts because they have been oriented to believe that to be a real man one should not succumb to pain. This behaviour has resulted in late treatment of STIs among male students. In some cases masculinity has influenced male students to think that they are supposed to have multiple and concurrent sexual partners to measure up to societal expectations. Some gender roles of woman on the other hand have made them succumb to the violation of their sexual and reproductive health rights. The culture of being silent on issues of sexuality make female students unable to negotiate for safer sex.

Negative Implications of Gender Roles Include:

- Power imbalance between males and females in favour of men – predispose female students to SRHR challenges such as STIs, unplanned pregnancy etc., since they cannot negotiate for safer sex
- Premarital intercourse is not regarded as an issue among young males which increases their risk of contracting HIV
- The gender role of providing care for the child affects female students in their academic commitments especially in agricultural colleges whose practical learning might not be suitable for pregnant or lactating individuals
- Society perceives men as initiators of sex and this gives them more control over sex including condom negotiation and use

Gender Related Pre-Disposing Factors to HIV:

1. The lack of economic empowerment increases vulnerability of female students. To ensure their welfare some female students resort to transactional and intergenerational sex
2. In most cases the burden of caring for HIV positive family members is the responsibility of females, young women in particular.
3. Intergenerational sexual relationships subordinate female students to older or rich men, increasing female students' vulnerability as they do not have control over their sexuality
4. 'Masculine' practices increase the vulnerability of male students as they engage in behaviours that they think are 'macho'
5. Non-health seeking behaviour and attitudes discourage and delay male students from seeking treatment of STIs from the clinics and hospitals
6. Limited participation of male students in gender activities results in limited knowledge around SRH and gender issues including knowledge of services
7. Low risk perception among male students contributes to their engagement in risky behaviour

FACTS ABOUT HIV, Sex, and Gender

- Female students are 2-4 times more susceptible to HIV infection because they have a larger exposed mucosal area. Younger females are particularly vulnerable as an immature mucosal surface is more liable to tearing. In addition, semen has a high concentration of HIV and stays in the vagina for a long time
- In Sub-Saharan Africa, girls in the 15-19 age group are 5-6 times more likely to be infected than boys of the same age
- Society has kept girls and women ignorant of sexual matters rendering them less able to protect themselves against HIV
- For HIV-positive female students, childbirth without access to treatment increases the risk of fast progression to AIDS
- 60% of people living with HIV in Southern Africa are women
- HIV prevalence for ages 15 to 24 are 7.5 % in women whilst only 3.5% in men

Some Important Considerations on Gender and SRHR

- There is disparity in morbidity and mortality due to SRH conditions/problems with women bearing much of the burden
- Physical violence is reported by 29% of young women aged 15-19 yrs, increasing their vulnerability to sexual abuse
- About 23% of young women aged 15-19 yrs experienced forced first sexual encounter
- Review and amendments to laws is needed to protect the rights of women and girls
- Involvement of male students in gender activities is critical for sharing responsibilities of SRH related challenges

In light of the above considerations, **gender equality** is crucial for women to make decisions affecting their health.

Gender equality is a social order in which women and men share the same opportunities and the same constraints on full participation in both the economic and the domestic realm.
Gender Equity refers to fairness, thus recognizes and accommodates difference in prevention of the continuation of an inequitable status quo.

In tertiary institutions, a gender equality approach will ensure that both male and female students have a fair share of the benefits and responsibilities, as well as equal treatment before the institutional regulations and laws, and equal access to services including sexual and reproductive health services.

Conclusion

There is a gender dimension to the SRHR debate. Women bear the brunt of SRHR challenges due to several biological, social, economic and cultural factors. Gender considerations are an important entry point to successfully addressing SRHR challenges.

RESOURCES

1. DAC Guidelines for Gender Equality and Women's Empowerment in Development Co-operation,
2. http://www.developmentgoals.org/About_the_goals.htm
3. "Trends in Research and Practice" The Journal of Developing Areas
4. Handbook on Gender, Human Rights and HIV and AIDS, SADC Parliamentary Forum. 2006.
5. Training Manual on Sexual Reproductive Health and Rights and HIV Prevention for Medical Students in Nigeria

MODULE FOUR: Contraception

Contraception

Contraception

Module Four: Contraception

BY THE END OF THIS MODULE YOU SHOULD BE ABLE TO UNDERSTAND

1. The definitions, types and importance of contraception. This shall help you to make an informed choice of a contraception of your preference
2. The advantages and disadvantages of various contraceptives

Introduction

Contraception is an essential component of reproductive health for young people, including students in tertiary institutions. Contraceptives work by preventing a man's sperm from fertilizing a woman's ovum, and can be achieved in several ways. Condoms are a form of contraceptive that can also prevent the transmission of STIs including HIV. Unplanned pregnancies and STIs do not only disturb students' studies but also have bearing on their health and can threaten their lives..

In Zimbabwe, where abortion is illegal and access to treatment of STIs and HIV remains challenging, contraceptives remain the most viable option. Contraception, therefore, allows students to plan their lives without the obvious disruptions that come with unplanned pregnancies and the effects of STIs or induced abortions. Contraception ensures that students enjoy their sexual and reproductive health rights that include being free from diseases as well as planning for when and how often to have children. Information on a wide range of contraceptives is important so that students are able to make informed choices about their sexuality.

Types of Contraception

There are two main modes of contraceptive action:

- Barrier methods physically prevent body fluids from mixing. This prevents fertilization by avoiding seminal fluid from entering the vagina
- Hormonal methods alter a woman's hormonal cycle to prevent fertilization

These are the main types of contraception that are generally used by the young people who constitute the majority of the student population. This module explores some of these contraception methods – particularly those that are popular and available to students and young people in Zimbabwe.

Type of Contraceptives

- Male condom
- Female condom
- Diaphragm
- Intrauterine Device (IUD)/Intrauterine System (IUS)
- Contraceptive pills- emergency contraceptives, combined oral contraceptives, progestin only pills
- Female sterilization
- Male sterilization
- Implants

The intrauterine device (IUD) and intrauterine system (IUS), also known as 'the coil', are generally not used by young people although in some countries, such as the UK, they are now considered suitable for all age groups.

How Do You Know Which One to Choose?

Different methods of contraception have their individual advantages and disadvantages. There's no single 'best' method of contraception, so you have to decide which is most suitable for you. Whatever your situation, there should be a contraception option that works for you. For many people, barrier methods of contraception are best, because they do not only prevent pregnancy, but also prevents HIV and other sexually transmitted infections from being passed on during sexual intercourse.

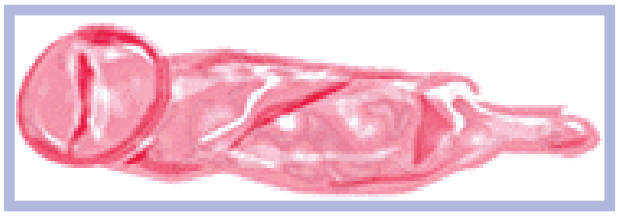
Where Do You Get Contraceptives From?

Where you can get contraceptives depends on which type of contraceptive you're looking for. Barrier methods such as condoms are available at health centers, clinics, college campuses and various shops in Zimbabwe. They're also available from most healthcare providers. There are many different condom brands that are distributed free of charge. Free, distributed condoms are equally as strong as the brands available for purchase in shops, contrary to the widely circulated myth that they are not safe to use. Hormonal methods are available with advice and counseling from qualified medical personnel.

Barrier methods of contraception

There are two main barrier methods: the male condom and the female condom.

The male condom



The male condom is a method of contraception that can be used by males. The male condom is made of a thin sheath of latex rubber which is closed at one end and tightly encloses the penis. The male condom can only be put on when the penis is erect and just before sexual intercourse.

These are the steps that one has to take when putting on a male condom for a safer sexual act.

- Buy or get a condom from a clinic, pharmacy, tuck shop, condom distributor and not from an open space
- Ensure condom packet is intact
- Check the expiry date
- Remove condom from package
- Make sure the condom will unroll properly
- Squeeze air out of the tip of the condom
- Place condom on erect penis
- Roll condom down penis
- Smooth out air bubbles
- Do not use oil based lubricants
- With condom on, insert erect penis for intercourse
- After ejaculation hold on to condom at the base of penis
- Withdraw penis while still erect
- Remove condom from penis
- Use each condom once only
- Dispose condom safely

The condom can be disposed using the "3" B`s concept which is burying, burning, putting in a Blair toilet or in a bin.

ADVANTAGES	DISADVANTAGES
• It is cheap and easily available from clinics/health centers, college campuses and health workers • Does not require a health check-up in order to use it • It prevents the spread of STIs including HIV • Works as dual protection	• Can tear or slip off if not used properly • Interferes with the sexual act as it can only be put on an erect penis and must be removed whilst the penis is still erect • Some people are sensitive or allergic to latex material that is used in manufacturing the male condom

The female condom

The female condom is not as widely available as the male condom and it is more expensive (although in Zimbabwe some brands of both the male and the female condom are distributed free of charge). It is however very useful when the man either will not, or cannot, use a male condom. It also gives females, who are usually prejudiced by culture, a say in negotiating for safer sex. The female condom is equally as effective as the male condom.

ADVANTAGES	DISADVANTAGES
• Female condoms give women more control and a sense of freedom in their sexual reproductive health • A woman doesn't need to see a clinician to get it as no prescription or fitting is required • The condom can be put in several hours in advance of sexual intimacy • It is safe and fairly effective at preventing both pregnancy and infection • The inside of the condom is lubricated • It can be used by individuals who are allergic or sensitive to latex • Polyurethane/nitril transmits heat well which some people find enjoyable • The femidom is odourless	• The female condom is large and some consider it unattractive or odd looking. Its size and unattractiveness may decrease enjoyment of sex for some • The condom will not work if the man's penis enters the vagina outside of the female condom • It can make rustling noises prior to or during intercourse. (A lubricant may contribute to less noise) • The condom takes practice to use it properly. Some people complain that it is hard to use. • It is not available in as many stores as the male condom and may be hard to find

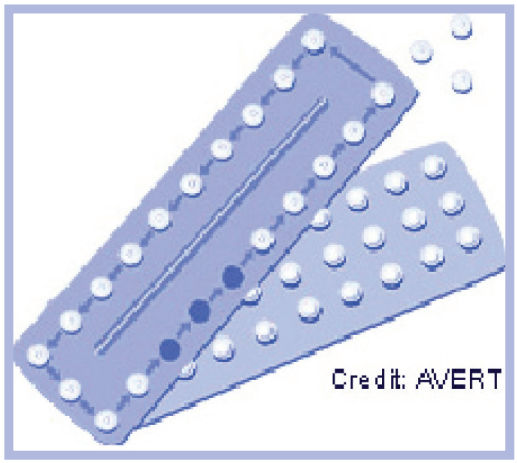
Hormonal Methods of Contraception

The most common types of hormonal contraceptive which can be used by female students are the contraceptive pill, and the injectable hormonal contraceptive. If used properly, both are extremely effective in providing protection against pregnancy – but they provide no protection at all against sexually transmitted infections. For protection against both pregnancy and sexually transmitted infections like HIV, a hormonal method should be used together with a condom, a practice refered to as the double method protection.

The Contraceptive Pill (sometimes known as the birth control pill)

- What does 'going on the pill' mean?
  People often talk about being 'on the pill'. This means they are using the oral contraceptive pill as a method of contraception. This has nothing to do with oral sex, and just means that the contraceptive is in pill form which is taken orally (swallowed).

The contraceptive pill



- How does it work?
  The pill contains chemicals called hormones. One type of the pill is called 'the combined pill' and has two hormones called Oestrogin and Progestin. The combined pill stops the release of an egg every month – but doesn't stop periods.
  The other type of pill only has Progestin in it. It works by altering the mucous lining of the vagina to make it thicker. The sperm cannot get through the thickened mucous lining to meet the ovum and in this way prevents the female from becoming pregnant. This method is usually recommended for lactating mothers.
- What do you do?
  Usually a female has to take one pill everyday for three weeks, followed by one week of no pills while menstruating, and then the cycle starts again with taking the pills everyday for three weeks. It's very important not to forget to take the pills. When a pill is not taken, protection against pregnancy is lost. The Progestin-only pill also has to be taken at the same time every day.
- How effective is the pill?
  The contraceptive pill is a very effective method of contraception when taken correctly. If the pill is taken exactly according to the instructions, the chance of pregnancy occurring is practically nil. However, if a pill is forgotten or missed, its effectiveness is reduced. Another disadvantage of the pill is that it does not provide any protection against STIs. For protection against both pregnancy and STIs, the birth control.

Implants

- What is it?
  The 'implant' is a newer form of contraceptive that has become available in some countries. It is a small tube, a little over an inch long, which is inserted under the skin on the inside of a female`s arm.
- How does it work?
  The implant works in a similar way to the contraceptive pill, but instead of taking a pill every day, hormones are steadily released into a female's body from the device. This is seen as an advantage, particularly for females who have trouble remembering or don't like having to take a pill every day. However, the implant can cause unwanted side effects, and like the other hormonal contraceptives, the implant does not protect against STIs.

The Emergency Contraceptive Pill

If a female has had unprotected sexual intercourse, but doesn't want to conceive, one option is the emergency contraception pill. Also traded as 'the morning after pill.', it is an emergency contraceptive that can prevent pregnancy when taken after unprotected sexual intercourse. The name is actually a little bit misleading as it doesn't necessarily have to be taken 'the morning after' – it can work up to 120 hours after you've had unprotected sexual intercourse. However, it is most effective when taken within 72 hours of unprotected sex. The sooner the emergency contraceptive pill is taken after unprotected sex, the more effective it is. Although the morning after pill can be an effective way to avoid pregnancy if you have had unprotected sex, you shouldn't rely on it, or use it regularly. It's not as effective as other methods of contraception and can have side effects. What's more, it won't protect you from HIV or other sexually transmitted infections. The emergency contraceptives are available in most pharmacies in Zimbabwe without prescriptions.

Although the above could be classified not only as the widely used but also most available options for young people, there are many other forms of contraception and birth control.

These include:

1. **The cervical cap** which is a small cap made of soft latex. A doctor or nurse practitioner "fits" a woman for a cervical cap. The woman puts spermicide (which destroys the sperm) in the cap and then places the cap up into her vagina and onto her cervix (the opening of the womb). Suction keeps the cap in place so sperm cannot enter the uterus (the womb). Women should obtain a new cap yearly. Among typical couples who initiate use of the cap before having a child, about 16 percent of women will experience an accidental pregnancy in the first year. If the cervical cap is used consistently and significantly higher if the cervical cap is used after a woman has had a child. A condom should be used with the cervical cap for protection against HIV and other STIs.

ADVANTAGES	DISADVANTAGES
• The cervical cap is small and easy to carry. It can be inserted up to one hour before sex. • It will work continuously for 48 hours. • It does not matter how many times a couple has sex as long as you leave it in at least six to eight hours after the last time you have sex. • Your partner doesn't have to know you are using it.	• Is not the best protection against HIV and other STIs • The cervical cap must be fitted by a clinician • You must wash your hands with soap and water before inserting the cap • It may interrupt sex • A woman has to take it with her on vacations or trips • It increases a woman's risk for inflammation of the surface of the cervix • It is difficult for some women to insert a cervical cap properly even after being taught • If left in too long, slightly increases a woman's risk for a very serious infection called toxic shock syndrome. It is not safe to leave a cervical cap in for more than 48 hours • It may accidentally be placed onto the cervix improperly or may slip out of place during sex • After insertion, a woman must check to be sure it is covering the opening of the uterus, called the cervix • New fittings may be necessary after a baby, abortion, miscarriage, or gaining 15 pounds • Latex may cause irritation or a woman may be allergic to it • A woman should have a new cap each year • You need fresh spermicidal cream or jelly each time you use your cap • It is not recommended that you use a cervical cap during menstruation

2. A diaphragm is a latex disc a woman places in her vagina. It should be left in the vagina at least 6 hours but no more than 24 hours after intercourse. The diaphragm blocks a man's semen from entering the cervix (the opening to the womb).
A spermicide placed onto the diaphragm kills sperm. A diaphragm and the spermicide keep sperm from getting to the ovum. Among typical couples who initiate use of the diaphragm, about 16 percent of women will experience an accidental pregnancy in the first year. If the diaphragm is used consistently and correctly, about 6 percent of women will experience pregnancy. Condoms as well as the diaphragm should be used for the most effective protection. Complete information about this contraceptive is available through a family planning association, clinician or through the package inserts accompanying a diaphragm.

ADVANTAGES	DISADVANTAGES
• A diaphragm gives a woman fairly good control over contraception • When used perfectly, only six women in 100 become pregnant the first year using a diaphragm • It can inserted in up to several hours in advance of sexual intercourse • Diaphragms are safe; there are no hormones and no side effects from hormones • The penis can remain inside the vagina after ejaculation	• A diaphragm does not provide adequate protection from HIV Requires the use condoms as well • The diaphragm must be fitted by a clinician • You must wash your hands with soap and water before inserting a diaphragm • Inserting the diaphragm may interrupt sex • A woman has to take it with her on vacations or trips • A diaphragm increases a woman's risk for urinary tract infections • It is difficult for some women to insert a diaphragm properly even after being taught • If left in too long, it slightly increases a woman's risk for a very serious infection called toxic shock syndrome • A diaphragm should not be left in for more than 24 hours after intercourse • It may slip out of place during sex. It is important to check that the diaphragm is still covering the cervix during intercourse • After insertion a woman must check to be sure it is covering the opening of the cervix • A new fitting may be necessary after having a baby, abortion or miscarriage, or gaining 15 pounds • It is not recommended that you use a diaphragm during menstruation

3. Injectables - The most commonly used injectable is called Depo-Provera. Depo-Provera is a shot given every three months. It is a hormone, much like the progesterone a woman produces during the last two weeks of each monthly cycle. Injectables stop the woman's ovaries from releasing an ovum and have other contraceptive effects. Among typical couples who initiate use of injectables, about three percent of women will experience an accidental pregnancy in the first year. For the most effective protection against sexually transmitted infections, condoms must be used in addition to getting the injection. Complete information about this contraceptive is available through a family planning clinic, local health department, or clinician.

ADVANTAGES	DISADVANTAGES
• Nothing needs to be taken daily or at the time of sexual intercourse • Injectables are extremely effective • Women lose less blood during menstruation when they are using injectables and have less menstrual cramps • Privacy is a major advantage No one has to know a woman is using this method • Nursing mothers can receive injections; it is best to receive after the baby is six weeks old • It is okay for a woman to start another contraceptive method if it is less than 13 weeks since the last shot • Injectables may lead to improvement in PMS (premenstrual symptoms), depression or symptoms from endometriosis in some women	• Injectables do not protect you from HIV infection or other STIs. Condoms must be used to reduce risks • Injections can lead to very irregular periods. If a woman's bleeding pattern is bothersome, there are medications which can be given to help have a more acceptable pattern of bleeding. • Some women gain weight. To avoid weight gain, women should watch their calorie intake and get lots of exercise • A woman has to return every three months for her injection • Depression and premenstrual symptoms may become worse. • It may be a number of months before a woman's periods return to normal after her last shot • Injectables may cause bone loss, especially in smokers. Women should get regular exercise and consider taking extra calcium to protect their bones from osteoporosis • Some women are allergic to injectables

Injectable contraceptives are available from your clinician, health department, or family planning clinic. Most clinics provide the first shot when a woman is on her period or within seven days of the start of the period.
Be sure to use condoms or another method for added protection against pregnancy and the transmission of STIs including HIV.

4. An Intrauterine Device (IUD) is a small device which is placed into the uterine cavity. There are two highly effective intrauterine contraceptives: the Copper T IUD and the LNG-IUS. IUDs are safe, relatively inexpensive, and provide extremely effective long-term contraception. Complete information about this contraceptive is available through your clinician or the package insert accompanying the IUD. Recent evidence has indicated that use of IUDs carries no increased risk of reproductive tract infections.
In the horizontal arms of the Copper T 380A IUD there is some copper. The IUD slowly gives off copper into the uterine cavity. This does several things. Most importantly, it stops sperm from making their way up through the uterus. Among typical couples who initiate use of this IUD, just less than 1% will experience an accidental pregnancy in the first year.

ADVANTAGES	DISADVANTAGES
• The Copper T IUD is the second most effective reversible method, after surgical sterilization in preventing pregnancy • The IUD is effective for at least 10 years • Only 2 of 100 women using a Copper T for 10 years will become pregnant. • Prevents ectopic pregnancies • Far more readily reversible than tubal sterilization or vasectomy • Protects against endometrial cancer • Very low cost over time • Convenient • Safe • Private	• No protection against sexually transmitted infections. Condoms must be used for protection against STIs including HIV • There may be cramping, pain or spotting after insertion • The number of bleeding days is slightly higher than normal and you could have somewhat increased menstrual cramping. If your bleeding pattern is bothersome to you, contact your clinician. There are medications which may make you have a more acceptable pattern of bleeding • High initial cost of insertion • Must be inserted by a doctor, nurse practitioner, nurse midwife or physician's assistant • A small percentage of women are allergic to copper

You can get intrauterine contraception from your clinician, health department, or family planning clinic. Not all clinicians, however, offer intrauterine contraception services. You might want to check on this in advance. Most clinics insert intrauterine contraception when a woman is on her period or within 7 days of the start of the period.

5. Outercourse —or what you might call "alternatives to sexual intercourse"—usually refers to types of sexual intimacy which does not involve oral, vaginal, or anal sex. This may include:

- Holding hands
- Kisses
- Petting below the belt
- Hugs
- Petting above the belt
- Mutual masturbation

But outercourse does take some discipline! Both partners must be committed to this method or else these exciting forms of sexual intimacy can lead to sexual intercourse. It is not an extremist position to practice only outercourse in this age of viral infections. It works better if there has been communication in advance. Decide in advance what sexual activities you will say "yes" to and discuss these with your partner. Tell your partner, very clearly and in advance, not at the last minute, what activities you will not do. At the same time learn more about the methods of birth control and safer sex so that you will be ready if you change your mind

ADVANTAGES	DISADVANTAGES
• Outercourse is always an option…no supplies and it's free! • There is no risk of pregnancy • No fluid is exchanged, providing protection against sexually transmitted infections • It can increase emotional closeness between individuals	• Touching your partner's genitals or anal area during masturbation could possibly result in transmitting STIs. You may want to use some method of protection, such as latex gloves • For some partners, the desire to have intercourse can cause stress • This method may have either partner thinking, "Is this going to go farther than I want?" This concern may decrease enjoyment

6. Withdrawal (Coitus Interruptus) is when the man withdrawals his penis from the vagina when he senses that he is about to ejaculate (come). He ejaculates outside of the vagina. This takes a lot of discipline! If the woman has not had an orgasm, the man can stimulate her in other ways after withdrawal. It works best if the couple has agreed to use this method in advance. Among typical couples who initiate use of withdrawal, about 27 percent of women will experience an accidental pregnancy in the first year. If withdrawal is used consistently and correctly, about 4 percent of women will become pregnant. The withdrawl method should be used in combination with spermicides for increased effectiveness.

ADVANTAGES	DISADVANTAGES
• Withdrawal is always an option, and is completely private • While not the most effective method, it is definitely better than no method at all • No fluid or much less fluid is deposited in the woman's vagina. This means that there is somewhat less chance of infection spreading from a man to a woman • It has no medical complications, no hormones, no supplies, and is free	• It provides poor to no protection against STIs, including HIV • The big problem is the desire to keep thrusting when it is time for a man to the man to withdrawal • This method gets the man thinking: "Will I withdraw in time?" And the woman is thinking "Will he withdraw in time?" This concern may decrease their enjoyment of intercourse • Semen may be present in the fluid that comes out of the penis before ejaculation

Oops!

What can be done if plans change and a man and women have unprotected sex or should the method used seem to have failed? Sperm swim very fast. In minutes after ejaculation into the vagina, sperm are up through the uterus into the fallopian tubes, where they will meet up with the ovum, if an ovum is there. The emergency contraception discussed already can be used as an alternative.

Abstinence

Although the above methods of contraception and birth controlling have proved to be of use to varying degrees as demonstrated in the module, for young people and students, abstinence is the most effective.

Abstinence means different things to different people. For some, abstinence means avoiding vaginal, anal, and oral-genital intercourse altogether. For others, it means avoiding any type of sexual or intimate contact, including hugging and kissing. On this page, it refers to not having penetrative sexual intercourse.

ADVANTAGES	DISADVANTAGES
• Abstinence is free and available to all • Abstinence is extremely effective at preventing both infection and pregnancy. It is the only 100% effective method of preventing sexually transmitted infections (STIs) and unintended pregnancy • Abstinence can be practiced at any time in one's life • Abstinence may encourage people to build relationships in other ways • Abstinence may be the course of action which you feel is right for you and makes you feel good about yourself	• If you're counting on abstinence, and change your mind in the heat of the moment, you might not have birth control handy

Other types of contraception, which are generally not used by young people, include natural methods such as only having sex at certain times of the month (these are often not effective enough), and sterilization, which is a permanent surgical procedure.

Conclusion

Students and youth's appreciation and use of contraceptives goes a long way in mitigating several and most of the greatest SRHR challenges like unplanned pregnancies and STIs, including HIV. Therefore it is important to ensure that there is widespread dissemination of information in tertiary institutions and that these contraceptives are available. It is the responsibility of students to seek information on contraceptives.

RESOURCES

Adapted from Hatcher RA et al. Contraceptive Technology. 18th rev. edition. New York, NY: Ardent Media, 2004.

http://www.advocatesforyouth.org/youth/health/contraceptives/abstinence.htm
MayoClinic.Com. Birth Control Guide: Diaphragm; http://www.mayoclinic.com/health/birth-control/BI99999/PAGE=BI00009; accessed 10/03/2006.
http://www.avert.org/birth-control-contraception.htm

MODULE FIVE:

Sexually Transmitted Infections Including HIV

BY THE END OF THIS MODULE YOU SHOULD BE ABLE TO UNDERSTAND

1. Definitions and key facts on STIs
2. How STIs are transmitted
3. How STIs including HIV transmissions can be prevented
4. Treatment of STIs

Introduction

Sexually transmitted infections are a major global cause of acute illness, infertility, long term disability and death, with severe medical and psychological consequences for millions of men, women and children. The World Health Organization (WHO) states that "in developing countries, STIs and their complications are amongst the top five disease categories for which adults seek health care" With the exception of HIV and a few others, many STIs can be treated and cured relatively easily and cheaply if diagnosed early. To fight these epidemics college authorities must act to expand access to testing and treatment facilities; educate students about safer sex and risk reduction, avoidance and to counter the prejudice surrounding STI infections.

Key Points on STIs

- STIs are not only a cause of acute morbidity in adults but may also result in complications such as:

Infertility in men and women

  - Ectopic pregnancy
  - Cervical cancer
  - Prematurity
  - Ophthalmic neonatorum.

- Sexually transmitted infections (STIs) are infections that you can contract through sexual intercourse and/contact with an individual who is infected. These infections are usually passed by having vaginal intercourse, but they can also be passed through anal sex, oral sex or skin-to-skin contact.
- STIs can be caused by viruses, fungal or bacteria. STIs caused by viruses include but are not limited to hepatitis B, genital herpes and HIV. STIs caused by bacteria include but are not limited to chlamydia, gonorrhea and syphilis.
- Most STIs that are caused by fungi and bacteria are curable by appropriate antibiotics and chemotherapeutic agents. In spite of this STIs have remained a major challenge, particularly in developing countries
- HIV is another sexually transmitted pathogen
- 7 in 10 STIs occur among individuals between 15 and 24 years old. (FHI, 2001)
- Many STIs can be treated and cured
- Early treatment is necessary to avoid complications and permanent damage
- Symptoms and signs may not be noticed, particularly in women until complications appear
- There is need for assurance that privacy, confidentiality, and respect are guaranteed within service providers if STI treatment responses are to be effective
- Most STIs can be diagnosed by a doctor through the examination of the secretions from your vagina or penis, or through a blood test.
- The other way to prevent STIs is by not having sexual intercourse. If you have sexual intercourse, you can lower your risk of getting an STI by only having sexual intercourse with someone who is not sexually indulging with anyone else and who does not have an STI.
- You should always use condoms when having sex, including oral and anal sex to prevent STIs
- Cleaning your genitals with soap and water and urinating soon after sex may help clean away some germs before they have a chance to infect you (this does not prevent HIV acquisition.)

How HIV is Related to Other STIs

- The predominant mode of transmission of HIV and other STIs is sexual. Other routes of transmission STIs include blood, blood products, donated organs or tissue and vertical transmission from an infected mother to her fetus or newborn infant
- Many of the measures for preventing sexual transmission of HIV and STIs are the same.
- Clinical services for STIs are important entry points to contact individuals with high risk of contracting HIV.
- Other STIs, when present, facilitate the transmission of HIV, making early diagnosis and effective treatment of STIs an important strategy for the prevention of HIV transmission.
- Trends in STI incidence and prevalence can be useful early indicators of changes in sexual behaviour and are easier to monitor than trends in HIV seroprevalence or incidence.
  This has been adopted from Sexually Transmitted diseases: policies and principles for prevention and care, WHO/UNAIDS, 2001

Prevention

- Primary Prevention - strategies for the prevention of STIS and sexually transmitted HIV are essentially the same because the primary mode of transmission for both is sexual intercourse.
- In primary prevention the aim is to prevent the acquisition of infection. This can be done by promoting;
  - Safer sexual behaviour;
  - The use of condoms for penetrative sexual acts. (For more information refer to the on HIV and AIDS and Contraception)
- Secondary Prevention entails the provision of treatment and care for infected and affected persons. The activities include:
- Promotion of health care seeking behaviour directed not only at those with symptoms of STIs, but also at those at increased risk of acquiring STIs, including HIV infection;
- The provision of clinical services that are accessible , acceptable and effective, and which offer diagnosis and effective treatment for both symptomatic and asymptomatic patients with STIs, and their partners;
- Support and counselling services for both STI and HIV patients

It is important to seek care for STIs from the public sector and the certified private sector practitioners. It is discouraged to seek care from uncertified traditional healers and uncertified pharmacists.

In Zimbabwe it is encouraged that when one is tested for an STI there should be partner notification. Again because of the relationship between STIs and HIV one is encouraged to test for HIV when they are found to have an STI.

Am I At Risk for Having an STI?

If you've ever had sex, you may be at risk for having an STI. Your risk is higher if you have had many sexual partners, have had sexual acts with someone who has had many partners or have had sexual intercourse without using condoms. Some common symptoms of STIs are listed in the box below.

Classification of Sexually Transmitted Infections

Sexually transmitted infections	Symptoms	Area of infection	Causative agent	Other information
Chlamydia trachomatis	Vaginal discharge, and pelvic pain, painful urination, symptoms are after 1-3 weeks	Urethra, rectum and eyes, cervix in women	Bacteria	It can be treated and cured with antibiotics.
Genital herpes	Can cause painful and disturbing blisters	Genitals	Viral (herpes pappiloma virus)	Like all viral caused STIs.It can not be cured.
Gonorrhea	Vaginal discharge, painful urination	Urethra, cervix, anus, throat	Bacteria	Can be treated and cured with an antibiotic, there might not be symptoms in women.
Genital warts/ condyloma accuminata	May cause warts on the genital area	genitals	Viral	May be treated with creams but they tend to recur
Syphilis	Small painless blisters that quickly disappears and might reappear and disappear again after three weeks.	Penis and vagina	Bacteria	It usually spread to the nervous system if it is left untreated. can be treated and cured by antibiotics
Hepatitis B		liver	Viral	Hepatitis B is a liver disease and it can be transmitted via infected blood. People can get a vaccine to reduce chances of contraction but it can not be cured just like all other viral infections Like other viral infections HIV can not be cured but there are anti retroviral drugs that suppress HIV in sero-positive individuals
HIV	It is difficult to diagnose HIV on symptoms only as its symptoms might be just as any other disease and these are usually detectable when one has developed AIDS	Non specific	Viral, the human immune-deficiency virus	

You should visit a clinic if you're at risk for having an STI, if you have any of the symptoms listed above, or if you have concerns about whether you have one. STIs can present complications if left untreated. For example, chlamydia can lead to problems that can cause women not to be able to have children (infertility). HPV can lead to cancer of the cervix or penis, and syphilis can lead to paralysis, mental problems, heart damage, blindness and death.

Most STIs affect both men and women, but in many cases the health complications they cause can be more severe for women. If a pregnant woman has an STI, it can cause serious health problems for the baby. If you have an STI caused by bacteria or parasites, your health care provider can treat and cure it with antibiotics or other medicines. If you have an STI caused by a virus, there is no cure. Sometimes medicines can keep the disease under control. Correct usage of condoms greatly reduces, but does not completely eliminate, the risk of catching or spreading STIs."

Pregnancy and Genital Herpes

Having herpes does not affect a woman's ability to become pregnant, though if herpes is first transmitted in the first 3 months of pregnancy there is a small risk of a miscarriage. A first episode of herpes during pregnancy carries a greater risk of transmission to the baby. Becoming infected towards the end of pregnancy may cause the baby to be born prematurely.

Though transmission of herpes from a mother to her newborn is rare, if it does occur, it can pose a serious risk to the baby. If left untreated, the infection can cause damage to a newborn's internal organs, skin, and central nervous system and may even prove fatal. Prompt testing and treatment with acyclovir of any baby thought to be at risk is therefore essential.
However, most women who have an outbreak (or even several outbreaks) of genital herpes during pregnancy have a normal delivery and a healthy baby.

Common Effects of STIs on Men and Women

STI	Signs & Symptoms	Treatment	Area of infection
Chlamydia	**Women** A minor increase in vaginal discharge caused by an inflamed cervix. Cystitis (an inflammation of the lining of the bladder). The need to urinate more frequently, or pain whilst passing urine. Pain during sexual intercourse or bleeding after sex. Mild lower abdominal pains. Irregular menstrual bleeding. A painful swelling and irritation in the eyes (if they become infected). **Men** Men are more likely to notice symptoms early than women, though they too may be asymptomatic. A white/cloudy and watery discharge from the penis that may stain underwear. A burning sensation and/or pain when passing urine. A painful swelling and irritation in the eyes (if they become infected).	The treatment of chlamydia is effective once the infection has been diagnosed, consisting of a short course of antibiotic tablets. If a patient is allergic to any antibiotics, or if there is any possibility that they may be pregnant, it is important that the doctor is informed as this may affect which antibiotics are prescribed.	Urethra, rectum and eyes, cervix in women
Gonorrhea	Men are more likely to notice symptoms than women. Symptoms can include: A burning sensation when urinating. A white/yellow discharge from the penis. A change in vaginal discharge	Treatment is essential. The patient will be given an antibiotic in tablet, liquid or injection form. No penetrative sex until infection is gone	Genitals
Genital Herpes	Both men and women may have multiple symptoms that include: Itching or tingling sensations in the genital or anal area. Small fluid-filled blisters that burst leaving small painful sores. Pain when passing urine over the open sores (especially in women). Headaches. Backache. Flu-like symptoms, including swollen glands or fever	There is no cure for the herpes virus and treatment is not essential, as an outbreak of genital herpes will usually clear up by itself. A doctor may however prescribe a course of antiviral tablets that reduce the severity of an outbreak. The antiviral tablets work by preventing the herpes virus from multiplying. These tablets are only effective when taken within 72 hours of the onset of symptoms, and will cease to have any effect once the patient stops taking them.	Urethra, cervix, anus, throat

Trichomoniasis	If symptoms do appear, they commonly include: Discharge in both men and women (sometimes copious and unpleasant smelling in women). Discomfort or pain whilst having sex. Pain when urinating and inflammation of the urethra.	Treatment for both men and women is a drug called metronidazole which can be taken orally or applied as a gel. It is important for any sexual partners to also be treated as trichomoniasis can be carried and spread without symptoms. If a woman is pregnant then she should seek medical advice before pursuing treatment.	Genitals
Syphilis	Syphilis symptoms can be difficult to recognise and may take 3 months to appear after sexual contact with an infected person. They include: One or more painless ulcers on the penis, vagina, vulva, cervix, anus or mouth. Small lumps in the groin due to swollen glands. A non-itchy rash. Fever or flu-like symptoms.	Treatment of syphilis usually consists of a two-week course of intramuscular penicillin injections or, in some cases, antibiotic tablets or capsules. If the patient has had syphilis for less than a year then fewer doses will be needed.	Liver
Genital Warts	If symptoms do appear then the infected person may notice pinkish/white small lumps or larger cauliflower-shaped lumps on the genital area. Warts can appear on or around the penis, the scrotum, the thighs or the anus. In women warts can develop around the vulva or inside the vagina and on the cervix. If a woman has warts on her cervix, this may cause slight bleeding or, very rarely, an unusual coloured vaginal discharge.	There is no treatment that can completely eliminate genital warts once a person has been infected. Often outbreaks of genital warts will become less frequent over time, until the body naturally clears the virus and the warts disappear of their own accord. However, in some people the infection may linger.	Non specific
Thrush	The symptoms of a thrush infection are: in women - irritation, itching, thick white discharge, redness, soreness and swelling of the vagina and vulva. in men - irritation, discharge from the penis, difficulty pulling back the foreskin usually caused by the swelling of the head of the penis (balanitis). Thrush occurs a lot less frequently in men	Treatment for thrush involves applying an anti-fungal cream that contains Clotrimazole. If an infection is recurring then Fluconazole may be prescribed to be taken orally, unless the patient is pregnant. It may also be suggested to wash the genitals with water only to avoid irritation, use sanitary towels instead of tampons, and wear loose fitting cotton underwear and clothes.	

MODULE SIX:

Peer Education

Peer Education

Peer Education

Module Six: Peer Education

BY THE END OF THIS MODULE YOU SHOULD BE ABLE TO UNDERSTAND

1. Peer education and its basic functions
2. Peer education in the context of SAYWHAT and its objectives in tertiary institutions
3. The characteristics and roles of effective peer educators
4. Peer education approaches that can work in tertiary institutions
5. Monitoring and evaluating peer education interventions

Introduction

Peer education can be an effective strategy for information and knowledge sharing among people of the same age, status and socialization if it is well planned and if there is investment towards its sustainability. This is especially true of students within tertiary institutions.

What is Peer Education?

- **Peer education** involves the development of knowledge, skills, attitudes, beliefs, or behaviours of peers on a particular area e.g. prevention and management of HIV and AIDS, family planning and/ practicing safer sex
- In SAYWHAT Peer Education is a way of empowering students. It offers them the opportunity to participate in activities that affect them and to access the information and services related to SRH that they need.

Who is a Peer?

- A peer is a person who belongs to the same social group as another person.
  For example, a peer could be any persons of the same age, educational status, or workmate that are free to formally and informally engage in common issues that affect them in the private and public sphere.
- Students in tertiary institutions are peers
  What is education?
- Education is the process of acquiring knowledge through learning.
  Individuals can learn through circular education,real life experiences, media, and their peers amongst other things

Objectives of the SAYWHAT Peer Education in Tertiary Institutions:

- To increase the participation of students in sexual and reproductive health activities
- To share and generate information on sexual and reproductive health and improve knowledge, attitudes, skills and behaviours
- To offer psychosocial support to peers
- To coordinate, monitor and evaluate SAYWHAT activities at college level

Peer Education Trainings

SAYWHAT values training of its peer educators to give them an opportunity to acquire skills, knowledge and behaviours that enhance their work.
Peer educators must be well informed and must support each other as a team. SAYWHAT conducts the following trainings for Peer Educators to help them become useful to their college communities:

- Life-skills training
- HIV and AIDS Education including Positive Living
- Sexual and Reproductive Health Education
- Basic Peer Counselling and Psycho-Social Support
- Monitoring and evaluation trainings
- Participatory research approaches trainings
- Gender Trainings
- Data management and research skills training
- Writing and facilitation skills

Characteristics of a Good Peer Educator

Peer Education involves the building and nurturing of the peer educators' personal behaviour in order to make peer educators acceptable to their society. In educating others, peer educators themselves must examine and enrich their own values, attitudes and attributes.

Characteristics of a good peer educator

- Initiative
- Confident
- Creative
- Patient
- Confidential
- Committed
- Open
- Knowledgeable
- Gender sensitive
- Trustworth
- Accountable
- Team player
- inclusive

Skills applicable to peer educators

- Decision-making
- Self-awareness
- Assertiveness
- **Practical Skills**
- Negotiating skills
- Managing Situations and providing leadership

A good peer educator should be:

- Motivated and committed to the cause
- Able to work in a team
- Respected, trusted and sociable
- Someone that other young people spontaneously turn to for sharing and support
- Capable of respecting confidentiality
- A good listener and communicator
- Aware of which sources of information or counselling to refer for appropriate help

Roles of Peer Educators

Peer educators must be aware of the clinics, information sources, and SRH supportive related services available in their area.

In addition, they should;

- Share and generate information amongst peers at colleges
- Manage and provide leadership in Peer Educators' Clubs
- Facilitate discussion forums during club meetings
- Manage and update Resource Centers
- Networking with other local structures from the community that can provide support to students
- Build behavioural skills of other peers
- Monitor and evaluate peer education activities

Peer Education Activities

Peer educators achieve their objective of knowledge and skills provision through

- Discussion Forums
- Information Sharing
- Networking
- Resource Center Management
- Peer Education
- Advocacy
- Leadership and Facilitation

Discussion Forums

A very critical role for peer educators in colleges is to facilitate discussion forums at least once a week. The discussion forums must focus on issues of sexual and reproductive health. There must be adequate preparation and research on the topic for discussion. Peer educators must be able to talk about sexual attitudes, behaviours, and the consequences of unprotected sex. Discussion Forums will allow participants to open up and speak freely about their own values, attitudes, beliefs and perceptions. The community will be able to share ideas and support each other. In preparation for the meetings Peer Educators must:

- Mobilize the participants – students and other peer educators
- Choose a topic for discussion – e.g. STIs, HIV and AIDS etc
- Provide the facilitator – a peer educator, a resource person, a lecturer or any person who is knowledgeable on the subject at hand.

Focus group discussions can be guided by SRH related toolkits like the SAYWHAT positive living toolkit, SAYWHAT manual, Aunty Stella etc

Preparing for a Group Discussion (GD)

When you are preparing for a GD you should:

- Define the objectives of the GD
- Determine the topic/issue for discussion
- Select an appropriate venue, depending on the nature of the GD.
- Determine the number of participants attending the discussion (This should be a manageable number)
- Estimate the length of the discussion
- Select a facilitator

Guidelines for Organizing a Group Discussion

- Group discussions work best with around fifteen participants. The minimum size is six people and the maximum size is 15. This group size enables everybody to participate.
- Group discussions usually last between thirty minutes and two hours.
- People will participate in a group discussion more easily if they share important characteristics.
- Discussions with groups of adults will work best if participants have similar education, authority, or political position, enabling them to talk openly amongst themselves.
- Hold group discussions in a place where the participants feel comfortable and where they can talk openly. Consider how the location may influence the discussion. For example, participants may not feel able to talk openly about the attitudes of service providers towards young people if the discussion is held in the local health center!
- The note-taker should sit where they can easily see and hear all the participants.
- Mobile phones can help record discussions, if participants are comfortable with this. If recorders are used, the note-taker is responsible for operating the recorder. Make sure that all participants understand who the note-taker is, what information they are writing down, and how it will be used.

Information & Knowledge Sharing

There is a lot of diverse information on sexual and reproductive health including, STIs and HIV/AIDS available for students in colleges. It is also the role of the peer educators to source the correct and relevant information and then share with others. Information to share can be available from different centers and formats. It becomes the responsibility of peer educators to network with strategic organizations, hospitals, clinics and other service providers in order to source information to share with other students. Examples of some of the information, education and communication materials on SRH include but are not limited to pamphlets, fact sheets, newsletters, journals, posters and videos.

Networking

Peer Educators must be well networked with a lot of organizations, referral groups, and support networks for support and resource provision. Peer educators must be proactive and participate actively at national and regional level. It is important for peer educators to network with other peer educators from different communities including colleges, to share experiences and learn from each other.

Peer education is also about students networking with the local community, adults, college staff members and working together to reach a common goal of improving the health and well-being of the students. This would also contribute to continuity, effectiveness and sustainability of all peer education programmes. Peer educators must also create partnerships with individuals and groups that are strategic and have a similar goal. It is important for peer educators to undertake a mapping of possible partnership organizations within their locality.

Resource Centers and Information Dissemination Activities

A resource center is an information hub, where information and resources on Sexual and Reproductive Health including STIs and HIV and AIDS is sourced, stored and distributed systematically.

- Resource Centers must be accessible to all students at any time.
- Resource Centers must always be youth or peer friendly for all health services. It must be managed by the peer educators themselves.
- Resource Centers should have information materials as well as resources like condoms for students.
- It must also be a confidential area that allows for open interaction amongst peers.
- Peer Educators and other students must be identified with their Resource Center for it to be effective.

Besides Resource Centers, peer educators may use various other methods of information dissemination such as the following:

- Dramas
- Awareness raising events
- Sports
- Group discussions
- Role plays
- Youth friendly corners/ centers
- Songs
- Poster-making
- Quiz
- Debates and Speeches
- Workshops
- Film-showing

Activities that provide students with both education and entertainment are referred to as edutainment. Edutainment is one of the most interactive and enjoyable ways of disseminating information for students.

Advocacy

- Advocacy may be referred to as the process of speaking up, or drawing the attention of communities to a certain important issue and with the intended effect of directing decisions makers towards a solution.
- Advocacy can also be defined generally as set of actions meant to inform a certain decision.

Advocacy is more effective if a group knows exactly what they want to gain or achieve by the advocacy.
The following are some simple general steps in advocacy;

Step 1: Identify the problem and see the real cause of that problem, as well as the possibility of the situation to be changed. Information gathering on the problem may include researches, visits to key informants and assessing risks possible supporters and hindrances. There is also a need to identify the purpose
for which the advocacy is being done.

Step 2: This second stage involves the collective decision making by the people affected to take action or not and planning on how to make and sustain the action.

Step 3: Take actions and evaluate.

Methods of Advocacy

- Meetings
- Drama, songs and slogans
- Press statements or releases
- Posters and fliers
- Public meetings
- Demonstrations
- Conferences
- Petitions

Leadership & Facilitation

- Skills-building is an essential component of peer education and health education. It is important to build capacities of peer educators around life-skills.
- Life-skills are abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life.
- Leadership is a process of positively influencing others to accomplish certain objectives and direct organizations/institutions in certain direction that makes them more cohesive and coherent; leaders are the people who carry this process by applying their skills, values, character, knowledge and beliefs.
- Reproductive health needs critical leadership that is willing to positively transform society and to be positively transformed by society.
- The student community should be empowered to appreciate that they are the owners of their problems and can actively participate in providing solutions.
- Leadership in reproductive health needs to be gender-sensitive because more women than men experience challenges associated with SRHR

Peer leadership

In SAYWHAT, peer educators are seen as leaders in their own right, hence are referred to as peer leaders. These individuals should be:

- Trustworthy
- Effective communicators
- Motivational to encourage member followers to develop their personal skills
- Able to solve problems
- Open to change and criticism
- Punctual, among other character traits

Facilitation

- Peer educators must be equipped with facilitation skills that will allow them to be able to train their peers.
- They should also know how to deal with different types of peers/participants and be able to handle sensitive discussions.

A good facilitator:

There are certain features that are expected if one is to become a good facilitator. These include;

- Showing respect for the people one is working with
- Believing in people's capacities, including the capacities of women, youth etc
- Listening attentively and respecting other people's opinions
- Readiness and willingness to learn from participants
- Confidence and knowledge about issues under discussion
- Creativity and ability to improvise with local resources
- Flexibility and ability to adapt tools and approaches to different situations
- Sensitivity to participants' feelings and understanding of group dynamics
- Ability to help participants, organizing and analyzing information

Monitoring and Evaluating Peer Educators' Activities

Monitoring and Evaluation is one element that the Peer Educators should take as their responsibility so that the college based interventions are effective.

Monitoring of a program or intervention involves the collection of routine data that measure progress toward achieving program objectives. It is used to track changes in program performance over time. Its purpose is to permit stakeholders to make informed decisions regarding the effectiveness of programs and the efficient use of resources.

Monitoring is sometimes referred to as **process evaluation** because it focuses on the implementation process and asks key questions:
How well has the program been implemented?
How much does implementation vary from site to site?
Did the program benefit the intended people? At what cost?
Monitoring is:

- An ongoing, continuous process
- Requires the collection of data at multiple points throughout the program cycle, including at the beginning to provide a baseline
- Can be used to determine if activities need adjustment during the intervention to improve desired outcomes

Evaluation measures how well the program activities have met expected objectives and/or the extent to which changes in outcomes can be attributed to the program or intervention. The difference in the outcome of interest between having or not having the program or intervention is known as its "impact," and measuring this difference is commonly referred to as "**impact evaluation**."

MODULE SEVEN:

Primary Health Care and Support

Module Seven: Primary Health Care and Support

BY THE END OF THIS MODULE YOU SHOULD BE ABLE TO UNDERSTAND

1. The definition and components of primary health care as it relates to SRH
2. How to promote primary health care in tertiary institutions
3. Specific SRH primary health care needs for female students
4. Proper use and disposal of sanitary wear

Introduction

One of the challenges in promoting a healthy environment for students in tertiary institutions is the limited access to knowledge and services that supports primary health care. Students in tertiary institutions require primary health care and support so that they are able to pursue their studies without health related complications.

Most college campuses do not have facilities and infrastructure that enable students to access primary health care services. There is need for institutions to devise strategies that ensure the provision of comprehensive, affordable and friendly health care packages for students. College administrators and authorities should realise that primary health care is a right for students.

Defining Primary Health Care

The concept of Primary Health Care was adopted at the Conference of Alma Ata in 1978. A progressive primary health care approach:

- Challenges the society to address the socio-economic causes of poor health and makes provision for basic health needs
- Encourages community empowerment (ensuring that people are fully able to manage resources that are available to them)
- Provides comprehensive quality health care including promotive, preventive, curative, rehabilitative and palliative services
- Demands concerned and accountable health worker practice
- Prioritises the people who are most disadvantaged ensuring that health care is accessible, equitable and affordable to all
- Recognises the importance of integrated service provision from primary to tertiary levels of care within a coherent health system
- Promotes inter-disciplinary, multi professional and Intersectoral collaborative teamwork for development

How Do We Ensure Primary Health Care Support?

Primary health care in Zimbabwe is guaranteed to individuals through the Patient's Charter. It can be ensured through functional health systems and policies. These systems and policies include:

- Medical Aid
- General Health Policies (National and College level)
- Particular policies on issues of Reproductive Health e.g. The HIV and AIDS Policy, The Reproductive Health Policy
- Functional Peer-to-Peer Health Interventions e.g. Peer Education, Post Test Clubs, Health Clubs
- Legal Instruments in support of the above mentioned policies and their popularisation e.g. the Gender Based Violence Act, the Termination of Pregnancy Act, the Criminal Codification Act

Primary Health Care: Campus Barometer

According to SAYWHAT research, many institutions are battling to provide comprehensive primary health care support. Most tertiary institutions lack in facilities, drugs and personnel to guarantee the provision of primary health care services.

Resolutions from consecutive SAYWHAT Annual Conferences on Sexual and Reproductive health have reiterated the need to address these challenges. Ensuring that students have access to primary health care is part of SAYWHAT advocacy work in tertiary institutions of learning.

Requisite College-Level Systems and Infrastructure for Health Care

The following infrastructure and systems are necessary for health care delivery to students, and each college administration must ensure the provision of:

- A college clinic with flexible operational hours
- Adequate and competent health service providers
- Availability and affordability of essential drugs
- Privacy and confidentiality
- Psycho-social support services
- Functional referral Services

Other Important Considerations for Primary Health Care:

At National Level:

- Functional referral system
- Supportive legal framework
- Budget commitment to providing primary health care for young people

For College Authorities:

- Health Coordinators who work in liaison with college level health care providers
- College Curriculum to integrate health care information
- Policies and strategies that ensure an enabling environment for primary health care service provision
- Budget commitments towards supporting provision of primary health care

Students must ensure viable:

- Peer Educators Clubs
- Health Clubs
- Post Test Clubs
- Youth-Friendly Centres and
- Health-related Resource Centres

Other Considerations
Institutions should also ensure the provision of sporting and recreational facilities as well as a balanced diet. Such provisions are key in ensuring disease prevention as well as health living for individuals who might for example require special dietary considerations. Provision of good sanitation is also another essential consideration that institutions should make especially with the background that some diseases like cholera are preventable through provision of proper sanitation (sanitation generally refers to the provision of facilities and services for the safe disposal of human urine and faeces) services and a safe environment environment. It's important to ensure that toilets are clean and that running water is always provided to avoid exposing students to health risks.

The Patients' Charter

The Patient's Charter is an official government document which provides guidelines on how health services should be delivered to patients in Zimbabwe. It is the mandate oif all health centres including the college clinics to have the patient's charter were it can be accessed by patients at all times.

The Patients' Charter gives individuals certain rights to access health care. These rights include:

- All individuals must have access to competent health care and treatment regardless of age, sex, ethnic origin, religion, economic status or social class
- Health care services must be available on the basis of clinical need, regardless of the ability to pay, and it is the responsibility of the government to ensure that all people have access to essential health services
- All patients must be treated with care, consideration, respect and dignity without discrimination of any kind
- All drugs and vaccines dispensed must be of acceptable standards in terms of quality, efficacy and safety
- All individuals have the right to prompt emergency treatment from the nearest government or private medical and health facility
- Patients must be interviewed and examined in surroundings designed for reasonable privacy and have the right to be chaperoned during any physical examination or treatment
- Children admitted to hospital, wherever possible, have the right to company of a parent or guardian

Source: The Patients' Charter.
Peer educators and students in general have a responsibility to monitor the implementation of the Patients' Charter as its realisation can be a guarantee of access to primary health care.

Female Student Health

Female students' primary health care needs are different from those of males. During menstruation, for example, females need primary health care facilities and commodities such as sanitary wear and disposal facilities in order to ensure hygiene and reproductive health care.

Campus Barometer

The SAYWHAT Gender Desk runs a programme that promotes access to knowledge and services on sanitary wear.

Peer Educators may arrange with the SAYWHAT secretariat to make available these services or to get subsidised sanitary pads for their colleges.

These services come against a background of high use of unhealthy alternatives by female students in tertiary colleges due to hindrances around affordability and accessibility of sanitary pads.

What Happens During Menstruation

- Menstruation is the biological process whereby the walls of the uterus are shed in the event of an unfertilised ovum. Ovulation is the release of an ovum from the ovaries and it normally happens once every 28 days. When the ovum is released into the oviduct the body naturally releases hormones that stimulate the growth of the uterine walls, which will be a bed for the fertilised ovum to settle.
- In the event that the ovum is not fertilised by sperm, the walls and the unfertilised ovum are released from the body via the birth tract as what is commonly referred to as the 'monthly period'
- Menarche marks the beginning of menstruation at the puberty stage (usually between the ages of 9-16 years). From this stage a woman can fall pregnant if she has unprotected sex.
- Menopause marks the end of the menstrual cycles. This happens around the ages of 45-50 years and women will not be able to bear children after this period
- Females use sanitary wear to improve hygiene during their monthly menstrual cycle

Sanitary wear

- Menstruation (monthly periods) is a biological process that women undergo hence the need for sanitary wear to be taken as a basic need for women. Sanitary wear should be made accessible, available and affordable by college authorities to female students as a form of primary health care support.
    - There are different types of sanitary wear and these include:
        - Sanitary pads
        - Tampons
        - Cotton wool
        - (Other female students have resorted to the use of cloth as an alternative)
- The most common sanitary wear among female students today are sanitary pads, cotton wool and cloth. These materials are cheaper and easier to access for most female students.
- Without sanitary wear in colleges students may resort to unhygienic substitutes like unclean and uironed cloth, pulp paper like newspaper, tissues and mattress foam rubber which might cause reproductive tract infection (RTI), which in turn can cause some cancers like cervical cancer.

Sanitary Wear Disposal: Situation in Institutions

The proper disposal of sanitary wear is an important aspect of hygiene and sanitation. The provision and advocacy of sanitary pads by SAYWHAT takes into cognisance the need to have proper disposal methods in place. Colleges have embarked on different disposal methods for sanitary wear. Female students normally use sanitary pads and they continue to face challenges of disposal. Colleges have considered several options of disposal although each method has its own challenges.

a) Red Bins – The red bins are found in some hostel toilets and are normally disposed once a week. In those colleges that have incinerators female students have to take turns to dispose the bins outside in the bigger incinerators.
b) Toilet Incinerators – The toilet incinerators use electricity to burn the pads. These are normally placed in the toilets. Very few colleges have these facilities and in most cases where they are available they are no longer working.
c) Built-in (fuel) Incinerators – These incinerators are big and are found outside the hostels. Sanitary pads are burnt regularly using fuel. In some colleges the red bins are emptied into these incinerators every week. The SAYWHAT Female student's pads and can go for months without being burnt.

Sensitization and education must be done on the proper disposal of sanitary wear. Young women must actively lead the process and encourage one another to take proper and effective measures in ensuring safe disposal.

Sanitary Wear Disposal

Refers to the methods used to get rid of used sanitary wear. These include,

- Incineration/burning
- Use of the Blair toilet
- Removing the pulp to flash (for sanitary pads)
- Flashing e.g. tampons
- NB-Washing, drying and ironing is encouraged for students who use cloth

General Health Care in Using Sanitary Wear

There is need to maintain high levels of hygiene and to observe basic health standards when using sanitary wear. The following are some of the hygienic precautions that can be observed,

- Having clean hands when putting on and removing sanitary wear
- Constantly changing sanitary wear to avoid discomfort and toxic shock syndrome(TSH) at least after every 2-3 hours
- Keeping sanitary wear in dry cool places and away from dust
- Seeking medical attention in the case that one reacts to sanitary wear

Use of Improper Material for Sanitary Wear

Unconventional substitutes to sanitary wear may cause the following problems:

- Chemical dies on materials like newspapers and tissue paper
- Germs on any unclean material used, may cause reproductive tract infections
- Discomfort
- Messing up
- Unhygienic disposal

Hygiene of Genitalia

Care and hygiene of one's genitalia is important.

1) Bathing of one's genetalia
   Bathing regularly and changing clothes and underwear keeps the genital area clean and odourless. In women it reduces chances of thrush infection. A lot of oil and sweat is normally expected between the buttocks, armpits, feet and special attention must be given to these when bathing.

   Women are expected to take extra care and hygiene during menstruation. Pads and tampons should be changed frequently and underwear must be washed properly. Toxic shock syndrome can result if pads and tampons are left in place for too long.

   In men, the penis, scrotal area and anus, should be cleaned regularly. No attempt should be made to try and clean the inside of the urethra; this can cause serious damage. Special care should be taken by uncircumcised men to make sure the head of the penis is cleaned. This can be done by allowing warm water to act as a lubricant and the foreskin should be gently pulled back. Failure to clean this area properly will result in smegma collection, causing bad odours and an increased risk of infection. It is important to remember to return the foreskin to its natural position after cleansing and drying.

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