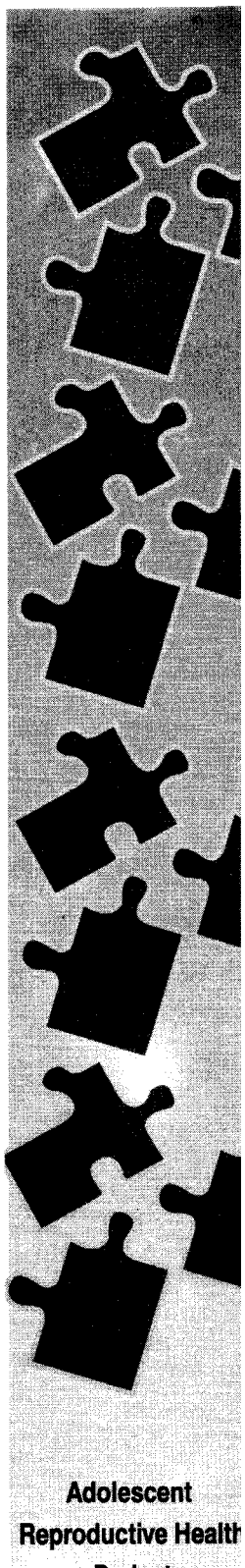
What they don't know can hurt them

How school-based reproductive health programmes can help adolescents lead healthy reproductive lives



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Adolescent Reproductive Health Project of the Training and Research Support Centre

TARSC

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARHEP	Adolescent Reproductive Health Project
CSO	Central Statistical Office
G & C	Guidance and Counselling
HIV	Human Immuno-Virus
HPV	Human Papilloma Virus
NGOs	Non-governmental Organisations
SAfAIDS	Southern African AIDS Dissemination Service
STI/STD	Sexually Transmitted Infection/Sexually Transmitted Disease
TARSC	Training and Research Support Centre
UN	United Nations
UNICEF	United Nations Children's Education Fund
VVF	Vesico Vaginal Fistula
WASN	Women and AIDS Support Network
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic Health Survey
ZNFPC	Zimbabwe National Family Planning Council

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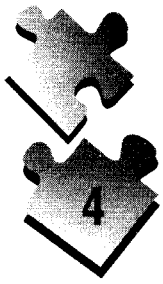

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Executive Summary

This monograph seeks a better understanding of the elements of good practice in school-based reproductive health programmes. It is intended to help parents, educators and policy makers answer the following questions:

- ❑ What is reproductive health and why is it important?
- ❑ Why do adolescents need information about reproductive health?
- ❑ Why is it important for schools to provide such information?
- ❑ How can schools best do this?

Answers to these questions are important because young people are important. In Zimbabwe, because of their large numbers, young people are especially important. Young people (10-24 years) comprise nearly one-half of the population. These young people carry the hopes and dreams of their families, communities and the nation. They also live in a world where to be an adolescent is increasingly risky. The AIDS epidemic means that risk-taking typical of adolescence has deadly consequences. Most new HIV infections occur among adolescents and young adults. And there are other long term health consequences of unplanned and unprotected sex. Pregnancy is more risky. Both mother and baby are more likely to die. Pregnancy may have lasting complications such as vesico-vaginal fistula. Other bacterial and viral sexually transmitted infections can cause infertility or cervical cancer. In addition to health consequences, early sexual activity may limit educational attainment and deprive young people of the opportunity to form mature, loving relationships.

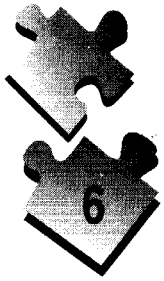
Many young people have sex before they are married. Survey data suggest that at least one-half of young people will be sexually active by age 20 (ZDHS 1995, ZNFPC 1997). Smaller studies suggest that for the minority of students who report beginning sex while in school (perhaps 15%), the average age at which sex begins is in early adolescence (12-13 years) (Mbizvo, 1995) This pattern of sexual behaviour probably differs from the practices of a generation or two ago. Different factors have combined to alter what it means to grow up today as compared to the past. Changes include high rates of urbanisation, extended periods of schooling and growing poverty. These factors are all inter-related and contribute to a social context that creates many challenges for young people.

Poverty spurs rural-urban migration, as does rising demand for educational attainment. Traditional ways of preparing young people for adulthood, which relied on the tete/babakazi or sekuru/malume, are no longer as important. In addition, changes in adolescence mean that, even if it were always available, traditional education might not be adequate. In the past, sexual maturity was closely followed by marriage. But today, young people reach puberty at younger ages and wait longer to marry. Because the tete/babakazi or sekuru/malume may not be available, or may not be considered

relevant, many turn to other sources. Today many young people learn from peers or the media. Much of this information is inadequate; sometimes information is just plain wrong.

Schools represent an ideal setting in which to reach large numbers of young people with a structured programme of reproductive health knowledge and life skills. But, wherever it has been introduced the teaching of reproductive health in schools has been controversial. Debate exists around what information should be given, and how much, especially regarding sexual intercourse, pregnancy and disease prevention. Some people question whether adults should even acknowledge teenage sex. Even more common is the concern that sex education will lead to sexual activity. This document reviews these longstanding controversies. The goal here is not to give answers but to help understand the elements of the debate.

Zimbabwe has reached a national consensus that reproductive health teaching should be provided during classroom time, beginning with primary school, before voluntary sexual activity has begun. The Ministry of Education, Sport and Culture launched the National AIDS Action School Programme in 1993 and the Population Education Programme in 1999. Both draw on participatory learning techniques and seek to promote values as well as impart information. In addition, a number of pilot projects, mainly supported by non-governmental organisations, have supplemented these national programmes.



A review of existing programmes suggests a number of areas where uncertainty remains. Most classroom programmes are teacher-led, but teachers vary in their interest and ability to adopt participatory techniques. Teachers may have strong values that they are unwilling to discuss with young people. Such lack of openness to different views would likely hinder student involvement. Some teachers may retain a policing role, and report those students whose behaviour they question, based on the students' class participation. Student-led sessions that are administered by teachers may help get around some of these concerns about teachers completely controlling the classroom discussion.

Most teaching of reproductive health takes place in Guidance and Counselling classes, which means that it is not examinable. Given the pressure on teachers to produce good examination results, it is not surprising that a subject that is not examined may not get the same emphasis as those that are assessed by examinations. Working elements of reproductive health knowledge into examinable subjects, which will be achieved by the newly launched Population Education Programme, is a step toward ensuring that the knowledge content is taken seriously. But there is no formal method to enforce learning of crucial life skills that are also critical to a healthy reproductive life.

Finally, maintaining a programme on a national scale poses many challenges. Small-scale pilot projects suggest the importance of involving all those who have 'on the ground' responsibility for programme implementation. Successful pilot projects have built partnerships with parents, community at large and collaborated with other Ministries. Such a network of support may be hard to replicate as programmes scale up. Scaling up and maintaining momentum is a challenge for all pilot projects. There is no formula, but maintaining community input is clearly crucial.

Zimbabwe has made important strides towards implementing a reproductive health programme that will provide each adolescent with both the information and the skills he or she will need to have a healthy reproductive life. But gaps remain in making what is planned into a reality. Hard questions remain regarding protection of the sexually active teenager. Today, there are still too many young people who have too little information to ensure their health. To succeed, reproductive health programmes need to galvanise community participation, adopt a genuinely multi-sectoral approach and, most of all, give young people an opportunity to be heard.

1 Introduction

Youth are important for who they are and who they will become. Among adolescents are the future leaders and, perhaps as important, the future parents of the next generation. They carry with them the hopes and dreams of their families, their communities and their nation. They link one generation to the next. Each year Zimbabwe's government demonstrates its commitment to this future in its expenditure on education. Despite the economic difficulties of recent years, the Ministry of Education continues to receive the largest single budget allocation.

Zimbabwe has a young population. Nearly one-half of its population is under 15 years of age. Twenty-six percent of the population is between 10-19 years, the usual definition of adolescence (see Table 1). About 43% are classified as "young people" (10-24 years) (CSO, 1994). Many Zimbabweans are young people and worldwide young people comprise a large and growing group. In fact, in the world today there are about 1 billion adolescents.

Adolescence is a period of challenge, promise and change. It is a period of experimentation. Increasingly in today's world adolescence is also a period of danger. The AIDS epidemic, which already spans one generation and shows few signs of slowing, makes the escapades of youth more dangerous than ever. Because young people tend to downplay future risks, they often do not grasp fully their own vulnerability. Also, as the trend toward puberty at younger ages continues, more young people reach biological maturity long before they are socially mature.

Adolescents are not yet entrusted with adults' rights and responsibilities, but they are no longer fully under the control of adults. Tensions arise as they challenge adult authority. For this reason, adults often view adolescents as a source of difficulty. At the same time, young people are an invaluable asset to a family, a community and a nation. They are a force of change, and may be better able than adults to adopt new ways of thinking and acting. As the challenges of adolescence grow, so do the responsibilities of adults to respond to these challenges in ways that affirm the importance and value of our youth. Adolescence is an important period of both opportunity and vulnerability.

Adolescents are not yet entrusted with adults' rights and responsibilities, but they are no longer fully under the control of adults.

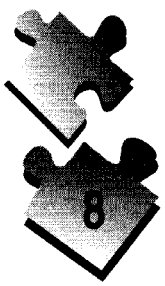
Some of the common definitions used for adolescents and young people are given in Table 1. Adolescence begins with puberty, when the first physical changes appear, and spans the period of development to adulthood. This involves many developmental changes: physical, psychological and social. Adolescence is a period of transition: to sexual and reproductive maturity, to adult mental processes (which is characterised by forward planning) and from the dependence of childhood to the independence of adulthood. Many of the behaviour patterns of the adult are formed during adolescence.

TABLE 1: *YOUNG PEOPLE IN ZIMBABWE: DEFINING TERMS*

PHRASE	DEFINITION	% ZIMBABWEAN POPULATION**
'Young population'	varies	
	< 15 years	45%
	< 25 years	67%
'Young people'	WHO*: 10-24 years	35%
'Youth'	WHO: 15-24 years	22%
	National Youth Policy 10-29 years	42%
'Adolescent'	WHO: 10-19 years	26%
	Young 10-14 years	–
	Middle 15-17 years	–
	Older 18-19 years	–

** WHO = World Health Organisation*
***based on 1992 census, CSO*

Now more than ever young people need adult help in making their future healthy and safe. How should we teach young people about what it means to be an adult? Who should teach them? When? Where? Finding answers to any of these questions is more difficult than it was a few generations ago. All adults who feel responsible for young people - parents, educators, policy-makers - struggle to find ways to promote healthy futures for our youth. The world is more complicated, and the future holds more possibility and less certainty than in the past.



The AIDS epidemic especially lends urgency to protection of a healthy future for our youth. For example, in 1995 a survey done by Professor A. Latif and others showed that among pregnant women in Harare aged 15-19 years, 28% were HIV positive (World Bank, 1997, cited in SafAIDS 1998). Most adults agree that it would be best to avoid pregnancy among 15-19 year olds. And everyone agrees that it is a tragedy to have such high rates of HIV infection among young women. Somehow, adults should help young people avoid such devastating risks. Recent data published by UNAIDS offers very sobering statistics on what the future holds for young people in Zimbabwe, where adult HIV prevalence is high. According to their projections, in 1983 a 15 year-old boy had a 15% chance of dying before his 50th birthday. By 1997, because of AIDS, one-half of 15 year olds faced a likelihood of death before the age of 50 years (UNAIDS, 2000). In this context, how do adults help young people have healthy reproductive lives?

1.1 What is reproductive health and why is it important?

Reproductive health has been defined by the World Health Organisation as:

"... a state of complete physical, mental and social well being, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Implicit are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice. Reproductive health care is defined as the constellation of techniques and service that contribute to reproductive health and well-being" *(UN, 1995).*

This sweeping statement has been operationalised in a wide range of areas that have a bearing on reproductive health:

- sexuality and sexual behaviour
- reproductive tract infections (including HIV/AIDS)
- family planning
- pregnancy, child-birth, post-partum
- abortion
- violence against women.

All of these areas are influenced by the social context in which they occur, cultural beliefs, gender roles and the economic status of the population. Adolescent reproductive health includes these areas as they relate to adolescents, who are recognised as a group with special needs. The extent to which programming in all of these areas is appropriate to adolescents is not universally agreed.

This review aims to provide adults with some insights into issues related to adolescent reproductive health. We hope parents, educators, policy makers and others who work with young people will use it to make the futures of young people healthier and safer. Topics reviewed include the longstanding controversies of how much information should be given to young people about sex and reproduction. We explore the changing social context of adolescence and how gender relations affect the choices of girls. We provide facts. Data are summarised that review what we know about what young people do, whether adults like it or not, and what we know about how young people are learning about adult roles. In the final sections, the existing school based intervention programmes are reviewed and challenges discussed. We conclude by identifying issues that will determine the way forward. We have learned a great deal in the last 10 years, but uncertainty remains. By framing clearly some unresolved issues, we hope that readers will gain clarity in thinking.

We hope parents, educators, policy makers and others who work with young people will use it to make the futures of young people healthier and safer.

2 Reproductive health and sex education in schools: an on-going debate

School attendance in Zimbabwe is high. Primary school attendance remains almost universal and over half of young people complete four years of secondary school. Because schools are the best placed to reach young people in large numbers, schools are an important setting in which to teach about family health relationships.

All over the world, the introduction of formal reproductive health education into the school curriculum is a source of great controversy. Many now agree that young people need to be taught at school about the changes that come with puberty. But many questions - and disagreements - remain. How much information should be given about sex and reproduction? How explicit should this information be? At what age should schools introduce sex education? Efforts to answer these questions have fueled an ongoing debate that now spans decades. topito The AIDS epidemic in Zimbabwe, amongst the most grave in the world, has lent a new urgency to the issue of reproductive health education. In fact, most existing programmes have focused on AIDS, rather than the broader topic of reproductive health.

At issue is the nature of society's responsibility for adolescent well being. These are some of the questions that frame the debate:

- Should schools supplement the role of parents in preparing young people for adulthood?
- Is it the main obligation of schools to reduce the harmful physical consequences of adolescent sexual activity?
  OR
  Is it the obligation of schools to convey cultural values, which across many cultures stress sexual abstinence before marriage?
- Can we do both?

2.1 Contending views: duty to protect or duty to object

One view is that the educational system's main social responsibility is the *duty to protect* all adolescents including adolescents who do not follow adult advice. The need for protection includes the adolescent who is not sexually active and plans to remain abstinent until marriage, the adolescent who will begin to have sex before marriage and those who are already sexually active. This view acknowledges that some adolescents will become sexually active before marriage. It aims to make this choice safer with information. Providing adolescents with information about preventing pregnancy and sexually transmitted infections is the most controversial part of this view.

BOX 1: CONTENDING VIEWS ABOUT THE ROLE OF SCHOOLS IN TEACHING REPRODUCTIVE HEALTH

View 1:	***"Duty to acknowledge and protect"*** Acknowledges that some adolescents will be sexually active and need information to avoid pregnancy and disease.
View 2:	***"Duty to object thereby protect"*** Views sex before marriage as immoral: to acknowledge it would be a form of approval.

Another perspective is that adults - and the school - protect young people by assuming a *responsibility to convey clear moral values,* which do not sanction sexual activity before marriage. In this view, to acknowledge the sexually active teenager and provide information on how to avoid pregnancy or sexually transmitted infections would be the same as giving a "green light" to potentially dangerous behaviour. Adults, it is argued, should not give such a mixed message. They should clearly **object** to any suggestion that sex before marriage is allowed.

The difference between these two contesting viewpoints on sex education is based less on facts than on values. This is why the same arguments are repeated again and again, year after year, and likely will continue in the future.

2.2 Information guides policy

Nonetheless, facts do help. Reviewing what we know about adolescence and reproductive health in Zimbabwe today will help parents, educators and policymakers make better judgements. Facts can help guide decisions about what should comprise education about sexual and reproductive health in schools. Today's adolescent lives in a different world than his or her parents. No amount of hoping will bring back the world that many of today's adults see as simpler, safer and healthier.

Facts help us to understand:

- how the changing socioeconomic and cultural environment affects adolescents as they reach sexual maturity;
- what adolescents are learning, even in the absence of formal school-based instruction;
- the burden of unwanted, unintended outcomes of adolescent sexual activity.

In the last decade a great deal has been learned about adolescence in Zimbabwe. While this review will not outline what values each of us should have, it will describe the growing challenges to fostering a healthy sexual identity for adolescents, both male and female. Many factors, in particular AIDS, combine to make the need to protect young people greater now than ever before.

3 Growing up today: the changing social context

Modern adolescence begins earlier than it did in the past. The world over, the time at which girls begin to show signs of puberty, including menstruation, is shifting to younger ages. In Zimbabwe, on average, girls begin to menstruate at between 12-13 years. We do not have data from a generation ago, but most agree puberty used to begin at about 14-15 years. The younger age at which puberty begins is a biological fact, probably related to better nutrition. It also interacts with many social changes, such as:

- weakening of traditional sources of authority
- massive movement to urban areas, especially of young people
- rising school enrolment and extended schooling
- growing economic crisis with loss of 'social safety nets.'

3.1 Traditional culture in today's world

In traditional culture the period of adolescence was short, especially for girls. For girls, the main accomplishment of adolescence was to identify a future husband. Education for adult roles was structured and relied mainly on the paternal aunt *("tete" in Shona or "babakazi" in Ndebele)* for girls and the maternal uncle or grandfather *("sekuru" or "malume")* for boys. Parents were not expected to take a direct role in such instruction. Information prior to identification of a marriage partner consisted mainly of information about puberty and good behaviour. More explicit sex education came only when marriage was imminent. Professor Michael Gelfand documented this system as recently as 1970 (Gelfand, 1973). These roles are still widely identified as part of traditional culture, but many more people know what 'should' happen according to tradition than actually experience traditional instruction.

Several factors have combined to undercut this traditional system. Among the most important have been the high rates of rural-urban migration, the rise in access to formal education and, in the 1990s, growing poverty. These are inter-related. For example, poverty spurs migration, as does educational attainment.

3.2 Urbanisation

For the last three or four decades, Africa has had the highest rate of urban migration in the world. Land hunger and the prospect of new economic opportunities in urban areas have propelled people away from the rural areas and into towns. The extended family, so crucial to an agriculture-based peasant economy, has begun to fall away.

Traditional culture is often seen as a casualty of urban life. Sub-Saharan Africa is urbanising faster than any other region in the world and Zimbabwe is no exception to this trend. In 1982, 20% of the population was urban. By the time of Zimbabwe's second census (CSO, 1992) this

proportion stood at 30%, a 50% increase. Today at least one in three Zimbabweans is an urban dweller, a proportion that mirrors Africa more generally. Urban social structures do not support the extended family. The role of *tete/babakazi* and *sekuru/malume* has been weakened, in part because families now frequently live far apart from other members of the extended family.

But families living in different geographic locations are only part of this shift. For urban families, even living in the same city does not mean that a relative is accessible to a teenager. Being resident in the same city is not the same as living in the same village. For example, for an adolescent to move from Mufakose to Tafara in Harare now costs a lot of money. In addition to the problems of geographic distance, urbanisation has introduced new social distances within extended families. One family may be much better off than its other relatives. If paternal aunt does not have the same social status as her brother's family, she may not be considered a suitable person to instruct her niece. Or perhaps the *tete's/babakazi's* own children have been a problem. Issues of status and affluence increasingly test kinship ties. In studies done in the early 1990s, the issues of social distance appeared to be larger obstacles to the *tete's/babakazi's* role than actual physical distance.

Some aunts are just corrupt. They just want to use their niece by making boyfriends give money. My tete does not have money, so I do not trust her.

My mother does not get along with my aunt, because she is not a steady person.

Source: Bassett and Sherman, 1994

3.3 Independence: a revolution in education

Another part of the changing nature of adolescence is the greatly extended period of formal education. Young people today spend many more years in school and then often seek to join the labour force. As a result, adolescence now extends for many years, rather than just a year or two. Access to education increased enormously after 1980, most strikingly for girls. Universal primary enrollment was achieved equally for boys and girls and, though a gender gap still exists for secondary school, girls' access to secondary school is greatly increased. For example, in 1994, 51% of rural female adolescents had attended secondary schools, compared to 60% of boys (Bassett and Sherman, 1994).

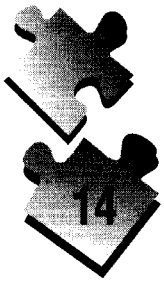
Great strides in access to education have been one of the triumphs of post-colonial Africa. It has been accompanied by impressive gains in adult literacy. There is no doubt that improving access to education is a sound investment in the future. In addition to the economic opportunity afforded by education, there are non-economic social gains. The educational attainment of women is an important overall indicator of social development, even when incomes remain low.

The desire for education is insatiable and achieving the highest possible level of education will remain an important activity of teenagers. Education has become a principal means of improving one's situation and gaining access to employment. But as with any major social change, there have been consequences. The expansion of educational opportunity means that goals to be accomplished in adolescence have changed. They now include not only finding an appropriate partner, but also finding a job in the formal economy. Growing investment in education has also helped to create what is sometimes called the "biosocial gap". There is now an extended period between sexual maturity and entering the adult world. Enforcing adolescent sexual abstinence used to mean a year or two of abstinence. Prolonged schooling now means this may extend to five years or longer. Traditional structures were never meant to cope with many years of sexual maturity during which marriage was not a goal.

Along with the gains in education come other social consequences. As young people identify with authority figures at school, not only those at home, the authority of the parents and extended family becomes less exclusive. Adult relatives, who may have less formal education than young people, may feel ill-equipped to assert their role as a source of knowledge about the adult world. This results in the often-heard lament: "they don't respect us as they once did". In this way, education has contributed to a growing "generation gap".

3.4 The 1990s: growing poverty

Urbanisation and rising access to education are both aspects of 'modernisation' that have changed adolescence. In addition, since Zimbabwe opened its economy in 1990 with adoption of economic reforms, poverty has increased along with a growing gap between the rich and the poor. A recent government survey showed that two-thirds of Zimbabwean households live below the official Poverty Datum Line. (CSO, 1998). Because poor families tend to be large families, this translates into 75% of Zimbabweans living in official poverty. One-third have too little money to assure access to adequate food. Although many young people attempt Ordinary and Advanced level examinations, the failure rate is very high. Failure to pass these examinations may create a sense of failure and lost opportunity. When even those who do pass cannot find jobs, frustration increases. The sad fact is, despite having more educated young people than ever before, the economy cannot provide them with jobs.



Growing poverty affects everyone in the society. For adolescents, economic pressure creates a social context where sexual risk-taking may be linked to getting money for school fees or even simply getting transport. The need to earn money may place young girls in situations outside of their home where they are vulnerable to sexual advances by adults. One in ten schoolgirls aged 15-16 years have jobs to earn money (CSO, 1998). And for three-quarters of young people who leave school, lack of money for school fees is the most important reason. Avoiding this consequence of poverty may cause teens to take desperate and dangerous steps. Work done by ARHEP highlighted how girls perceived the impact of economic pressure on parental guidance (Kaim, et. al.1997; Ndlovu and Kaim,1999).

"Unouya wakangorembedza maoko usina shuga unoti ini ndini ndinoiwanepi?"
If you come home empty handed without sugar, where do you think I will get it? (A girl quoting what some mothers say to their adolescent girl children)

"Parents never ask where we get new clothes even if our boyfriends buy for us".

(Ndlovu and Kaim 1999a)

3.5 The future in an uncertain world

Urban migration and poverty are inter-related because lack of opportunity in rural areas often drives young people to migrate to town. In towns, traditional ties between people are less strong, providing a setting for experimentation and shifts in cultural values. At the same time, education makes young people less likely to see a future in being a peasant, and more likely to question traditional values.

Today's adolescent comes of age in a time of great uncertainty. There is cultural uncertainty, as Western culture becomes more pervasive. The peasant agricultural society is now firmly tied to the cash economy and its traditional structures are less firmly rooted. There is economic uncertainty. Although a contemporary adolescent seeks to gain economic self-sufficiency, this goal is increasingly difficult to achieve because there are too few jobs. In a time of increasing uncertainty, young people may drift into relationships that are exploitative, abusive and even fatal.

4 Sexual activity among young people: what do we know?

Many adults believe that more young people are having more sex than ever before. This is one of the issues that research can help us with. But there are limitations in collecting information about behaviour. Research relies on "self-report": what people say they do. Because we can never be sure how accurate this self-report is, we need other measures to corroborate self-report. That is why it is important to look at outcomes such as pregnancy, or marriage, which are less likely to be reported inaccurately.

4.1 Survey data on adolescent sexual behaviour

Many young people in Zimbabwe begin having sexual intercourse during their teenage years. This is generally true in many countries. The most comprehensive data on sexual behaviour in Zimbabwe comes from the Zimbabwe Demographic and Health Survey (ZDHS) that has been conducted every 4-5 years since1988 by the Central Statistical Office. The most recent survey was completed in 1994. A survey conducted in 1999 will be available in 2000. The 1994 survey showed that 30% of adolescents age 15-19 years are sexually experienced. For women who were 20-24 years at the time of the survey, half reported that they had had sexual intercourse by age 19 years (CSO, 1995).

The ZNFPC also conducts periodic national surveys that are an important complement to the ZDHS. Their recent 1997 survey suggests that age at first sexual intercourse may actually be younger than suggested by the ZDHS, the average age at first intercourse was 17.6 years for girls and 16.6 years for boys. By age 21, 65% of women and 58% of men were sexually experienced (ZNFPC 1997).

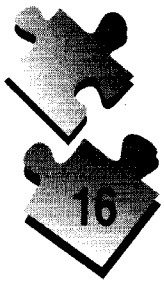
These large-scale surveys were conducted among young people aged 15 years and over. In some surveys that also included younger adolescents, (under 15 years) there is a suggestion that sexual activity may begin quite early for an important minority of young people. For example, in a school survey of over 1600 secondary students, 83% of pupils reported that they had never had sex. Among the 17% of pupils who reported they were sexually experienced, the average age at first intercourse was 12 years for boys and 13.6 years for girls (Mbizvo, 1995; Mbizvo 1997).

Based on these data, we can conclude that by the time they are 20 years old, about one-half of young people have had sex. For many, this is sex before marriage. For those young people who are married at age 20, sex may have preceded marriage and may even have prompted marriage. Early marriage is often a consequence of unplanned pregnancy. In Shona culture, an early sexual contact *(kutizira)* may also result in early marriage. We do not have data to separate out those young people who married "because they had to" and those who married young because of personal preference.

4.2 *Unprotected sex: adolescent contraceptive use*

Adolescents who are sexually active are at high risk for pregnancy, poor pregnancy outcomes and STIs. These outcomes are largely a consequence of unprotected sexual intercourse. STIs and pregnancy could be avoided with contraception, especially condoms. But most adolescents who are sexually active have unprotected sex. In Zimbabwe there is generally a large gap between contraceptive knowledge and contraceptive use. Overall, use of modern methods is reported by just under one-half of married women (42%), one of the highest rates in Africa (CSO, 1995). Use of modern methods has increased by about 75% since the 1980s (CSO, 1997). Preliminary data from ZDHS 1999 shows modern contraceptive prevalence now stands at 50%, a continued rise. Among married women (age 15-49), eight of ten had at some time used a contraceptive, usually (71%) a modern method (CSO, 2000).

Among adolescents, the situation is different. Knowledge of modern methods is near universal, even among 15 year-old girls. But only about 20-25 % of 15-16 year olds girls who are sexually experienced have ever used contraception (CSO, 1997). The proportion of 'ever use' of contraception stands at 54% for older teenaged girls (17-19 years). When questioned about current use of contraception, this proportion falls substantially: 10% of 15-16 year olds and 33% of 17-19 years olds reported current use of contraception. This means that almost all young people know about contraception, but hardly any adolescent girls use this information if they become sexually active. This is probably largely because of lack of access to contraception. A young girl who is not married will more likely get a scolding than advice from a clinic nurse. And many young people think contraception is meant for women who have already begun child bearing.



Even though fertility is declining in Zimbabwe, the data suggest little shift in child bearing in younger years. The average number of children a woman will have in her lifetime has fallen from 6 children in the 1980s to 4.3 children in recent years. Preliminary data from the ZDHS 1999 shows a continued decline in fertility, with an average of 4 children born in a lifetime. But women still begin their families quite young (CSO, 1997). On average, the first birth is still at 20 years. It is because older women stop having babies that the family size is becoming smaller. In 1984, the first national survey on reproductive health was conducted by ZNFPC, (ZNFPC, 1984). The rate at which adolescents are having babies has remained more or less the same since that time.

4.3 *Consequences of pregnancy at a young age*

Pregnancy in adolescents is often an unwanted outcome of sexual activity. It carries risks related directly to the pregnancy, and longer term consequences (both biological and social).

4.3.1 Birth outcomes

Pregnancy before the age of 20 years carries risks for both the mother and the baby. Maternal mortality in adolescent mothers is 2-5 times higher than in older women (WHO, 1998). The basis of this increased risk is multi-fold. Very young mothers are much more likely to be single and the pregnancy unplanned. They lack both economic and social support. They are less likely to receive antenatal care: Lack of antenatal care and a caring environment increase the risk of pregnancy at any age. But pregnancy in the teen years also carries a greater medical risk. There is a higher risk of toxaemia of pregnancy. Because their bodies are still immature, there is a greater chance of obstructed labour that requires operative delivery by caesarean section. The baby born to a very young mother is more likely to be underweight and to die in the first year of life (UNICEF, 1995).

Table 2 shows the proportion of teens that are pregnant or has had a baby. At age 16 nearly 10 percent of girls are already mothers or soon will be. By 19 years this proportion is just under one-half.

TABLE 2: ADOLESCENT PREGNANCY AND MOTHERHOOD

	Percentage who are:		
Age	**Mothers**	**Pregnant 1st child**	**Total %**
15	1.5	1.4	2.9
16	6.2	3.4	9.7
17	8.2	8.0	16.2
18	25.4	5.6	30.0
19	37.0	7.2	44.2
Total (15-19 years)	**14.7**	**5.0**	**19.7**

Source: CSO, 1995

4.3.2 "VVF" – Vesico-vaginal fistula

A long-term medical consequence of obstructed labour is the development of obstetric fistula. Very young women have about twice the risk of VVF as older mothers, because they are still growing and more likely to have a difficult labour (UNICEF, 1995). During a prolonged labour, a small tear may occur that connects the bladder to the birth canal. This is called a vesico (bladder)-vaginal (birth canal) fistula (channel). Usually, it is referred to as "VVF". As a consequence of the tear, urine leaks out and cannot be controlled, leading to a socially unacceptable smell. This can be a terrible source of shame to a young woman. We do not know how common this problem is in Zimbabwe. Anecdotally, VVF seems to be less common here than in some other African countries, probably because the quality of Zimbabwe's health care delivery system means fewer women are subjected to prolonged obstructed labour.

4.3.3 Abortion

Because teen pregnancy is more likely to be both unplanned and unwanted, a disproportionate share of women who seek illegal abortions are adolescents. Worldwide, some 2 million adolescents undergo unsafe abortions each year. Illegal abortion is common in Zimbabwe, but data about it are scarce, partly because it is illegal (Klofkorn, 1999). The 1997 ZNFPC survey found that one-fifth (22%) of adolescents reported that they knew someone who had had an abortion (ZNFPC, 1997). Abortion is a leading cause of maternal mortality, especially among teens. While teens account for about 20% of pregnancies, they account for one-third of abortion-related deaths. Teens who survive illegal abortion may have medical problems as a consequence. These include such serious problems as tubal pregnancy and infertility.

4.3.4 Baby dumping or infanticide

Young girls also appear more likely to resort to 'baby dumping' or infanticide. Reports of this practice are more likely to appear in the press than in the medical literature. Throughout the 1980s, press reports occurred frequently and are likely underestimated by prosecutions in court. Between 1980-1990 a total of 4102 cases of abandonment or infanticide were reported to police (Jijde, cited in Loewenson and Edwards, 1996).

4.3.5 Social costs of adolescent pregnancy

In addition to the health consequences of teen pregnancy is its social cost. A pregnant schoolgirl is expelled and not permitted to return to her school after delivery. Girls are not permanently barred from school. A girl can resume schooling at a different school in another area after she has

her baby. But in many cases, this is not possible. The girl now has a baby to look after and relocating means extra costs. For most girls, a pregnancy means the end to education and the future opportunities that education offers. Although the policy suggests that boys who father children should also be required to withdraw from school, this is more difficult to enforce and probably does not occur very often.

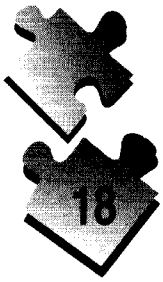
4.4. Sexually transmitted infections

The AIDS epidemic has focused attention on STIs as a consequence of unprotected intercourse. The fact that HIV infection is widespread and deadly has shifted concern from pregnancy to reproductive tract infections.

4.4.1 "Classical" STIs: "drop" and "maronda"

The "classical STIs" are gonorrhoea, syphilis and chlamydia. Studies based in schools and antenatal clinics suggest that young people are at higher risk for these infections. Few studies have been done in Zimbabwe, but studies in Kenya and Nigeria suggest that between 20-30% of female adolescents in clinic settings had a STI (UNICEF, 1995).

Zimbabwe has long had very high rates of STIs. STIs are typically due to gonorrhoea and chlamydia (which cause the syndrome called "drop") and syphilis, chancroid and herpes (which cause the syndrome called "genital ulcer" or "maronda".) With the exception of herpes, which is a virus, these syndromes are caused by bacteria and can be treated with antibiotics.



Throughout the 1970s and 1980s, data from the City Health departments in Harare and Bulawayo showed STI to be the most common reason for both male and female adult attendance, accounting for over 25% of all first outpatient visits. In the 1990s, the proportion of first visits that are STIs declined substantiality and in 1997 stood at 6% of all visits. Many clinicians believe that STIs actually have become less common in Harare and Bulawayo. Reasons for this might be behaviour change (partner reduction, condom use), better medical management, or both. It also may be that rising costs and declining services make people less likely to seek care at government clinics. If the latter were the case, because people may be getting STI care elsewhere, the STI visits to government clinics would also decline. We do not have data to distinguish these possible interpretations, but the decline in STI treatments at clinics has been dramatic.

Anyone who gets "drop" or "maronda" is at a high risk for also acquiring HIV. Another serious long-term consequence of bacterial STI in women is infertility because the tubes become scarred and blocked especially when the STI is untreated. The high prevalence of infertility in Central and Southern Africa is due mainly to inadequately treated infections of the reproductive tract. In cultures where fertility is highly valued, infertility places a woman at grave risk for divorce and abandonment.

4.4.2 Cervical Cancer

Another sexually transmitted infections linked to early sexual activity is carcinoma of the uterine cervix, usually called cervical cancer. This is the most common cancer in Zimbabwe, which has one of the highest rates of cervical cancer reported in the world (Kaim, 1997). Although this cancer occurs later in life, mainly after age 50, it is linked to sexual activity in early life. Women who begin having sex at 14-15 years have double the risk of cervical cancer compared to women who are 20 years or older.

It is now thought that cervical cancer is a sexually transmitted infection caused by a virus called Human Papilloma Virus (HPV). This virus causes cells on the cervix to become cancerous, but this is a long and slow process that occurs over perhaps 20 years. Because the cervix is accessible on physical exam, it is possible to detect the early changes and remove abnormal growth before it spreads. Cervical cancer is preventable and treatable when diagnosed early.

4.4.3 HIV/AIDS

AIDS is by far the most deadly of the sexually transmitted infections and in Zimbabwe it has been studied much more than the other STIs, most of which are treatable (Bassett and Sherman, 1999). At the end of 1999, estimates placed global HIV infections at nearly 34 million (UNAIDS, 1999). Most (70 percent) of these infections are in sub-Saharan Africa.

Adolescents and young adults have been hard hit by the AIDS epidemic. The UN agency responsible for AIDS prevention, UNAIDS, estimates that world-wide, half of all people who become infected after birth are under 25 years old. As noted in the introduction, AIDS casts a long shadow over today's adolescents. In Zimbabwe, half of today's 15 year-old boys are predicted to die of AIDS.

Data from Zimbabwe, as elsewhere, show that the peak ages for HIV infection for young women is 5-10 years earlier than for young men. This reflects the fact that most young women enter into relationships with men who are several years older than they are. Because older men are more likely to be sexually experienced and, therefore, more likely to be HIV infected, their younger female partners are exposed to risk. Also, below the age of 20 years the female reproductive tract is more vulnerable to HIV infection (as well as other viral infections, like the virus associated with cervical cancer) because the cervix is still immature.

There are data to suggest special concern for adolescent girls. As noted in the introduction, a study done among antenatal care attenders in Harare in 1995, showed 28% of pregnant girls aged 15-17 years to be HIV positive. Data from a study in Murehwa collected in 1991-1993 are also very worrying. In STI clinics among patients aged 15-19 years, 50% of teenage men and 42% of teenage women were HIV positive (cited in Klofkorn,1999). Among male factory workers, the rate of newly acquired HIV was twice as high among young men under 23 years as compared to older men (Mbizvo MT, et al. 1999). In summary, young people are at substantially higher risk of becoming newly infected with HIV than older adults. The risk is especially high for adolescents.

Young people are at substantially higher risk of becoming newly infected with HIV.

4.4.4 Combined risk: HIV and STIs

There is good evidence that having another STI, like "drop" or "maronda", enhances HIV transmission. This is because inflammation makes it easier for HIV to infect additional cells. Treating STIs such as gonorrhoea reduces HIV transmission by about 40%. But adolescents are less likely to seek health care for symptoms than adults. They may lack money; they may be embarrassed. Health staff is more likely to scold young patients and generally treat them with disrespect.

4.5 Violence against women

Violence against women includes both physical and mental abuse. Within marriage, abuse has only recently even been recognised. Husbands were presumed to have the right to hit their wives and have sex on demand. Physical abuse may be sexual, the most extreme case of which is rape.

Report of rapes is increasing in Zimbabwe, and many of these rapes are among minors, who are below the age of consent (16 years). Factors that underlie the rise in reported rape are undoubtedly multiple. They include less reluctance to report rape, growing social disruption with urbanisation and the loss of family controls, along with beliefs that young girls are clean and safer sex partners. There are some myths that sex with a virgin girl will cure STIs or HIV, which may motivate men to seek sex with very young girls (10-14 years or younger) as "treatment".

Most sexual abuse of minors takes place in the home or community setting. Sex between pupils and teachers is widely known to happen, but its extent is not known. Commercial sex also places young girls at risk. Girls may turn to selling sex to raise money for themselves and their families. In times of growing economic hardship, families may not insist on knowing how a girl makes money or buys new things (which would normally raise suspicion). They even encourage girls to earn money for the family in this way (Ndlovu and Kaim, 1999a).

4.6 Traditional practices

There are many ways in which traditional practices continue to influence life today. For example, polygamy is often cited as justification for men's entitlement to multiple partners. In fact modern day "multi-partnering" is very different from polygamy. In the past, taking a second wife occurred in an organised way that involved negotiation between families, not just individuals, and carried obligations. Today's "multiple partners" carries little long-term responsibility.

Another near universal practice is the bride price, which is given by the future husband and as a token of respect and as compensation to the woman's family. Because a married woman joins her husband's lineage, there is need to acknowledge the investment made in her upbringing and the loss her family incurs with her marriage. Traditional *lobola* has been affected by the cash economy. Today the bride-price may be very high. The high cost of marriage forces many young people to wait many years before marriage, even though they wish to marry. As a consequence, an exorbitant lobola may even promote pre-marital sexual relationships that might have taken place within marriage.

Finally, very young girls may be affected by *ngozi*, where one family offers a young girl to another in compensation for a crime committed by a member of her family. These girls generally have a dismal future. Such young girls rarely are entitled to education and advancement within the family that required compensation. Most will be married and become pregnant at a young age.

5 Understanding adolescent sexual behaviour

What underlies the continued high rate of adolescent pregnancy, about one-half of which occurs amongst unmarried youth? The answer to this question is complex and lies in the socialisation of young men and young women, the gender roles that contemporary culture supports, access to information and access to health services.

Surveys can help us count up the number of young people who admit to having sex, or who know about contraception. To get a better understanding of the contemporary sexual culture requires more in-depth study. We want to know WHY people do what they do, not only WHAT they do. Because sex is such a private activity, and so much silence exists around patterns of sexual behaviour, such information is difficult to come by. It is clear that widely endorsed social norms of abstinence before marriage and sexual fidelity within marriage often do not reflect real sexual patterns. To sustain the heterosexual AIDS epidemic, on average each HIV infected person must have sex with a minimum of two partners, becoming infected by one and passing infection to at least one other. If most people actually adhered to the values of monogamy, we would not have an AIDS epidemic of the present magnitude.

5.1 Education for adult roles

Adults do ensure that adolescent girls understand that they should not have sex. When young people describe how adults view an 'ideal adolescent', the image that adolescents think would be met with adult approval is asexual. Tidiness and politeness are key attributes of girls and boys, though a boy may be allowed "only one girlfriend" (Kaim, 1997). Beyond the warning to "stay away" from the opposite sex, little information is conveyed to girls by adults, even information about puberty. Many young girls begin to menstruate without being informed in advance about what to expect. The onset of menstruation may be the first time that a girl receives any information about puberty (Bassett and Sherman, 1994).

Mothers feel that the culture 'forbids' them to talk with their daughters about sex.

Parents are conspicuously absent in the sexual education of their children. Mothers feel that the culture 'forbids' them to talk with their daughters about sex. The very idea of having such a discussion makes most mothers feel uncomfortable. While a few mothers will instruct their daughters on personal hygiene, most of them feel unable to do more than admonish their daughters to stay away from boys. Girls are also embarrassed to ask questions of their mothers. Fathers are still more distant and often feared figures.

In the absence of any organised source of information, most young people learn about sex from their friends, siblings and cousins. Magazines and novels are another important source. How much accurate information is conveyed through peers and the media is unclear.

For example, in one study, few Form 3 schoolgirls could explain in any detail what sexual intercourse meant (Bassett and Sherman, 1994). While many girls said they picked up information from the popular Mills and Boon romance novels, these novels actually contain no facts about sex. The bedroom scenes fade out with a swoon or an embrace, leaving to the imagination what happens next.

Commercial media has made sexual images a part of everyday life. Advertising has long used erotic images to sell products, from soap to Coca-Cola. But these are marketing strategies, not educational tools. They make "sexiness" attractive and commonplace for adolescents but offer no information.

In fact, reliance on peers and media as sources of information has allowed misinformation to flourish. Many young people continue to believe such myths as: "sexual intercourse will not make you pregnant the first time" or " sex standing up won't cause pregnancy." Others believe that contraception is harmful to young people. Oral contraceptive use, it is believed, will cause infertility unless a woman has had at least one child. The fact that most women begin using family planning after their second child may be to establish fertility before "interfering" with it. These practices help reinforce the idea that contraception is unhealthy for young girls.

5.2 Gender Roles

Predictably, boys and girls view sex differently. Girls prize virginity and fear humiliation if they become sexually active. In contrast, boys prize, and gain prestige from, sexual experience. Girls seek companionship and prefer to have just one steady boyfriend, while boys seek experience with more than one girlfriend. Girls equate sex with romantic love, while boys see sex as a source of physical satisfaction (Ministry of Education/UNICEF 1995). Both girls and boys agree that when sex happens among teenagers it is without much prior planning. For girls, this is explained by being swept away by love. Boys suggest that their sexual desires overwhelm reason (Ndlovu, 1999; Bassett and Sherman, 1994). The views expressed by young people show how differently society perceives the sexuality of boys and girls. A boy who has sex is just experimenting; a girl who has sex is "loose".

Peer pressures are especially important among teens. When students were asked to rank what influenced them to have sex, boys ranked "peers" first, closely followed by "biological instincts". Girls also ranked peers followed by economic pressure (Ndlovu and Kaim, 1999a). The important role of economic pressure on girls emerged repeatedly. Girls need money to stay in school and to buy hygiene products, but they have less access to income generating activities than boys. Some rural girls even suggest that their parents hint that they should trade sex for money, to help support the family.

Girls can readily outline the many dire consequences of sexual activity. In a session in a rural secondary school (see Figure 1) they generated this chain of events which, although exaggerated, still shows clearly their fears about engaging in sexual activity.

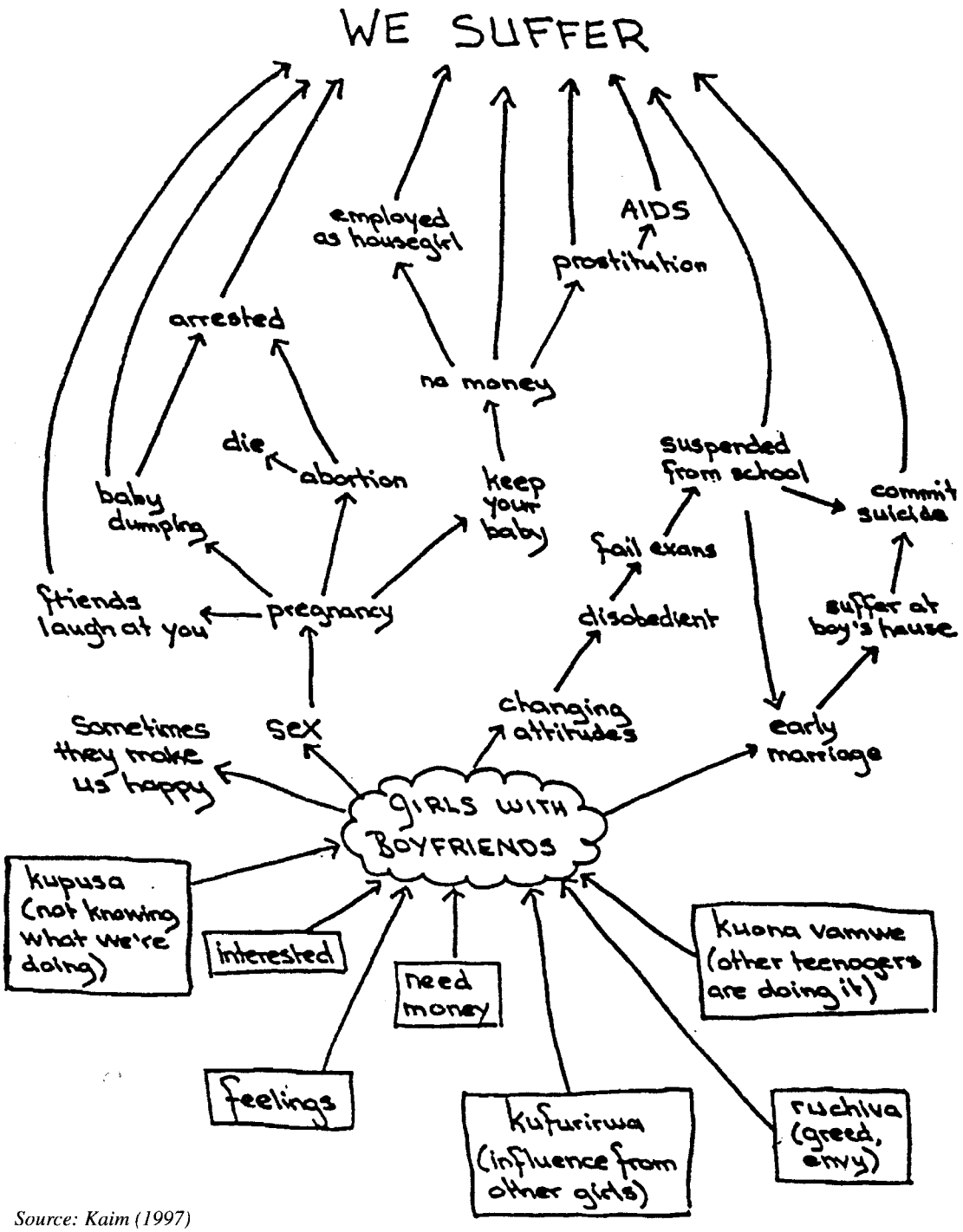
In studies, very few girls express a desire for sexual pleasure, but anyone who listens to popular music or reads popular romances will know that a desire for physical closeness is expressed. Young people, perhaps more girls than boys, recognise the emotional dimension of sexual relationships and both looks forward to sexual pleasure. Interestingly, secular education about reproductive health is less likely to include this aspect of a healthy reproductive life than religious education, although sexual pleasure is only sanctioned within marriage. Religious education stresses the deep emotional content of sexual relationships. By stressing only the dire consequences of sex and not acknowledging sexual pleasure, adults have portrayed an incomplete perspective that does not match reality.

Because stereotypes deny that girls even have sexual desires, girls especially are poorly placed to recognise or plan for these feelings. Instead, they must interpret all their feelings as 'love', an experience that should not require protection. Once the one rule they are taught ("don't have sex") is broken, girls have nothing more to guide them.

FIGURE 1:

PROBLEM TREE: REASONS WHY GIRLS HAVE BOYFRIENDS AND ITS CONSEQUENCES

(View of thirty girls in one rural secondary school)



Source: Kaim (1997)

6 Why have a formal reproductive health curriculum in school?

Adolescents begin having sex in a context that is influenced by a wide array of factors: social, economic, cultural and biological. They enter a transitional period of their lives in a complex world that is full of pressures: from parents, peers and the future ahead. And they have little adult guidance to assist them in negotiating the changes in their bodies and around them.

It is perhaps not surprising that, lacking a forum to discuss the emotional aspects of their developing sexuality, adolescents drift into sexual relationships at a time when their lives are full of uncertainty and vulnerability. To avoid this, they need a "safe space" to ask questions, get accurate facts, express their feelings and acquire communication skills that will protect them. Life skills, not just facts, are key to enabling adolescents to act in their own interest.

The desire to protect adolescents is a goal shared by all adults. What differs is how adults believe they can assure this protection. It is clear that for too many young people, efforts have failed to protect them from unplanned pregnancy and sexually transmitted infections. The AIDS epidemic and its devastating impact on young adults gives a new urgency to equipping young people with the information and skills they need to make healthy decisions.

As the extent of the AIDS epidemic became more apparent during the 1980s, Zimbabwe began to put in place school-based programmes on health education. Often these occurred as collaborations between district or provincial offices of the Ministry of Education and non-governmental organisations or churches. These programmes often were done during club time and were supported by extra-budgetary (often donor) funds. Although often well received, these activities tended to be small scale. It was evident to the Ministry of Education that to achieve greater coverage a nation-wide programme was needed.

6.1 A national curriculum

A national curriculum on family health has been in place for many years. In 1978, the ZNFPC started the Family Life Education, which continues to this day. This is a special session taught by visiting staff. In 1993, in recognition of the need for a formal school-based national curriculum, Zimbabwe implemented the AIDS Action program, initially beginning in Grade 7. The adoption of a programme on a national level reflected a broad consensus regarding the need for action, largely motivated by the looming AIDS epidemic. This was a very important step. Through a consensus building process there was agreement that a school curriculum that took place during lesson time was needed, that the curriculum should be skills based (as well as factual) and start at a young age, before sexual activity had occurred (see Section 6.5 for more information about the AIDS Action Programme).

There were areas in which a consensus was not achieved, especially concerning teaching the broader area of reproductive health. The present curriculum does not include "sex education": teaching about human reproduction. This is covered in biology class. Contraception and sexually

transmitted infections, along with the social context in which sexual activity can occur (for example, forced sex) are also not included. In particular, use of condoms is not a part of the national curriculum.

6.2 Does sex education cause sexual experimentation?

Why is sex education so controversial? Some of the moral concerns, often grounded in religious belief, were outlined in the introduction. In fact, in Zimbabwe as elsewhere in the world, church groups have been among the chief opponents of teaching young people about reproductive health, including sex. This is largely founded on the creed of "no sex before marriage, fidelity within marriage." In the past year, however, the Roman Catholic Church has acknowledged the devastating impact of AIDS and the role of condoms in reducing HIV transmission. This represents an important shift in ecclesiastic thinking, but it is not clear yet how this shift will be reflected in programmes.

There is also enduring widespread concern among many adults that if given information about sex, young people will become curious and give sex a try. Many people are deeply concerned that sex education actually causes young people to begin having sex. If a curriculum resulted in earlier or increased sexual activity, then the curriculum would be harmful, not helpful.

"There is also widespread concern among adults that if given information about sex, young people will become curious and give sex a try."

To help address this universal concern UNAIDS recently commissioned a review of world literature on sex education (UNAIDS, 1997). The purpose of the review was to assess whether there was any evidence that teaching about sex increased sexual activity. This review offers many interesting facts. Some countries, notably Scandinavian countries and the Netherlands, introduced explicit sex education in schools several decades ago. The authors compiled all the studies that could help assess the impact of sex education on adolescent sexual behaviour. In all, 53 studies were identified. In these, 27 showed no impact of the programme on behaviour, 22 reported a positive effect (safer adolescent sexual behaviour). Only 3 studies showed an increase in sexual activity, but in all three there were concerns about the study design used and the validity of conclusions.

This careful and thorough review process showed that there was no concrete evidence that sex education caused young people to have sex. In fact, the better evidence is that by giving young people more complete and accurate information, they made more responsible choices. On a global scale, countries with the most open-minded attitudes about teaching teens about sex (like the Nordic countries or the Netherlands) have lower rates of teen pregnancy, abortion and sexually transmitted infections (Santou and Branches, 1999). And there is no evidence in these countries that teens have more sex than elsewhere. The United States, which has not introduced sex education, has among the worst statistics for adolescent reproductive health in the developed world (more teen pregnancies, more STIs and abortion). Of course, these broad generalizations do not prove a casual connection. And unfortunately, these studies are all from developing countries. Few data on the impact of school based curricula in developing countries are available. In Zimbabwe, a study by Mbizvo et.al. showed that an educational program led to better knowledge, but no conclusive data were available on behaviour.

The UNAIDS review is very reassuring. But many parents, educators and policy makers will not be convinced by this academic exercise to review the impact of sex education. To them, the concern that information will do harm just "makes sense", and no number of studies will shake this belief. But there is broad consensus that young people need help and this help should come from schools. Parents agree; young people agree; the Ministry of Education agrees.

6.3 Adopting a pragmatic approach: plan, implement and learn

We can learn from programmes that have been implemented in Zimbabwe. A great deal of work has been done by many dedicated individuals in the Ministry of Education, NGOs and University. The wisdom accumulated through experience, even if not the result of formal evaluations, is very useful. These "lessons learned" help improve programmes to better achieve this goal: to ensure young people are prepared to become healthy, responsible adults. We want young people to enter loving, pleasurable adult relationships based on mutual respect that supports sexual relationships free of fear. Such relationships are probably the best protection against the many dangers of the adult world.

6.4 Existing programmes in schools

In 1993, the Ministry of Education adopted the "AIDS Action Programme" curriculum in primary and secondary schools. This is the only national curriculum and it has not yet been formally evaluated. There are a number of smaller pilot projects in government schools. None so far have achieved substantial coverage of school-going youth. These smaller programmes mainly arise from the NGO sector (as well as churches) and are conducted mainly in rural areas in collaboration with the Ministry of Education's regional offices. This review focuses on formal teaching, rather than club activities. Table 3 shows the different programmes currently being implemented.

6.5 Challenges for programme development

There are several unanswered questions about how best to teach reproductive health in the school setting. These include concerns about how to deliver instruction. Should teaching be integrated across different topics- such as biology, maths, and social studies? Or should it be taught as a stand-alone programme taught in its own time slot? Who should teach? Should the programme be teacher-led or student-led? Curriculum content continues to be an issue, with ongoing discussion about how much information appropriately should be given about sex, contraception and infection. What is the balance between life skills (such as coping with peer pressure) and facts (such as knowing what sexual intercourse is)?

Next, there are logistic/training concerns about how to ensure the right inputs and implement a programme to schools. How can we assure that teachers are able and willing to teach or co-ordinate this subject? How much training do they need, when should they received it and how can it be delivered? How can we assure importance will be attached to a subject area if it is not examined? How do we maintain the quality of the programme throughout thousands of schools? For small scale NGO-supported projects, the question of how successfully to "scale up" a pilot project and maintain the quality of the pilot is a common issue. But for everyone, including the nation-wide programmes, the introduction of the AIDS /reproductive health curriculum means "scaling up". These curriculum-based programmes did not exist before 1993.

Few of the programmes have been formally evaluated. As a result, it is not possible to say what works and what does not work based on a formal review that uses measurable indicators. Even among the programmes that have been evaluated, none have used what programme evaluators call "hard outcomes." We are unlikely to know in the near future whether any school-based programme reduces teen pregnancy or HIV infection rates. Instead we rely on assessments of whether the programme is acceptable and has actually been implemented. Not infrequently, educational interventions are not successful simply because they have not been delivered. These factors all limit our ability to make definitive conclusions about what works and what doesn't. But the thinking about some of the issues described above assists us in compiling the lessons from the experience so far.

TABLE 3: ONGOING SCHOOL BASED CLASSROOM REPRODUCTIVE HEALTH/AIDS PROGRAMMES IN ZIMBABWE

NAME	GRADES	TIME TABLE	MATERIALS	CONTENT	METHODS	LAUNCHED
National AIDS Action Program for schools	Grade 4 – Form 4; Grade 7 – Form 4 implemented	G & C	Student books for each year. Teacher's guide	Relationships Life skills Human growth and development Health (including HIV)	Teacher-led participatory	1993 National coverage
Population Education Programme	Grades 2-7	Integrated into: Home economics Social Studies Shona/Ndebele Environmental Science	Grades 2-7 books, Teachers' guide	Population Socio-cultural/religious values Gender Health and nutrition	Teacher led participatory	1999 Coverage not known
Dept of Community Medicine, AIDS and Adolescents	Forms 1-4	G&C	8 lessons in Teachers' guide	Aids facts Life skills	Teacher-led participatory	1992 58 schools in Mashonaland East
"Auntie Stella" Adolescent Reproductive Health Project, TARSC	Forms 2-4	G&C	15 lessons on laminated cards, Teachers' Guide	Reproductive health Life skills	Student led, teacher administered (some teacher-led sessions)	1997
Women and AIDS Support Network	Secondary (girls only)	Day workshop	Now under development: communication sex/sexuality; contraception. Case study: women of Chikwaka/positive living	Woman's body Assertiveness HIV/STIs safer sex	Led by WASN staff	1995 7 schools now Chikwaka only
ZNFPC "Family Life Education" project	Primary and secondary	Classroom teaching, group/individual counselling	Youth manual, posters and pamphlets	Human sexuality Puberty Facts on STDs	Led by IEC officers of the ZNFPC	By invitation from headmasters to all provincial ZNFPC officers
Scripture Union	Primary and secondary	Scripture class	7-8 sessions. Two books: 'Adventures Unlimited' and 'Choose Freedom'	AIDS facts Christian values	Led by "torch-bearers" Peer educators 18-27 years	1994 40 schools around Zimbabwe.

The Ministry of Education AIDS Action programme remains the sole national programme. It was developed in 1992, with financial and technical support from UNICEF. In a one-year effort, 5 books were produced for each year from Grade 7 to Form 4 (Ministry of Education, 1993). The programme consists of books for pupils (all with the theme title "Think About it"), along with teacher guides. At present, it begins in Grade 7 and continues through Form 1-4. Extension to Grade 4, primary school level is underway. In 1993, the Ministry of Education began distribution of books to schools.

This is a teacher-led programme conducted during lesson time in the Guidance and Counselling slot. The programme is skills oriented, focusing on life-skills, especially decision making and coping with peer pressure. It lacks information about contraception, including condoms. It also does not contain any description of sexual reproduction, which instead is covered in biology class.

The Ministry of Education is responsible for over 4700 primary schools and 1700 secondary schools in Zimbabwe, so that implementing a programme on this scale has been a substantial achievement. On the other hand, smaller pilot projects (discussed below) continue to be implemented. Because they are not constrained by issues of scale and often have additional donor resources these pilot projects can be a source of innovations and new ideas.

6.5.1 Teacher-led versus teacher-facilitated programmes

One important issue about how to deliver the programme is the question of teacher-led versus teacher-administered programmes. Everyone agrees that the skills we wish young people to acquire (to resist peer pressure, for example) require participatory learning (Ministry of Education, 1993). In this process, students are not passive recipients of information but actively pursue problem identification and solutions. In general, teaching in Zimbabwe is conducted in the "stand and deliver" format, where the teacher stands in front of the class and lectures. In teacher-led programmes in reproductive health, teachers require training in both course content and new teaching methods in order to succeed in learning that is based on interaction and discussions. Some teachers have difficulty with not being the person who is the source of knowledge and the one with all the correct answers. Experience has shown that teachers vary in their interest and ability to teach a curriculum in reproductive health.

However, there are benefits to having an adult source of information that a teacher-led programme provides. Aside from parents and relatives, teachers often are the most important adults in a young person's life. Teachers can use their authority to support adolescents' exploration of their feelings and values. Teachers form an important bridge to the larger community. In addition, teachers are experienced at implementing a curriculum, can keep a programme "on track" and ensure that misinformation does not circulate among the pupils.

Because the course in the Guidance and Counselling slot is not examinable, teacher performance is not assessed against any objective benchmark. An uninterested teacher may mean that learning goals are not achieved but there is no way to assess this. The pilot project "Adolescence and AIDS" run by the Community Medicine Department in Mashonaland East uses Guidance and Counselling teachers, as does the national programme. This project is in place in 58 schools in Mashonaland East and has provided training to over 300 secondary school teachers since 1992. Its experience, never formally evaluated, offers some more in-depth insight into the advantages and disadvantages of a teacher-led curriculum.

In the Community Medicine programme, training in participatory methods helped teachers to adopt new teaching approaches, but did not guarantee their success. Much appeared to rely on the personal inclination of the individual teacher, something that is very difficult to programme. Many teachers were interested and committed, but others were not. Some teachers simply felt uncomfortable with the subject matter of reproductive health and were not able to teach effectively

because of this. Where teachers were successful, the character of the teacher-student relationship greatly improved. This was good for the morale of teachers as well as students. But there were also teachers who did not establish, and perhaps did not deserve, trusting relationships with their students. Students worried that teachers would use classroom discussion to make assumptions about the behaviour of individual students and punish them.

"Training in participatory methods helps teachers to adopt new teaching approaches, but does not guarantee their success."

These experiences suggest that concerns about how best to identify the "right" teacher have not been resolved. Should this be done on a volunteer basis, based on interest? Teaching this programme is an extra workload and teachers are already overworked. Should headmasters identify teachers for reproductive health? In this case the headmaster may make the assignment based on teacher seniority and give the responsibility to more junior teachers. How much training should there be? What happens when teachers are transferred? Resources are limited, so that training cannot be offered every time a new teacher is assigned.

Some programmes have got around the issue of teacher selection by using volunteers or paid staff. Scripture Union, a regional Christian NGO, runs its two programmes in this way. The Women and AIDS Support Network (WASN) also provided its own staff for its school-based project. But these adults are visitors in the young peoples' lives, and usually visitors to the communities in which schools are located as well. Furthermore, sustainability of using a volunteer or paid staff limits replicability.

6.5.2 Letting students take the lead

An alternative to teacher-led programmes is student-led programmes in which teachers play an administrative role. The most common form of student-led activities is clubs, which takes place outside of classroom time. The only student-led programme that takes place during classroom time is "Auntie Stella". This programme was developed by TARSC and then piloted in eight schools in Mashonaland East with support from the Ministry of Education. The curriculum is packaged as laminated cards. It uses the format of a magazine help-line, such as "Aunt Rhoda". During a class, students divide into single sex groups. They review the first card, which poses a question from a young person to Auntie Stella. When they are finished discussing the issue, they ask the teacher for the card with Auntie Stella's reply. Auntie Stella's reply then stimulates further discussion. Each reply by Auntie Stella has a set of action points that can help young people live healthier lives. The curriculum recently has been expanded to 15 lessons. The Auntie Stella pack covers a broad range of topics in reproductive health: sex, gender roles, forced sex, communication with parents, relationships, depression, wanted and unwanted pregnancy, infertility, cervical cancer, HIV/AIDS and STIs. It is targeted at Form 2-4 students and is designed to supplement existing class work in Guidance and Counselling/AIDS.

Auntie Stella was developed so that it could function without the input demanded of teachers in AIDS Action. In addition to the variability in teacher interest, ability and commitment, many students are concerned that teachers will not treat their views with respect and will not maintain confidentiality. The advantage of a student-led approach is that it bypasses all the obstacles that a teacher who is not a good facilitator can pose. It also avoids problems of teachers who are judgmental or who report students whose contribution to discussion suggests morals or behaviour that the teacher does not endorse.

An initial evaluation suggests that reducing the teacher role may raise teacher concerns. The teachers reported that they felt somewhat marginalised as their role was only to record activities (TARSC, 1998). This observation has led to a revision of the pack, with some teacher-led activities, interspersed with student-led ones.

6.5.3 Participatory learning: whose participation do we want?

The issue of teacher-led versus student-led learning raises a broader issue about what is meant by participatory learning (Ministry of Education, 1993). We want young people to learn what it means to be a responsible adult. To do so involves more than facts; it also involves the development of values. No teacher or parent or Ministry of Education official will be there when adolescents find themselves in risky situations. The best we can do to ensure that young people act in their best interest is to give each young person a chance to develop a personal code of conduct in which he or she believes. This is more than rules; it is the development of personal identity and values. To do this requires not merely taking notes, but active involvement in discussion and debate. Participatory learning draws on techniques like role-plays, mock debates, voting games, all of which encourage each pupil to participate and challenges them to articulate a viewpoint.

Who should participate in this process? The main target is the student. Most of all, we want the student to benefit from this learning process. But, in all likelihood, there is also a benefit to adult involvement: both teachers and the broader community. The values of young people do not exist in a vacuum. A process that also involves adults may help young people as well. There is a hint of this work done by the Department of Community Medicine. In schools which had both afternoon clubs run by young people and an in-school class run by teachers, students reported the largest change in risky behaviour (Mataure, 1998). A practical approach is needed, which does not pose teacher-led versus student-led as a conflict but as two ends of a continuum. We need the involvement of teachers, students, parents and the community at large.

6.5.4 Curriculum Content

The curriculum in the national programme was developed over eight years ago and, as yet, has not been revised. Its information on human reproduction is limited and there is no mention of condoms. This reflected the strong position taken by religious groups that had input into the national programme. Pilot projects that liase with Regional offices and do not form part of the official national syllabus have had more latitude. In these projects there has been discussion of what sexual intercourse is, and how pregnancy and infection can be prevented. These more explicit materials appear to have been well-received, reducing concern that communities would find such learning materials difficult. In addition, the national curriculum more often is focused on "education for living" issues and AIDS rather than more broadly on reproductive health. The TARSC and WASN programmes are exceptions to this. Both have developed approaches in the broader area of reproductive health.

Since the Ministry of Education curriculum first was developed, the extent of the Zimbabwean AIDS epidemic has become more apparent. At present Zimbabwe has one of the most severe epidemics in the world (UNAIDS, 1999). It is expected that overall mortality will double and that life expectancy at birth will decline from 57 years to below 40 years. Such bleak statistics make critical the need to protect youth. Although a national consensus is unlikely, more latitude may be possible in curriculum content at community level where decisions can be made locally about what information is needed by young people.

6.5.5 Reproductive health as an examinable subject?

One point that seems key is the fact that the Guidance and Counselling time period is not examined. A successful teacher is not measured by the quality of their relationship with their students, but by student performance on exams. It seems unrealistic to expect a teacher to devote the effort that this new curriculum requires to a subject that will not be assessed. The recently launched Population Education programme (PEP) integrates a number of important topics into the course syllabus of nine examinable subject areas, such as social studies, home economics and environmental science. This paves the way for ensuring that at least some of the content area of reproductive health can be examined across a range of subject areas.

Topics include interactions between populations and the environment, economic growth, reproductive health and adolescence, STIs/HIV/AIDS, parenthood, gender equity, population planning and policy, migration and urbanisation. By placing these topics in the syllabus, they now can be examined. This is an important step.

6.5.6 Issues of scale

The national programme represents Zimbabwe's largest effort to assure that school-going youth have access to information about adult roles and reproductive health. Thc scale of the programme in itself is impressive: 1700 secondary schools and 4700 primary schools. And this does not include the mission schools and private schools that also adhere to the national syllabus. It perhaps is not surprising that the programme coverage is not complete. Not every school has maintained programme implementation. A massive effort has been undertaken to train teachers. At the time of this writing 20 000 of a projected 35 000 teachers have been trained in the Ministry of Education curriculum. The "Think About It" series of books has been reprinted, to ensure that all schools have an adequate number of books. Nonetheless, although the process is ongoing, there remain young people in school who are not exposed to either books or classroom teaching. Incomplete coverage means that too many young people do not have the information and skills they need.

Pilot projects are a source of innovative ideas that can bolster the national programme. But these projects always face concerns about "scaling up". A small scale project that is managed by dedicated staff may not translate easily into a national programme conducted within the Ministry of Education infrastructure. For example, in the Department of Community Medicine programme, visits to schools each term and a newsletter seemed important adjuncts to the two-day training. But visits would likely be impossible if the education officer alone was tasked with them.

Successful pilot projects also suggest the importance of involving multiple levels of government and other community institutions (such as churches or hospitals) The Ministry of Education Regional Office, headquartered in each provincial capital, has a critical role in programme success. Endorsement by education officers, whose job it is to follow up curriculum implementation in schools, is central to the success of a new programme. While policy agreement may be achieved at head office level, the importance of regional and district levels in ensuring that policy is put into practice should not be underestimated. To be involved effectively, their views and opinions are needed.

"Successful pilot projects suggest the importance of involving multiple levels of government and other community institutions."

In addition to Ministry of Education structures, other community institutions may be usefully involved - such as churches or other local Ministry officials (from Health and Child Welfare or Agriculture). Also key is involvement of community leaders and parents. These adults, also important in young people's lives, may need education themselves. At the least, they should be informed about this new programme and urged to support it. Recognition of the need for broader community involvement has prompted the Ministry of Education to conduct outreach activities. NGO led programmes may offer experience in these efforts.

7 The way forward

This review has examined the need for teaching reproductive health in schools, the content of such a programme and the controversies surrounding it. Schools are the best way to reach young people with new information because schools form a single organisational structure that reaches the largest numbers of young people face to face. After young people leave school, adults will never again have them in an organised environment over a prolonged period during which they form a ready audience. In a world that is increasingly complex and in which the initiation of sexual activity has more risks than ever before, schools have expanded their roles. No longer adequate is the 3 R's – "reading, writing and arithmetic". In Zimbabwe today, and all over the world, schools have taken on added responsibilities for preparing young people for adult roles.

The challenges are great. Many social factors contribute to adolescent risk-taking. Growing poverty means more young people will be forced to leave school before they, or their parents, wish them to leave. Pressures for girls to seek partners for economic security will not go away. At the same time, powerful social forces, such as urbanisation, are transforming traditional cultural values. The social forces are not created by the educational system, but they will continue to affect its work.

At a time when many Zimbabweans find making ends meet their main concern, why should we call up schools to assert new roles that have little to do with skills-training for getting a job? One reason is the AIDS epidemic, which threatens the very fabric of society. How many teachers, doctors, lawyers who represent years of investment in training will be lost to AIDS? In Zambia, it is projected that perhaps one-half of teachers will be lost (UNAIDS, 2000). Another reason to make reproductive health a school concern is that a young person who can make responsible decisions about sexual health is a young person who will be a responsible adult. Achieving this will serve them well in all aspects of their lives, from personal relationships to getting a job.

A successful reproductive health programme is not simply an educational issue. It is a youth issue, a gender issue, a human rights issue and a health issue. Many partners are needed to achieve a vibrant school-based programme. Teachers need training in participatory methods and content areas of reproductive health. While in-service training is needed now, enhancing training in these areas in the Teacher Training Colleges is vital. Clearly preparation for a career in teaching must include education in the full range of reproductive health issues including pregnancy, contraception and infection.

Teachers do not carry the responsibility for young people alone. Parents, civic leaders, other government ministries all have a role to play. Support of youth is a multi-sectoral effort. As adults planning for a better future for our young people, we are all parents.

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