







Adolescent Sexual + Reproductive Health and Rights

Participant's Hand Book

social development

Department:
Social Development
REPUBLIC OF SOUTH AFRICA

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HIV/AIDS, Gender Equality, Human Rights

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Content

PARTICIPANT HAND BOOK

PARTICIPANT HAND BOOK: WORKSHOP AGENDA

Objectives	**Session 1**	Establish a workshop framework and a platform for engagement on Sexual and Reproductive Health and Rights
08h30-10h00		Welcome and introduction to the workshop on ASRHR
10h00-10h30		TEA BREAK
Objectives	**Session 2**	Provide information on SRHR and identify the socio-cultural factors that impact on SRHR
10h30-12h00		A rights-based approach to ASRHR
12h00-13h00		LUNCH BREAK
Objectives	**Session 3**	Identify gender role expectations and understand the different values associated with gender roles
13h00-14h30		Building Gender Awareness
14h30-15h00		TEA BREAK
Objectives	**Session 4**	Demonstrate positive and negative listening. Explore communication and principles for working with youth.
15h00-16h30		Communication/Presentation on ASRHR in the Region & Development Indicators (SA)
Objectives	**Session 5**	Provide conceptual clarity and understand how sexuality is mediated.
08h30-10h00		Sex, Sexuality, Sexual Orientation
10h00-10h30		TEA BREAK
Objectives	**Session 6**	Build awareness on HIV prevention through information sharing on STIs, HIV and Medical Male Circumcision.
10h30-12h00		STIs, HIV, Medical Male Circumcision
12h00-13h00		LUNCH BREAK
Objectives	**Session 7**	Develop an understanding of teenage pregnancy through an analysis tool - The Problem Tree
13h00-14h30		Teenage Pregnancy
14h30-15h00		TEA BREAK
Objectives	**Session 8**	Define Violence and Substance Abuse, identify risks and explore accountability
15h00-16h30		Violence, Substance Abuse
Objectives	**Session 9**	Introduce a framework for advocacy and elements of the IDP.
08h30-10h00		Introduction to Advocacy and the Integrated Development Plan (IDP)
10h00-10h30		TEA BREAK
10h30-12h00	**Session 10**	Group Work: Develop Presentations for Stakeholder Engagement
12h00-13h00		LUNCH BREAK
13h00-14h30	**Session 11**	Group Presentations in Plenary
14h30-15h00		TEA BREAK
15h00-16h30	**Session 12**	Workshop Evaluation, Closure/Way Forward

PARTICIPANT HAND BOOK: PRE-WORKSHOP ASSESSMENT

CODE:

How do you rate your understanding of?

Session	1	2	3	4	5
The Human Rights Framework					
ASRHR (in the region)					
ASRHR Sustainable Development in SA					
Principles of Communication					
Sex, Sexuality and Sexual Orientation					
HIV/STIs/Medical Male Circumcision					
Teen Pregnancy					
Violence: GBV/Sexual Violence/Prevention					
Advocacy					
IDP					
My knowledge of ASRHR is?					

Scale:

1- Excellent

2- Good

3- Average

4- Below Par

5- Poor

PARTICIPANT HAND BOOK: PROCESS AND CONTENT OBSERVATION SHEET

1. Ears - Report back on what was heard: things spoken, not spoken, key issues, silences and bogging down discussion

2. Eyes - Report back on what was seen: who moved where, who interacted with whom, images on drawing exercises, observation of body language, etc.

3. Hearts - Report back on feelings during each session, what was the group energy, what changes occurred, why, monitor fatigue/boredom, enthusiasm, hope, tension, anxiety

4. Hands/Feet - Report back on actions mentioned, actions to be taken personally or as a group, or how to improve the next workshop

5. Adult View of the content/process
   - Strengths (what worked well)
   - Concerns (what did not work well)
   - Needs (what will assist in future/recommendations)

6. Youth View of the content/process
   - Strengths (what worked well)
   - Concerns (what did not work well)
   - Needs (what will assist in future/recommendations)

PARTICIPANT HAND BOOK: POST WORKSHOP EVALUATION

CODE

	1	2	3	4	5
The workshop met my expectations					
The workshop content met the objectives					
The exercises contributed to my understanding of the workshop content					
I am familiar with the topics presented in this workshop					
I am satisfied with this workshop – I can engage with the youth in a meaningful manner					
The workshop is relevant to my work					
The learning material is?					
The length of the workshop is?					

Scale:

1- Excellent
2- Good
3- Average
4- Below Par
5- Poor

Facilitator

	1	2	3	4	5
The facilitator stated the workshop objectives					
The facilitator provided relevant examples					
The facilitator clarified concepts and terms					
The facilitator encouraged class participation and interaction					
How effective was the facilitator?					

List three strengths of this workshop

1._____

2._____

3._____

List three areas of improvement for this workshop

1._____

2._____

3._____

PARTICIPANT HAND BOOK: SEXUAL AND REPRODUCTIVE HEALTH RIGHTS AND OBLIGATIONS

The Legal and Policy Framework

International Instruments

A series of global conferences of governments was organized by the United Nations in the 1990's, which produced an action agenda for socially equitable, sustainable development for the 21st century.

- The World Conference on Human Rights (1993)
- The International Conference on Population and Development - ICPD (Cairo 1994)
- The Fourth World Conference on Women (Beijing 1995)
- The World Summit for Social Development (Copenhagen 1995)

These conferences culminated in a progressive, ambitious agenda for social equality, justice, development and peace.

International Treaties, Consensus Documents and Regional Instruments that South Africa is committed to

- International Covenant on Economic, Social and Cultural Rights
- United Nations General Assembly Special Session on HIV and AIDS
- International Covenant on Civil and Political Rights (ICCPR)
- Convention on the Rights of the Child
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW
- African Charter on Human and People's Rights Convention on the Elimination of All Forms of Racial Discrimination (CERD)
- United Nations Millennium Declaration (Millennium Development Goals)
- The Maputo Plan of Action
- The Abuja Declaration
- The SADC Gender Protocol
- The South African Constitution - The Bill of Rights

Chapter 9, The Bill of Rights, of the South African Constitution firmly entrenches equality and health rights and enshrines reproductive rights and access to reproductive health care.

- Section 9 - right to equality includes the full and equal enjoyment of all rights and freedoms
- Section 12 - freedom and security of the person - protects the right to bodily and psychological integrity including the right to make decisions concerning reproduction and to security in and control over their bodies; and not to be subjected to medical or scientific experiments without their informed consent
- Section 27 - right to health care, food, water and social security
- Section 32 - right of access to information

Human Rights and Responsibilities

Human rights are basic conditions that everyone should have simply because they are human beings. Rights may be defined as that which is morally or socially acceptable or just.

With every right comes a duty and responsibility. If an individual has a right to receive

something, this means that someone needs to do or give something to him/her (duty-bound). The individual in turn has to behave in a responsible manner that entitled him/her to that right. The enjoyment of rights and freedoms also implies the performance of duties on the part of everyone.

Health was first articulated as a human right in the Universal Declaration of Human Rights stating that, "everyone has the right to a standard of living adequate for the health and wellbeing of her/himself and her/his family, including food, clothing, housing, medical care and the right to security in the event of sickness. Motherhood and childhood are also declared as entitled to special care and assistance". Under Article 12 of the Covenant of Economic, Social and Cultural Rights, the right to the enjoyment of the highest attainable standard of physical and mental health is recognized.

Health Rights and Responsibilities

The concept of health rights encompasses the right of clients (patients) as well as rights to health promotion and access to clean water, sanitation, nutrition and housing. Since with every right comes responsibility, users of a health care system are required to, on certain responsibilities to, help ensure that their rights are met.

These responsibilities include to have realistic expectations of the health service; taking care of their own health; being sensitive to others; being respectful to healthcare providers; assist their communities to meet the needs of young people or disadvantaged citizens; provide accurate information to providers; comply with treatment; be constructive when raising a complaint; take care of their own health records; use health facilities properly.

Reproductive Health

The definition of the International Conference on Population and Development (ICPD 1994) is "reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes".

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Implicit in this last condition is the right of men and women to be informed of and to have access to safe, effective, affordable, and acceptable methods of contraception (family planning method) of their choice and the right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant. It also includes the right to a safe, legal termination of pregnancy.

Sexual Health

The terms sexual health includes aspects of sexuality not necessarily related to reproduction. It recognizes the fact that people may have sex for the purposes of pleasure, not just reproduction, and that people have health needs related to such sexual activity.

Sexual health is defined as the state of complete physical, mental and social wellbeing in all matters related to the sex organs and their functioning, which allows people to have a satisfying and safe sex life. It implies that people feel satisfied about the way they express their sexual

feelings and are free to do so as long as their sexual behaviour does not harm themselves or others.

Achieving sexual health requires a positive approach to human sexuality and mutual respect between partners. By recognizing sexual health and sexual rights, health and education systems can help prevent and treat the consequences of sexual violence, coercion, discrimination and can ensure that healthy human sexuality is enjoyed by all people and is accepted as part of their overall wellbeing.

Sexual health includes the psychological aspects that underpin relationships between men and women, girls and boys, parents and children and between sexual partners. Central to SRH are gender balance in society and the opportunity for people to express their sexuality. These impact on behaviour patterns with respect to health and access to services.

Sexual and Reproductive Health and Rights (SRHR)

SRHR means that we have control over and can decide about our bodies with respect to sexual and reproductive matters and our sexuality. It includes the right to:

- Be free of coercion, discrimination and violence
- Privacy
- Information and education to make free and informed choices and decisions
- SRH and services that are comprehensive, accessible, private and confidential, respectful of the dignity and comfort of the service user, provide choice, are safe and allow the service user to express views and preferences.

Expanded understanding of sexual and reproductive rights:

- Choose when, if and whom to marry.
- Choose whether or not to have children - also how many and spacing between them.
- Access to information about reproductive health to enable people to make free and informed choices.
- Equality and equity.
- Sexual and reproductive security - freedom from sexual violence
- Right to quality reproductive and sexual health throughout life

Adolescent Sexual and Reproductive Health and Rights

South Africa is a signatory to the United Nations Convention on the Rights of the Child and The African Charter on the Rights and Welfare of the Child. Both treaties recognise access to health-related education and information, including sexual and reproductive health as an important health right. Various laws and policies exist to protect the rights of children in South Africa.

The United Nations Committee on the Rights of the Child says that adolescents have a right to health services that can meet their particular needs, including the right to information on sexual and reproductive health, family planning, contraception, risks associated with early pregnancy, and the prevention and treatment of sexually transmitted diseases.

Every young person has the right to be healthy, to have access to services and to have control in decision making. When the sexual and reproductive health rights of adolescents are recognised, for example, by giving age-appropriate information about sexual and reproductive health issues

and by helping young people to deal with the practice and outcomes of sex in a responsible, respectful and safe way, it becomes possible for them to have satisfying relationships that are characterised by respect and concern for the other.

Sexual Rights

The right to enjoy sex in sexual relationships means that you have the right to:

- Enjoy sex just for the pleasure of it
- Enjoy sex right up into old age
- Be treated as an equal sexual partner
- Be treated with dignity and respect
- Express your desires, needs and concerns - and be listened to
- Be the one to initiate sex
- Choose your sexual partner, whether they are the same or the opposite sex.
- You too have the responsibility to respect the rights of your sexual partner.

The right to safer sex

Safer sex is a way of having sex that protects you from sexually transmitted infections, including HIV/AIDS and from unwanted pregnancy. It is therefore your right to:

- Have a clinic or health facility nearby that can offer you safe and reliable ways to protect yourself from unwanted pregnancy
- Be given the correct information about safer sex, so that you can choose how you want to have sex
- Have access to affordable health care
- Be treated by health care workers in a respectful, caring and sensitive way
- Use male or female condoms to protect yourself from sexually transmitted infections, including HIV.

You have the responsibility to protect yourself and your partner.

PARTICIPANT HAND BOOK: DEFINING SEX, GENDER, GENDER STEREOTYPYING

Definition of Sex

- Sex is the biological aspect of an individual that characterizes the person as male or female
  - The physical difference between women and men.
  - It is biologically determined, and refers to biological characteristics that define humans as female or male.
  - There are cases where people have both male and female sex organs.
  - The World Health Organization defines SEX as either male or female.
  - In most cases SEX is often used to mean Sexual activity/Sexual Intercourse
  - Sex does not vary from culture to culture: a female is a female and male is a male.

Definition of Gender

- Gender describes the behavior and roles played by males and females, based on social expectations.
  - The socially-defined differences between women and men
  - It is socially constructed
  - It is society's idea of what it means to be a man or woman
  - It is the 'rules of behavior' expected of women and men
  - We are born male or female but we learn to be boys/girls who grow to be men/women
  - Gender is a dynamic concept and gender roles change from culture to culture, across societies and over time.

Gender is how an individual or society defines 'female' or 'male'. Gender is used to describe those characteristics of men and women which are socially determined, in contrast to those that are biologically determined; gender roles are socially and culturally defined attitudes, behaviours, expectations, and responsibilities for males and females; to emphasize everything women and men do, and everything expected of them, with the exception of their sexually distinct functions (e.g. childbearing) and can change, over time and according to changing and varied social, economic, political, and cultural factors.

People are born female or male, but learn to be girls and boys who grow into women and men. They are taught what the appropriate behaviour and attitudes and roles and activities are for them, and how they should relate to other people. This learned behaviour is what makes up gender identity and determines gender roles and responsibilities. Gender roles vary greatly from one culture to another and from one social, political and economic group to another within the same culture.

Gender Stereotyping

- From birth boys and girls are treated differently.
  - Girls are raised to be 'sweet', caring, gentle and should help around the house.
  - Boys are encouraged to be tough, strong and confident.
- In the same way women are thought to be more suited for certain types of careers, mainly care-giving roles
- Men are thought of as strong, confident, domineering – suited for positions of leadership, power and control.

Gender and sexual and reproductive choice

- Sexual relationships are gendered
- This plays itself out in a patriarchal context in which men are dominant (make decisions) and women are subordinated
- Results in women not having the confidence, resources, power to make choices and decisions about their bodies and lives

Gender Identity

Is the personal, private conviction each of us has about being male or female; it defines the degree to which each person identified him/herself as male, female or some combination of the two.

For some people their gender does not match their biological sex anatomy. That is, a person born with a male sex anatomy who identifies as a woman or a person born with a female sex anatomy who identifies as a man. Such people do not relate to gender identity associated with the biological sex assigned to them at birth. As a result they feel that their sex is a false or incomplete description of themselves. People who think about themselves in this way have a transgender identity.

Some transgender people choose to change part or all of their sex anatomy by taking hormone treatment and/or undergoing gender reassignment surgery often called 'sex change' operations.

Gender Equality

Gender equality refers to equal opportunities and outcomes for women and men. It implies the removal of discrimination and structural inequalities in access to resources, opportunities and services, and the promotion of equal rights.

Equality does not mean that women should be the same as men. Promoting equality recognizes that men and women have different roles and needs and takes these into account in development planning and programming.

Gender equality permits women and men equal enjoyment of human rights, socially valued goods, opportunities, resources, and the benefits from development results. The fact that gender categories change over time means that development programming can have an impact on gender inequality, either increasing it or decreasing it.

Gender Equity

Gender equity is the process of being fair to women and men. To ensure fairness, measures must be available to compensate for historical and social disadvantages that prevent women and men from operating on a level play field. Gender equity strategies are used to eventually attain gender equality. Equity is the means; equality is the result.

Gender Integration

Gender integration means taking into account both the differences and the inequalities between women and men in program planning, implementation, and evaluation. The roles of women and men and their relative power affect who does what in carrying out an activity, and who benefits.

Taking into account the inequalities and designing programs to reduce inequality should contribute not only to more effective development programs but also to greater social equity/ equality.

Gender Mainstreaming (A strategy for gender equality)

Gender equality strategies have been formulated within many initiatives to try and achieve the equal treatment of and equal opportunities for women and men through changes in institutional practices, legislation and planning methods. Success is measured by examining the overall impact on women, men and gender equality. The Beijing Platform for Action (1995) emphasised 2 aspects for mainstreaming:

- Equitable distribution of resources, opportunities and benefits of the mainstreaming process. This requires the integration of equality concerns into the analysis and formulation of policies, programmes, and projects with the objective of ensuring that these have a positive impact on women and reduce gender disparities
- The inclusion of needs, experiences and visions of women in the definition of development approaches, policies and programmes. This requires strategies that enable women to formulate and express their views and participate in decision-making across all development issues
- Mainstreaming as a strategy, does not preclude initiatives specifically directed towards women or towards achieving equality between men and women. Such initiatives are necessary and complementary to a mainstreaming strategy.

Relationship between Gender and Health

Patterns of health and illness in women and men show marked differences. Women suffer considerable mortality (death) and morbidity (ill health) particularly their SRH such as pregnancy-related illness, STIs, infertility and reproductive tract cancers (e.g. cervical cancer).

- Differences in anatomy and power in relationships puts women at risk of physical and sexual abuse; their ability to negotiate safe sex to protect women from STIs/HIV is limited
- A range of cultural practices have negative effects such as female genital mutilation and dry sex
- Child marriage and child bearing increases the risk of pregnancy related complications, in addition to limiting the socio-economic opportunities for young girls
- Women face a higher risk of poverty than men, due to a lack of economic resources such as access to credit, land, inheritance, education)
- In some societies, preference for male children is expressed through allocations of food for boys, education for boys, and access to health for boys etc. Poor nutrition results in health deficiencies especially in later life during pregnancy and breastfeeding when nutritional requirements increase.

Gender-based inequalities in health that exist in society also influence health and the health sector:

- Women predominate among health care workers (as nurses, midwives etc)
- Women provide most of the (unpaid) health care in families and communities, but are under-represented in community-level decision making processes
- Although women are targeted in maternal health and family planning programmes, this is largely focused on them only in relation to children and child-bearing functions. This focus neglects men as fathers with responsibility for children

- Science/medical research has neglected both the physical and socio-economic differences between men and women. There are gaps on gender differences (as contributing factors), disease courses and treatment. There is limited investment into women-specific health problems such as cervical and breast cancer compared to investment into products for male sexual pleasure - Viagra.

Why gender is important

There is growing consensus (agreement) that sustainable development requires and understanding of both women's and men's roles and responsibilities within the community and their relations to each other. The main objective of the Gender and Development Approach (GAD) is mainstreaming women's needs and perspectives into all activities.

Mainstreaming acknowledges that all development operations have a gender impact and do not automatically benefit men and women equally. Thus it is necessary to adopt a GAD approach for development programmes to benefit both men and women, and also for sustainable development and positive impact on society as a whole.

Why Gender is considered as Women's Empowerment

Although 'Gender and Development' includes both women and men, in most cases its focus is given to women. It is because of the imbalance and unequal status of women in most societies, where women do not have the same opportunities and personal freedom as men do. Therefore, there is a need to focus on women compared to men. It is like two glasses, where one is half full and another is empty, thus the empty glass should get water first and when both glasses become equal, then fill both. If someone tries to fill both glasses without noticing the level of water it won't work.

Gender, Economics and Reproductive Choice

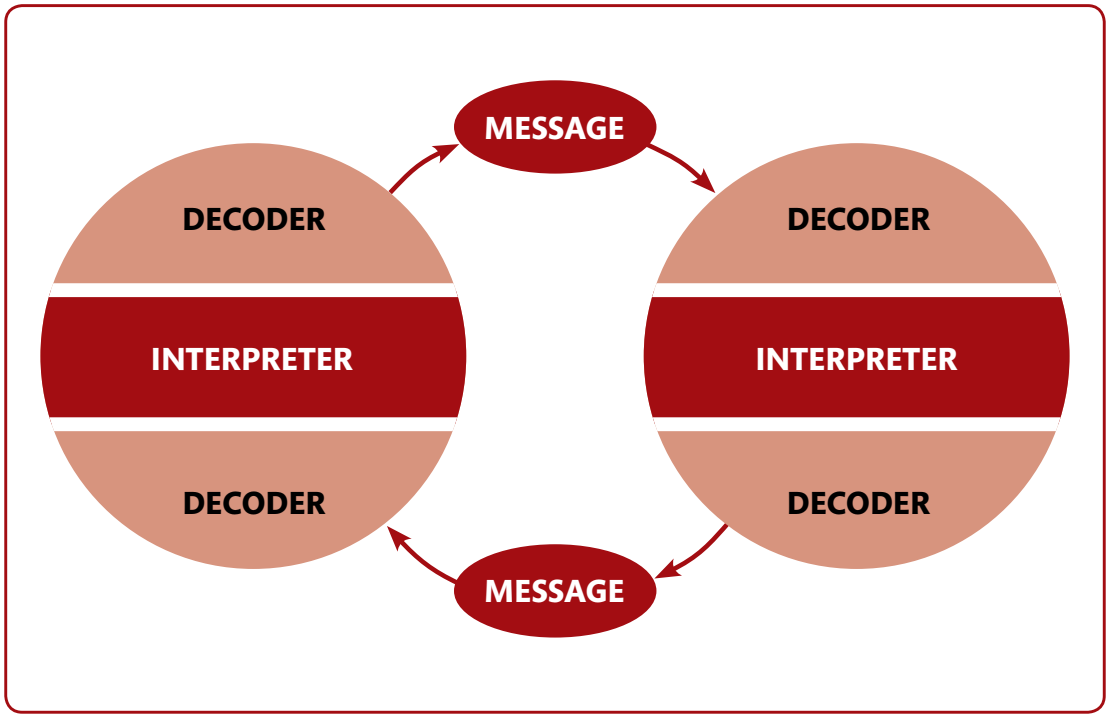
The extent to which women and men can exercise their choices is determined by their access to resources

- Access to quality care RH services is extremely uneven and linked to:
  - class position - whether we can pay for it which
  - for historic reasons, links to previous racial classification
  - gender
  - geographical location
  - age: very few youth friendly services that enable young people to make healthy reproductive choices

PARTICIPANT HAND BOOK: THE 24 HOUR DAY

Men's Activity	Paid Y/N Approximate Value	Women's Activity	Paid Y/N Approximate Value
01h00-02h00			
02h00-03h00			
04h00-05h00			
06h00-07h00			
08h00-09h00			
10h00-11h00			
12h00-13h00			
14h00-15h00			
16h00-17h00			
18h00-19h00			
20h00-21h00			
22h00-23h00			
23h00-24h00			

PARTICIPANT HAND BOOK: MODEL OF COMMUNICATION



PARTICIPANT HAND BOOK: PROVOCATIVE IMAGE

PARTICIPANT HAND BOOK: COMMUNICATION

Forms of Communication

Verbal Communication

Verbal communication includes sounds, words, language, and speech. Speaking is an effective way of communicating and helps in expressing our emotions in words. This form of communication is further classified into four types, which are:

Intrapersonal Communication - is extremely private and restricted to ourselves. It includes the silent conversations we have with ourselves, wherein we juggle roles between the sender and receiver who are processing our thoughts and actions. This process of communication when analyzed can either be conveyed verbally to someone or stay confined as thoughts.

Interpersonal Communication - takes place between two individuals and is thus a one-on-one conversation. Here, the two individuals involved will swap their roles of sender and receiver in order to communicate in a clearer manner.

Small Group Communication can take place only when there are more than two people involved. Here the number of people will be small enough to allow each person to interact and converse with the rest. Press conferences, board meetings, and team meetings are examples of group communication. Unless a specific issue is being discussed, small group discussions can become chaotic and difficult to interpret by everybody. This lag in understanding information completely can result in miscommunication.

Public Communication takes place when one individual addresses a large gathering of people. Election campaigns and public speeches are examples of this type of communication. In such cases, there is usually a single sender of information and several receivers who are being addressed.

Nonverbal Communication

Nonverbal communication manages to convey the sender's message without having to use words. This form of communication supersedes all other forms because of its usage and effectiveness.

Nonverbal communication involves the use of physical ways of communication, such as tone of the voice, touch, and expressions.

Symbols and sign language are also included in nonverbal communication.

Body posture and language convey a lot of nonverbal messages when communicating verbally with someone.

Folded arms and crossed legs are some of the defensive nonverbal signals conveyed by people. Shaking hands, patting and touching, express feelings of intimacy. Facial expressions, gestures and eye contact are all different ways of communication. Creative and aesthetic nonverbal forms of communication include music, dancing and sculpturing.

Written Communication

Written communication is the medium through which the message of the sender is conveyed with the help of written words.

Letters, personal journals, e-mails, reports, articles, and memos are some forms of written communication.

Unlike other forms of communication, written messages can be edited and rectified before it is communicated to the receiver. Thereby, making written communication an indispensable part of informal and formal communication.

This form of communication encapsulates features of visual communication as well, especially when the messages are conveyed through electronic devices such as laptops, phones, and visual presentations that involve the use of text or words.

Visual Communication

This form of communication involves the visual display of information, wherein the message is understood or expressed with the help of visual aids. For example, photography, signs, symbols, maps, colours, posters, banners and designs help the viewer understand the message visually.

Movies and plays, television shows and video clips are all electronic form of visual communication.

Visual communication also involves the transfer of information in the form of text, which is received through an electronic medium such as a computer, phone, etc.

Icons and emoticons are a form of visual communication. When these icons are used in a public place, phone or computer, they instruct the user about their meaning and usage.

The greatest example of visual communication is the World Wide Web which communicates with the masses, using a combination of text, design, links, images, and colour. All of these visual features require us to view the screen in order to understand the message being conveyed.

Media communication is developing at a fast pace to ensure clarity and to eliminate any misunderstanding. Verbal, non-verbal, written and visual communication have played a vital role and continue to do so, in bridging the gap between people, commerce, education, health care, and entertainment.

What you perceive is it not necessarily so.....

Direct (effective) Communication

It is two-way communication. Ideas, opinions, values, attitudes, beliefs, and feelings flow freely from one person to another.

It is marked by active listening. People take responsibility for what they hear—accepting, clarifying, and checking the meaning, content, and intent of what the other person says.

It utilizes effective feedback. Each person not only listens actively, but also responds to the other person by telling that person what he or she is hearing. The process of feedback tests whether what was heard is what was intended.

It is not stressful. Communication is not effective if people are concerned that they are not communicating; when this happens, it is a key that the communication is not functioning properly.

It is clear and unencumbered by mixed or contradictory messages. Such messages, whether verbal, nonverbal, or symbolic, serve to confuse the content

Negative listening behaviours

Give advice when you were not asked for it – say something like "you should" or "if I were you"

Interrupt the speaker while he or she is talking

Try to top the speaker's story with a better one of your own

Put the speaker down by criticising his or her behaviour, saying things like "that's dumb" or "why would you do that"

Change the subject to something unrelated to what the speaker is talking about

Lean over and whisper to someone else while the speaker is talking

Listen carefully at first, then begin to look bored; gaze around the room, sigh, look at your watch, roll your eyes.

Disagree with the speaker: each time she/he says something, challenge it and say what you think he/she should be doing

Start writing, reading, drawing, or scribbling

Positive listening skills

Give the speaker your full attention

Lean towards the speaker

Make eye contact with the speaker, unless that would be rude to your culture

Nod or shake your head in response to the speakers comments.

Make verbal responses that lets the speaker know that you are listening, such as "yes' or "go on"

Change your facial expression to reflect the appropriate emotion, such as concern, excitement, fear and so on

Check out the meaning of the speaker's message – say what you think he/she is saying and ask if that is correct

Intergenerational Communication

What is Intergenerational Communication?

Interactions between age groups

In the family: parent to child, grandparent and grandchild, uncle and niece, aunt and nephew

Outside the family: child and adult, middle-aged person and older person

Much of our communication is intergenerational (across varying age groups of people)

The potential for miscommunication exists across generations

Intergenerational Communication Challenges?

Absent Parents

Increasing role of grandparents in child-rearing

Rural verses Urban families

Engaging Youth

Involving youth in community development

Don't expect more from a youth than you would expect from an adult

Treat young people as individuals; an individual (youth) does not represent a group

Be mindful not to interrupt when communicating

It's okay to ask for help when you don't know how to do something

Acknowledge the positive; always start with gifts, knowledge, talents, aspirations and skills of young people – never with their needs and problems

Affirm the uniqueness of the individual, never the category to which a young person belongs to

Embrace and share the conviction that every community is filled with useful opportunities for young people to contribute towards

There is no community institution or association that can't find a useful role for young people

Distinguish between real community-building work and falsehood (games/fakes)

Challenge segregation that is based on age; work to overcome the isolation of young people

Move away from stereotyping (aggregating people by their sameness)

Principles when working with young people

Work with them, not for them

Assist youth to understand, analyze, plan and carry out

Young people must decide the major issues, basic needs and how to address these

Development is an awakening process

Enable young people to see their right to human dignity. Draw on their strength, listen to them.

Let youth grow

Build youth, so that they build themselves, so that they experience dignity and self-respect

Build solidarity

Build together, with other youth, in solidarity

Build up youth organizations

Establish links with other organizations and groups to increase their participation and bargaining power

PARTICIPANT HAND BOOK: SEX, SEXUALITY, SEXUAL ORIENTATION

The definition of Sex

Sex can mean the biological characteristics (anatomical, physiological and genetic) that make us male or female. Sex can also mean sexual activity, including sexual intercourse.

Sexual Orientation

Sexual orientation refers to emotional, romantic or sexual attraction to men, women, neither sex, the same sex or both sexes.

- Some people are attracted to the opposite sex. We refer to such people as heterosexual.
- Some people are attracted to the same sex. We refer to such people as homosexual. Men who are attracted to other men are sometimes called gay. Women who are attracted to other women are called lesbian.
- Some people are attracted to both sexes. We refer to such people as bisexual.
- Some people are born with sex anatomy that is not clearly male or clearly female. This can be at the level of their reproductive organs inside their bodies, or sex organs on the outside of their bodies, or a combination of these. This means that a person has some parts usually associated with males and some parts usually associated with females. We refer to these people as intersex. It does not mean that a person has all the parts of a female anatomy and all the parts of a male sex anatomy.
- Transgender does not imply any specific form of sexual orientation. Transgender people may identify as heterosexual, homosexual, bisexual, or asexual.
- Lesbian, Gay, Bisexual, Transgender and Intersex people form a group collectively known as LGBTI.

The definition of Sexuality by the World Health Organization

"A central aspect of being human throughout life and encompasses sex, gender identities, roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.

Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships.

While sexuality can include all these aspects, not all of them are always experienced or expressed.

Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors."

PARTICIPANT HAND BOOK: SEXUALLY TRANSMITTED INFECTIONS (STIs)

Table of commonly contracted STIs and their symptoms

Name of STI	Symptoms	Cause /Type	Curable?
Syphilis	Hard, painless, single, clean, ulcer/ lesion on the penis/vaginal area, inside rectum or mouth, persistent fever, sore throat, patches of hair loss, rashes on palms, soles, chest and back	Bacterial infection	Yes
Chancroid	Ulcers – painful, multiple, soft, painful swelling of lymph nodes (one side)	bacterial infection	Yes
Herpes genitalis	Multiple ulcers, shallow erosions, incurable, severe pain, fever, difficulty urinating, tenderness on the inside of the legs	Viral infection	No - but treatable
Gonorrhoea	Thick yellow discharge from penis/ vagina, pain urinating and, or, during sex	Bacterial infection	Yes
Chlamydia	Abnormal discharge from the penis/vagina, infertility , bleeding/ pain during intercourse, pain while urinating	Bacterial infection	Yes
Hepatitis B	Severe infection shows: Loss of appetite, nausea/vomiting, fever, joint pains, jaundice symptoms, dark urine, pain in abdomen	Viral infection	No - but treatable
Urethritis	Mild/severe pain while urinating, pus/ mucous discharge from penis/vagina	Bacterial infection	Yes
Proctisis	Itching/burning around anus, pus/ mucous discharge in stool, mild/ severe pain during bowel movement, occasional diarrhoea or fever (3 out of 10 boys show no symptoms)	Bacterial infection	Yes
Genital warts	External warts around anus or penis/ vagina	Viral infection	No - but treatable
Crabs	Lice in the hairy parts of the body, itching (mostly) at night	Parasite	Yes
Scabies	Itchy red spots or rash on wrists, ankles, hands, penis/vagina, chest and back	Parasite	Yes
HIV	Damages immune system, incurable, leads to AIDS	Viral infection	No - but treatable

PARTICIPANT HAND BOOK: TEENAGE PREGNANCY

Consequences of early childbearing (Department of Education)

Elevated risks of maternal death	There is conflicting evidence on the health risks associated with teenage pregnancy. While some studies suggest that pregnancy before the age of 20 carries more health risks than pregnancies at older ages, others suggest that the greatest risk are for those at younger ages, if any at all (NRC &IOM, 2005
Elevated risk of obstetrics complications	Risks associated with physiological immaturity include cephalopelvic disproportion, toxaemia, hypertension and vagio-rectal or urethral fistulae and placental abruption (Blum, 2007; Blum & Nelson-Mmari, 2004).
Low birth weight	Low birth weight is a significant risk factor for infant mortality. In fact, low birth weight is the number two killer among South African children under five, second only to HIV and AIDS
High risk of infant mortality	International studies indicate that children of teen mothers are more likely to experience health problems compared to children of older mothers. (Shaw et al., 2006).

Consequences for Education

School dropout	Studies in the US have shown that child-rearing, lack of parental support and lack of support from peers, all contribute to high dropout rates (Cassell, 2002)
School absenteeism	
Poor academic performance	Low birth weight is associated with negative outcomes later in life such as cognitive and physical disabilities and lower educational attainment
Lower educational attainment	
Poorer cognitive development of children	
Poorer educational outcomes for children	Children of teenage mothers are more likely to drop out of school, obtain lower grade point averages and report poorer school attendance records (Cassell, 2002; Kirby, 2007).

Economic Consequences

Lower family income	Young mothers are barred by a lack of education and inexperience from earning a sound living (Bissell, 2000).
Increased dependency ratio	
Exacerbated poverty	For teenagers whose mother had an adolescent birth, 32 % had given birth by the age of 20 compared to 11% of those whose mothers delayed child bearing beyond 20 years of age. In this way the intergenerational transmission of poverty is perpetuated between mothers and daughters
Children most likely to be poor	

Social Consequences

Stigma and discrimination	Because of the relation of teen pregnancy, contraceptive use, HIV and STIs to sexuality, it will forever remain bounded with morality and stigma. Stigma during or after pregnancy can lead to depression, social exclusion, low self-esteem and poor academic performance affecting future employment prospects (Abe & Zane, 1990).
Less likely to be married	Studies carried out in the US have reported that teen mothers are more likely to be single parents and if married to experience high divorce rates (Ashcraft and Lang, 2006; National Campaign to Prevent Teen Pregnancy, 2002; UNFPA, 2007).
Most likely to suffer abuse	Studies from sub-Saharan Africa, US and Europe have indicated that teenage mothers face a high frequency of physical abuse (UNFPA, 2007)
Less supportive and stimulating home environment for children	
Increased behaviour problems among children	
Higher rates of imprisonment among sons	For sons, teenage motherhood increases the risk of behaviour problems and, particularly, for imprisonment (Hoffman, 2006).
Children more likely to give birth as teenagers	For teenagers whose mother had an adolescent birth, 32 percent had given birth by the age of 20 compared to 11 percent of those whose mothers delayed child bearing beyond 20 years of age

Source: Breheny & Stephens, 2007; Hoffman, 2006; Kirby, 2007

Key determinants of teenage pregnancy

- Individual/Intrapersonal factors

Individual or intrapersonal factors are those attributes of an individual that increases his/her likelihood of engaging in risky behaviour by influencing how he/she interacts with the other contexts, and the influence that those contexts bring to bear on him/her (Bronfenbrenner, 1979).

- Sexual behaviour

The sexual behaviour of adolescents has the potential to confer significant risk to adolescents experiencing early pregnancy and contracting STIs and HIV.

- Interpersonal factors

The day-to-day social environment in which young people participate and develop can have a profound effect on behaviour. Families, together with partners, peers and schools play a significant role in identity formation and decision making (NRC & IOM, 2005).

- Families

Many aspects of family life exert substantial influence on adolescents' sexual behaviours and pregnancy risk (Miller, Benson, Galbraith, 2001; Miller, 2002). These include socio-economic status (to be discussed later on), family type, parental values and role-modelling, parental style, monitoring and support and parent-child communication.

- Institutional factors

Staff at public health clinics, as the gatekeepers to health care services, can have a significant impact on young people's sexual behaviour (Eaton et al., 2003). When quality health care services are provided by skilled professionals without judgement and respect for the confidentiality of adolescents, they are more likely to make use of these services (WHO, 2002). In addition, services that are convenient in terms of open times, do not involve having to stand in long queues and are free or at least affordable, are more likely to attract young people (WHO, 2002).

Yet studies conducted across the world have shown that when young people require health services, the public sector is often the last resort. The conditional nature of health services – either through physical distance, poor quality of clinical services, lack of privacy and respect, high costs and a culture of shame that surrounds certain conditions that are reinforced by health care workers, makes health care inaccessible, unacceptable and inappropriate (WHO, 2002).

- Structural factors

Much emphasis has been placed on how individual behaviour and social interaction with important others confer risk for pregnancy, STIs and HIV. However, increasingly, the context in which young people grow up is being identified as the differentiating factor for which young people are protected against negative life outcomes and which are at heightened risk.

- Public policy

Government policy has the power to influence the trajectory of teenage pregnancy through both direct and indirect ways. Policy decisions can determine the availability (or the lack thereof) of resources to provide critical services and to implement programmes (Brindis, 2006). Highly-politicised debates on public policy have the capacity to determine the direction of policy, the types of services that are made available to young people (Brindis, 2006) and to raise the consciousness of the public about the issue being discussed, often with the potential of producing shifts in norms. As the agency of young people to influence their own development and that of others is increasingly recognised, they become targets of policies and programmes (NRC & IOM, 2005). Some policy decisions are targeted at youth directly as primary decision makers, while others influence the context in which young people are growing up (NRC & IOM, 2005)

The Choice on Termination of Pregnancy Act, 92 of 1996 (CTOPA)

This was the first health legislation to be passed by the new democratic government. The CTOPA touted as among the most liberal abortion laws in the world, gives women of any age or marital status access to abortion services upon request during the first 12 weeks of pregnancy, and under certain conditions, extends access to the first 20 weeks of pregnancy. This Act is also viewed as one that fully embraces a reproductive health rights culture, by giving due recognition to women's rights to make the full range of reproductive choices including termination of pregnancy.

- Consent

No consent (from a parent or partner) is required, only the consent of the pregnant woman.

The Act defines a woman, as a female of any age. It does not require the consent of a parent for a girl under the age of 18 years.

It does advise that a girl under 18 years should be advised to consult with a parent, family member, friend before the pregnancy is terminated. Should she however choose not to do so, it is her choice to continue with the TOP. She will be required to sign a form that states that she has been advised in this regard.

The act provides for a TOP upon request of a pregnant woman within the first 12 weeks of pregnancy, and can be provided by a registered nurse or midwife, trained in abortion care.

A TOP may be provided at 13-20 weeks of pregnancy, by medical practitioner if the:

- Pregnancy as a result of incest or rape
- Continued pregnancy – risk to physical or mental health of woman
- Continued pregnancy – risk to physical or mental health of foetus
- Continued pregnancy – cause major social or economic problems for woman

A TOP may be provided post 20 weeks of pregnancy, by a medical practitioner, if the health of the woman or foetus is at risk.

Certain health facilities have been designated by the Minister of Health to provide the service.

The Act provides for penalties:

- If a TOP is done at an un-designated facility
- If a TOP is performed by an untrained provider and/or if a health care provider is found to obstruct a woman from exercising her reproductive right to access a TOP

PARTICIPANT HAND BOOK: RISK BEHAVIOUR AND RISK FACTORS FOR YOUTH & VIOLENCE

a. Participating in physical fights, bullying and carrying of weapons is common amongst school going youth and those who have dropped out of school. Aggression such as bullying and physical fights can lead to more serious forms of violence

b. Children exhibit behaviour in early childhood that gradually escalates to more severe forms of aggression. Adolescents and young adulthood is a time when violence, as well as other types of behaviour is often given heightened expression. Aggression can continue through a pattern of persistent offending from early childhood to adolescence and to adulthood.

Risk Factors for Youth and Violence

a. Individual level: biological, psychological and behavioural characteristics - these may appear in childhood or adolescence and may be influenced by family, peers, other social and cultural factors.

b. The influence of families is usually the greatest during childhood. During adolescence friends and peers have an important effect. Parental behaviour and the family environment are central factors in the development of violent behaviour in young people. Poor supervision of children by parents and the use of harsh physical punishment as a form of discipline are strong predictors of violence during adolescence and adulthood.

c. Peer influences during adolescence are generally considered positive and important in shaping interpersonal relationships, but they can also have negative effects - a correlation between having delinquent friends and the use of drugs.

d. Community factors, the nature of peer relations and exposure to situations that lead to violence. Boys living in urban areas are more likely to be involved in violent behaviour than those living in rural areas.

e. Gangs, guns and drugs are a potent mixture, increasing the likelihood of violence.

f. Media impacts on youth and violence.

PARTICIPANT HAND BOOK: SEXUAL VIOLATION

VIOLATIONS THAT TAKE PLACE IN DIFFERENT CIRCUMSTANCES AND SETTINGS

Type	Examples
Rape	Rape within marriage Rape by an Intimate Partner Date Rape Rape by Strangers Gang Rape Systematic Rape (during armed conflict) Homophobic Rape (rape of LGBTI) Forced Sexual Initiation
Sexual Abuse	Unwanted sexual advances Sexual harassment Sexual abuse of disabled people, children and the elderly Sexual violence against men and boys, women and girls Sexual abuse of people in police custody, in prison and/or in the army
Harmful Practices	Forced co-habitation/marriage Genital Mutilation/Obligatory Virginity Testing Sexual Trafficking/Prostitution/Sex slavery Violence as a form of punishment, for honour and/or for humiliation Denial of support (education, shelter, food, health, money)
SRHR Violation	Denial of the right to use contraception Denial of the right to protect against pregnancy, STIs, HIV Forced Abortion Backstreet Abortion Forced sterilization Forced Co-habitation Child Marriage Gender Based Violence (includes violence against men and women) Sexual Violence Violence against Women (violence that is specifically targeted at women)

PARTICIPANT HAND BOOK: THE DVA AND SOA

THE DOMESTIC VIOLENCE ACT

The Domestic Violence Act (DVA) was promulgated in 1998 in order to provide victims (survivors) of domestic violence with an accessible legal tool to stop abuses taking place within domestic relationships. The DVA defines domestic violence as physical abuse, sexual abuse, emotional abuse, verbal abuse, economic abuse, intimidation, stalking, causing damage to property, entering your home.

The Act defines a domestic relationship as a relationship between a complainant and a respondent in any of the following ways: A husband and wife married to each other, including marriage according to any law, custom or religion whether they are still married or not; A gay or lesbian couple whether they are still a couple or have separated; A couple who live or lived together but who are not and have never been married to each other; Parents of a child or are persons who have or had parental responsibility for a child whether or not at the same time; Family members whether the family relationship is blood, marriage or adoption; People who are or were engaged; People involved in a dating or customary relationship including an actual or perceived romantic, intimate or sexual relationship of any duration; or They share or recently shared the same residence.

THE CRIMINAL LAW (SEXUAL OFFENCES AND RELATED MATTERS) AMENDMENT ACT

The Act, commonly known as the Sexual Offences Act was promulgated in 2007, defining a range of sexual offences.

Rape, compelled rape and acts of consensual sexual penetration with certain children (12 years and older but under 16 years) – formerly defined as statutory rape.

Sexual assault, Compelled sexual assault, Compelled self-sexual assault and Acts of consensual sexual violation with certain children (12 years and older but under 16 years)

Other contact sexual offences: Compelling or causing an adult to witness a sexual offence, sexual act or self-masturbation, Exposure or display of or causing exposure or display of genital organs, anus or female breasts to adult persons ("flashing"), Exposure or display of or causing exposure or display of child pornography to adults, Incest, Bestiality, Sexual act with a corpse, Sexual grooming of a child, Exposure or display of or causing exposure or display of child pornography or other pornography to children, Using children for child pornography, Compelling or causing children to witness sexual offences, sexual acts or self-masturbation, Exposure or display of or causing exposure or display of genital organs, anus or female breasts to a child ("flashing"), Sexual grooming of a person who is mentally disabled, Exposure or display of or causing exposure or display of child pornography or other pornography to persons who are mentally disabled, Using persons who are mentally disabled for pornographic purposes, Trafficking in persons for sexual purposes and Procuring females for prostitution

Attempted sexual offences: Attempt, conspiracy or incitement to commit a sexual offence

Sexual offences detected as a result of police action: Engaging the sexual services of adults for financial or other reward, favour or compensation; Keeping a brothel, Furthering acts of prostitution; Living from the earnings of prostitution and Public indecency.

Sexual Violence and HIV

- Violent or forced sex increases the risk of transmitting HIV
- Adolescent girls are particularly susceptible to HIV infection through forced sex because their vaginal mucous membrane has not yet acquired the cellular density providing an effective barrier, that develops in the later teenage years
- Anal rape makes boys and girls susceptible since tissues are easily damaged, than would be the case when sex is not forced
- Forced sex in childhood and adolescence increases the likelihood of engaging in unprotected sex, having multiple partners, participating in sex work and substance abuse
- People in intimate relationships who experience forced sex, find condom use difficult to negotiate

Reducing the incidence of both sexual violence and HIV infection

- Education is foremost
- Comprehensive interventions in schools, universities, colleges, youth groups, workplaces
- School curricula should cover relevant aspects of sexual and reproductive health, relationships and violence
- Life skills should cover how to avoid risk or threatening situations, including violence, sex, drugs and how to negotiate safe sexual behaviour
- For adults accessible information on sexual health and consequences of specific sexual practices, interventions to change harmful patterns or behaviour and social norms that hinder communication o sexual matters
- Health care workers and educators should receive integrated training on gender, reproductive health, GBV, STIs and HIV infection
- Rape victims/survivors should be screened and referred for HIV infection and access PEP and counselling
- Voluntary HIV counselling programs for HIV should incorporate violence prevention strategies

PARTICIPANT HAND BOOK: SUBSTANCE USE AND ABUSE

TYPES OF DRUGS

Socially 'acceptable' Drugs	Tobacco, Alcohol, Caffeine
Household Drugs	Thinners, Glue, Tipex, Aerosol, Nail Polish Remover, Benzine
Over the Counter Drugs	Cough Syrups, Laxatives, Pain Relievers, Steroids, Slimming Tablets and Pills
Stimulants 'Uppers'	Cocaine, Khat (Cat), Amphetamines (Speed, Crystal Meth)
Depressants 'Downers'	Valium, Rohypnol, Anti-depressants
Hallucinogens (alter perception and mood)	LSD, Mushrooms, Cannabis, Ecstacy
Narcotics (dulls the senses)	Morphine, Codeine, Heroin

SIDE EFFECTS OF DRUGS

Physiological	Headaches, Chest Pains, Heart Palpitations, Shortness of Breath, Diarrhoea and Vomiting, Nausea, Numbness, Sweating, Muscle Spasms, Double Vision, Internal Organ Complications, Blood Diseases, Skin Infections
Psychological	Paranoia, Hallucinations, Depression, Anxiety, Fear, Suicidal thoughts, Confusion

HARMFUL EFFECTS

DAGGA	ALCOHOL	COCAINE	TOBACCO
Paranoia, Risk of Psychosis, Drowsiness and reflective mode, Confusion and Restlessness, Impaired logic, reasoning and coordination, Loss of short term memory, Bronchitis, Emphysema, Infertility, Miscarriages, Psychological problems	Liver Disease, Liver failure, Heart Disease, Irregular heartbeat, Stomach Ulcers, Intestinal Ulcers, Intestinal Cancer, Osteoporosis (bone disease), Blurred Vision, Slurred Speech, Bleeding throat	False sense of euphoria, Mood swings, Paranoia, Heart Failure, Anxiety, Stroke, Nervousness, Respiratory failure	Lung cancer, Increased risk of osteoporosis, Asthma, Emphysema, Decreased circulation, Increased pulse rate, Cancer of the mouth, Larynx, Pharynx, Pancreas

PARTICIPANT HAND BOOK: ADVOCACY

What is advocacy?

Advocacy is about change. Advocacy identifies root causes of problems. It is geared towards influencing decision- makers and includes activities such as lobbying, mobilizing, research, and networking.

A Framework for understanding Advocacy

Advocacy is an ACTION directed at change. It involves putting a problem on the table and proposing a solution to that problem. Advocacy includes building support for the proposed solution and for working towards the realization of that solution.

Key Questions Asked

- What is the problem?
- Why is it a problem?
- How do we know that it is a problem?
- How does it relate to the current context?
- Who are the key stakeholders – those that have a stake in the problem?
- What is the proposed solution?
- What are the key messages?
- How will we get these messages out?
- What strategies are required?

Levels of Advocacy

Advocating for reproductive and sexual health arises from the recognition that: reproductive and sexual health problems are caused by decisions made at the (i) household level and (ii) from decisions made within community leadership structures, (iii) national legislatures, (iv) international organisations, and (v) powerful public and private institutions FEMNET 2008

Benefits of Advocacy

- Tackles root causes of poverty and injustice and brings long-term change
- Sees people as agents of change in their own communities
- Can help to generate more resources for other development work
- Can change power structures and systems of injustice

Tearfund 2002

Advocacy Tools

The tools that are used in advocacy include: research; building coalitions/networks, undertaking media advocacy, litigation (instituting legal cases), mobilizing communities, lobbying policy makers and government officials, and strategic networking.

A framework for research - Policy Analysis

Step 1: Identify the problem, a government policy that is linked to the problem (i.e. Teen Pregnancy)

Step 2: Explore government's commitment, which mainly examines the treaties, documents, policies (consensus documents) relating to the issue of teen pregnancy

Step 3: Examine the capacity to implement the policy by analysing resources available for implementation (ASRHR services)

Step 4: Assess the impact of the policy on the right to health: availability, accessibility, acceptability, quality of services and facilities. (Steps 3+4 imply data collection for an analysis in order to determine the rights affected and people affected)

Step 5: Holding government accountable based on the State's obligation and minimum standard

Step 6: Formulate recommendations based on the gaps you identified through analysis and develop an advocacy action plan.

PARTICIPANT HAND BOOK: THE IDP

Definition

In 1995 the Forum for Effective Planning and Development (FEPD) defined iIntegrated development planning as

"A participatory approach to integrate economic, sectoral, spatial, social, institutional, environmental and fiscal strategies in order to support the optimal allocation of scarce resources between sectors and geographical areas and across the population in a manner that provides sustainable growth, equity and the empowerment of the poor and the marginalised."

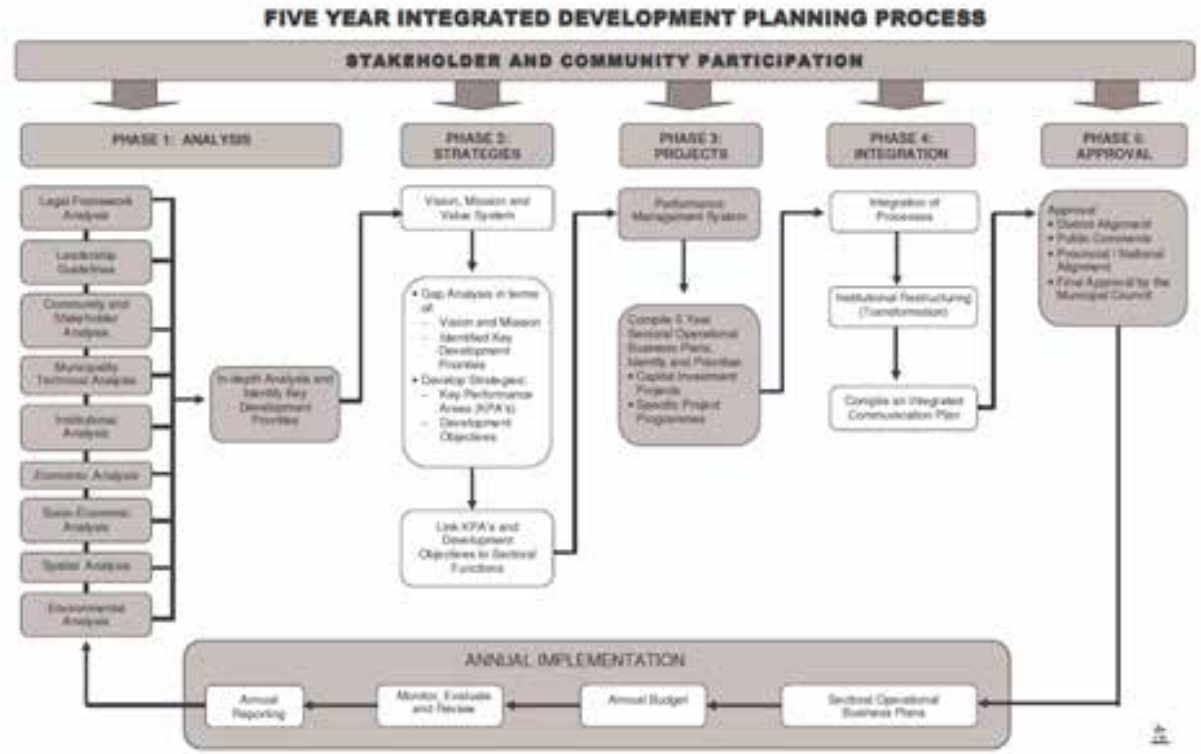
Municipal Responsibilities

- Municipalities are now required to be developmental in their approach and activities.
- Municipalities are also required to make informed projections about and anticipate future demands
- Integrated development planning is a process through which municipalities prepare a strategic development plan which extends over a five-year period.
- The value of integrated development planning for municipalities is embedded in the formulation of focused plans that are based on developmental priorities.

Intended purpose of the municipal IDP:

- Ensure sustainable provision of services;
- Promote social and economic development;
- Promote a safe and healthy environment;
- Give priority to the basic needs of communities; and
- Encourage community involvement.

The IDP Process



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social development

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