



aahungnama

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WHO Defines SRH Competencies for PHC Providers



World Health Organization (WHO) has collected the core sexual and reproductive health (SRH) competencies that are desirable for use in primary health care (PHC) in a document titled Sexual and Reproductive Health Core Competencies in Primary Care: Attitudes, Knowledge, Ethics, Human Rights, Leadership, Management, Teamwork, Community Work,

Education, Counseling, Clinical Settings, Service, Provision. The document, released early this year reflects the attitudes, tasks, knowledge and skills that health personnel in PHC may need, to protect, promote and provide SRH in the community. These competencies serve as the first step for policy-makers, planners, service organizations and academic/

training establishments, to understand and meet both the education/training requirements and the service-delivery support needed by SRH staff to provide safe, quality SRH care. The competencies have been developed through a technical consultation of SRH experts in research, education, policy and service, over more than two years.

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Director's Note

September 2011 brings with it the beginning of a new strategic planning period for Aahung. The last three years have resulted in groundbreaking work in sexual and reproductive health (SRH), with Aahung forging significant relationships with public teaching and medical institutions, community outreach organizations and private reproductive healthcare institutions. Since 2008, Aahung has successfully trained hundreds of staff from partner NGOs, faculty from medical schools and teachers. Aahung's training modules have successfully been incorporated into the curricula of renowned medical schools in Pakistan and taught at private and government secondary schools across Sindh.

Reflecting on accomplishments and areas for improvement in the last three years has allowed Aahung to use its learnings to develop a new three-year strategic plan which will further focus on institutional strengthening. Aahung will work with partner institutions to develop their management and staff capacity on SRH while providing tools, implementation support and feedback to ensure that activities and information sessions carried forward into the field and classrooms is done so with quality and accuracy. Aahung will also support institutions in building their capacity to deal with the SRH needs of those that they service so that an overall enabling environment can be further created for men, women and young people.

Where there is a supply of quality services, however, there also needs to be a demand for such services. Therefore, Aahung aims to increase its outreach to individuals through the use of media and communications strategies in the coming three years. This will involve creating materials for distribution in schools and clinics as well as the development of media campaigns that spread vital information regarding sexual and reproductive health and rights.

As always, the success of our work depends on our partnerships and we would like to thank those institutions and organizations that have prioritized SRH and used their time and resources to improve their services in this area. We look forward to the next three years of successful partnerships and to taking a few steps closer towards having a sexually healthier society in Pakistan.

Sheena Hadi, Director Aahung

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The consultation included two workshops and many rounds of review in a Delphi-research-style process. A survey on the role of PHC providers in SRH was also undertaken to inform the competency definitions.

The document suggests to countries to use the competencies to clarify and match competencies with job descriptions of different health providers working in the SRH team in PHC. It also recommends that the local health managers support service personnel in the field by ensuring that they have job descriptions reflecting the competencies required in their SRH role and that they have the updating and supervision necessary. This may also mean that standards and guidelines need to be updated. The competencies should then be the starting point for the education/training curricula of SRH providers.

The competencies

There are 13 competencies grouped into four domains:

1 The first domain is the overarching attitude, which builds on SRH workers' knowledge of ethics and principles, and thus becomes the "sine qua non" (essential item) for the fulfilment of the individual client's human rights. Domain 1 is not actually a group of competencies, but the fundamental basis of all competencies to make sure that all SRH services and associated competencies are driven by human rights and the social values of equity, solidarity and social participation.

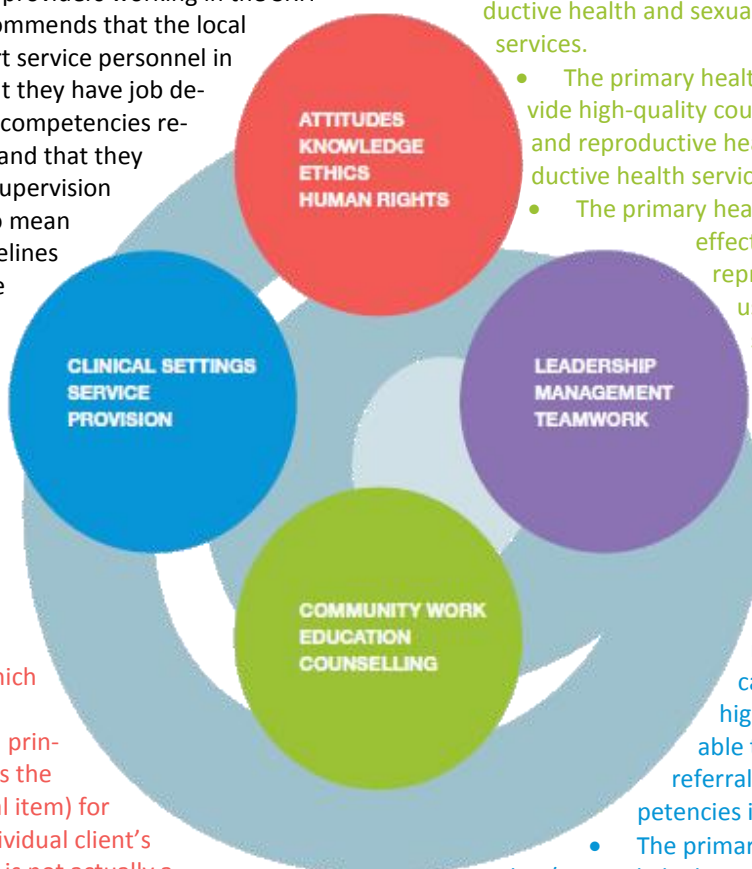
2 The second domain is the leadership and managerial domain, addressed to national SRH programme leaders and managers, but which could also apply to any level including at a health facility level; it has two competencies: Leadership and management. The first competency focuses on performing a leadership role that provides an environment that enables primary healthcare team members to perform effectively. The second competency in this domain is about effective management of the primary health-care team to allow the efficient provision of quality sexual and reproductive health services.

3 The third domain has four general SRH competencies for health providers, including:

- The primary health-care team member/s provide comprehensive and integrated sexual and reproductive health care, working efficiently in and with the community.
- The primary health-care team member/s provide high-quality health education related to sexual and reproductive health and sexual and reproductive health services.
 - The primary health-care team member/s provide high-quality counselling related to sexual and reproductive health and sexual and reproductive health services.
 - The primary health-care team member/s effectively assess the sexual and reproductive health needs of users of primary health-care services for treatment and referral when necessary.

4 The fourth domain includes seven specific clinical competencies for different types of sexual and reproductive health-care provision, related to the knowledge and skills needed by primary health-care teams/providers to make high-quality SRH services available to individuals, and include referral when required. These competencies include:

- The primary health-care team member/s provide high-quality family-planning care
- The primary health-care team member/s provide high-quality sexually transmitted infection and reproductive tract infection care
- The primary health-care team member/s provide screening and treatment/referral for reproductive tract cancers
- The primary health-care team member/s provide high-quality comprehensive abortion care
- The primary health-care team member/s provide high-quality antenatal care
- The primary health-care team member/s provide high-quality care during labour, birth and immediate postpartum
- The primary health-care team member/s provide comprehensive, high-quality postnatal care for women and neonates



Research Highlights Need for SRH Module in Medical Curriculum

Sexual and reproductive health (SRH) accounts for 20% of the global burden of ill health for women and 14% for men (WHO); however, in Pakistan the general belief is that sexuality issues are not our problem. This belief is reflected in health care practices as shown by a recent study published in Journal of Pakistan Medical Association.

It is known that knowledge, opinions and attitudes are related to behaviours, as reproductive health training and attitude are predictive factors for reproductive behaviours. However, the overall knowledge score of all candidates interviewed in the study indicated that the participants lacked the basic knowledge for managing cases of SRH effectively. Majority of candidates (80%) in informal interviews indicated that an important reason behind the lack of knowledge is that SRH care is significantly under-represented in the basic educational curriculum for medical and other health professionals as well as in continuing medical education programmes. Others reported lack of integration of sexual health related topics in health care professionals' education as a contributing factor.

In the research study, female doctors scored better than their male counterparts on knowledge levels. This may be due to the fact that they deal with such cases more frequently than male doctors. Another factor contributing to this lack of knowledge among male doctors could be the general attitude of males towards such issues, as not being their problem. The research results also indicated a severe lack of knowledge related to female reproductive health issues.

Sexual history taking can be influenced by medical college training, cultural brought-up, attitudes towards sexual orientation and patient and doctor gender. It is therefore not surprising

that many doctors in the research sample reported being uncomfortable when taking sexual histories, particularly from the young and elderly patients. A lack of appropriate vocabulary of words for sexual and reproductive parts in the local languages is also an important reason for the discomfort in taking a comprehensive history.

One crucial skill for effective and proper management of patient is that a doctor should be fully aware of the local resources, ethical norms of society and law. Health care providers should know the ethical guidelines specially about the patients' rights regarding disposal of information, confi-

Sexual and reproductive health training should be provided at undergraduate, postgraduate & health care providers

dentiality and informed consent. These issues are particularly important in providing SRH services; however participants in the study showed poor knowledge in this area.

When asked about abortion, around 20% of participants disagreed with the thought for giving referral for safe medical abortion, another 30% gave controversial opinion showing the judgmental (as opposed to professional) attitude towards abortion. These practices contribute to an increase in the incidence of unsafe abortion and associated complications.

Sexual health problems significantly impact the quality of life of millions of

individuals. It is necessary that public healthcare providers should be experienced and sensitive when dealing with patients with sexuality issues. Respect of all categories of patients with reproductive health issues is vitally important, but is rarely discussed as a public health or medical issues. This study pointed out that students had insufficient training about SRH before coming into clinical practice.

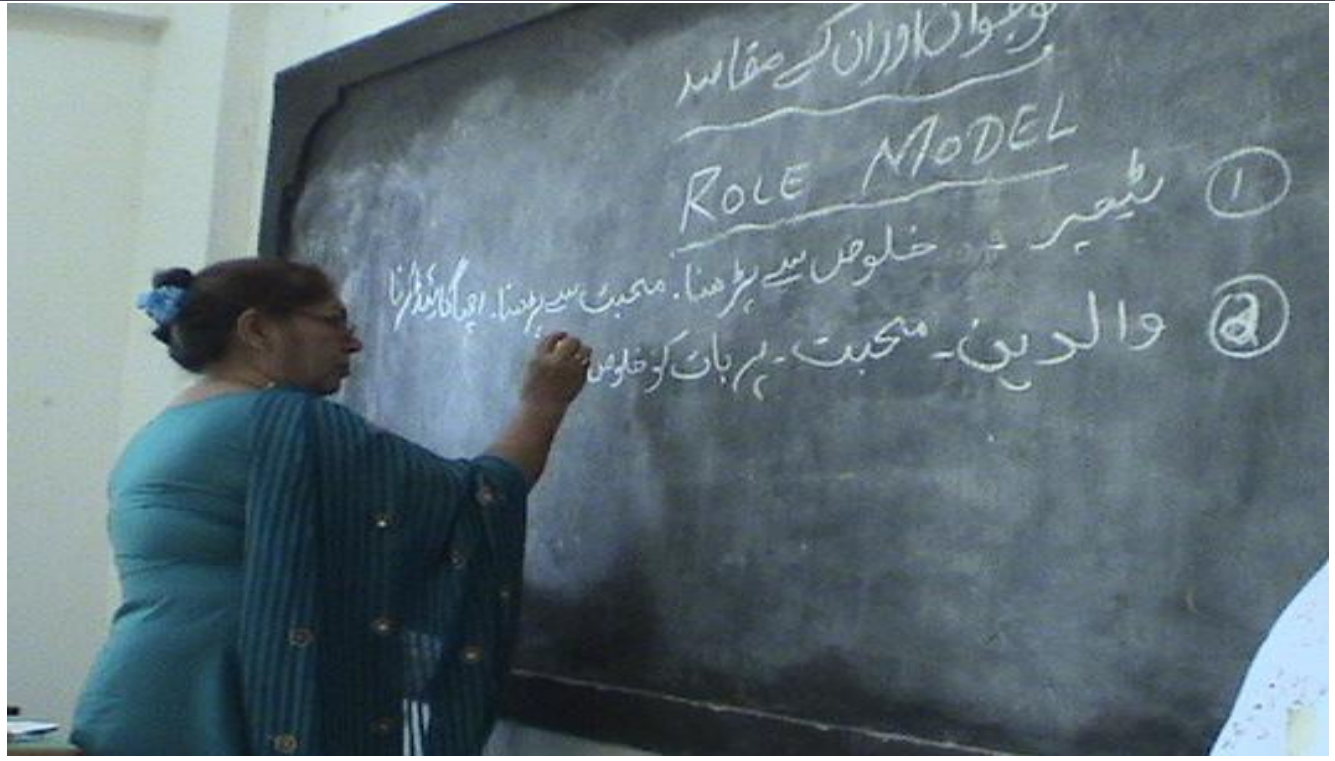
The research study concluded that traditional education in obstetrics and gynaecology rarely provides students with adequate training in understanding the sexuality problems of patients in the clinical practice. It suggested that SRH training should be provided at undergraduate as well as at postgraduate level with refresher courses for continuing medical education. The article notes that there should be a module on sexuality, which develops emerging doctor's awareness about the need of community sexuality and its impact on care of patients and understanding of male and female sexual responses.

In addition, it should help students to understand social, physiological and emotional influences on sexual function and dysfunction, different modes of sexual expression and the implication of body image and self esteem. They should be fully trained with the legality issues (like informed consent) for reproductive and sexual health.

Finally there is utmost need of refresher courses as continued medical educations for doctors working in community, to improve community sexual health management by properly trained doctors. It is suggested to bring changes in undergraduate medical curriculum to develop a better attitude towards working in community.

Full article can be accessed at

<http://jpma.org.pk/PdfDownload/2860.pdf>



Knowledge of Life Skills Based Education Improves Parenting

Shaheena, a 50-year-old woman from a middle class family, has been teaching at a government secondary school for the last 27 years. She holds a Masters degree in Urdu Literature and Administration. She got married to Asim, a journalist, at the age of 25. In 2009, she attended the life skills based education (LSBE) training that has transformed her approach towards life. She feels that the training has changed her perspectives towards both her personal and professional life.

Shaheena has three children - two sons and one daughter. With her eldest son being mentally handicapped, Shaheena has tried her best to get him through formal schooling; however he left school after grade six despite all the strict measures taken by Shaheena. Since 2001 he has been at home.

Shaheena claims that the LSBE training has changed her perspective towards life. "I would not have lost my

elder son to abnormality had I gone through LSBE training 10 years ago. He was a slow learner, in fact mentally handicapped which I could not realize at that time and as a reaction I used to beat him up for not taking interest in studies. He was so scared of failures that he would break into tears in loneliness. His teachers also insulted him in the class and his class fellows used to make fun of him too". Shaheena narrates with her eyes filled with tears.

After Shaheena attended the LSBE training, she realized the importance of understanding children and being their friend. She says, "I have transformed from a conventional teacher to more of a facilitator. I empower children and give them confidence and help to make their own decisions. This applies for my own children as well. I don't use a stick any more, but there were times when I used it very frequently to beat children in order to force them to study. Now, I talk to them and communicate with them

about practicing positive attitude in life. I involve myself with them and also help my colleagues in dealing with their issues, as well as with problematic and naughty students."

Regarding information gained from the human development part of the LSBE curriculum, Shaheena was of the opinion that children should be given information on body changes and development by their trusted adults because "There are so many options to get information now, so we should be the first one to give knowledge with correct information to our children; this would save them from misguidance".

Shaheena suggests that parents must be oriented with LSBE as times have changed and they must have knowledge as well as skills to communicate with their children on topics which are usually ignored.

Note: Names have been changed to maintain privacy.

By Zoab Mansoor

CSBR Celebrates its 10th Birthday at the 4th Sexuality Institute

The Coalition for Sexual and Bodily Rights in Muslim Societies (CSBR), founded a decade ago with an aim to stand in solidarity with and learn from each other's experience for promotion of sexual and bodily rights, held its 4th Sexuality Institute from July 16 – 23, 2011 in Kuala Lumpur, Malaysia. The institute brought together 21 sexual health and rights activists from Malaysia, Indonesia, Lebanon, Pakistan, Turkey, Sudan, Nigeria, Palestine, Kyrgyzstan, Philippine, and USA/Iran.

Over the course of eight days, participants revisited ideas about sexuality, gender, rights, sexuality education, Islam and sexuality, sexuality politics, global debates on sexuality, advocacy strategies and the use of new technologies for sexual rights advocacy. The course was taught by activists and academics using workshops, lectures, discussions, group work and exercises, roundtables, a panel session with SRHR activists from Malaysia and theatre.

A significant portion of time was dedicated to experience sharing, in particular those related to the challenges faced by each of the participants in their national setting and the advocacy strategies used to counter the varied sets of issues. Those attending the institute returned with answers to many of their questions while bringing back a whole new set of questions. The participants also carried back with them a hope that the knowledge and skills acquired, and the network of sexual health and rights activists established during the institute will help them to come up with answers to many of these questions.

By Farhat Firdous

While the CSBR Sexuality Institute answered many questions, it also opened up new avenues for SRHR debate for activists

UNHRC Passes Resolution on Sexual Orientation and Gender Identity

In a groundbreaking achievement for upholding the principles of the Universal Declaration of Human Rights (UDHR), the United Nations Human Rights Council passed a resolution on human rights violations based on sexual orientation and gender identity on June 17, 2011.

The resolution, presented by South Africa along with Brasil and 39 additional co-sponsors from all regions of the world, was passed by a vote of 23 in favour, 19 against, and 3 abstentions. A list of how States voted is attached. In its presentation to Council, South Africa recalled the UDHR noting that "everyone is entitled to all rights and freedoms without distinction of any kind" and Brasil called on the Council to "open the long closed doors of dialogue".

The resolution is the first UN resolution ever to bring specific focus to human rights violations based on sexual orientation and gender identity, and follows a joint statement on these issues delivered at the March session

of the council. It affirms the universality of human rights, and notes concern about acts of violence and discrimination based on sexual orientation and gender identity. This commitment of the Human Rights Council sends an important signal of support to human rights defenders working on these issues, and recognizes the legitimacy of their work.

The resolution requests the High Commissioner for Human Rights to prepare a study on violence and discrimination on the basis of sexual orientation and gender identity, and calls for a panel discussion to be held at the Human Rights Council to discuss the findings of the study in a constructive and transparent manner, and to consider appropriate follow-up.

The resolution is consistent with other regional and national jurisprudence, and just this week, the 2011 United Nations Political Declaration on HIV and AIDS recognised the need to address the human rights of men who have sex with men, and the Organiza-

tion of American States adopted by consensus a resolution condemning violence and discrimination on the basis of sexual orientation and gender identity.

Earlier in this 17th session of the Human Rights Council, the UN Special Rapporteur on violence against women, its causes and consequences, Rashida Manjoo, reported to the Council that:

"Contributory factors for risk of violence include individual aspects of women's bodily attributes such as race, skin colour, intellectual and physical abilities, age, language skills and fluency, ethnic identity and sexual orientation."

The report also detailed a number of violations committed against lesbian, bisexual and trans women, including cases of rape, attacks and murders. It is therefore regrettable that a reference to "women who face sexuality-related violence" was removed from the final version of another resolution focused on the elimination of violence against women during the same session.

