

Module 7

Adolescent Reproductive Health



SRI LANKA
ZIMBABWE

June, 2002

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Cover Photo: UNESCO/Winsome Gordon
Printer: AG2i Communication
ED.99/WS/16
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Regional Training Seminar on guidance and Counselling
Module 7, Adolescent Reproductive Health

MODULE 7
**ADOLESCENT
REPRODUCTIVE HEALTH**
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FOREWORD

African Ministers of Education have long been aware of the growing number of social problems which affect the lives of young Africans, particularly girls, and determined some time ago that their education systems had to play a much more active and positive role, in promoting the growth and development of the young people entrusted to their care.

Before taking action they took into account the declarations and recommendations of the Pan-African Conference on the Education of Girls (Ouagadougou, Burkina Faso, 1993), and the Fourth World Conference on Women (Beijing, China, 1995), and other international gatherings on matters related to women. They then convened a series of technical meetings in English and French-speaking countries, at both the regional and the national level, to decide in greater detail what should be done. The consensus reached was that Guidance and Counselling should be an integral part of the education of children, and should be included in teacher training programmes.

This coordinated effort resulted in the establishment in April 1997, of a Board of Governors, made up of African Ministers of Education, who would be responsible for policy decisions, and for establishing procedures in the development of the Guidance and Counselling Programme. In preparing the programme African countries would collaborate so that it would benefit from the best African expertise. It was also agreed that The Guidance, Counselling and Youth Development Centre for Africa, designed to provide training for teacher trainers and youth and social workers from all over the continent, would be set up in Malawi. While this programme was intended for use with boys and girls, its content and organization are such that special attention is given to the needs and requirements of girls.

Assistance is being given by a number of international and regional agencies such as UNESCO, UNICEF, UNFPA, FAWA (the Forum for African Women Educationalists), DANIDA, the Rockefeller Foundation, and from countries such as Finland and the USA.

A training package on Guidance and Counselling has been prepared by African specialists from various countries in consultation with other competent persons. It consists of eight training modules — Guidance, Counselling, Social Work, Behaviour Modification, Gender Sensitivity, Guidance and Counselling Programme Development, Adolescent Reproductive Health, and Workshop Administration and Conduct Guidelines. The modules encourage the use of non-threatening approaches, particularly with regard to sensitive issues, and are accompanied by charts, transparencies, and video films as

teaching aids. Supporting materials are also drawn from other relevant programmes being implemented in the respective countries.

Although intended for use in the training of trainers, the suggested activities are also generally suitable for use with school-age children. Each module is comprised of units, and sets out objectives and activities for small and large groups. Because of the shortage of appropriate reference materials for Guidance and Counselling, each module includes additional reading.

ACKNOWLEDGEMENTS

This Module was developed over the years by several committed trainers of the regional training programme in Guidance and counselling that is held in Malawi every year. Ms Ranjine C. Jayawardana, Secretary, National Education Commission, Sri Lanka, and Dr Tapiwa Jhamba, Lecturer, Centre for Population Studies, University of Zimbabwe, finally prepared this module based on the work of their predecessors. They are both trainers in the regional training programme. The programme has benefited from their knowledge of Adolescent Reproductive Health, and HIV/AIDS, in particular.

I wish to take this opportunity to thank this international team for their contribution.

I must also express my thanks to Italy, the Danish International Development Agency (DANIDA), Finland, UNICEF, UNFPA and UNDP for their contributions, both in cash and kind, to the preparation of this modules.

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MODULE 7

Adolescent Reproductive Health

INTRODUCTION

This module deals with Adolescent Reproductive Health.

Adolescents or, more generally, young people represent an important segment of society; particularly in developing countries, where they are the bulk of the population. They form the majority in terms of size, and also as the reservoir for future leaders, and are the promise of a better life for the community.

Adolescence can be defined in terms of age, physical development, social behaviour, or social concepts. Within this module we define adolescence as the growing process between childhood and adulthood, particularly between the ages of 10 and 18. Adolescence can be divided into three development stages, which are shown in Reading # 1, Development Stages, on page 6. For the ages from birth to full adulthood we use the broader term youth. Finally we define teenager in terms of reproductive maturity.

In adolescence young people face substantial physical and emotional changes. Adolescents are often insecure, and have problems in articulating their obvious needs due to ongoing changes. Sometimes family members or friends try to help the adolescent to adjust. But, especially with the beginning of sexuality, questions arise which are taboo, and about which family members and friends refuse to talk. Such problems could, for example, be questions concerning sexual protection, unplanned adolescent pregnancies, or sexually transmitted diseases like HIV/AIDS. In general adolescent reproductive health will be defined, not only as the absence of disease, but also as a state of physical,

mental and social well-being. Teachers can help to prevent some of the problems by means of careful, and open, education. They can also help adolescents to find their personal and sexual identity.

This module will provide crucial information, and will propose practical guidance for teaching about this sensitive subject.

UNIT 1

Physical Changes During Adolescence

RATIONAL

The purpose of this unit is to provide information concerning physical changes, as well as the development of the reproductive system in both genders.

LEARNING OUTCOMES

By the end of the unit, you should be able to:

- Identify and explain physical changes during adolescence;
- Be aware of the differences in changes in male and female adolescents;
- Explain the development of the reproductive system of both genders.

CONTENT

This unit includes the following:

Topic 1. Puberty

Topic 2. The Development of the Reproductive Systems of Males and Females

Topic 3. Menstruation

Topic 1

PUBERTY

The puberty of females begins normally between the ages of 8 and 12, and ends around the age of 16. In contrast, the onset of puberty in males starts between 10 and 14 years, and lasts until 18. Thus, the onset of puberty is consistently two years earlier in girls than in boys. The development stages of male and female adolescents are given in **Reading #1**, on page 6.

The physical signs, which accompany puberty, are listed in **Reading # 2**, The Changes During Adolescence, on pages 7-13.

Activity 1.1

Group Work:

This activity involves watching the film 'From Birth to Adolescence'.

1. After viewing the video, form groups of five, and discuss the differences between each member of the group according to:

- Physical appearance
- Facial features
- Posture
- Height
- Weight
- Size

2. Discuss the differences identified, and what could have contributed to them.

3. To which development stage do the secondary school pupils of your schools belong?

4. Discuss with the group the changes that take place during puberty in females and males.

After your discussion, check how many of the following points have been raised.

For females:

- a) Breast budding
- b) Growth of bony pelvis
- c) Growth spurt
- d) Pubic hair
- e) First menstrual period

- f) Underarm hair
- g) Oil and sweat producing glands
- h) Completion of the growth of the uterus and vagina

For males:

- a) Growth of testes and scrotum
- b) Straight pubic hair
- c) First ejaculation
- d) Growth spurt – arms, legs, penis
- e) Voice change
- f) Underarm and coarser body hair
- g) Oil and sweat glands activated
- h) Facial hair – beard

Discuss with the group each of the changes, and explain them with the help of **Reading # 2**.

Topic 2.

THE DEVELOPMENT OF THE REPRODUCTIVE SYSTEMS OF MALES AND FEMALES

One of the important changes during puberty is the development of the reproductive system of females and males.

Talking openly about this subject is difficult for most adolescents, because it is taboo in families and society. The following activity should help to encourage adolescents to speak about this topic.

NOTE : Review for yourself **Reading #3, Human Reproduction** on pages 16-21.

Activity 1.2

Go through **Reading # 4, Diagrams of the Male Reproductive System**, on pages 22-23.

Look at the diagram (male reproductive system) under Assessment 1.3 on page 24, and write the correct name for each part.

Using **Reading #3** discuss the functions of the different parts of the male reproductive system.

Using **Reading #3** do the **Assessment 1.4** on page 25.

Activity 1.3

Go through **Reading #5**, Diagrams of the Female Reproductive System on pages 26-28. Look at the diagram (female reproductive system) under Assessment 1.5 on page 29, and write the correct name for each part.

Using **Reading #3** discuss the functions of the different parts of the female reproductive system.

Use **Reading #3** and do the Assessment 1.6, on page 30.

Topic 3. **MENSTRUATION**

The first menstruation is a big event in a young girl's life, and it is anticipated with ambivalent feelings and expectations. Teachers can help to make this event a positive experience by:

1. Affirming the mother's role in preparation for the first menstruation. When there is no mother in the home, some fathers and daughters may be comfortable preparing for the first menstruation together. If this is not the case, encourage girls to seek a trusted female adult, or the school nurse, to prepare for the first menstruation.
2. Discussing menstruation in class can be embarrassing for girls if boys start teasing. Remind the class that a period is a normal function of a healthy female body, that it is a personal matter, and that teasing or joking about it is not acceptable mature behaviour, and shows a lack of respect for the feelings of others.
3. Male and female teachers often team up to present ovulation and menstruation topics. In this way, girls can discuss hygiene with a woman, while a man has a separate class with boys. Male teachers can be important role models for boys, by approaching the subject of menstruation in a matter of fact, and respectful, way.
4. Parents and students may benefit from seeing a film about menstruation together. Your school might invite students, or their parents, to a special showing in the afternoon or evening. However, teachers need to be sensitive to students whose parents cannot attend such programmes, by not over-emphasizing their importance.

Activity 1.4

Go through **Reading # 6, Ovulation and Menstruation**, on page 31.

One person will explain the process in class.

Activity 1.5, Role Playing

A young girl hears about menstruation, and is frightened by it. She asks her friend to explain what it is, and her friend takes her to the village midwife, who tells her about it. The midwife tells her of the development of her body, and the relationship to sexuality and reproduction.

1. Select one member of the group to be the midwife, and the other to be the girl.

Readings

Reading # 1 **DEVELOPMENT STAGES**

The development stages manifest general tendencies, but they do not necessarily describe a particular child. The stages may overlap.

Early adolescence : Onset of puberty, female ages, 8-12;
 Male ages, 10-14

- Starts to move among peers
- Vacillates between clinging and rebellion
- Strives for independence
- May be confused, preoccupied with body, wonders 'Am I normal?'
- May experiment with same-sex sexual behaviour
- Begins to think abstractly

Middle adolescence : Female ages 13-16, male ages 14-17
 (defined by peer group)

- Continues effort to establish separate identity from parents
- Often becomes idealistic and altruistic
- Interested in dating, exploring sex
- Loves intensely, 'desperately'
- Continues to develop abstract thinking

Late adolescence : Females aged 16 and over, males aged 17 and over.

- Declares independence
- Establishes a set body image
- Loves more realistically, develops commitments
- Peer group becomes less important, more selective in choosing friends
- Develops more consistent framework of values, morals, ethics
- Able to think abstractly
- Defines life goals

Reading # 2

THE CHANGES DURING ADOLESCENCE

1. THE FEMALE BODY CLOCK

I. PUBERTY

A. Begins between the ages of 8 to 12, and ends around the age of 16 or so.

1. It takes approximately three to five years to complete this stage of growth.
2. The onset of puberty is consistently two years earlier in girls than in boys, girls reach full height about two years earlier than boys.
3. Females are born with slightly more mature skeletons and nervous systems, and gradually increase this development lead throughout childhood.
4. The earlier sexual maturation of females is one reason why males are about 10 per cent taller as adults; by virtue of maturing later, males have more time to continue growing.
5. Biological changes vary in the time of onset, and duration, yet these changes fall into definite and predictable patterns.

II. SEQUENCE OF CHANGES

A. Breast Budding (first change)

1. This starts between the ages of 8 and 13 (an average age of 11)
2. This development is completed between the ages of 13 and 18 (an average age of 15)
3. This holds psychological importance for the young female, who may worry about size and shape
 - a. It is not unusual for one breast to develop faster than the other
 - b. An adolescent girl may worry about the asymmetry that results, especially if she does not know that the difference is usually corrected by the time development is completed
 - c. A certain amount of preoccupation and self-consciousness is quite common

B. Growth of Bony Pelvis (second change)

1. Girls at birth already have a wider pelvic outlet, so that the natural adaptation for childbearing is present from a very early age.
2. This change primarily involves a widening of the pelvic inlet, and a broadening of much more noticeable hips.

C. Growth Spurt (third change)

1. This usually starts at about the age of 10.5 (it may begin as early as the age of 9.5 years), and peaks at age 12:
 - a. Growth spurt usually ends at around the age of 14;
 - b. Any further noticeable growth in stature stops at the age of 18;
 - c. At the end of the growth spurt, the average girl of 14 has already reached 98 per cent of her adult height.
2. The first menstrual period invariably occurs after peak height velocity is passed (usually one year), so that a girl can be reassured about future growth if her periods have begun.
3. The growth of legs and arms is not uniform:
 - a. Usually the more distal parts of the limbs (feet and hands) grow faster first;
 - b. This accounts for the gangly, and awkward, appearance of adolescents; e.g.: foot accelerates first followed by calf and thigh
 - e.g.: hands, forearms, followed by upper arms.

D. Pubic Hair (fourth change)

1. Pubic hair begins to grow between the ages of 11 and 12 (11.6-14.4) on average.
2. The growth is completed by age 14:
 - a. Curly pubic hair appears after the period of maximum growth in height;
 - b. This development is a sign that the first menstruation is approximately six months to one year away.
3. Axillary hair appears on the average some two years after the beginning of pubic hair growth.

E. First Menstrual Period or Menarche (fifth change)

1. One lingering misconception – many people think menstruation marks the beginning of puberty, when actually it is one of the later events to characterize this stage of life.
2. Generally the age range for the menarche may vary from 9 to 18 years.
3. This usually begins two years after the start of breast development (it occurs after the peak of the growth spurt in height)
4. First menstrual cycles may be more irregular than later ones.
5. There may be a time lag of one year to eighteen months before ovulation becomes well established (however, this cannot be relied upon in individual cases)
6. The present trend shows that:
 - a. Successive generations generally get taller and attain puberty at progressively earlier ages;
 - b. There is a declining age of the menarche, i.e. four months per decade;
 - c. While in 1990, the average age for the first menstrual period was 14 years, today the average age is 12.8 years – a development that is attributed to factors such as better nutrition and health.

F. Underarm Hair and Coarser Body Hair (sixth change)

While this development is expected, the ultimate amount of body hair an individual develops seems to depend largely on heredity.

G. Oil and Sweat Producing Glands (seventh change)

The activation of glands causes the following:

1. The appearance of acne;
2. Body odour.

H. Completion of the Growth of the Uterus and Vagina (eighth change)

1. Although these start developing early, their growth is the last to be completed.
2. The musculature wall uterus becomes larger and elaborate:
 - a. This is designed to accommodate the foetus during pregnancy, as well as to expel it during childbirth;
 - b. Cyclical changes occur in its lining (endometrium).

3. The vagina becomes larger and its lining grows thicker.
4. Vaginal contents, which are alkaline at the beginning of puberty, become acidic at this stage.
5. At birth, the ovaries are a fairly complete organ:
 - a. It contains about half a million immature ova – each one capable of becoming a mature egg;
 - b. The female is born with all of the eggs which she is going to develop – usually four hundred eggs;
 - c. These follicles remain immature until puberty when ovulation begins;
 - d. At puberty, the follicles start maturing into eggs in monthly cycles.

2. THE MALE BODY CLOCK

I. PUBERTY

The sequence of pubertal maturation is predictable, but the rate at which the events occur is highly variable. Generally, the onset of puberty begins between the ages of 10 or 11.

1. The onset of puberty is consistently two years later in boys than in girls.
2. The onset of puberty ranges from the age of 10 to 14.
3. Girls reach full height about two years before boys.
4. In the year in which a boy grows fastest he normally adds three to five inches to his height.
5. An average boy of 16 has already reached 98 per cent of his adult height.

II. SEQUENCE OF CHANGES

A. Growth of Testes and Scrotum (first change)

1. The onset of puberty is marked by the initial enlargement of the testes.
2. The growth of the testes and the scrotum usually begins between the ages of 10 and 13.5 years.
3. Development remains in progress through most of puberty, and is completed sometime between the ages of 14.5 to 18.

4. Along with the increasing growth of the testicles, a reddening and wrinkling of the scrotal skin occurs.
5. The testes are the male reproductive glands that produce sperm and male hormones:
 - a. Unlike ovaries, the testes do not contain all the sperm that will be produced;
 - b. The testes are a conglomerate of solid threadlike cords called “seminiferous tubules”;
 - c. During puberty, these tubules increase in size, and the cells of the lining of the tubules pass through a succession of stages;
 - d. From puberty on, the testes continuously produce sperm, generating billions in the course of an adult lifetime;
 - e. Unlike ovaries, a decline in testicular function is far more gradual in terms of both sperm and hormone production.

B. Straight Pubic Hairs (second change)

1. Usually an early event of puberty, this occurs between the ages of 10 and 15.
2. A prepubescent boy may have some finely textured hair, but no true pubic hair.
3. Later, long strands of slightly curly hair appear at the base of the penis.
4. Pubic hair becomes darker, coarser, and curlier as it spreads over the scrotum and higher up the abdomen.
5. Straight pubic hair appears before the first ejaculation, but pubic hair becomes curly after this milestone is reached.

C. First Ejaculation (third change)

1. This usually occurs about a year after testicular growth.
2. The average age for the first ejaculation is 14.6 years of age.

D. Growth Spurt – arms, legs, penis (fourth change)

1. The start of penis growth spurt occurs normally between the ages of 10.5 and 14.5 years (average age 12.5)
 - a. The age for completion of this growth spurt ranges from 12.5 to 16.5 years (average age 14.5)
 - b. A late developer may begin to wonder whether he will ever develop his body properly, or be as well endowed sexually as others.
2. The height spurt occurs relatively later in boys than in girls, between the ages of 11 and 13 years.

3. The average age for the increase in height is 14.
4. A short adolescent male, whose genitalia are beginning to develop, can be reassured that an acceleration in height is soon to take place.
5. In the year in which a boy grows faster, he normally adds from about 3 to 5 inches to his height.
6. The legs as a rule reach their peak growth first.
7. The spurt in trunk length follows almost a year later.
8. Leg growth itself is not uniform. The foot accelerates first, followed by the calf and thigh (more distal parts of the limbs grow faster first).

E. Voice Change – Growth of Larynx (fifth change)

1. Deepening of the voice results from the enlargement of the larynx.
2. This occurs relatively late in adolescence, and is often a gradual process.
3. Voice change is in two stages:
 - a. Some early voice changes occur prior to the first ejaculation;
 - b. Transition to a deep tonal voice comes after the appearance of axillary hair, and the period of maximum growth.

F. Underarm and Coarser Body Hair (sixth change)

1. These generally appear a couple of years after the body and facial hair.
2. This change is accompanied by increased body and facial hair.

G. Oil and Sweat Glands Activated (seventh change)

1. Body odour develops with this occurrence
2. The appearance of acne is also a result of this.
 - a. Body odour and acne are common concerns for many adolescents;
 - b. The increased production of androgen hormones accompanying puberty in both sexes, leads to an increase in skin thickness, and stimulates the growth of sebaceous glands (small glands in the skin which produce oil);
 - c. Often these small glands grow more rapidly than the ducts that lead to the surface of the skin, resulting in clogged pores, inflammation, and infection, along with the appearance of blackheads and pimples.

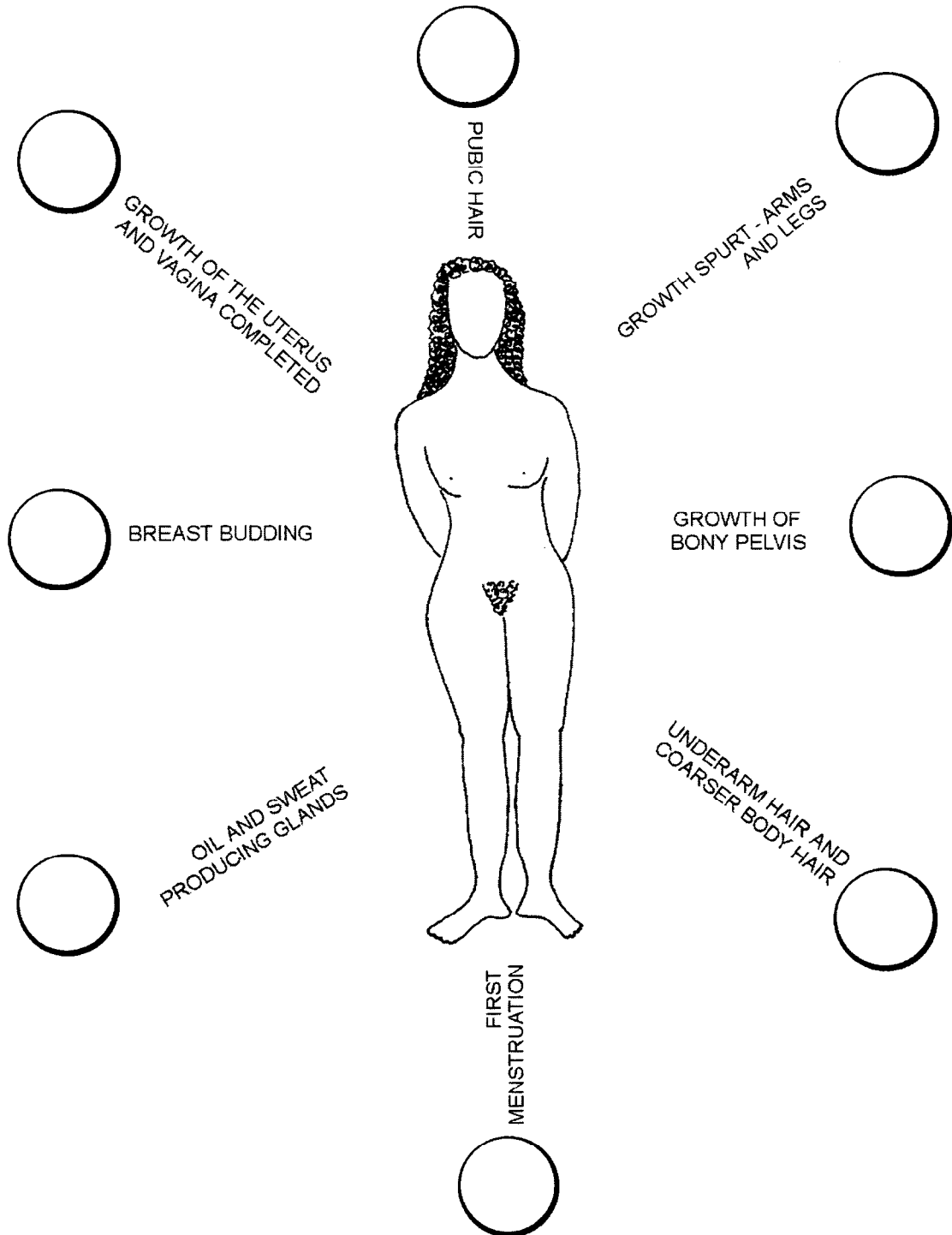
H. Facial Hair – Beard (eighth change)

1. This is an important event because of its social implications as a symbol, or badge, of manhood.
2. Facial hair begins to grow at about the time when axillary hair appears.
3. There is a definite order in which the hairs (moustache and beard) appear:
 - a. The first facial hair to grow is that at the corners of the upper lip;
 - b. Then it spreads to form a moustache over the entire upper lip;
 - c. This is followed by the appearance on the upper part of the cheeks, and the area under the lower lip;
 - d. It eventually spreads to the sides and lower border of the chin, and the rest of the lower face;

ASSESSMENT 1.1

THE FEMALE BODY CLOCK

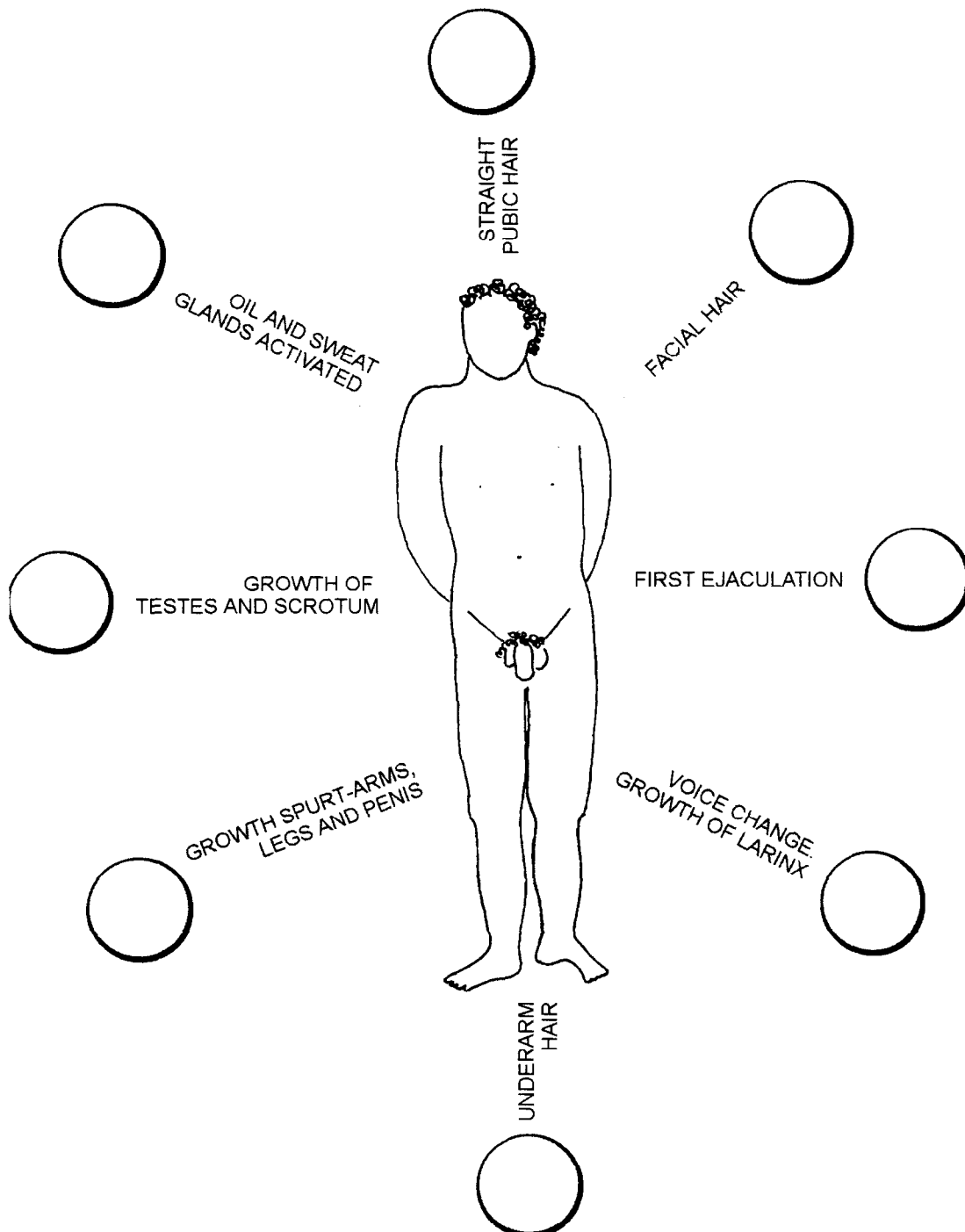
Many changes happen during puberty. Place the numbers 1 to 8 in each circle below to show the order in which these changes take place.



ASSESSMENT 1.2

THE MALE BODY CLOCK

Many changes happen during puberty. Place the numbers 1 to 8 in each circle below, to show the order in which these changes take place.



Reading # 3

HUMAN REPRODUCTION

B. MALE REPRODUCTIVE SYSTEM

The testicles, or testes, and the penis are the male external sex organs.

A. Penis

1. The penis is made up of spongy erectile tissue
2. Most of the time it is soft and limp.
3. When a man becomes sexually excited, his penis stiffens, and grows larger in width and length. When a man has strong sexual feelings, the blood flow out of the penis is slowed down, and the spongy tissue of the penis fills with blood, causing the penis to become firm. This action is called an erection.

B. Testicles or Testes

1. The testicles are two sex glands located in a wrinkled-looking pouch, or sac, called the scrotum, which hangs behind the penis.
 - a. Adult males have two testicles, which are about the size and shape of plums.
 - b. The testicles contain hundreds of thousands of chambers where sperm develops.
 - c. The testicles correspond to the ovaries in women, because both ovaries and testicles produce reproductive cells.
2. The scrotum controls the temperature of the testicles. Its temperature is about six degrees below body temperature. This is ideal for producing sperm.

C. Testosterone, Androgens and Sperm Cells

1. One vital function of the testicles is hormone production. These male hormones are called androgens. Androgens are responsible for the physical development of the male. Moreover they help activate male sexual behaviour.
2. The chief androgen produced in the testicles is testosterone. Messages from the pituitary gland signal the development of testosterone, the male sex hormone that prompts the production of sperm.
3. As sperm is produced, it passes through a very minor tube called the

epididymis. While the sperm is resting in the epididymis, it matures until it is ready to be used. Then from the epididymis it passes through the vas deferens, on its way to the seminal vesicles. The seminal vesicles are small, sac-like structures which connect to the ejaculatory duct.

4. At the time of ejaculation, secretion from the two primary glands, the seminal vesicles and the prostate are mixed with the sperm cells. The seminal vesicles empty some sugar into the vas deferens to provide energy for the sperm. The prostate gland empties some milky fluid called semen into the ejaculatory duct, to enable the sperm to swim easily. Two pea-sized bulbo-urethral glands, or Cowper's glands, also produce some fluid to cleanse the urethra of any urine residue that may prove harmful to the sperm.

a. Semen, or seminal fluid, is the whitish fluid that carries the sperm, and is ejaculated during intercourse.

b. Each ejaculation contains 100 million to 600 million sperm in about a teaspoon of fluid.

5. From the ejaculatory duct, the sperm moves through a long tube called the urethra through the penis. Both urine and sperm are released from the body through the urethra. When the sperm is released, a valve closes off the flow of the urine.

6. Sperm

a. Sperm, which is microscopic male reproductive cells, makes less than two per cent of the total ejaculate.

b. It is much smaller than the egg.

c. It has a head and tail, resembling tadpoles.

d. When ejaculated during sexual intercourse, it swims through the vagina, into the uterus through the cervix, and on up into the fallopian tubes.

e. Sperm can live for six to eight hours in the vagina.

f. But once it gets up into the uterus and tubes, it can live for three to five days.

g. It usually reaches the tubes within one to one and a half hours after ejaculating.

h. Upon reaching the top of the uterus, half goes into one fallopian tube, and half goes into the other.

i. It swims against currents set up by the cilia in the fallopian tubes, which act to draw the egg down towards the uterus.

j. Of several hundred million sperm ejaculated, only about 2,000 reach the tubes.

k. Even though the egg must be totally surrounded by sperm in order to be fertilized, only one sperm is able to penetrate it. The rest is absorbed by the body.

1. Sperm cells retain the ability to fertilize an egg for only forty-eight to seventy-two hours.

II. FEMALE REPRODUCTIVE SYSTEM

A. Vulva

1. The female external reproductive organ, or genitalia, is called the vulva.
2. At the upper part is the mons pubis, which is the fatty cushion situated in the pubic area where the pubic hair grows.
3. Below the mons pubis are two rounded folds of skin parallel to each other called labia majora or outer lips. Under the labia majora are the labia minora or the inner lips. The labia cover, and protect, the vaginal opening.
4. The clitoris is a small cylindrical body located in the soft folds in the upper part of the vulva. The clitoris is the counterpart of the penis of the man. Because the clitoris comes from the same tissue that develops into the head of the penis in the male, it has the same nerve endings as the glands, and because it is so much smaller, it is very sensitive.
5. Below the clitoris is the urethra, which is the passageway for urine from the bladder to the outside of a woman's body.

B. Vagina

1. Just below the urethral opening is the entrance to the vagina.
2. The vagina is the elastic muscular passage extending from the woman's outer sexual organs (the vulva) to the uterus.
3. The vagina which is about four inches long is the female organ for sexual intercourse. It receives the penis during sexual intercourse.
4. Besides serving as the organ for sexual intercourse, it also serves as the birth canal, the passage through which a baby is born.
5. The vagina is not a hollow tube. The walls are collapsed when empty; however, it can stretch to accommodate various sizes during birth, intercourse and menstruation.
6. The vagina is designed to clean itself by periodically shedding mucus and dead cells.
7. Often, but not always, there may be a small web of skin called the hymen partly covering the opening of the vagina.

C. Cervix

1. At the upper end of the vagina and the opening of the uterus, is a button-like structure called the cervix.
2. The cervix is the entrance to the uterus and contains mucus producing glands.
3. The cervix feels like the end of a nose with a dimple in it.
4. If fertile mucus is present in the vagina during intercourse, sperm released by the male will travel through the cervical opening and into the uterus.

D. Uterus

1. The uterus, also known as the womb, is a pear-shaped muscular organ in which the fertilized egg grows and develops into a foetus.
2. Normally, the uterus is about three inches long and two inches wide. During pregnancy it stretches, and grows, with the foetus.
3. In pregnant women, the lining of the uterus, called the endometrium, nourishes the foetus.
4. In non-pregnant women, the lining is shed about once a month if an egg is not fertilized. This shedding is called menstruation.

E. Fallopian Tubes

1. In a mature female the fallopian tubes are four to six inches long. They curve around the ovaries and extend to the uterus. These tubes are the passage way through which the egg travels from the ovary to the uterus.
2. Each fallopian tube links one ovary with the uterus.

F. Ovaries

1. Two ovaries are connected by ligaments to the uterus: one on each side of the uterus.
2. These are the organs, which store the egg cells. They also produce some of the female sex hormones, which regulate the menstrual cycle, and are responsible for the development of female secondary sex characteristics.
3. At birth, a girl's ovaries contain all the eggs she will ever have - about 400,000. However, she will probably use only about four hundred of the eggs in her lifetime.
4. The ovaries produce a hormone called oestrogen, which is carried by

the bloodstream to the uterus, where it stimulates the growth of the lining of the uterine wall called the endometrium.

G. Eggs or Ova

1. Eggs or ova (which are about the size of a dot made by a sharp pencil), are some of the largest cells in the human body.
2. When the egg is expelled from the ovary, it travels to the uterus in one of the fallopian tubes. This takes between three to five days.
3. The egg cell dies if it is not fertilized within twelve to twenty-four hours after ovulation.
4. Fertilization occurs in the outer one third of the fallopian tube.
5. If fertilization does not occur the egg cell will dissolve, and be absorbed by the body.
6. After ovulation, the ovary secretes progesterone, and is absorbed by the body.
7. The progesterone maintains the uterine lining.
8. If fertilization does not occur, the ovary will stop producing oestrogen and progesterone after about two weeks.
9. This decline in hormones signals the uterus to shed its lining (menstruation)
10. If fertilization does occur, oestrogen and progesterone continue to be produced, and the uterine lining is not shed. This lack of a menstrual period is usually one of the first signs that pregnancy has occurred.

H. Menstruation

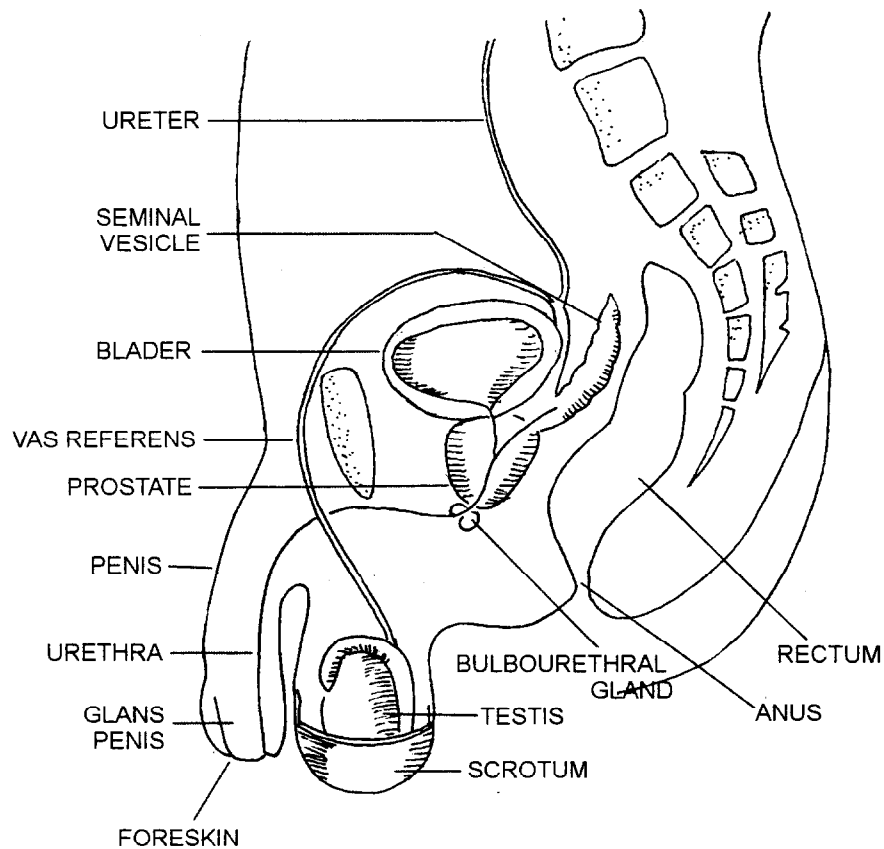
1. Menstruation, or periods, come about once a month for most women.
2. Menstrual flow consists of blood, mucus, and fragments of lining tissue. This flow gradually comes out of the uterus through the vagina. Shortly afterwards more egg follicles begin to develop, a new lining begins to build up, and the cycle starts all over again.
3. Periods last three to seven days in most women, but this also varies.
4. At the onset, a woman's periods may be irregular - every three, four, five or six weeks. Then gradually the body develops its own pattern of regularity.

5. Some women feel uncomfortable on the first, or second, day of their periods, but for most women menstruation does not interfere with their normal activities.

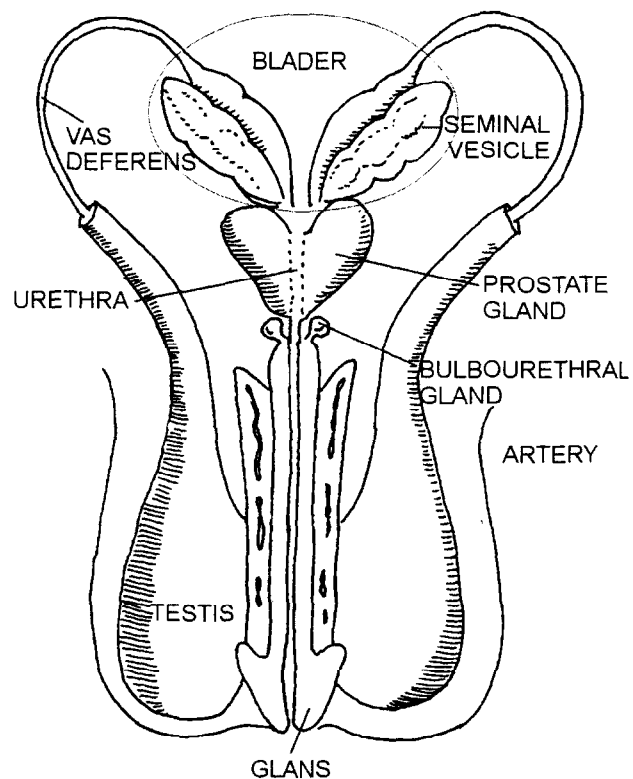
Reading # 4

DIAGRAMS OF THE MALE REPRODUCTIVE SYSTEM

A. The Male Reproductive System (Side View)



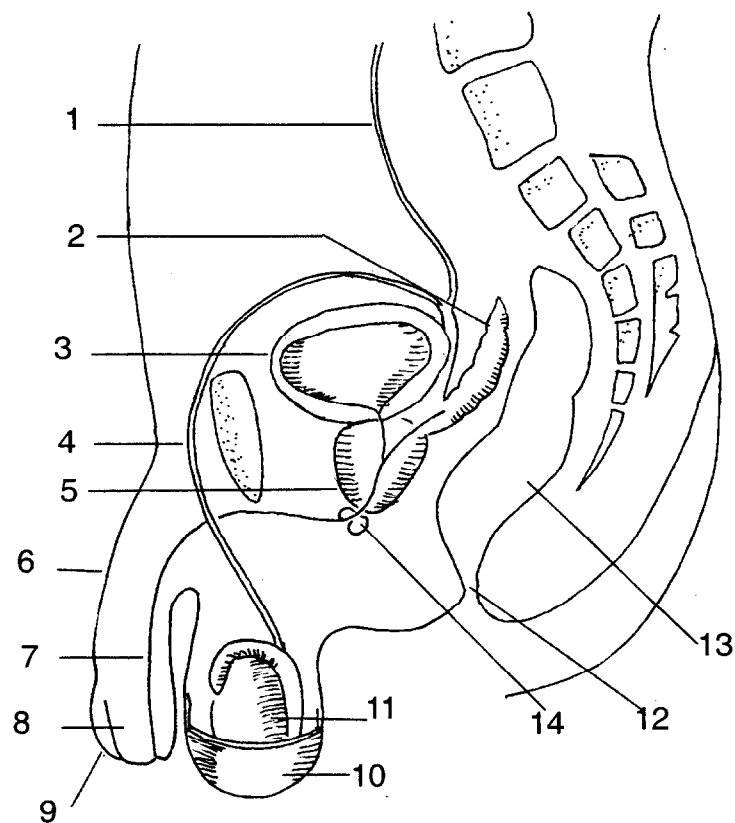
B. Bulbourethral Glands and Penis



ASSESSMENT 1.3

Direction : Look at the diagram below, and write the correct name for each part.

Male Reproductive System (Side View)



ASSESSMENT 1.4

Directions: Write in the bracket provided the letter corresponding to the definition of each of the organs of the male reproductive system.

(1)

(2)

Male Reproductive Organs

Definitions

1. Testicle/Testis ()

A. Duct

through which urine and semen are discharged.

2. Penis ()

B. Either of two ducts that allow sperm to pass from the testicle.

3. Scrotum ()

C. A rod which connects the vas deferens and the urethra.

4. Urethra ()

D. A filling station that provides the sperm with sugar energy.

5. Vas Deferens ()

E. The gland in the male that produces sperm.

6. Seminal Vesicle ()

F. The external pouch that contains the testicles.

7. Semen ()

G. The male sex organ; also the male urinary organ.

8. Sperm ()

H. A small tube like a resting station on top of each testis where the sperms mature.

9. Testosterone ()

I. A gland in the brain that sends a message to the testicles to make sperm.

10. Androgens ()

J. A storage container for milky water which helps the sperm swim more easily

11. Epididymis ()

K. A milky, sugary liquid containing the sperm which leaves the male body through the urethra in the penis.

12. Prostate Gland ()

L. The male reproductive cell made in the testicles.

13. Cowper's Gland ()

M. The male sex hormone which prompts the production of sperm.

14. Ejaculatory Duct. ()

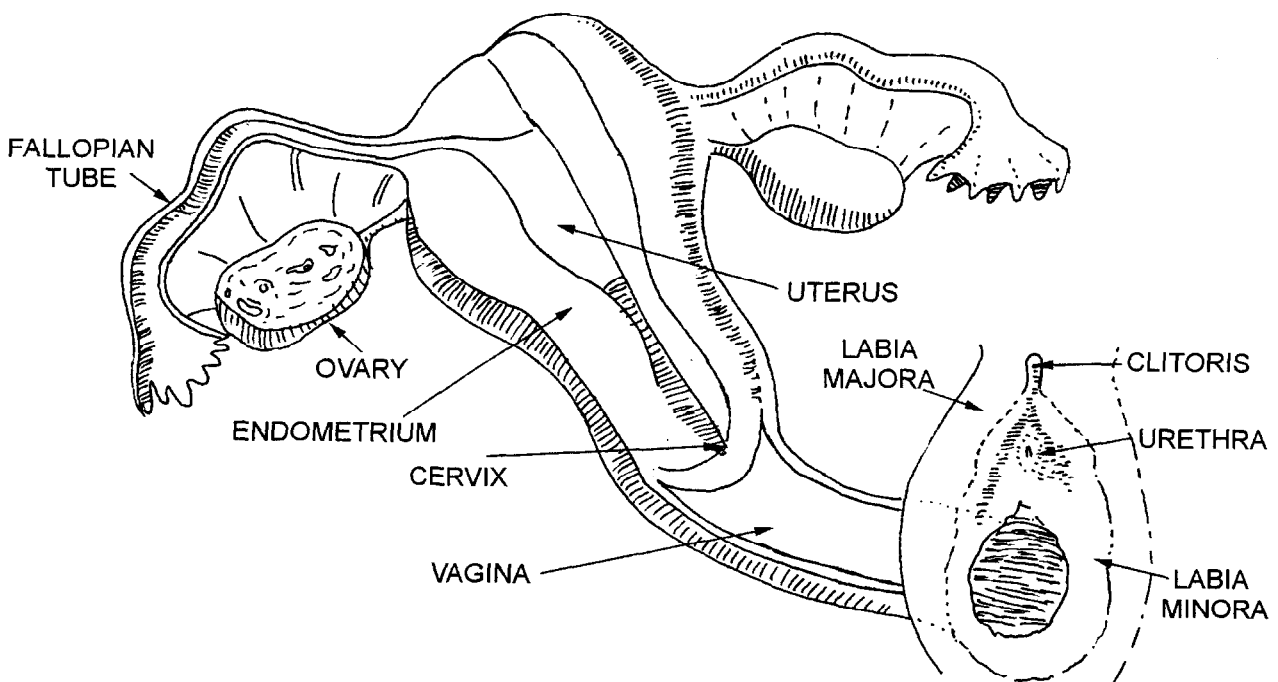
N. Gland that squirts out a cleansing fluid to clear the urethra.

15. Pituitary Gland ()

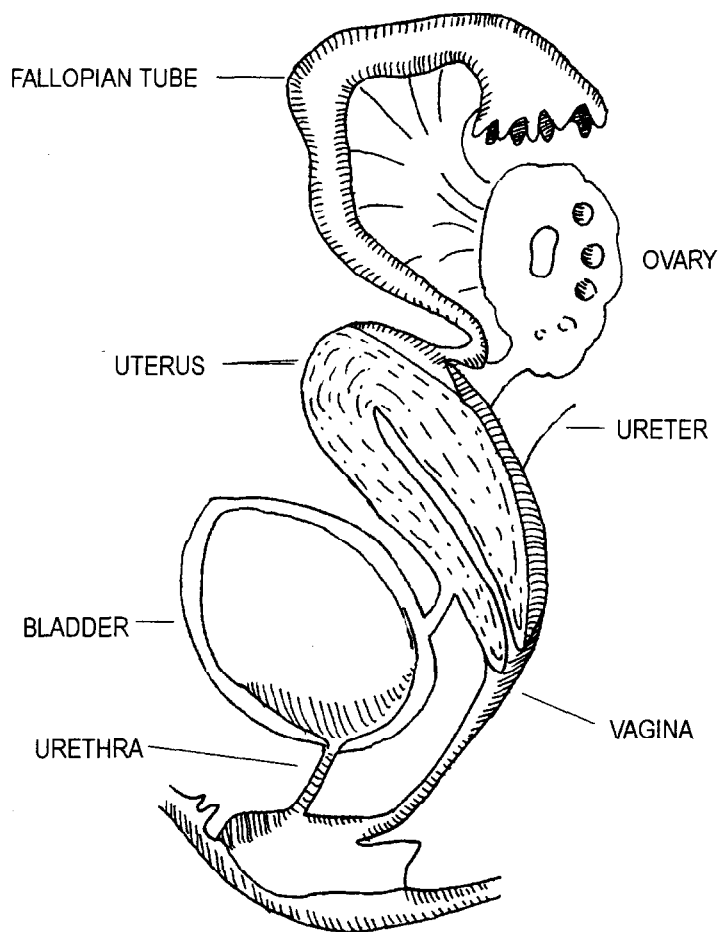
O. Hormone which is responsible for physical development in males.

Reading # 5
DIAGRAMS OF THE FEMALE REPRODUCTIVE SYSTEM

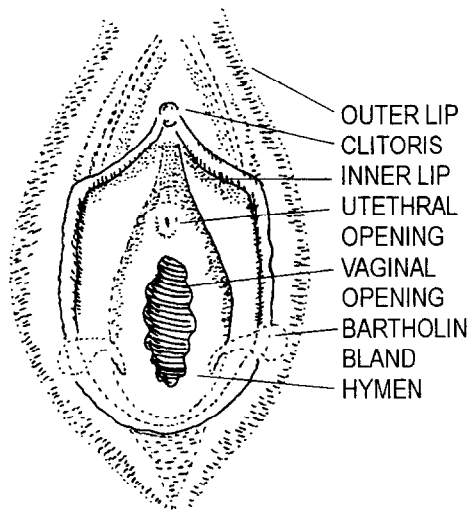
A. The Female Reproductive System



B. The Female Reproductive System (Side View)



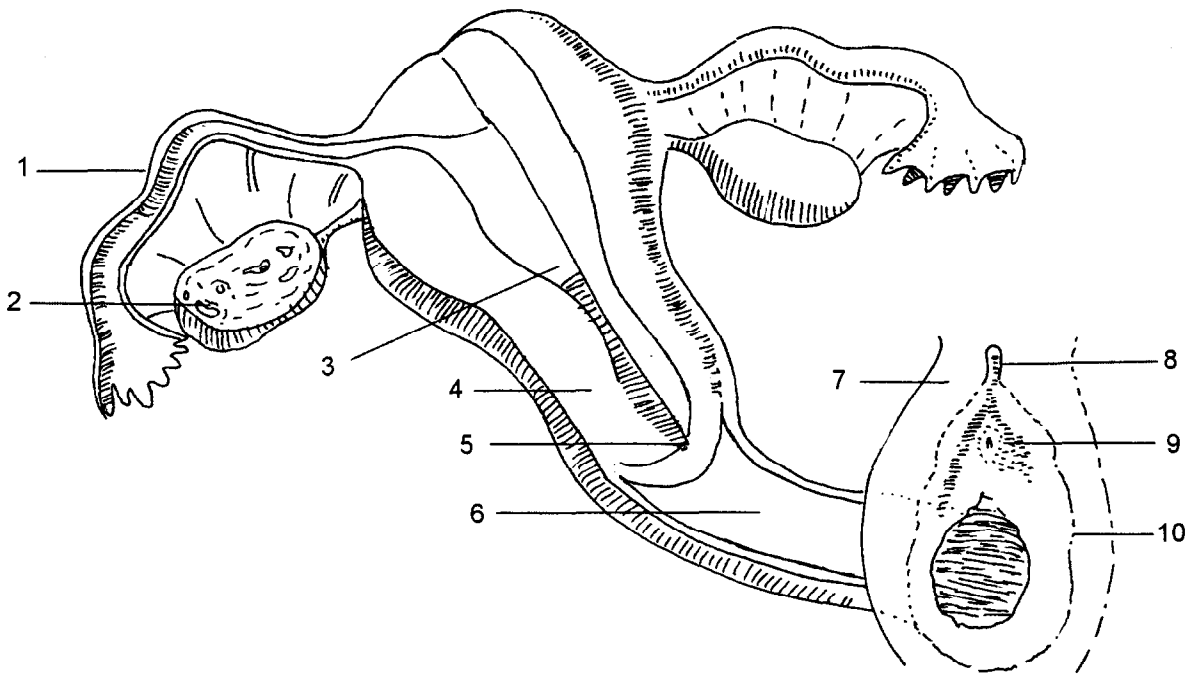
C. The Female External Genitalia



ASSESSMENT 1.5

Direction : Look at the diagram below, and write the correct name for each part.

Female Reproductive System



ASSESSMENT 1.6

Direction: Write in the bracket provided the letter corresponding to the definition of each of the organs of the female reproductive system.

(1) Female reproductive Organs	(2) Definitions
1. Vulva ()	A. Pear-shaped female reproductive organ in which the foetus grows and develops until birth
2. Mons pubis ()	B. Female organ in which egg cells and sex hormones are produced.
3. Labia majora ()	C. Neck-like, narrow end of uterus which opens into vagina; it stretches to allow a baby to be born.
4. Labia minora ()	D. Either of two tubes through which egg released from an ovary every month travels to the uterus
5. Clitoris ()	E. The external reproductive organ
6. Urethra ()	F. Passageway of urine from the bladder
7. Vagina ()	G. Fatty cushion at the upper part of the vulva situated at the pubic area where the pubic hair grows
8. Hymen ()	H. The lining of the uterus which nourished the foetus
9. Cervix ()	I. Hormone which is carried to the uterus to stimulate the growth of the lining of the uterine wall called the endometrium
10. Uterus ()	J. Hormone which maintains the uterine lining
11. Endometrium ()	K. Outer lips of the vulva
12. Fallopian tube ()	L. Inner lips of the vulva
13. Ovary ()	M. Web of skin which partly covers the opening of the vagina
14. Egg cell or ovum ()	N. Considered as the counterpart of the penis of the man, it is a small cylindrical body located in the soft folds in the upper part of the vulva
15. Oestrogen ()	O. Female reproductive cell which, if fertilized, produces a baby
16. Progesterone ()	P. The passage that extends from the outer sexual organs to the uterus and is the organ to sexual intercourse

Reading # 6

OVULATION, MENSTRUATION AND CONCEPTION

I. TEACHING ABOUT OVULATION, MENSTRUATION AND CONCEPTION

- A. The first menstruation is a big event in a young girl's life, and it is anticipated with ambivalent feelings and expectations. Teachers can help make this event a positive experience by :
1. affirming the mother's role in the preparation for the first menstruation. When there is no mother in the home, some fathers and daughters may be comfortable preparing for the first menstruation together. If this is not the case, encourage girls to seek a trusted female adult, or the school nurse, to prepare for the first menstruation.
 2. alleviating two major concerns: what to do if the period starts at school, and the fear that blood will 'gush out.'
 3. being sure school staff are prepared to give assistance to female students, in a manner that will alleviate any embarrassment.
- B. Discussing menstruation in class can be embarrassing for girls if boys start teasing. Remind the class that a period is a normal function of a healthy female body, that it is a personal matter, and that teasing or joking about it is not acceptable mature behaviour, and that it shows a lack of respect for the feelings of others.
- C. Male and female teachers often team up to present the topics of ovulation and menstruation. In this way, girls can discuss hygiene with a woman, while a man has a separate class with the boys. Male teachers can be important role models for boys, by approaching the subject of menstruation in a matter-of-fact and respectful way.
- D. Parents and students may benefit from seeing a film about menstruation together. Your school might invite students, and their parents, to a special showing in the afternoon and/or evening. However, teachers need to be sensitive to students whose parents cannot attend such programmes by not over-emphasizing their importance.

II OVULATION

- A. One of the things that happens during puberty is the production of hormones by the ovaries.
- B. Oestrogen is the female hormone that causes changes during puberty: physical growth, development of the ovaries, breast development, body hair, and body contours.
- C. Each month an ovum (egg cell) matures and ripens.
- D. At the same time, the lining of the uterus (endometrium) builds up preparation for a fertilized egg.
- E. The ovum takes a four to six day trip down the fallopian tubes into the uterus. Occasionally, two or more ova are released at the same time.
- F. If the egg is not fertilized, the uterus will know that the endometrium is not needed.

III MENSTRUATION

- A. Menstruation occurs when the lining of the uterus (the endometrium) begins to slough off the walls, and slowly pass out of the body through the vagina.
- B. The first menstruation usually comes between the ages of nine and sixteen, although it is normal to begin earlier or later. The first menstrual period is called the menarche.
- C. The first menstruation may begin before ovulation takes place (and ovulation may take place before the first menstruation).
- D. The menstruation flow is quite slow and gradual. The first sign of menstruation will be a small spot of discharge, not a 'gushing.' (As mentioned earlier, the teacher should make a special effort to alleviate the common fear that a large amount of blood will gush out.)
- E. The first periods are often very irregular. It is not uncommon to skip a month, or to have periods close together.
- F. The length of periods varies from two days to a week.
- G. Gradually, a regular cycle will be established; but it is still quite normal and common during the teen years to have irregular periods.

IV PREPARATION FOR MENSTRUATION

- A. Soon after puberty begins, young girls and their mothers will need to get ready for the first menstrual period.
- B. In some homes, the first menstrual period is considered a special event, deserving family celebration. In other homes, the event is quietly acknowledged by mother and daughter. However it is received, it marks the passage into womanhood.
 - 1. Although for most women there is a lapse of a few months, to a year, before conception can take place, some young women can conceive immediately. Others have conceived before the first menstrual period.
 - 2. Being able to conceive does not mean a readiness for parenting. In some cultures, parenting involves a great level of maturity and self-reliance.
- C. Girls will want to discuss the different things they will need when their periods start. They will need to be prepared with sanitary pads, or tampons, and possibly a sanitary belt or special underwear. Sanitary pads, or napkins, are gauze-covered cotton pads worn during menstruation to absorb the flow of blood. They have a plastic layer on the underside, to keep blood from coming through and staining clothes.
- D. The class should understand how teachers, and other adults at their school, are ready to help girls if the need arises.
- E. Menstrual blood has little odour and a daily bath, or shower, will be sufficient to keep clean and smell fresh.
- F. Some people feel uncomfortable just before, and during, their periods. There are some simple things that can help.
 - 1. The body may retain more water at this time. Cutting down on salty foods will help prevent this.
 - 2. Exercise speeds up circulation, and helps ease tension or headache. Exercise also relieves constipation, which frequently increases the feeling of discomfort.

3. Drinking several glasses of water each day will aid digestion, and lessen constipation.
4. Most girls will feel better if they get plenty of sleep during their periods.
5. If girls do get cramps, there are several things they can do:
 - a. Place a hot water bottle on the abdomen (or on the back, if that is where the cramps are)
 - b. Take a warm bath
 - c. Drink a hot beverage (camomile, comfrey and/or raspberry leaf tea are sometimes suggested due to their high calcium content, and reported cramp relief).
 - d. Take a walk
 - e. Rub or massage the abdomen (or ask someone to rub your back if it aches).
 - f. Get on elbows and knees so that the uterus is hanging down, which helps.
 - g. Lie on the back with knees up, and move the knees in small circles.
1. Most of all, since menstruation is natural and normal, girls should follow their usual routine, unless it causes discomfort.

V Conception

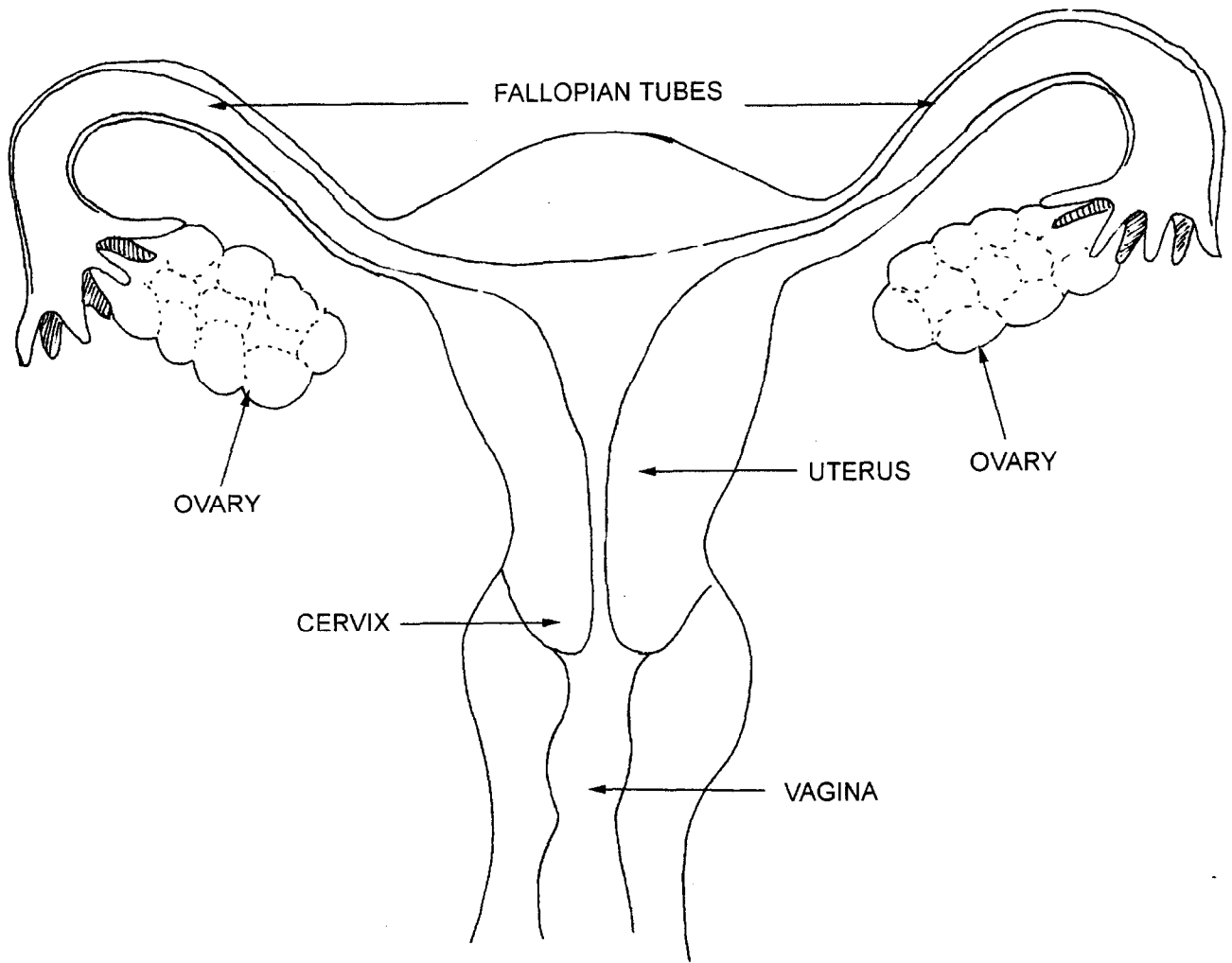
The ability to reproduce is necessary for the continuation of the human race. New life occurs when male and female sex cells unite at conception. The sex cells are needed to give birth to a new life. These sex cells are given the chance to fuse, and form a new life, during sexual intercourse. During intercourse, sperm from the man's penis is deposited in the woman's vagina.

As sperm reaches the fallopian tubes, where an ovum is likely to be found, fertilization takes place. After fertilization, the fertilized ovum travels from the fallopian tube to the uterus. Six to seven days after fertilization implantation occurs in the lining of the uterus

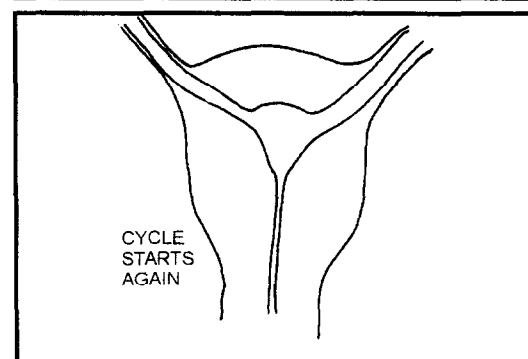
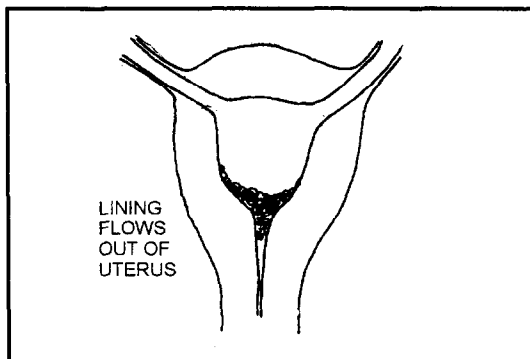
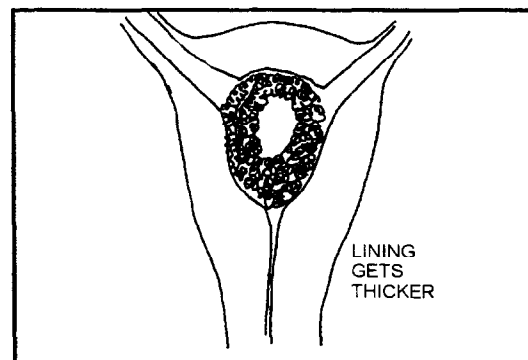
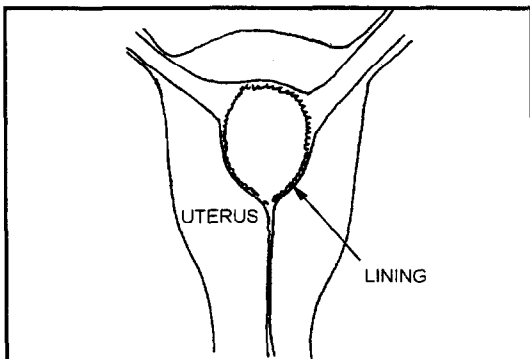
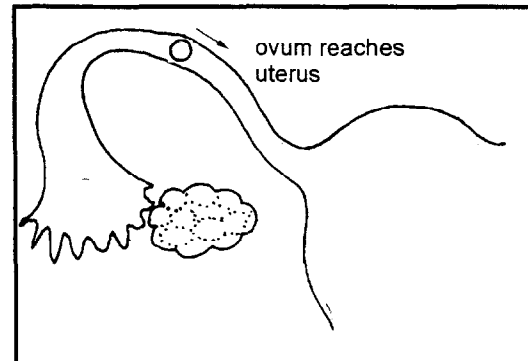
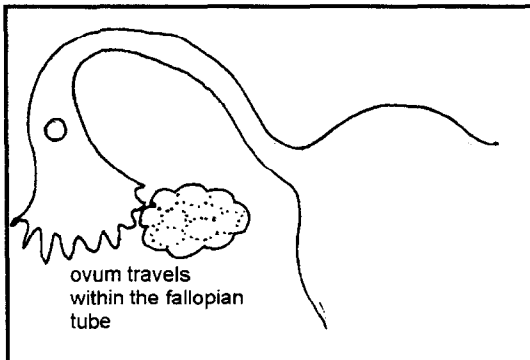
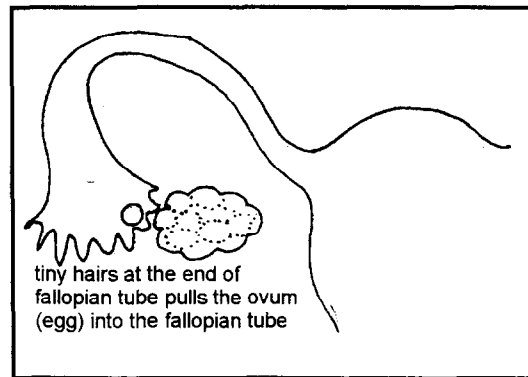
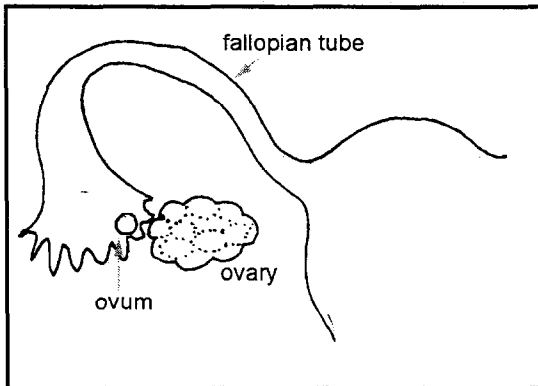
or the endometrium. The fertilized ovum, now called the embryo, grows here until it is born.

At the moment of conception the genes and chromosomes from the mother and father unite, to form a unique individual with particular traits and characteristics.

Reading # 7
THE FEMALE REPRODUCTIVE ORGANS

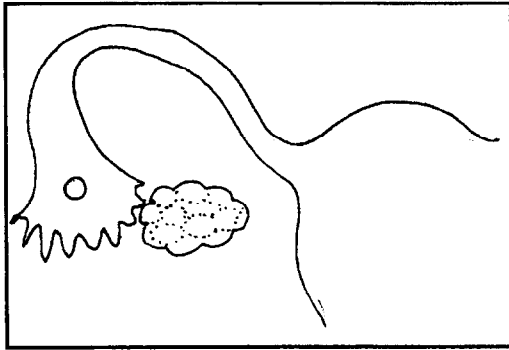


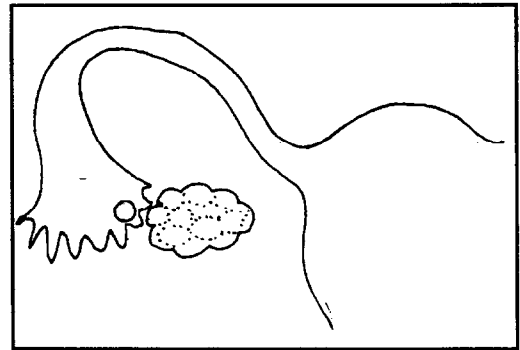
Reading # 8 Ovulation and Menstruation

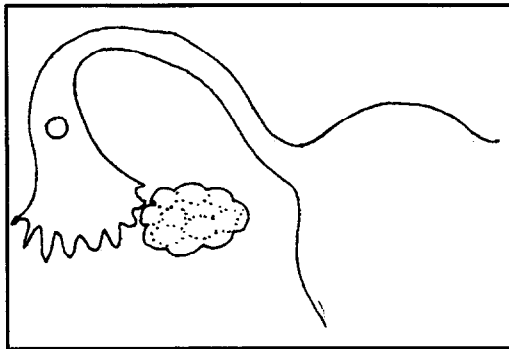


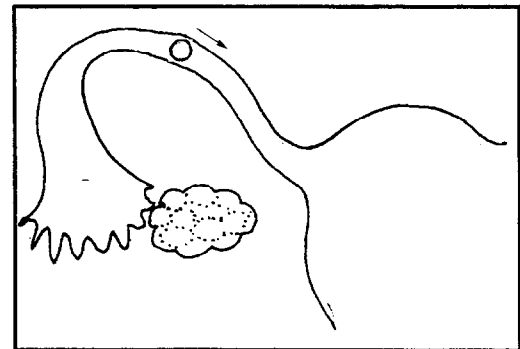
ASSESSMENT 1.7

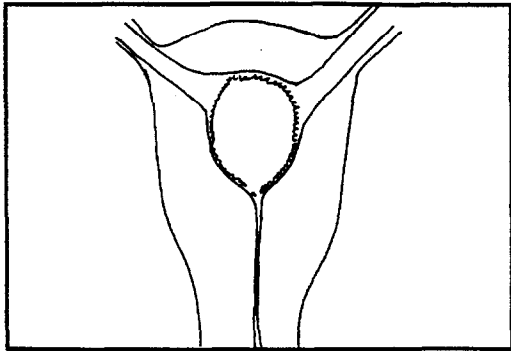
Below are eight illustrations describing the various stages of ovulation and menstruation. For each illustration, or stage, write the corresponding description of events that occur.

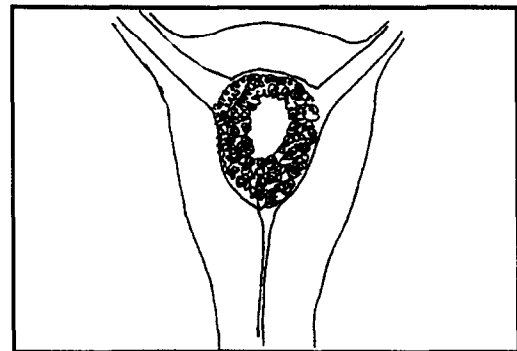


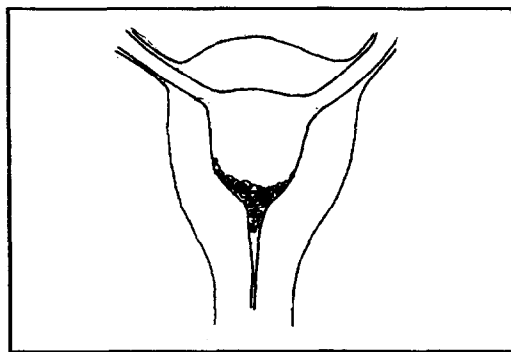


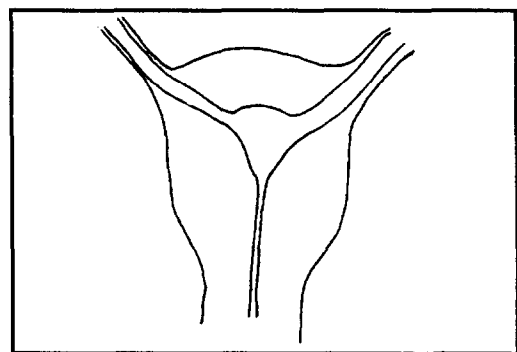












ASSESSMENT 1.8

1. Ask the learners to list the physical changes that take place during adolescence for both girls and boys. Collect their lists and summarize the data on the board such as:

Physical changes during adolescence

Female changes

Spurt in weight
Spurt in height
Budding of breasts

Growth of pubic hair
Growth of hair under arms
Deepening of voice
Increase in perspiration

Acne
Menarche (onset of menstruation)
Widening of hips
Thighs become funnel-shaped

Changes in body shape:
from a slender child's
body to that of an adult

Arrest of skeletal growth

Male changes

Spurt in weight
Spurt in height
Slight, temporary development of
breasts around nipples

Growth of pubic hair
Growth of hair under arms
Voice change
Increase in perspiration
Growth of penis and testicles

Acne
Involuntary ejaculation
Widening of chest and shoulders
Arms become more muscular:
Considerable hardening of muscles
Heavy growth of hair on face
and body

Changes in body shape:
from a slender child's
body to that of an adult

Increase in physical strength and stamina

Arrest of skeletal growth

UNIT 2

Emotional Changes and Sexuality

RATIONALE

The purpose of this unit is to explain the emotional changes which accompany the physical changes. This unit will also discuss the topic of sexuality.

LEARNING OUTCOMES

By the end of the unit, you should be able to :

explain why certain emotional changes take place;
help students understand these changes;
help students understand their own sexuality

CONTENT

This unit includes the following:

Topic 1. Emotional Changes
Topic 2. Sexual Changes and Sexuality
Topic 3. Needs of Adolescents

Topic 1

EMOTIONAL CHANGES

The physical changes that take place during adolescence are accompanied by emotional changes.

NOTE : Go through Reading # 9, I Emotional Changes of Adolescence, on page 45. Young people need to learn how to cope with their emotions. Extremes of these emotions

Activity 2.1

1. Write the following words, each one on a small piece of paper: guilt, shame, fear, satisfaction, confusion, pity, concern, anger, embarrassment, happiness, pride, envy, arousal.
2. Fold the pieces of paper, and put them in a box
3. Ask each member of the group to take one
4. The group member should tell the others in what situations he or she displays the emotion written on the paper

could lead to psychological disorders.

Activity 2.2

1. Go through Reading #9, II Characteristics of Adolescents, on page 46
2. List any other characteristic which you have noticed in adolescents:
Adventurous
Innovative
Creative
Imaginative
may be some of them
3. Discuss how these adolescent characteristics can be used for their individual benefit, and also for the benefit of society

Activity 2.3

1. Go through Reading # 10, Looking at Myself, on page 47
2. Do the Assessment 2.1, on page 49

Activity 2.4

1. Go through the Case Study in Assessment 2.2, on page 50
2. Answer the questions that follow

Topic 2

SEXUAL CHANGES AND SEXUALITY

Adolescents need to be able to control their desires. Sometimes they develop strong sexual feelings for persons in their environment. They need to know that such feelings are normal, and must learn how to cope with them. They can divert their attention by playing games, reading, walking or getting involved in sports

Activity 2.5

1. In small groups, discuss your feelings, and in which ways you can cope with your sexual desires.
2. Prepare a group record of activities.

Topic 3

NEEDS OF ADOLESCENTS

Rapid physical growth during adolescence results in new day-to-day needs.

It is important to be concerned about personal needs, as well as those such as nutrition, exercise, and leisure, during this period in life.

Activity 2.6

Study the picture in Reading# 1

- 1 What personal needs are shown here?
- 2 If you were the class teacher of a group of adolescents of the ages shown in the picture, what steps would you take to help them with their specific needs?

Reading # 9

EMOTIONAL CHANGES OF ADOLESCENCE

I. EMOTIONAL CHANGES FOR BOTH BOYS AND GIRLS

A. The increased production of hormones prompts sexual thoughts and daydreams in most young people; there is a heightened awareness of sexual attraction.

1. The release of semen by boys during sleep, called nocturnal emission or 'wet dreams' is common at this time. It is also quite normal not to experience them.
2. Both boys and girls may experience sexual excitement from simply watching, or being near, someone they are attracted to. They may not understand that the emotions they are feeling are sexual in nature.
3. Sexual fantasies are common at this time
 - a. Some parents feel that this is a natural stage of development, and not a matter of concern;
 - b. Other parents feel that some daydreams or fantasies are not wrong, but others are; and like various facets of human behaviour, some fantasies need to be controlled.
4. In general, boys and girls become more interested in each other during puberty.
5. While sexual interest and thoughts are common, it is also quite normal not to be sexually concerned, especially in the early years of puberty.

B. Puberty is a time of frequent shifts of mood for most adolescents

1. Discomfort, and concern, about the changes in their bodies and feelings may cause emotional stress.
2. Moods shift quickly and unpredictably.
3. Crying over seemingly small matters is common for both boys and girls, and is not something to be ashamed of.
4. It helps young people to share their concerns with parents or friends. Often, they find comfort in discovering that others share similar concerns and feelings.

C. Increased feelings of independence are a part of the normal development in adolescence

1. Adolescents experience frequent shifts from mature to childish behaviour.
2. Relationships with parents begin to change, as young people assert their independence, sometimes causing difficulties.

II. SOME CHARACTERISTICS OF ADOLESCENTS

Independence :

Adolescents need to become less dependent on parents. They begin to shift from parents to peers, or to belief systems, in order to achieve independence. This shift is strong, and may involve rebellion.

Identity :

Adolescents struggle to define themselves and what they want to accomplish. They are answering the questions: 'Who am I?', 'What can I be?' This process involves experimenting. Adolescents need to develop gender role identity, a positive body image, and a sense of esteem and competence.

Intimacy :

Adolescence is a time of preparation for loving relationships. Adolescents learn to express, and manage, emotions. They develop the capacity to love, and be loved, and to be intimate in relationships with others.

Integrity:

Adolescents must develop a foundation for sorting out values. Parents have provided a base for this. However, there is a tremendous amount of other inputs at this time - peers, media, school, etc. Adolescents decide what to believe in, and how to behave.

Intellect:

The adolescent's intellectual capacity increases, and changes from concrete thinking to include abstract thinking. Many adolescents become capable of conceptual thinking, and understanding logic and deductive reasoning. This increased ability may heighten self esteem. Some adolescents tend to overvalue their intellectual theories, and see things from an idealistic point of view.

Reading # 10

LOOKING AT MY SELF

A. SELF-ESTEEM

Self-esteem is closely identified with self-respect. It includes a proper regard for oneself as a human being, and an accurate sense of one's personal place within the large society of family, friends, associates, and others. In the extreme, self-esteem can degenerate into conceit, while a lack of it can result in a sense of unworthiness. The key is balance. Too much focus on self causes the inflation of conceit, blocking the experience of cooperative relationships. On the other hand, a deficient sense of self, makes one unable to interact freely, and responsibly, with others at home, in school, in work, and in society.

Parents and teachers have the greatest influence on children's self-esteem. Children's experience of being loved, and lovable, during the early years form their self-concept and self-esteem. Harris Clemes and Reynold Bean have defined the following four conditions that must be fulfilled, in order for a high sense of self-esteem to be developed, and maintained:

Connectiveness, that results when a child gains satisfaction from associations that are significant to the child, and the importance of these associations has been affirmed by others.

Uniqueness, that occurs when a child can acknowledge, and respect, the qualities or attributes that make him or her special and different, and receives respect, and approval from others, of these qualities.

Power, that comes about through having the resources, opportunity, and capability, to influence the circumstances of his or her own life in important ways.

Models, that reflect a child's ability to refer to adequate human, philosophical, and operational examples, that serve to help him or her establish meaningful values, goals, ideals and personal standards.

It is important for a student's self-esteem that the school provides experiences that satisfy these four conditions every day, that learning itself becomes self-enhancing. Most important are successful relationships with peers and teachers, and the satisfaction of academic achievement. Second to these are learning experiences specifically designed to build self-esteem, while providing cognitive learning.

The importance of positive self-regard should not be minimized, or given only token acknowledgement. Self-esteem is the foundation upon which personal and social development is based. Indeed, to a considerable degree, personal success can be

measured, in terms of how well one has succeeded in constructing an accurate model of himself or herself, in relation to others.

While a person's sense of self is ever changing, reflecting the flux of events both internal and external, students at the upper elementary level are at a crucial period of development, at a period of life when the self-images of early childhood broaden out into the more encompassing visions of adolescence. The child's personal experience of the world expands, taking in ever-widening spheres of interest and accomplishment. Self-understanding in relation to others, the development of a positive and accurate sense of self, can have immense significance. It affects one's sense of personal success within the family, at school, and elsewhere.

B. SELF CONCEPT

Self-concept can be defined as a person's perception of himself. This includes his perception of his abilities, character, attitudes, traits, appearance, aims and deeds. Other terms such as self-image, self-evaluation, self-esteem are used instead of self-concept.

Self-concept is described as the directing force in human behaviour, because a person acts consistently with his or her self-concept. In other words, what a person thinks, or how he behaves, is determined largely by the concept he holds about himself. A person who is confident, and has high regard for himself behaves differently from another person, who feels incompetent, inferior and insecure. Similarly, a person who feels competent in one situation can further reinforce his perception of himself. A person who perceives himself as a poor reader makes many mistakes when asked to read. Therefore his self-image as a poor reader is reinforced. Often we are afraid to try, because we feel we are not good enough.

A person perceives, interprets, accepts, rejects or resists, what he encounters in accordance with his self-image. His behaviour may appear irrational to observers, but to the person, they are consistent with the stimuli as perceived by him. To the onlooker, a headmaster's authoritarian behaviour in school is contradictory to his submissive behaviour at home. But to the headmaster his behaviour is consistent with his perception of his roles. So just as he expects the teachers and students under his supervision within his domain, to adhere to his rules and regulations, he expects similar behaviour from himself at home which is his wife's domain.

Our self-concept is formed through interactions with people. From the way others react towards us, and the appraisals they make of our efforts, we form concepts of who we are, and what we are capable of achieving. Consequently, the reactions of people, especially of those who are significant to us, will influence the formation of our self-concept.

ASSESSMENT 2.1

In using the 'Looking at My Self' chart below, tell the students that they have to list at least eight things they like about themselves. The chart also separates physical attributes from personality. It is especially difficult for young adolescents to say positive things about their body. Their bodies are still rapidly changing, and their self-concepts are not yet firmly established. As a lead into more in-depth discussions in later sessions, start the discussion on the changes that occur during puberty.

LOOKING AT MY SELF

WHAT I LIKE ABOUT MY SELF (at least eight things):

Physical Characteristics

Personality Characteristics

WHAT I DON'T LIKE ABOUT MY SELF:

Physical Characteristics

Personality characteristics

THINGS I WOULD LIKE TO CHANGE, OR IMPROVE, ABOUT MY SELF

HOW I MIGHT DO THIS:

THINGS I AM PROUD OF DOING:

ASSESSMENT 2.2

CASE STUDY

Ask the students to read the following. When possible, have copies of it distributed to the students prior to the lesson. Alternatively, the teacher may also write the situations on the chalk-board or flipchart. Follow this up with a discussion, using the guide questions suggested.

Situation No. 1

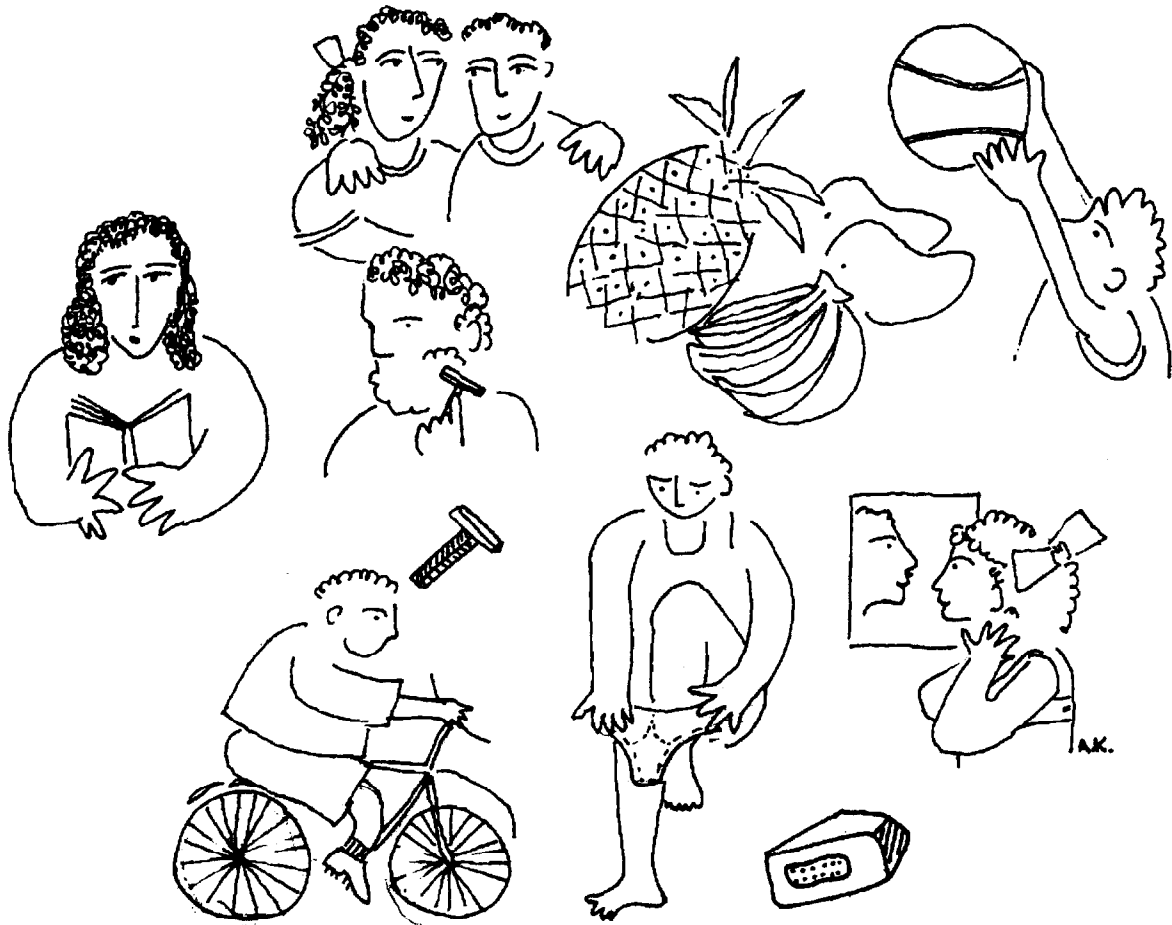
This letter appeared in the 'Dear Fatima' column of a local weekly magazine.

'Q, I have a big problem which has kept me from concentrating on my studies. It's about my classmate who's very shy. He doesn't talk to girls, except to those who talk to him first. As days pass, I find my infatuation for him growing. I sometimes think that it is love that I feel. Whenever we are in the classroom, I often look at him, and I am usually surprised to find him looking at me, too. There are many nights when I can't sleep just thinking about him. I always call him up for a chat. He's very nice, and seems very interested in talking with me over the phone. And yet, when we are in class, and I approach him to ask him about something, he is not as nice, and his answers are short. My best friend keeps telling me to stop calling him up, because he will think that I am chasing him. She also said that I should leave it up to him to make the first move in communicating with me. But I just can't follow her advice because I am really crazy about him. And since he's too shy to make the first move, I should be the one to do it, don't you think? Please give me your advice.'

Guide questions for discussion:

1. What, apparently, is the problem of the girl who wrote this letter?
2. What feelings are expressed by the writer in her letter?
3. Are her feelings natural? Why do you think so?
4. What term do we give to this intense feeling of attraction towards the opposite sex?
5. Have you experienced this yourself, or have you heard of boys and girls who are going, or have gone, through this experience?
6. If you were in the same situation, what would you have done?

Reading # 11
NEEDS OF ADOLESCENTS



Adopted from "Messages to Parents", a Booklet produced by the Population and Family Life Education (Reproductive Health), National Institute of Education, UNFPA Project 1996.

**Circumcision and Female
Genital Mutilation****RATIONALE**

The purpose of this Unit is to explain the consequences and risks of female genital mutilation and male circumcision. It will familiarize students with the different forms of female genital mutilation, legislation related to these practices, and introduce a new ritual that has been created to replace the physically harmful forms of female genital mutilation.

LEARNING OUTCOMES

By the end of the unit, you should be able to :

- explain the different forms of female genital mutilation and male circumcision, and their implications for the individuals
- help adolescents understand the social context of these practices and their harmful outcomes
- provide guidance to others in order to help them to change the harmful behaviour patterns
- assist teachers in dealing with this sensitive matter within the education setting;

CONTENT

This unit includes the following:

Topic 1. Female Genital Mutilation (FGM) and Male Circumcision

Topic 2. Consequences Related to FGM and Male Circumcision

Topic 3. National and International Efforts to Make FGM and Male Circumcision Safer

Circumcision is the act of cutting off the prepuce or foreskin of the penis or the clitoris. For young girls this procedure is difficult, and often affects the girl's normal sexual and reproductive functions. Therefore the different forms of this practice are called Female Genital Mutilation (FGM) in all official documents of the United Nations and those of world conferences. The different types of FGM are indicated in Reading # 12.

In Africa, circumcision and FGM are mostly performed as a rite of passage from childhood to adulthood. The age varies from area to area. The day of circumcision is one of fear and pain, but also accomplishment and recognition as a full adult. It is a collective experience.

Male circumcision seems to have positive health effects, and it is sometimes practised because of health reasons, such as hygiene. However, the preponderance of medical opinion today is opposed to the practice, as it has been indicated that usually it is unnecessary, and may lead to complications. As male circumcision cannot be considered a totally harmful practice, it has been suggested that safe male circumcision programmes be introduced.

All types of FGM create physical complications that in most cases need medical attention, either immediately or later in life. There is also evidence concerning the psychological effects. FGM violates human rights conventions that protect women and children from cruelty and violence, and ensure them access to health care, education, and self-realization. In Kenya, Maendeleo Ya Wanawake, a national women's organization at the Ministry of Culture and Social Services, and an international women's health organization, the Programme for Appropriate Technology in Health (PATH), have developed a new ritual that provides an alternative to FGM. It was developed following the studies concerning the use, cultural norms, and expectations of FGM.

Activity 3.1

Trainees will work in country groups on the following activities:

1. Describe the types of circumcision practised in your country.
2. Indicate the cultural, social and physical consequences of these practices.

Each group will present its report, and get feedback from the others. Reports of the groups will be compiled into one document.

Reading # 12

TYPES OF FEMALE GENITAL MUTILATION (FGM)

I. Excision (Sunna circumcision)

1. Excision of the prepuce, with, or without, excision of part, or all, of the clitoris. The amputation is usually done by a sharp object.
2. Bleeding is stopped by packing the wound with gauzes, or other substances, and applying a pressure bandage.

II. Clitoridectomy

1. In clitoridectomy the entire clitoris, the prepuce, and usually also the labia minora are removed, often with the same stroke.
2. Bleeding is stopped with packing and bandages or by a few circular stitches, which may, or may not, cover the urethra and part of the vaginal opening.

I.I.I. Infibulation (Pharaonic circumcision)

1. Infibulation is a clitoridectomy, excision of part, or all, of the external genitalia, followed by sewing up/narrowing the vaginal opening. The raw edges of the labia majora are brought together to fuse, using thorns, poultices or stitching to hold them in place, and the legs are tied together for 2-6 weeks.
2. The healed scar creates a hood of skin that covers the urethra, and part or most of the vagina, and which acts as a physical barrier to intercourse. A small opening is left to allow urine and menstrual blood to pass. The opening is surrounded by skin and scar tissue, and is usually 2-3 cm. in diameter but may be as small as the head of a matchstick.
3. If the opening is too small, the husband, or his female relatives, using a sharp knife or a piece of glass traditionally undertake recutting before intercourse. Defibulation must be performed during childbirth by an experienced birth attendant, otherwise foetal and/or maternal complications may occur because of obstructed labour or perineal tears.
4. Traditionally re-infibulation is performed after the woman gives birth, and it can also be done when the husband goes on a long journey.

II. Unclassified

1. Pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice or cutting of the vagina; introduction of corrosive substances or herbs into the vagina to cause bleeding, or for purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above.

A. FGM AND CIRCUMCISION ALL OVER THE WORLD

Activity 3.2

All societies have attempted to mark the transition from childhood to adulthood, or at least to understand this transition and its implications. In Africa the traditional practice of FGM is harmful, and needs to be modernized.

1. Using the results of activity 3.1, in country groups, design a ritual that could replace the FGM, and still meet cultural and social needs. In preparing the alternative ritual you should keep the following in mind:

- a) Rite of passage from childhood to adulthood
- b) Sexual security
- c) Confidence of the community in its traditional practice, particularly those who conduct FGM
- d) The role of parents in FGM

Each group presents and discusses its proposal for modernizing the process.

Reading # 13

FGM AND CIRCUMCISION IN AFRICA

FGM is mainly practised in Africa (types I-III), and Australia (type IV among the Aborigines), and as it is maintained among refugees and immigrants coming from these areas, it has become an important issue also in Northern America (Canada, The United States), and in Europe (in England and France, in particular). In fact, until the 1950s FGM was performed in England and in the United States as a treatment for lesbianism, masturbation, hysteria, epilepsy and other so-called female deviances.

FGM is a cultural practice among many tribes in twenty-eight African countries, mainly

in the North, West and East Africa, although it is also found, to a lesser degree, among some groups in Central and Southern Africa. In the Nile, Sahara, Sahel and Horn regions, where the custom is practised predominantly, most of the women have, or will experience, FGM. In addition, groups that traditionally do not have this custom, adopt it when they move into regions or urban zones where it is practised. Therefore the practice can also be found among Jewish and Christian groups in Egypt and Ethiopia. In addition, FGM can be found among small Islamic groups in India, Indonesia and Malaysia, among indigenous people in Colombia, Mexico and Peru, and among some ethnic groups in the Arabian Peninsula (it has been found in Bahrain, Oman, Saudi Arabia, the United Arab Emirates and Yemen).

Male circumcision is practised widely among Jews all over the world, as well as among Muslim and Christian populations. Today in the United States over 70 per cent of boys are circumcised, in Canada about 48 per cent, and in the United Kingdom 24 per cent. Circumcision is quite uncommon in the rest of Europe, in Asia, and in Central and South America. It is prevalent among the African tribes, but in East and Southern Africa there are areas where the vast majority of males are not circumcised. Male circumcision, as in the case of FGM, is also practised on the African continent among traditional Jews, traditional Christians, and among some Muslim groups.

B. AFRICAN SOCIAL CONTEXT

In Africa, circumcision and FGM are mostly performed as a rite of passage from childhood to adulthood; the age varies from area to area. For example, in southern Nigeria FGM is performed on babies in the first few months of life, while in Uganda it is performed on young adult women. In some areas it is delayed until two months before the woman gives birth. In Kenya, Uganda and West African countries, such as Sierra Leone, a girl may have a child out of wedlock to prove her fertility, then undergo genital mutilation and be married afterwards. In general, most girls undergo FGM when they are between 7 and 10 years old. However, FGM seems to be occurring at earlier ages in several countries. It has been assumed that by organizing the ceremony earlier the parents wish to reduce the trauma for their children, and want to avoid government interference, and/or resistance from children as they form their own opinions when they are older. Concerning the age at which male circumcision is performed there is a wide degree of variation as well. In some groups it is done to babies, whereas in Kenya, for example, the median age for male circumcision is 18 years (range 12 to 22 years), and it appears to be slowly rising. Traditionally both male and female circumcision is done without an anaesthetic, or by medically trained personnel. For example, elderly women usually perform FGM. The instruments used are often razor blades, knives or scissors.

The day of circumcision is one of fear and pain, but also accomplishment and recognition as a full adult. It is said that the three most difficult, and yet joyous times, in a

woman's life are at her circumcision, marriage and at the birth of her first child. Each marks a transition from one stage to another. Often the rationale for FGM and male circumcision is that it is necessary to make a child a real male or female. It is also often thought to purify and protect the next generation from outside influences, and to bind all young people to their peers or age set. It emphasizes and supports group solidarity, tradition over modern changes, and male authority over female as, for example, the respect and economic value of the bride is dependent upon her unquestioned virginity, demonstrated by intact infibulation.

For a mother in a society, where there is little economic viability for women outside marriage, ensuring that a daughter undergoes genital mutilation, as a child or teenager, is a loving act to give her better marriage prospects. Many parents want surgery for their daughters because they believe that it protects them from seducers and rapists, or because of other beliefs such as to deliver healthy babies. In different cultural thinking it is assumed that FGM ensures cleanliness, prevents promiscuity, and excessive clitoral growth, preserves virginity, and enhances male sexuality. Circumcision is a collective experience. In circumcising groups, a person who is not circumcised is considered unclean, not fully formed as an adult member of society, not prepared to marry and bear children, and is a perpetual child.

Activity 3.3

The whole class will discuss the follow-up activity to 3.2. As a follow-up activity, each group will identify a village in their respective countries, and discuss and test the proposal with the key players in FGM.

The groups will discuss ways and means of approaching the villages selected.

Reading # 14

CONSEQUENCES RELATED TO FGM AND MALE CIRCUMCISION

A. CONSEQUENCES RELATED TO FGM

All types of FGM create well documented physical complications that in most cases need medical attention, either immediately or later in life. There is also anecdotal evidence concerning the psychological effects. The physical complications depend on several factors, including the extent of cutting, the skill of the operator, the cleanliness of the tools used, and the physical condition of the child. Serious complications can follow any type of FGM, but they occur more frequently in the case of infibulation (type III).

The short-term complications include shock, injury to neighbouring organs (such as urethra, the vagina, the perineum, the rectum, or formation of fistulae through which urine or faeces will leak continuously), urine retention, infection, and severe pain, as well as death caused by bleeding, pain, shock, or infection. Severe bleeding can also lead to anaemia. In Sudan, for example, it has been estimated that one third of the girls undergoing FGM will die.

The long-term complications of types I and II include failure to heal, e.g. the scar can split open during childbirth and lead to renewed bleeding, abscess formation, a dermoid cyst which is the most common long-term complication (the size can vary from a small pea to a football), keloids (excessive growth of scar tissue), that can be psychologically distressing, and difficult to operate on, urinary tract infection, tumours consisting of neural tissue that makes sexual intercourse and washing very painful (the other complications can also lead to the same effect), HIV/AIDS, hepatitis B, and other blood borne diseases, and pseudo-infibulation (excessive type II).

Because of the extent of the initial and repeated cutting and suturing, the physical, sexual, and psychological effects of infibulation are greater, and longer lasting than for other types of FGM. The long-term complications of type III include all those already listed, as well as reproductive tract infections that can lead to infertility, painful or blocked menstruation, chronic urinary tract obstruction (including repeated infections and bladder stones), urinary incontinence, stenosis of the artificial opening of the vagina, and complications of labour and delivery. The highest maternal and infant mortality rates are in FGM-practising regions.

It may be asked why FGM has been perpetuated despite the negative effects. The answer to this question lies in the socio-cultural perception of its value. Despite the reported

physical suffering and trauma, even psychopathology, the perception of the incident is not always negative. There have been reported cases when teen-age girls have insisted on being circumcised, despite the reluctance of their parents to make them go through this experience. FGM for them is a desirable ceremony, with its social advantages of peer acceptance, personal pride and material gifts. FGM is related to the sense of impurity and shame, and this explains why the mothers want to pass the most intimate aspects of their self-perception and feelings of gender and social identity to their daughters. However, there is evidence that self-esteem and self-identity are disturbed both at the physical and psychological levels, and as nowadays more women from different societies feel free to speak about their experiences, the evidence suggests that the event is mostly remembered as extremely traumatic, and leaves a life-long emotional scar.

FGM also affects the lives of men. There is evidence that husbands often seek extramarital sex with women who are not circumcised. FGM can cause strained familial relations, which manifest themselves as anger, aggression and divorce. According to a study among polygamous men, 89 per cent preferred uncircumcised (or type I) women to circumcised, and 20 per cent had married a second wife because of the progressively toughening scars of their wives each time they had babies.

B. CONSEQUENCES RELATED TO MALE CIRCUMCISION

Male circumcision seems to have positive health effects, but at the same time it carries the risk of complications such as infection or sepsis, haemorrhage, partial penile amputations, or even death. Safe circumcision has proved to be costly, and its benefits can also be gained by practising proper penile hygiene and safe sex practices.

According to scientific evidence, circumcised boys have fewer urinary tract infections, and infections or inflammations of the skin of the penis, a lower rate of syphilis, genital herpes, genital warts, and genital cancer. Cancer of the cervix has been reported to be less common in the partners of circumcised men. Some scientific publications associate male circumcision with reduced risk of HIV infection in males in sub-Saharan Africa. This is due to the removal of the foreskin that has a high density of Langerhans cells, which represent a possible source of initial cell contact for HIV infection. However, some circumcision practices, and the cultural customs related to these practices, such as using the same knife for each man during the ceremony, alcohol consumption and increased sexual activity, may increase the risk of transmitting HIV. In addition, circumcision may raise a false sense of security that might lead to increased risk-taking behaviour. There is no evidence of lower HIV/AIDS risk among the partners of circumcised males, and no adequate studies are available about the impact of religion, as concerning STDs and AIDS. Muslims, for example, in general, may have a lower risk profile than non-Muslims.

Reading # 15

NATIONAL AND INTERNATIONAL EFFORTS TO MAKE FGM AND MALE CIRCUMCISION SAFER

A. MALE CIRCUMCISION

Although male circumcision is sometimes practised because of health reasons, such as hygiene, the preponderance of medical opinion today is opposed to the practice, as it has been indicated that usually it is unnecessary and may lead to complications. However, as male circumcision cannot be considered a totally harmful practice, it has been suggested (e.g. by the Population Council) to introduce and implement safe male circumcision programmes in developing countries. These programmes would include providing appropriate standards for training, techniques, and counselling, as well as an adequate package of surgical instruments and other commodities.

B. FEMALE GENITAL MUTILATION

In Kenya, Maendeleo Ya Wanawake, a national women's organization at the Ministry of Culture and Social Services, and an international women's health organization, the Programme for Appropriate Technology in Health (PATH), have developed a new ritual called Ntanira Na Mugambo (also known as "circumcision by words") that provides an alternative to FGM. It was developed following the studies concerning the use, cultural norms, and expectations of FGM. The ritual involves the whole community, and was piloted in one community in 1996, and has now reached several (in 1998 there were 13 communities involved). The girl is secluded for a week and undergoes classes in reproduction, anatomy, hygiene, respect for adults, developing self-esteem, and dealing with peer pressure. Her family also undergoes health education sessions, and men in the community are taught about the negative effects of female circumcision. At the end there is a ceremony of singing and dancing. The ritual marks the girl's passage from childhood to adulthood without being cut. Although some of the girls may yet come under pressure to be circumcised after the ritual, it has proved to be a successful alternative. (For further information concerning Alternative Rites of Passage, see Annex).

FGM violates human rights conventions that protect women and children from cruelty and violence, and ensure them "bodily integrity" and access to health care, education, and self-realization. These include the Declaration of Human Rights (1948), The United Nations Convention on the Rights of the Child (1959), The African Charter on the Rights and Welfare of the Child (1990), The United Nations Convention on the Elimination of All Forms of Discrimination Against Women (1992), The United Nations Declaration on

Violence Against Women (1993), The World Conference on Human Rights, Declaration and Programme of Action, Vienna (1993), and the United Nations High Commission on Refugees, Statement Against Gender-Based Violence (1996). FGM is nowadays a topic of national and international media attention. It has been included in the resolutions and action plans of the World Conference on Human Rights (1993), the International Conference on Population and Development (1994), that clearly stated the violation of reproductive and health rights, and the United Nations Fourth Conference on Women (1995). There are several women's groups in Africa that have raised the topic as well. Some national governments have made a public commitment to stop FGM through laws, professional regulations and programmes, and by signing international declarations (see Table 1.).

Many people have refrained from having their daughters undergo FGM, after having been exposed to education and information concerning its disadvantages, and why it is not necessary in order to achieve whatever it is believed to accomplish. Male education is critical of the fight against FGM. Circumcision is related to the pride of men, to ensure the faithfulness of their wives and the chastity of girls. Boys and men can contribute to the change of behaviour by helping women to value themselves for who they are as persons, and not for their external physical mutilation. Men are able to separate FGM from better marriage prospects, thus discouraging the mothers, those who carry out the circumcision, and the girls themselves (often under peer pressure), from continuing this practice.

In more than twenty African countries, the Inter-African Committee on Traditional Practices (IAC), with the collaboration of local NGOs, has launched an educational campaign in order to eradicate FGM. In 1997 WHO launched an African Region's Plan of Action, that is a 15-year strategy to accelerate the elimination of FGM. In addition, various NGOs (in Burkina Faso, Nigeria, Kenya, Senegal and Eritrea, in particular) and other international agencies, have provided technical assistance, advocacy and funding (these include UNICEF, UNFPA, USAID, PATH, Research, Action, and Information Network for Bodily Integrity of Women (RAINBE), Equality Now, the Centre for Development and Population Activities (CEDPA), the Population Council, the Wallace Global Fund, and the Women's International Network).

Activity 3.4

The negative consequences have led to a campaign against FGM. The school has a responsibility to ensure that children understand FGM, and why they should not perpetuate the practice. As a counsellor you will need to help teachers in addressing the problem.

Work in groups of four. Identify the age groups to focus on: 7 to 9, 10 to 13, and 14 to 18. Identify and describe the following for the specific age group:

1. The approach or approaches you would suggest in introducing the issue of FGM
2. Learner-centred activities
3. Learner-friendly materials
4. Assessment of children's understanding of FGM and its consequences

C. CURRENT ESTIMATES OF FEMALE GENITAL MUTILATION IN AFRICAN COUNTRIES

Country	Prevalence %	Type	Laws**
Benin	50	Excision	None. The government supports the eradication of FGM.
Burkina Faso	70	Excision	Recent legislation outlaws FGM and the government campaigns against the practice.
Cameroon	20	Clitoridectomy and excision	None. The government supports the eradication.
Central Afr. Rep.	43*-50	Clitoridectomy and excision	Law against FGM (1966).
Chad	60	Excision and infibulation	None.
Cote d Ivoire	43*-60	Excision	New law against FGM has been drafted.
Dem. Rep.of Congo	5	Excision	None.
Djibouti	90-98	Excision and infibulation	Law against FGM (1994).
Egypt	97	Clitoridectomy, excision, infibulation	Banned (1996) by the Ministry of Health.

Eritrea	90	Clitoridectomy, excision, infibulation	None. The government supports the eradication.
Ethiopia	85*-90	Clitoridectomy and excision, infibulation near Sudan and Somalia	None. The government supports the eradication.
Gambia	60-90 (average), almost 100 among the Fula and Sarahuli	Excision, infibulation (very small %)	None. The government supports the eradication.
Ghana (1994).	15-30	Excision	Law against FGM
Guinea	60*-90	Clitoridectomy, excision infibulation	Prohibited by the penal code.
Guinea-Bissau	50 (average), 70-80 among the Fula and Mandinka, 20-30 in urban areas	Clitoridectomy and excision	None.
Kenya	50	Clitoridectomy and excision, some infibulation near Somalia	None. The government supports the eradication.
Liberia	50-60	Excision	None.
Mali	90-94	Clitoridectomy and excision, infibulation in the south	None.
Mauritania	25 (average), 95 among the Soninke and Halpular, 30 among the Moor	Clitoridectomy and excision	None.
Niger	20	Excision	None. The government supports the eradication.
Nigeria	40*-50	Clitoridectomy, excision, and some infibulation in the northwest	None.
Senegal	20	Excision	None. The government supports the eradication.
Sierra Leone	80-90	Excision	None.
Somalia	98	Infibulation	None.
Sudan	89 in the north	Infibulation, some excision	Penal code (1947, rat. 1957) prohibited infibulation but not Sunna. New penal code (1993) does not mention FGM but there is government support.
Togo	12-50*	Excision	None. The government supports the eradication.
Uganda	5	Clitoridectomy and excision	None. The government publicly condemns FGM.
United Rep. of Tanzania	10	Excision, infibulation	None. The government has made efforts to eradicate FGM (campaign in 1971).

Sources: Amnesty International, WHO, PATH

*According to WHO./** According to Amnesty International and PATH.

Main sources:

Female Genital Mutilation. An Overview. World Health Organization Publications. www.who.int/dsa/cat98/fgmbook.htm 3/4/2001.

Female Genital Mutilation – A Human Rights Information Pack. www.amnesty.org/ailib/intcam/femgen/fgm9.htm 03/04/2001.

PATH: Female Genital Mutilation – the Facts. www.path.org/resources/fgm_the_facts.htm 19/04/2001.

Population Council. Reproductive Health and Family Planning. Male Circumcision and HIV Prevention: Directions for Future Research. www.popcouncil.org/horizons/reports/circumcision/conclusion.html 02/02/2001.

Other sources:

Apena, Adeline: Female Circumcision in Africa and the Problem of Cross-Cultural Perspectives. History Dept., Russel Sage College, Troy NY. www2.h-net.msu.edu/~africa/sources/clitorodectomy.html 13/09/2000.

Female Genital Mutilation (Female Circumcision) In Africa, The Middle East and Far East. Religious Tolerance Organization. www.religioustolerance.org/fem_cirm.htm 13/09/2000.

Iweriebor, Ifeyinwa 1996: Brief Reflections on Clitoridectomy. Black Women in Publishing. New York. www2.h-net.msu.edu/~africa/sources/clitorodectomy.html 13/09/2000.

Matias, Aisha Samad 1996: Female Circumcision in Africa. Director Women's Studies, CUNY. www2.h-net.msu.edu/~africa/sources/clitorodectomy.html 13/09/2000.

Richards, David 1996: Male Circumcision: Medical or Ritual? Journal of Law and Medicine. Volume 3, Number 4. May, 1996. www.cirp.org/library/legal/richards/ 18/09/2000.

UNIT 4

Protection Against Unplanned Pregnancies

RATIONALE

The purpose of this unit is to explain the risks of being sexually active, and show the disadvantages of an early unplanned pregnancy. It will also familiarize students with the available methods of sexual protection.

LEARNING OUTCOMES

By the end of the unit, you should be able to :

- explain the available methods of protection, with their advantages and disadvantages
- encourage adolescents to be able to cope with their sexuality
provide guidance to others on how to communicate on this sensitive matter;
- explain the disadvantages of an early unplanned pregnancy;
explain further negative consequences of unprotected sexual relations.

CONTENT

This unit includes the following:

- Topic 1. Methods of Sexual Protection
Topic 2. Sexual Behaviour
Topic 3. Consequences of Unprotected Sexual Relations

Many young girls are left unguided at a time when they are exposed to high reproductive health risks. This situation contributes to the growing number of adolescent pregnancies.

Adolescents are usually influenced by their peers. They do not normally discuss their sexual activities openly with their parents. Such matters are discussed with their peers, who may be uninformed, or wrongly informed. They sometimes learn from the media, which sometimes offer a distorted picture of the realities concerning sex and gender stereotypes. The age at which adolescents become sexually active is dependent on the local culture, and is usually different for boys and girls.

Education must, therefore, take over the guidance and counselling of young boys and girls, in order to prepare them for adulthood and a healthy reproductive life. Parents, counsellors, school teachers, religious and community leaders, should work together with adolescents, to ensure safer and more responsible reproductive and sexual behaviour, and to provide appropriate counselling services suitable for a particular age group.

Activity 4.1

1. Why is the school system becoming more important in providing guidance and counselling for young boys and girls today?
2. In groups of five discuss information given by peers on sex and love.

Some common misguided information includes:

1. A virgin does not get pregnant at her first try
2. Making love with a virgin will cure HIV/AIDS
3. Pepsi-Cola will cause infertility
4. Stout kills sperm
5. If girls make love in water, they do not get pregnant
6. Girls do not get pregnant if they make love standing up.

Topic 1

METHODS OF SEXUAL PROTECTION

NOTE : Go through **Reading # 16, Prevention of Pregnancy**, on page 72.

In addition to the instructions found in the Reading, you may also present a video concerning the subject, and/or invite a trained person to give further explanations.

Topic 2

SEXUAL BEHAVIOUR

Adolescents are often unsure how to respond to a sexual proposal, in particular to a proposal made by their boy or girl friends. Some adolescents believe that sexual intercourse is the only way of expressing affection towards another person.

With the following activities, you will clarify the advantages of delaying sexual activities. You will also explore possible answers to sexual proposals.

Activity 4.2

1. Go through **Reading # 18, Possible Consequences of Unprotected Sexual Relations in Adolescence**, on page 81.
2. Discuss with the group the contents of Reading # 18, and explain the several advantages for adolescents of being able to manage their sexuality.

Activity 4.3

1. Form a group of three, and plan a skit on a relationship between a boy named Henry and a girl called Mary. Henry insists on a sexual relationship, but Mary is cautious, because she does not wish to be infected by a careless sexual involvement.
2. How should she manage the situation?
3. Look at the **Assessment 4.1, 'Reasons to Say No'**, on page 83, and discuss the possible answers.

Activity 4.4

1. In small groups, discuss ways in which boys and girls can make, and maintain, healthy friendships.

Topic 3.

CONSEQUENCES OF UNPROTECTED SEXUAL RELATIONS

The following are the possible consequences of unprotected sexual relations:

1. Unwanted pregnancies
2. Sexually transmitted diseases (STD)
3. HIV/AIDS

Each of these will be discussed in detail below.

1. Unwanted pregnancies

Unprotected sexual relations can result in pregnancies for which adolescents are not prepared. The younger the adolescent, the more complicated pregnancy is likely to be. There is a greater possibility of miscarriage, still birth, premature birth, and babies with a low birth weight.

NOTE : Review for yourself **Reading # 17, Health Implications of Adolescent**

Activity 4.5, Role Playing

A young school girl became pregnant after having sexual intercourse for the first time. She was told by the young man that she would not get pregnant at the first try, and she believed him.

She missed her period. Her friend told her that she may be pregnant. The trauma began. What would she tell her parents? Would the young man accept his responsibility? What would her schoolmates think of her? What would the village leader think of her? How would she continue her education?

She thought of abortion, but she had no money. She thought of suicide, but this did not seem an appropriate solution. She went to her guidance counsellor.

1. Dramatize her experience, and describe how the guidance counsellor helped her.

Pregnancy, on page 78.

Social Disadvantages of an Early Pregnancy

An early pregnancy, especially an early marriage, has the following disadvantages:

- a) many children under one roof;
- b) early ageing of parents due to added stress;
- c) disharmony within the family due to the large size of the family;
- d) less individual attention for children resulting in a lack of love and care;
- e) sometimes a mother and her daughter become pregnant during the same period, leaving no one to look after them during pregnancy.

Activity 4.6

1. On a sheet of paper, write the numbers from one to twenty vertically down the sheet.
2. Make a list of twenty things in life that you love to do, and also the name of your favourite future profession.
3. Afterwards, discuss which of your favourite activities and profession you will not be able to do, or achieve, in an early marriage.

2. Sexually Transmitted Diseases (STD)

Sexually transmitted diseases can be avoided if:

- a) one abstains from having sexual intercourse;
- b) a condom is used; and
- c) there is an exclusive relationship between two people who are free of disease.

Boys and girls find it difficult to tell adults if they have caught STD. However, for girls it is even more difficult, because they feel guilty about having had sexual intercourse. They sometimes resort to self-medication, which may hide the symptoms, but does not cure the disease.

3. *HIV/AIDS*

Recent studies show that HIV (Human Immuno-deficiency Virus)/AIDS (Acquired Immuno-deficiency Syndrome), increases rapidly between the ages of eleven and nineteen, especially among young girls of fifteen to nineteen, who are five times more likely to become infected than boys. One reason that adolescent girls are at particularly high risk, is because they do not have the power to negotiate safe sex with their partners. While the subordinate position of women in most African societies denies them the opportunity of negotiating safe sex, the fact that many young girls have sexual relations with older men (sugar daddies), for material and financial support, also puts them at a disadvantage for negotiating sex. Furthermore, many older men deliberately seek out young girls, in the mistaken belief that their chances of AIDS infection will be reduced.

There is no known cure for AIDS. The virus can be passed on from one person to another through semen, blood and vaginal fluids. It can be passed on from mother to child through pregnancy, childbirth and breast feeding. The diagnosis of HIV/AIDS is complex.

Activity 4.7

1. Watch a video on **HIV/AIDS**
2. Go through Reading # 20 A, **How HIV Infection Spreads** on page 85, and list the ways of spreading **HIV/AIDS**
3. Go through **Reading #20 B, Testing for HIV**, on page 86.
4. Discuss in groups the importance of testing for **HIV**
5. Discuss the ways in which **HIV Infection** does not spread. The following could be highlighted:
 - Shaking hands
 - Mosquito bites
 - Hugging and kissing
 - Participating in sports
 - Swimming pools
 - Articles of use
 - Use of toilets

Activity 4.8, Role Playing

A young girl has contracted HIV/AIDS

1. Dramatize her experience until death, and the role of the guidance counsellor in helping her parents, friends, and herself, to cope with the disease.

Reading # 16

PREVENTION OF PREGNANCY

A. Some Methods of Preventing Pregnancy

The following list is not comprehensive, but includes most of the more commonly used methods.

Abstinence - Avoiding sexual intercourse until the adolescent is able to have a fully responsible, and emotionally fulfilling, relationship, and not merely capable of achieving orgasm, is an important principle in helping a young person to delay the beginning of sexual intercourse, though not necessarily all forms of physical contact. The young person also needs to know what the consequences of sexual intercourse can be, both in biomedical terms, including pregnancy and STD, and the ways in which it might affect their relationship, and their future. Furthermore, both adolescent females and males need to know, and have access to, protective measures, if they are to begin to have sexual intercourse.

What are the obstacles to abstinence among adolescents? What pressures exist for each sex to have intercourse? What are the counter-pressures? How is such conflict currently dealt with? What is sexual behaviour considered to be by the young person, and what are their views about the morality of such behaviour? What do they think adults want, and what are adult views? The answers to these questions, which the group should discuss, may be widely different from culture to culture, for the two sexes, and for different age groups among adolescents.

Natural Methods – These methods of contraception are based on a knowledge of how the female body works, in order to judge when ovulation is, and is not, possible. These methods are sometimes called rhythm, periodic abstinence, or **fertility awareness**. Using such a method is the simplest, if the adolescent girl has an established and regular menstrual cycle, which is often not the case, especially in early adolescence. More sophisticated techniques can be used, such as recording basal body **temperature (BBT Method)**, and observing cervical mucus (**Billings Method**), but that is not likely to be possible for most adolescents. But even if an adolescent is given the knowledge, and

perhaps the means, for determining a 'safe' period, it also requires cooperation with a partner which suggests not only good communication but a good relationship. As sexual intercourse in adolescence is often unplanned and sporadic, and even at best natural methods are not highly reliable, it is not likely to be useful for most adolescents, despite the fact that it costs no money, and avoids using any contraceptive device.

Withdrawal or Coitus Interruptus – This method requires the male to withdraw his penis from the vagina during sexual intercourse before ejaculation occurs. However, there is sometimes a leakage of semen before ejaculation. If used properly it may be 75-85 per cent effective, but it requires great self control (as well as knowledge) and the willingness of both partners. As male adolescents are often very quickly aroused, it is especially difficult for them to use the withdrawal method effectively. On the positive side, however, there is no cost involved, it is always available and perfectly safe, although its practice may sometimes lead to anxiety in sexual relations.

Diaphragm or Cap – This is a soft rubber cup with a stiff, but flexible, rim around the edge which, when correctly inserted into the vagina, covers the entrance to the uterus, and combined with the use of a cream, blocks sperm movement. It should be used with a **spermicide (contraceptive foam, jelly or cream)**, which helps to kill sperm if it gets past the diaphragm. It also provides protection against some STDs and, if used correctly, may be 80 to 90 per cent effective in preventing pregnancy. However it has a number of drawbacks for adolescents, especially in developing countries. The diaphragm has first to be fitted by a health worker, which means the adolescent girl must admit to someone that she is engaging in, or planning to engage in, sexual intercourse. She may also need to tell her sexual partner, and worry what he will think of her. It needs to be inserted before sexual intercourse, and kept in for some six hours afterwards. As sexual relations are often unplanned this is a considerable disadvantage. Adolescents may also find the method messy and embarrassing to use. It needs to be kept safely, and cleaned, and that may be especially difficult for an adolescent, who wants to keep its use secret from family members. It is not especially costly, but it requires access to a health service for it to be used effectively, and checked periodically for fit.

Intra-uterine Device (IUD or IUCD) - This is a small plastic or metal device inserted into the womb by a trained health worker. Again for an adolescent girl this may be difficult, since she needs to know about the method, or feel able to consult a health worker, and take the risk of a negative reaction to her revelation that she is sexually active. Once inserted it is an effective protection against pregnancy, but it is not recommended for women who have never given birth, which will be the case for most adolescents, especially the younger ones. For some there will also be unpleasant side effects. There is a risk of pelvic inflammatory disease (PID), with serious potential consequences which may affect future fertility.

Oral Contraceptive (“OC” or ‘The Pill’) – This method of contraception is one of the most widely used, and is highly effective in preventing pregnancy if taken regularly, most commonly for twenty one days a month. This means commitment and attention to the calendar. It may mean finding a place to hide the pills for some adolescents. In many countries it requires a prescription from a doctor, who must therefore be informed of sexual activity, and it usually requires some expenditure. The pill is often useful in regularizing the menstrual cycle, and providing some protection against PID. Alone, it is not an adequate protection against STD, but because it is effective against pregnancy the need for prophylaxis may be too easily ignored.

The Condom (Sheath) – A sheath of thin rubber put on before intercourse when the penis is erect. It collects the semen at the time of ejaculation, and prevents it from entering the vagina. It must be removed carefully after intercourse, but before the erection is lost, to avoid spillage of semen. This is an efficient, cheap, and reliable method both for preventing pregnancy and STD, if used properly, and so can be a valuable method for the adolescent. However it requires some knowledge, a little skill, some expenditure, a means of obtaining it with a minimum of embarrassment or censure, and some forethought before intercourse takes place. In some societies condoms are not easily available. It has no side effects, but some feel that its use reduces sexual sensation slightly. Because the girl has more at stake, and may be more concerned about the consequences of unprotected sexual intercourse than her partner, it would be a considerable advantage if girls found it possible to obtain condoms, but in most societies that is especially difficult. The vaginal sheath currently being developed may ultimately be of considerable value for this reason.

Injectable and Implantable Contraceptives – A variety of new methods are being developed, and tested, which have the advantage of procedures which, although requiring administration by a trained health worker, and thus requiring the revelation of sexual activity by the adolescent, require no further action on the part of the adolescent, for a period of several months to several years. However they vary in the length of time required for a return to fertility, which can cause problems for an adolescent who marries, and some have considerable side effects. For the most part they have not been fully tested on the adolescent population.

Vasectomy (Male Sterilization) and Tubectomy (Female Sterilization) – Vasectomy is a permanent method of contraception which prevents the movement of sperm from the testes to the penis, so that sperm does not become a part of the semen which is ejected. Similarly, tubectomy, a sometimes reversible method, prevents the egg from travelling through the fallopian tubes to meet the sperm, where fertilization would otherwise take place. Neither method is appropriate for adolescents, because they are not mature enough to make a decision to use permanent methods of preventing pregnancy.

B. Obstacles to the Prevention of STD/HIV

Attitude to STD – The attitude towards the presence of an STD in males and females may be different in adolescents and adults. In some communities having an STD may even be regarded as a mark of pride among boys, indicating sexual experience. If the adult attitude is pejorative, particularly towards girls, however, this will deter young people from seeking help, and so act as a major obstacle to diagnosis and treatment.

Symptoms of STD/HIV – As noted, an STD in the female is more likely to be without obvious symptoms than in boys. This prevents diagnosis and treatment, unless the young woman becomes informed about this. HIV will be asymptomatic in both.

Diagnosis and Treatment of STD – Most STDs can be treated once diagnosed. However, an adolescent may be anxious to avoid admitting to have had sexual relations. The adolescent may be concerned about the negative attitude of the health worker, a possible lack of confidentiality, and an attempt to inform the sexual partner(s) of the adolescent. They may also be concerned that they may have broken the civil, or religious, laws of the land. These anxieties may, or may not, be justified, but unless they are dealt with they will serve as a deterrent to accurate diagnosis, and ultimate treatment. If adolescents do not go for professional help, they are more likely to use self-diagnosis, and treat themselves, with considerable risk to their health, and those of their sexual partners.

Diagnosis and Treatment of HIV/AIDS (Acquired Immuno-Deficiency Syndrome) - Unlike most STD, HIV infection or AIDS cannot be treated, and is believed to be ultimately fatal for all who are infected, although the time from HIV infection to the full AIDS disease is uncertain. Thus the diagnosis of HIV infection does not lead to treatment and cure. It is likely to be profoundly disturbing to an adolescent, to learn that he or she is HIV positive, since it may be perceived as 'a sentence of death', and discourage all sexual activity, marriage and child bearing. Those who are married may have good reason for wanting to be tested, although the blood test can only determine whether one has come in contact with the HIV three months, or earlier, to the test. Knowing that one is infected may help protect others, but the same protective measures need to be taken to

protect oneself from becoming infected, and may serve as an even greater motivating force. They must prevent their semen and blood, in the case of a man, or vaginal fluids and blood in the case of a woman, from coming into contact with another person. If they are sexually active it calls for the practice of safe sex, which can include hugging, stroking and kissing, and the careful use and disposal of a condom every time they have sexual intercourse.

Thus while testing for STD is to be encouraged, whether or not a test for HIV infection is appropriate, requires careful thought in each individual case, and a readiness for counselling afterwards. There is a need for a better understanding of HIV infection and AIDS, not only for the adolescent, but for society as a whole, to avoid stigmatizing those infected, avoid the dangers of driving underground such knowledge, and enable people to speak more freely about preventive measures. Stigma breeds secrecy, and secrecy breeds fear and ignorance, which are the greatest obstacles to the prevention of HIV/AIDS in adolescence.

Reducing the Risks of STD/HIV

The groups, having reviewed the obstacles to the prevention of STD and HIV infection among adolescents, should now turn briefly to what can be done to reduce these obstacles, and the extent to which they can be achieved with, and for, adolescents including:

Provision of Information – to young people and adults about how diseases are contracted, how they can be prevented, how they are diagnosed, and how they may be treated, and the adolescent helped.

Provision of Counselling/Clinical Services – in an accessible and sympathetic manner.

Consequences of Untreated STD – potential consequences for the adolescent male, female, their sexual partners, and children.

Abstinence – the value of delaying sexual intercourse, until the young person is ready for a mature and responsible relationship.

Safe Sexual Practices – including sexual interaction without intercourse, the careful use and disposal of a condom, and sexual relations in which both partners are free of disease, and have sexual relations with no one else.

Role Playing

The groups should now choose at least one problematic situation to role play. It might be: a typical discussion between two adolescent boys, about whether or not one of them might have been infected with the 'AIDS virus', and what they should do about it; or a boy, or girl, trying to tell a parent that he, or she, thinks she might have 'caught AIDS'; or a young person talking with a friend, after a positive diagnosis of HIV infection has been made. Bear in mind that it is important to role play the most typical reactions which are likely to occur, in order to strengthen the understanding of the group, concerning the obstacles to the prevention of STD and HIV infection among adolescents in their own societies.

Reading # 17

HEALTH IMPLICATIONS OF ADOLESCENT PREGNANCY

Risks to the Mother

The health risks to the teenage mother fall into two broad categories: first, the problems, still imperfectly understood, which flow from the fact that the teenage mother is herself still growing, and second, the better known, and more easily documented, medical risks that arise with greater frequency during the course of a teenage pregnancy and delivery.

During that time a young woman will experience hormonal changes which control her linear growth; how they are affected by pregnancy, and when, is incompletely understood. What gives cause for concern in this regard, is the knowledge that the administration of oestrogens to growing girls accelerates epiphyseal maturation, and when administered in large doses is believed by some to cause premature fusion. More importantly, young women who do complete a pregnancy, apparently fuse their epiphyses during the nine months of gestation.

The importance of physical maturity is also apparent in data concerning pregnancy outcomes. Evidence suggests that the body of the girl who conceives within two years of the menarche (regardless of chronological age if under sixteen), is less able to produce a healthy infant. Such girls produce twice as many low weight infants at birth, as do mothers who are equally young, but who first conceive more than twenty-four months after the menarche.

What we know about the actual course of a teenage pregnancy and delivery, gives weight to the belief that pregnancy among girls of fifteen years of age and under, carries greater risk than does pregnancy among women in their twenties. Four problems are well-documented and particularly common:

- Teenagers are more likely to suffer from anaemia during pregnancy.
- Teenagers experience a higher incidence of toxæmia which, in its most serious forms, may result in high blood pressure, seizure, and sometimes death.

- There is a greater likelihood of prolonged labour, which multiplies the risks to the mother and her child.

Risks to the Infant

The difficulties that arise for the mother have a direct bearing on the risks faced by the infant, for whom they are both more obvious, and frequently more severe. Whatever difficulties there may be in documenting the potential risks to the young mother, the dangers faced by their infants are unambiguous. In the United States, babies born to very young mothers are three times as likely to die in the first year of life, and more than twice as likely to be born weighing less than 2,500 grams.

The cut-off used to identify low birth weight infants is 2,500 grams, and we know it to be one of the most accurate predictors of health status, i.e. predicting health problems in the first seven years of life. Low birth weight infants, including those born to teenage mothers, are more likely to suffer from birth-related defects, such as mental retardation, deafness, cerebral palsy, seizure disorders, blindness, and other congenital anomalies. In addition, these infants start life with less iron than larger babies.

One particularly striking piece of data will help to stress this point. Children born to women of fifteen years of age, and under, have three and a half times the number of neurological abnormalities than children born to older women. Although these data come from the United States, a brief overview of the international literature suggests that similar risks are faced by infants born to teenage mothers in other countries.

Repeated Pregnancies

The first-born child of a teenage mother faces formidable obstacles at the start of life, but the adverse effects of teenage pregnancies multiply when those mothers have a second child before the age of twenty. Infant mortality and maternal mortality rates increase with successive births, and short intervals between births.

But the more telling point is made by statistics on neonatal deaths. These are the deaths which occur in the first twenty-eight days of life, and which reflect not so much the poverty of the family, or the quality of the food and housing available for the growing infant, but the health status of the mother, and the conditions immediately surrounding pregnancy and delivery. Those deaths increase dramatically among the second, third, and subsequent children, born to a mother who is still in her teens.

This issue is particularly important, because having a first child at a very young age, increases the likelihood of additional children within a short period of time. When contraceptive programmes are not available, teenagers are most likely to have a second pregnancy. Eighteen per cent will be pregnant within six months after their first delivery, nearly half will be by the end of two years, and virtually all will have been by the end of five years. The details are less important than the conclusion: very early pregnancies are almost never a one-time occurrence, and multiple pregnancies among very young mothers almost always involve substantially greater risks.

In the past, even when family planning programmes were available, as many as one half of all very young mothers became pregnant again, within three years of having their first child. This appears to have been true, even when a full range of services was available to the mothers and their infants. In the United States, where young pregnancies are often frowned upon, many communities have established programmes, in the hope that providing comprehensive health, education, and social services will prevent a second pregnancy. Yet even in one of the best of these - a programme conducted in conjunction with the Yale University Medical School in New Haven, Connecticut - that proved not to be enough. Despite information, and all other forms of assistance, out of 180 mothers studied, 79 had delivered one, or more, infants within the two to four-year period following their first pregnancy. Still others were known to be pregnant, or to have had spontaneous miscarriages, before the time of the study's final interview.

Reading # 18

**POSSIBLE CONSEQUENCES OF UNPROTECTED SEXUAL
RELATIONS IN ADOLESCENCE**

I.

UNWANTED PREGNANCY

UNWANTED CHILD

ILLNESS, INJURY, DEATH

TO MOTHER

TO CHILD

INDUCED ABORTION

SEXUALLY TRANSMITTED DISEASES

STUNTED DEVELOPMENT OF PARENTS

EDUCATIONALLY

ECONOMICALLY

SOCIALLY

PSYCHOLOGICALLY

INADEQUATE PARENTING

DAMAGED CHILD

CHILD ABUSE

CHILD ABANDONMENT

INFANTICIDE

II.

SOME ISSUES IN ADOLESCENT PREGNANCY

MEDICAL RISKS

PREGNANCY COMPLICATIONS

SPONTANEOUS ABORTION (MISCARRIAGE)

STILLBIRTH

PREMATURE BIRTH

LOW BIRTH WEIGHT

CHILDBIRTH COMPLICATIONS

IS THE PREGNANCY –

WITHIN OR OUTSIDE MARRIAGE ?

WANTED OR UNWANTED ?

PLANNED OR UNPLANNED ?

HOW EARLY IS THE PREGNANCY –

SUSPECTED BY THE ADOLESCENT ?

CONFIRMED ?

WITH WHOM DOES SHE DISCUSS IT ?

HOW LATE IN THE GESTATION PERIOD ?

ASSESSMENT : 3.1 MAKING RATIONAL DECISIONS -

Reasons to say 'NO'










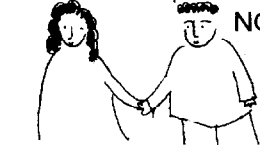

Delaying sexual intercourse until: more responsible, * older, * in a sure relationship with one person,* married

How ?

There are many good reasons for delaying sex until you are older. These are listed in the pictures below.

Why ?

Pick four reasons young people usually have for abstaining from, or delaying, sexual intercourse, and place () in these boxes.

<p>1. Fear of pregnancy</p> <p>NO</p> <p>No sex 100% effective</p> 	<p>2. Fear of STD</p> <p>NO</p> <p>HIV and other STDs are transmitted through sexual intercourse</p> 	<p>3. Not with right person</p> <p>Feel a need to be loved</p> <p>NO</p> 
<p>4. Fear of violence</p> <p>Possibility of being forced to have sexual intercourse</p> <p>NO</p> 	<p>5. You/partner are drunk</p> <p>NO</p> <p>Alcohol can lead to poor decisions</p> 	<p>6. Religious values</p> <p>NO</p> <p>Values that say no to sexual intercourse before of outside marriage</p> 
<p>7. Family expectations</p> <p>NO</p> <p>Parents expect "no sex"</p> 	<p>8. Not ready</p> <p>NO</p> <p>Too young or just not ready</p> 	<p>9. Wait until marriage</p> <p>Unable to trust your partner</p> <p>NO</p> 
<p>10. Friendship</p> <p>Allow time for friendship to develop</p> <p>NO</p> 	<p>Remember: there are other ways of expressing affection than sexual intercourse</p> 	

Reading # 19 MAKING RATIONAL DECISIONS

Responding to Persuasion

Learning how to respond to a person who tries to distract you, or persuade you, to do something that you do not want to do, is an important skill.

Why ?


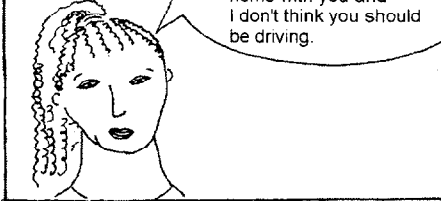
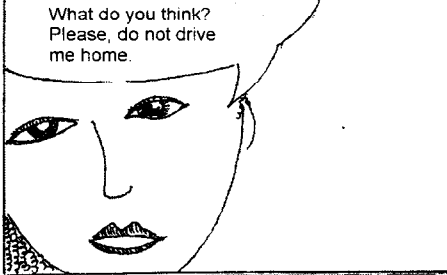
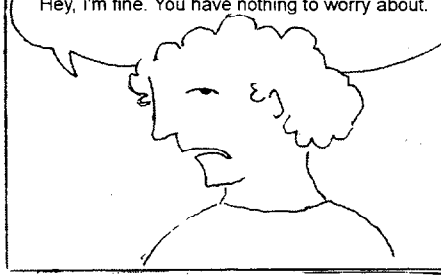
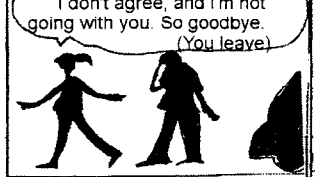


Learning how to respond to a person who tries to distract you, or persuade you to do something that you do not want to do, is an important skill

How ?

Your teacher will explain the steps to take when a person distracts or persuades you.

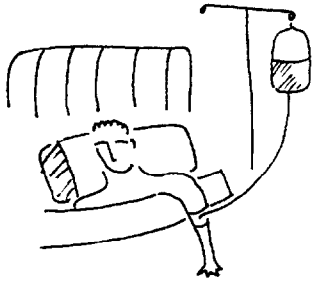
Situation

A friend of your elder brother offers you a ride home after work. He is staggering, and slurring his words. You feel he is drunk, and it would not be wise to drive with him. He tries to persuade you to go with him.

<p>1. Explain your feelings and the problem 2. Distracting statements</p> <p>I feel scared about driving with you when you have been drinking.</p> <p>What do you know about drinking, anyway?</p> 	<p>3. Get back on topic 4. Make your request</p> <p>Please, let me finish what I was saying. I don't want to drive home with you and I don't think you should be driving.</p> 	
<p>5. Ask how the other person feels about your request</p> <p>What do you think? Please, do not drive me home.</p> 	<p>6. Persuasive statements</p> <p>Hey, I'm fine. You have nothing to worry about.</p> 	
<p>7. Refuse...</p> <p>I don't agree, and I'm not going with you. So goodbye. (You leave)</p> 	<p>Delay...</p> <p>Let's go for a walk and talk about it.</p> 	<p>or Bargain</p> <p>Why don't you leave the car here and we will walk home together?</p> 

Reading # 20 HIV/AIDS

How HIV Infection spreads

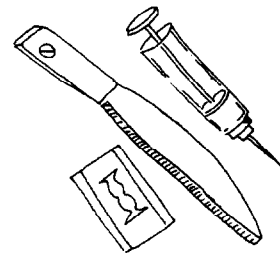


Through infected blood, or blood products

Through unprotected sexual contact with HIV infected person



To the child in the womb of an infected mother



The use of unsterilized needles, or blades, to puncture the skin

Cultivate the habit of ensuring that the implements used in receiving injections, having one's hair cut, shaving, and in the transfusion of blood, are sterilized. Emphasize the use of such implements. If possible carry your own syringe needles, or blades for use.

B. Testing for HIV

Why?

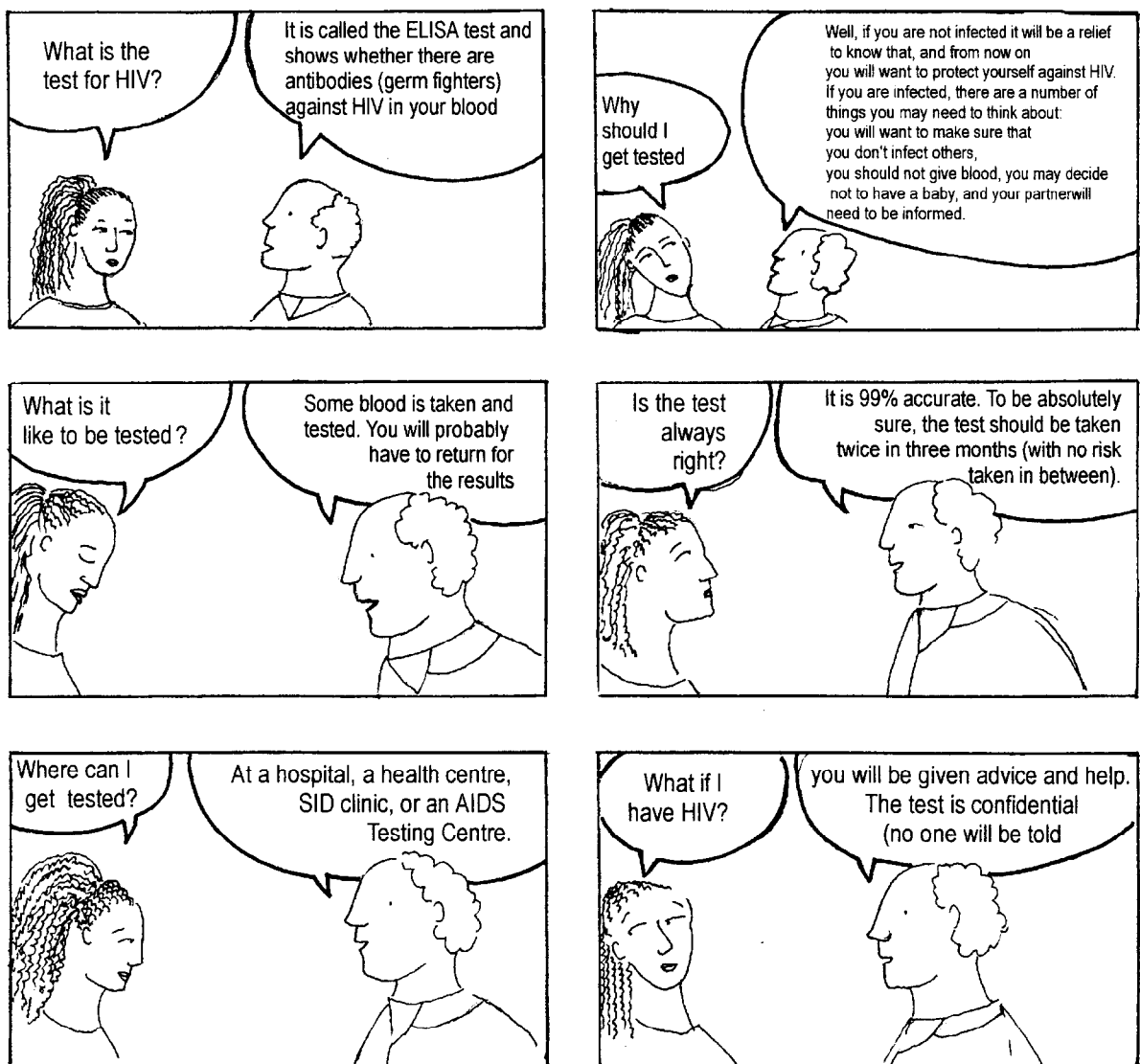
Some young people may need to know about testing for HIV/AIDS

How?

Your teacher will help you understand the information below and answer any questions you may wish to ask.

Marie is anxious that she may have HIV after having sex with three partners. She thinks one of her partners might have HIV. She finally got up enough courage to go to the health centre in her community. She tells the doctor about her situation and asks these questions.

Dr. Matango has worked with people living with AIDS for 7 years. He helps with testing and talks to people who have been tested. He answers Marie's questions in a kind, understanding way.



ASSESSMENT: 3.2

MAKING RATIONAL DECISIONS

Responding to Persuasion

Why ?

In this activity, you will try to write an assertive message to someone who interrupts you, and tries to get you to do something you do not want to do.

How?

1. With a partner, use the blank spaces to write an assertive message.
2. Select a statement that tries to get you to do something that you do not want to do.

Finally, write a 'refuse', 'delay' or 'bargain' statement.

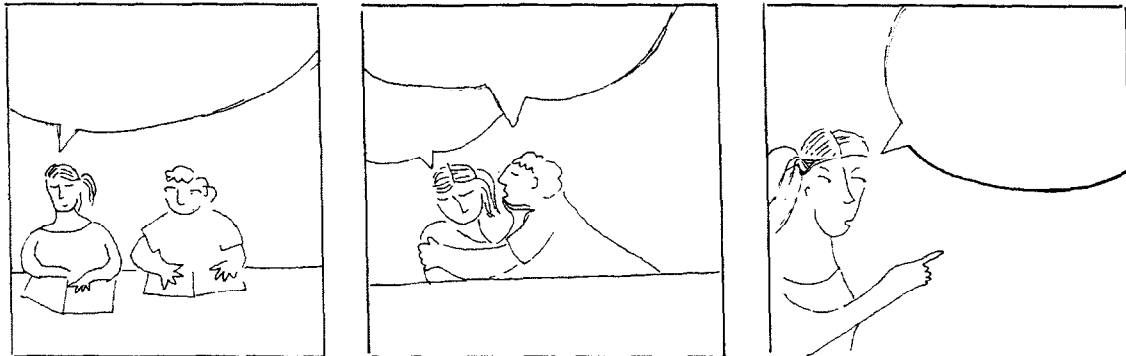
Situation 1

Your friend wants you to skip school, and go to the river and drink beer. He tells you a whole group is going. He says, 'You are afraid, are you?'. You got caught skipping school last month, and do not want to get caught again. You decide to tell him you do not want to go.



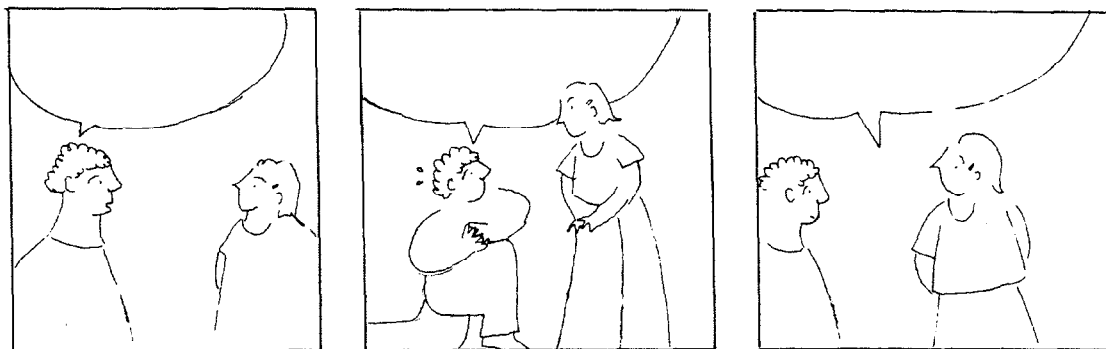
Situation 2

Your parents are at work, and you invite a friend of the opposite sex over to study. After doing the homework he/she grabs you, and tries to kiss you. You push him/her away but he/she says, 'Come on, you didn't invite me over just to do homework.' You take a firm stand so it will not happen again.



Situation 3

Your boyfriend/girlfriend thinks it is time to have sex. You love him/her but you feel that sex before you are ready is wrong. Your friend says, 'You're just scared. If you really loved me, you'd show it'. Although you are afraid it will end the relationship, you decide to tell him/her that you are just not ready.



Responsible Parenthood

Rationale

The purpose of this unit is to show that responsible living is the key to the success of the individual as well as society.

Learning Outcomes

By the end of the unit you should be able to

- explain the importance of being a part of a family
- value inter-personal relationships within the family
- emphasize that the nutrition of daughters is as important as those of sons
- internalize that family members should develop mutual love and care
- explain that all family members can contribute to the well-being of the family

Content

This unit will include the following

Topic 1	The Family Unit
Topic 2	Overcoming Challenges to the Family Unit
Topic 3	Nutrition of the Girl Child
Topic 4	Marriage

Topic 1

The Family Unit

The family is the smallest institution in society. In addition to nuclear (mother and/or father plus offspring), and extended (mother and/or father plus offspring plus grand parents, uncles, aunts, etc.) families, there are many other types of families today, e.g. one parent families, families with grandparents and grandchildren only.

What factors have contributed to the breakdown of the traditional family?

- Migration of one parent for better economic gains
- Death of one, or both, parents due to disease/internal conflicts/wars
- Maybe some of the reasons for becoming refugees

Activity 5.1

Mention other factors that have contributed to the breakup of the traditional family unit.

The nature of inter-personal relationships within a family is very important. The relationships are

- wife - husband
- parents – sons/daughters
- brother - sister
- brother - brother
- sister - sister

Each of these family members has a role to play, and obligations to fulfil. Yet, these roles and obligations do not exist in watertight compartments.

There should be no discrimination of any sort against any member of the family based on sex. In many societies, the family has the responsibility for preserving, and

Activity 5.2

1. Do you think that present day adults are able to transmit the traditional values that are worth preserving, to their offspring, or the younger members of the family? Give reasons for your answer.

2. Discuss how mutual help and cooperation among family members helps a family to progress.

Topic 2

OVERCOMING CHALLENGES TO THE FAMILY UNIT

transmitting, traditional values that are worth preserving.

The challenges facing the modern family are many. Some of them are:

Provocative information provided in electronic and print media

Modernization

Urbanization

Drug abuse

Teenage pregnancies

Unemployment and under employment

Adolescent problems

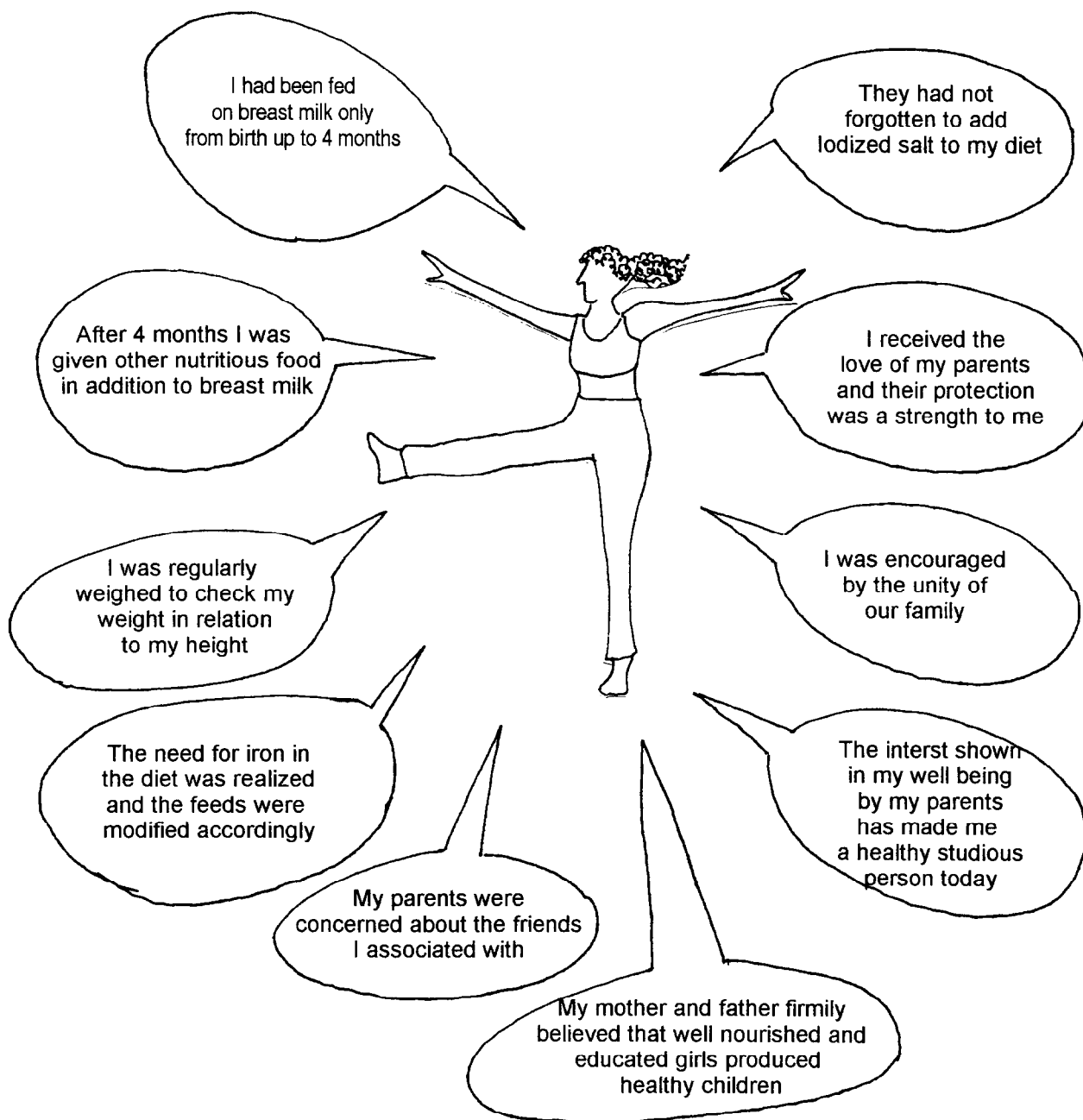
Erosion of traditional value systems

Members of a family working cooperatively, and with mutual understanding, can best deal with these challenges.

Activity 5.3

1. How can electronic media, and the print media, be a challenge to the family unit?
2. Do you think that traditional values are being eroded in your society? Give reasons for your answer. Mention traditional values that you are concerned about.
3. List three ways in which
 children can show concern about parents
 parents can show their concern about children
4. Why are decision-making skills important for adolescents ?

Reading # 21 CONTRIBUTIONS TO MY SUCCESS



THE NUTRITION OF THE FEMALE CHILD IS OF UTMOST IMPORTANCE IN MAKING HER SAFE DURING PREGNANCY

Adapted from the Population and Family Life Education Teacher Training Manual, National Institute of Education of Sri Lanka, UNFPA Project, 1998

Topic 3

Nutrition of the Girl Child

‘The hand that rocks the cradle rules the world’.

‘You educate a girl, you educate a whole family’.

These sayings lead us to believe that girls and women are an important segment of society. A country needs healthy, strong men and women. It is the responsibility of both mothers and fathers to produce strong and healthy men and women, by paying attention to the nutritional needs of both sons and daughters.

Activity 5.4

1. List the activities that a typical male with a family is engaged in, from the time of getting up in the morning until going to bed (mention the time of getting up and going to bed).
2. List the activities that a typical female with a family is engaged in, from the time of getting up until going to bed (mention the time of getting up and going to bed).
3. Compare the two lists of activities. Do you think it fair to pay less attention to the nutrition of women/girls? Give reasons for your answer.

ASSESSMENT 5.1

Go through **Reading # 21**, on page 92 and answer the questions below.

1. List the things that have contributed to the success of this girl.
2. Are there any more things you can add to this list? If so give five of them.
3. Is what is depicted in the picture true of your society? Give reasons for your answer.

Topic 4 Marriage

Marriage is generally described as a socially recognized, and approved, union between two individuals of the opposite sex, made with the expectation of permanence, and usually with the aim of producing offspring. Although marriage is a universal institution, people in different parts of the world have developed a great variety of practices and beliefs associated with it. Most societies have some sort of ceremony to mark this event.

The age at marriage in different societies varies greatly; but under present social and economic conditions most societies prefer delayed marriages.

Activity 5.5

1. Describe traditional marriage customs in your society.
2. Do you think all these should be retained?

Give reasons for your answer

3. Do customs and traditions in your society promote sexual relations outside marriage? Elaborate your answer.

Activity 5.6

1. Go through **Reading # 22, Delayed Marriage**, on page 95
2. What factors would have contributed to Amina's poor health?
3. Assume you are not married, and if you are to get married, which example would you follow? Why?

Reading # 22

DELAYED MARRIAGE

The fuller physical growth of a woman is assured by delayed marriage. A woman who marries late is physically, emotionally and mentally, more mature and able to understand, and respond effectively, to the needs of the baby, before, and after, delivery. An educated woman is economically self-reliant, and thus contributes to the economic well-being of the family. She is in a better position to contribute more to society, through her active participation in social, cultural, economic and political activities. Late marriage reduces the fertility span and, if accompanied by the adoption of contraceptive methods, can help to space better the births of children, and to reduce fertility.

CHOICE OF TWO SISTERS

Amina and her sister, Sheereen, were born one year apart. Both of them went to the village primary school until they were thirteen years old. Their father allowed them to continue their education, if they wished. Amina did not want to continue her education, but Sheereen accepted the offer, and decided to become a nurse. Amina was an exceptionally beautiful girl, and at an early age she had many admirers. She ignored them all, and finally accepted a young teacher's proposal in the village to marry him.

Sheereen finished her primary education, and joined a nurse's training course. During the period when Shereen was attending the course, Amina got married. Sheereen was able to complete her training by her eighteenth birthday. She decided to get a nursing job, and gave herself time to plan for her marriage. She got a job in a hospital in another village away from her home.

During her preliminary work in the hospital, she met a handsome young man called Mohammed, and fell in love with him. She dated him for one year. Mohammed was working as a doctor in the same hospital. Since both of them had a steady income, they were able to save enough money to buy the things they needed to set up a good home when they got married.

Shereen's parents were very happy to know that she had decided to settle down. The young couple then came to Sheereen's home, and asked her father's permission. Sheereen's father was very happy and proud of his daughter's choice, and gave her his blessing.

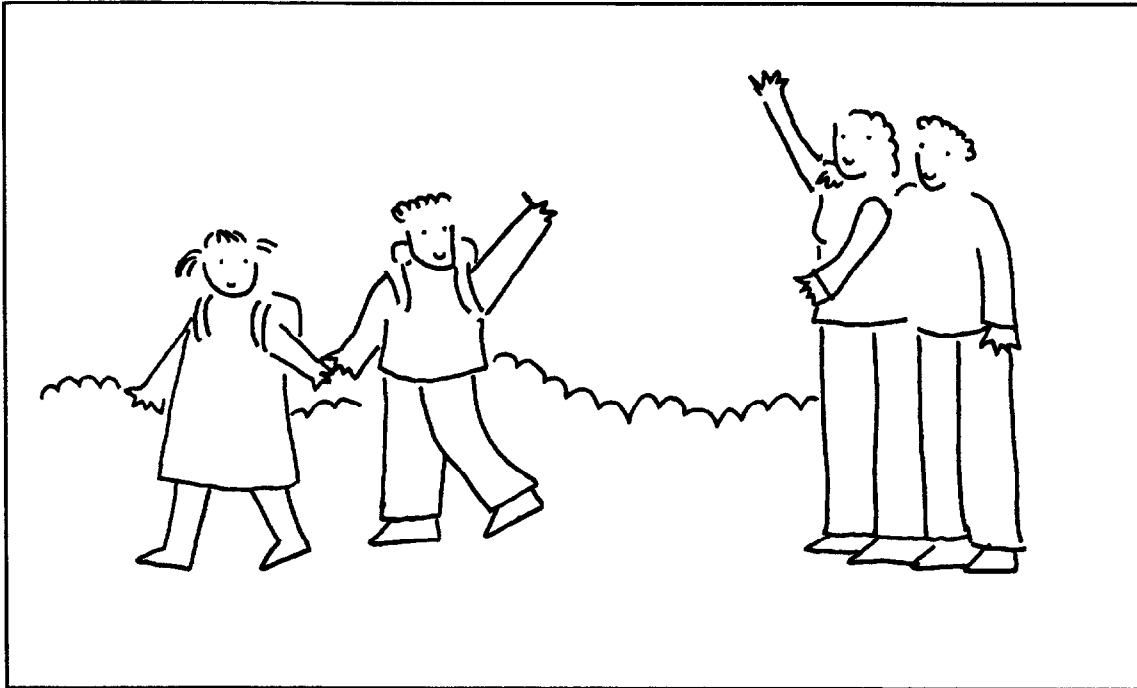
Sheereen and her husband were mentally and physically mature. They were educated,

and were aware of the problems of a large family. They wanted to have only two children, so that they could look after them properly, and give them a good education. As planned, they had two children - a boy and a girl who enjoyed a comfortable life, had a good education, and had educated parents.

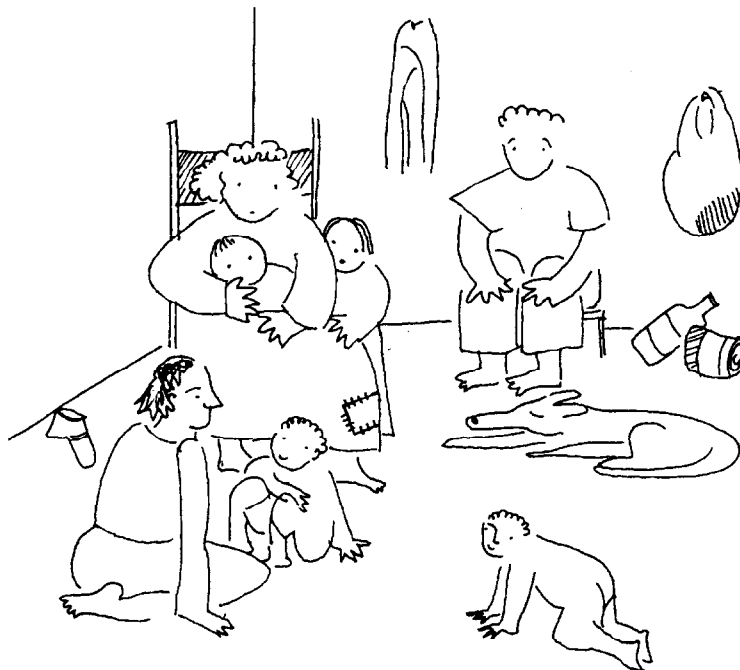
Amina, on the other hand, had problems. She and her husband had difficulties with their children. She had delivered a baby almost every year since her marriage, and was now the mother of seven children. She had become really weak, her body needed rest. She found it difficult to attend to, and provide for, her children's basic needs, such as their education, food, health and clothing. This was because she was sick most of the time. Sheereen became worried about Amina's health and family situation.

Reading # 23
DELAYED MARRIAGE - VISUALS

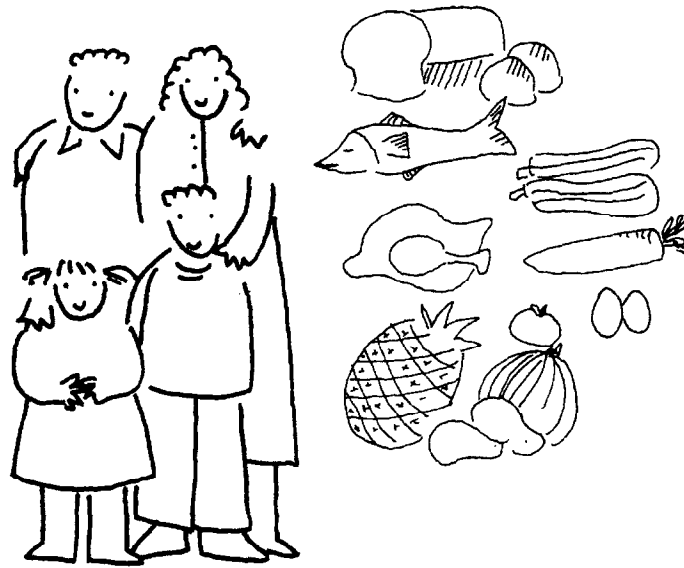
VISUAL 1



VISUAL 2



VISUAL 3



VISUAL 4



ASSESSMENT : 5.2

1. Study the visuals 1,2,3 and 4 in Reading #23. Which of them could be the result of a delayed marriage?
2. List five advantages of a delayed marriage
3. List the disadvantages of an early marriage
4. Which of the following age limits do you think is suitable for marriage? Justify your answer giving five reasons.

15 - 19 years

20 - 24 years

25 - 29 years

30 - 34 years

RATIONALE

The purpose of this unit is to identify problems like incest, rape, and teenage prostitution, in which adolescents are victimized.

LEARNING OUTCOMES

By the end of the unit, you should be able to :

be aware of problems like incest, sexual harassment, and rape;
explain the appropriate reactions towards such cases.

CONTENT

This unit includes the following elements of child sexual abuse:

- Topic 1. Rape.
- Topic 2. Incest
- Topic 3. Sexual harassment
- Topic 4. Teenage prostitution

Topic 1
RAPE

When someone is forced to have sexual intercourse without his, or her, consent, then the person is raped. Any time one has sex with another person when they do not agree, it is rape. It is rape even if the rapist does not use physical violence or threat of violence on the victim. It is rape even if the victim does not fight against the attacker, as long as it is clear that the victim does not agree to have sex. Sexual intercourse is usually defined

as vaginal penetration with a penis. “Usually, in the law the man’s penis must enter the woman’s vagina for rape to happen. But if the man tries to enter the woman and cannot, either because she fights him off, or he is caught in the act, or for any other reason, he is still guilty of attempted rape”. In some countries, rape includes penetration with any other object such as a pencil or finger either vaginally, anally or orally, as well as oral sex performed by a person on a victim even when no penetration occurs. However, in other countries if a man has sex with a woman in any way which does not involve his penis entering her vagina, he has also committed a crime, which is called indecent assault.

There is also statutory rape, which occurs when someone has sexual intercourse with a minor. In such a case, the act does not have to involve the use of force or threat of force. The legal definition of statutory rape varies from country to country, depending on the legal age of consent in a country. Rape occurs between members of the same sex as well as the opposite sex. Rape probably occurs within marriage more frequently than anyone knows. Some common myths and facts about rape, effects of rape, reasons why some women do not report rape, and some hints on helping children that have been sexually abused are discussed in Reading # 24, on pages 106-108.

Rape is only one element of child sexual abuse as shown in Reading # 25 on pages 108-109.

Activity 6.1

In small country groups participants will work on the following activities:

1. Give the legal definition of the following in your country:
 - Rape
 - Statutory rape
2. Discuss whether or not the anal penetration of a teenage boy by a man without the boy’s consent, would be legally defined as rape? Would the punishment be similar to that given to a man who rapes a teenage girl?

Activity 6.2

1. Go through **Reading # 24, Some Facts About Rape, on pages 106-108.**
2. List any other common false beliefs about rape prevalent in your community , and briefly discuss why the beliefs are inaccurate.

Topic 2 **INCEST**

Incest is defined as sexual relationships between blood relatives, and also among those related through adoption. For example between a father and daughter, a mother and son, and a brother and sister. An equally difficult situation is sexual relations between daughters and stepfathers, and sons and stepmothers. It is difficult for them to explain the relationship to their blood parents, for fear of misunderstanding and punishment. Incest is not only limited to genital intercourse between relatives, but is sometimes considered to include sexual activity such as oral-genital contact, fondling of genitals and breasts, and mutual masturbation. Some mothers know when their children are being abused, but are afraid to report to the police. Partly because the mothers are also victims of abuse by these fathers and need help to empower them on how to exercise their rights. Fear of breaking up the family by sending the father to jail, and the loss of financial support will make some mothers ignore the abuse.

In those relatively rare situations in which a child is conceived, genetic flaws may be concentrated in the child, but its worst problems are likely to be related to the psychological dynamics. In isolated situations, inbreeding of relatives for extended periods may give rise to disease deformities which come to typify the entire group.

If a brother and sister were to become separated as infants, and then unknowingly were to meet and become sexually involved, and were to marry, there is no reason to suppose that their unknown incestuous behaviour would cause them difficulty. Should they never have children, they would have as happy a relationship as any other couple. However, should their biological relationship become known, then the awful incest taboo would make itself felt. Clearly the negative effects would be psychological, and due not to evil consequences of the behaviour, but to the black magic of the taboo.

Activity 6.3, Role Playing

A mother of three teenage daughters remarried after her husband died. At first all went well, and the family was happy together. The girls accepted the man as their new father, and provider for the family. After some time, the stepfather noticed that the eldest girl had taken on womanly features, and was now an attractive young lady.

One day she came home from school and found him alone in the house. He called her to the bedroom and she went to him as normal. This time was different. He told her how pretty she was. He touched her breast and caressed her. Confused, she stood there not knowing whether to run, or to stand up. Eventually, he allowed her to leave the room. She did not know what to tell her mother. She noticed that her stepfather was now frequently at home when she returned from school. He called her from time to time, and touched her on the sensitive parts of her body.

She decided to tell her mother. The mother took her aside, telling her that her stepfather was just being nice to her. However, the mother was aware that something was wrong, but she was not prepared to break up the family. The girl decided to go to her guidance counsellor at school.

1. Suggest how the counsellor could help to resolve the problem.

Activity 6.4

1. In small groups, identify the common causes of incest and discuss the negative effects of incestuous sexual relations in your own communities. Individual groups present findings to the class.

Topic 3

SEXUAL HARASSMENT

The definition of sexual harassment is “any unwanted sexual advances from individuals of the opposite sex, usually in the workplace or educational institution”. Usually the definition is based on the sexualization of an instrumental relationship, through the introduction or imposition of sexist or sexual remarks, requests or requirements in the context of a formal power differential. However, sexual harassment can also occur where no such power differential exists, if the behaviour is unwanted by, or offensive to, the person concerned. Sexual harassment can be verbal or physical and includes the following :

Gender harassment

Seductive behaviour

Solicitation of sexual activity by promise of reward or threat of punishment

Sexual imposition or assault

Activity 6.5, Role Playing: Sexual Harassment in School

The male history teacher for a fourth form molested the girls in the class. Girls who rejected his charms were given low marks, and sometimes embarrassed in front of the class. This matter was brought to the attention of the guidance counsellor.

1. How could the guidance counsellor resolve the problem?
2. Discuss why you think the following should, or should not, be considered as sexual harassment:
 - a) A girl feels uncomfortable upon witnessing sexual overtures directed at the girl sitting in front of her.
 - b) On her way from college, Anna sits next to a young man who is smoking. The young man keeps on blowing smoke in Anna's ears despite her protests.
 - c) Each time Maggie is called into her boss's office she notices that pornographic pictures are placed in such a position that she cannot avoid looking at them.

Topic 4

TEENAGE PROSTITUTION

Prostitution is exchanging sex for money or other favours. Many young girls have been caught up in prostitution under the pretext of getting help. Others have voluntarily chosen a life of prostitution, sometimes not knowing its dangers.

Activity 6.6

Nandi joined a garment factory as soon as she had completed her primary education. She had to work according to a roster where, on certain days, she had to do a night shift, which went on till about 11.00 p.m. One day as she was returning to her boarding house, all alone after the night shift, she was kidnapped and raped by some men. After this incident she was reluctant to go back to her home village, and finally ended up as a prostitute.

1. Is this type of incident possible in your country?
2. Discuss what the authorities, and the legislation, can do to prevent this type of incident.

Reading # 24

SOME FACTS ABOUT RAPE

A.SOME COMMON MYTHS AND FACTS ABOUT RAPE

MYTH: Women incite men to rape.

FACT: Research has found that the vast majority of rapes are planned. Rape is the responsibility of the rapist alone. Women, children and men of every age, physical type, and demeanour are raped. Opportunity is the most important factor determining whom a rapist will rape

MYTH: Women secretly enjoy being raped.

FACT: No one enjoys being raped. It is a brutal intrusion on mind and body that causes lasting problems.

MYTH: Women 'cry rape' to get men into trouble.

FACT: Reporting rape is a debilitating and humiliating experience that all too rarely results in a conviction. A woman would gain almost nothing by falsely reporting a rape.

MYTH: If a woman didn't fight back, she wasn't raped.

FACT: Any rape is a potential murder, and this is clear to the victim during the assault. Women and children must receive appropriate training in order to have the option of effective physical resistance.

MYTH: A victim who does not report a rape to the police is responsible for any more rapes the assailant commits.

FACT: No one but the rapist is responsible for a rape.

MYTH: Nice people don't rape.

FACT: A rapist can be anyone.

B. EFFECTS OF RAPE

- A girl who is raped goes through a traumatic experience. She is usually too frightened and ashamed to tell anyone about her experience, and so the rapist gets away with it. Sometimes her local language is different from that of the courts, and she is unable to explain her experience in a way which is convincing, although she is telling the truth.

- Rape victims suffer from both the physical consequences of sexual assault and the equally debilitating psychological trauma. The physical injuries can range from cuts and bruises to broken bones and loss of consciousness.
- Immediately following a rape we can expect a woman to experience many emotions which include: fear, guilt, anger, helplessness, humiliation, embarrassment, disgust and revenge.
- Research has found that rape victims have high rates of persistent post-traumatic stress disorder, and rape victims are nine times likelier than non-victims to attempt suicide, and to suffer major depression.
- The majority of rape victims experience sexual dysfunction, including fear of sex and problems with arousal.
- Rape victims are also exposed to sexually transmitted infections including HIV/AIDS.
- The consequences of rape for female adolescents are especially tragic in many countries, where the prevailing conservative social attitude puts a premium on a young girl's virginity.
- The effects can be maximized or minimized according to the treatment provided after it occurs.

C. SOME REASONS WHY WOMEN DO NOT REPORT RAPE

Rape victims are less likely to report the crime of rape than other victims of other crimes such as theft. There are various reasons for this which include:

Self-blame

They may think the rape must somehow have been their fault, because they have grown up believing that women 'ask for' rape.

Shame

They may feel shamed or embarrassed. They do not want to talk about the rape in public. They do not want anyone else to know what has happened to them. They are worried about how their families will feel.

Fear

A woman may be worried about what a rapist will do if she reports him to the police. Will he get his revenge by attacking again? A rapist is likely to threaten his victim during the rape. He may say that he will come back, and hurt or kill someone she loves, if she reports the attack to anyone.

D. HELPING A CHILD WHO HAS BEEN SEXUALLY ABUSED

- Show her that you believe her.
- Tell her that she has not done anything wrong. The person who abused her is the one who committed a crime, and should be punished. This may be a major issue in incestuous abuse, where the girl may feel responsible for getting her father into trouble, splitting up the family, or causing the family financial problems.
- Make sure that she is not physically hurt, or ill, as a result of the abuse. If she is, help her to get appropriate medical attention.
- Treat her gently. Do not rush into action, or pressure her for details of the abuse.
- Try to make her feel comfortable and safe with you, and encourage her to tell you as much as she wants to, when she wants to.
- Provide her with support whilst making sure that you do not take over.
- Wherever possible, counselling should be done by someone who is specially trained to deal with children, or has experience in this field.

Reading # 25 SEXUAL ABUSE

Sexual abuse is defined as “a violation perpetrated by someone with power over someone who is vulnerable”, including rape, domestic violence, sexual assault or harassment, incest and teenage prostitution.

Sexual abuse of young people is a worldwide phenomenon, and contributes to early and involuntary entry into sexual activity and unwanted pregnancy. In one study in the USA, 33 per cent of women who became pregnant as teenagers had experienced coerced sexual intercourse. A study based on the records of the Maternity Hospital of Lima, Peru, revealed that 90 per cent of young mothers aged 12-16 years had become pregnant because they had been raped, and mostly by a close relative. In Nigeria, 20 per cent of university women surveyed said they had been forced to have sex. The majority

of rape and sexual assault victims are teenagers, and the majority of the victims knew the perpetrators. The problem of sexual abuse is not limited to young women and girls, males are also victims of sexual abuse.

Despite the fact that the problem of sexual abuse of children is common, discussion of the subject is generally taboo, and facts are therefore difficult to come by.

Illegal abortions due to sexual coercion and assault present many serious gynaecological problems for young girls. Despite restrictive laws, pregnant teenagers who are desperate, often risk the dangers of unsafe illegal abortions, and as a result, many young women die because of a lack of proper treatment in time to save them from the complications of an aborted pregnancy.

ASSESSMENT 6.1

1. Discuss the provisions in the legal system of your country with regard to incest, child prostitution, and sexual harassment.
2. Describe how responsible parenthood can work towards avoiding problems that involve sexuality, such as incest, rape, teenage prostitution, and sexual harassment.
3. Explain how decision-making skills can be useful for girls in dealing with sexually related problems in society.
4. 'Male participation is crucial to any programme designed to empower women'. Discuss this statement.

RATIONALE

The purpose of this unit is to identify other sexuality issues that adolescents commonly have to deal with as they grow up.

LEARNING OUTCOMES

By the end of the unit, you should be able to :

- be aware of issues such as masturbation, sexual addiction, and homosexuality
- explain the appropriate reactions towards such cases.

CONTENT

This unit includes the following :

- Topic 1. Masturbation
- Topic 2. Sexual Addiction
- Topic 3. Homosexuality
- Topic 4. Teenage promiscuity

Topic 1**MASTURBATION**

Masturbation is the self-stimulation of the genitals to achieve sexual arousal and pleasure, whether or not arousal leads to orgasm (sexual climax). It is commonly in both males and females by touching, stroking or massaging the penis or clitoris. Some women also use stimulation of the vagina to masturbate or use «sex toys,» such as vibrators.

Masturbation is practised by both sexes in the premarital, marital and post-marital stages of the life cycle, but usually reaches highest intensity in children aged 3-6 years and in adolescence.

Activity 7.1

1. Go through **Reading #26, Masturbation - An overview on pages 116-117.**

d) Discuss with the group the contents of Reading #26, and discuss common myths and realities about masturbation, also discuss the advantages and disadvantages of masturbation.

Topic 2

SEXUAL ADDICTION

The term **sexual addiction** is used to describe the behaviour of a person who has an unusually intense sex drive, or obsession with sex. Sex and the thought of sex tend to dominate the sex addict's thinking, making it difficult to work or engage in healthy personal relationships.

Sex addicts engage in distorted thinking, often rationalizing and justifying their behaviour and blaming others for problems. They generally deny they have a problem and make excuses for their actions.

Sexual addiction is also associated with risk-taking. A person with a sex addiction engages in various forms of sexual activity, despite the potential for negative and/or dangerous consequences. In addition to damaging the addict's relationships, and interfering with his or her work and social life, a sexual addiction also puts the person at risk for emotional and physical injury.

For some people, the sex addiction progresses to involve illegal activities, such as exhibitionism (exposing oneself in public), making obscene phone calls, or molestation. However, it should be noted that sex addicts do not necessarily become sex offenders. It is estimated that just over 50 per cent of convicted sex offenders can be considered sex addicts.

Generally, a person with a sex addiction gains little satisfaction from the sexual activity, and forms no emotional bond with his or her sex partners. In addition, the problem of

sex addiction often leads to feelings of guilt and shame. A sex addict also feels a lack of control over the behaviour, despite negative consequences (financial, health, social, and emotional).

Activity 7.2

1. Go through **Reading #27, Sexual Addiction on pages 117-118.**
 - e) Discuss with the group the contents of Reading #27, and discuss with the group types of sexual addiction behaviour prevalent in their communities.

Topic 3

HOMOSEXUALITY

A **homosexual** person is an individual whose patterns of sexual desires and behaviour are directed towards members of the same sex. A homosexual is attracted to, and sexually stimulated by, those of the same sex, and is not especially attracted to those of the opposite sex. A heterosexual is an individual whose erotic arousal from, and is sexually attracted to, members of the opposite sex. A bisexual is an individual who is sexually attracted to both same sex and opposite sex members.

Sexual orientation is viewed as a continuum with heterosexuality at one end, and homosexuality at the other, with various degrees of bisexuality in between. Sexual orientation is thus a matter of degree, though for the majority, erotic thoughts and behaviour are oriented towards either members of the same, or members of the opposite, sex. Heterosexuality is the most prevalent - a natural phenomena to promote procreation. Homosexuality has been found in all cultures throughout history. It is however, viewed differently in different societies, some condemn it completely, others tolerate it, and still others have esteemed it, or required it, at certain stages of life. In some societies, homosexuality is considered a crime (sodomy) liable to prosecution, while in others, being homosexual and practising same sex sexual activity in consensual and private settings is not a crime. However, even in societies where homosexuality is discouraged or severely punished, its incidence is substantial though statistics are difficult to obtain.

Many children have fleeting sexual play with members of the same sex, often out of

curiosity. Typically, such play is not a sign that the child will be a homosexual. By adolescence though, sexual contact with members of the same sex is taken more seriously. The origins of homosexuality and the challenges facing homosexual adolescents are discussed in Reading 28, Homosexuality, on pages 118-120.

Activity 7.3

1. In small country groups discuss how society perceives homosexuality and list down five adjectives that would commonly describe homosexuality.
2. Discuss the provisions in the legal system with regard to homosexuality in your country.

Activity 7.4

Peter is a young born again Christian, and is concerned about his sexual attraction to other men. He has been saved for about two years. He had hoped conversion would cure him of homosexual tendencies, but he still has these thoughts. He has not engaged in any homosexual activity since he was about 18 years old. At about 14 years, Peter had a friend whom he looked up to very much. The friend started playing with Peter's body, and Peter went along, not wanting to offend the friend. Since the sexual urge was awakening in him, it was easy to keep doing it, although he didn't care for it too much. As time went by he began to enjoy it. He also has crushes on strong muscled men. One day a colleague asked Peter to give him a rubdown. While giving him an amateurish rubdown, Peter began admiring his muscular body, wishing he had such a body too. In the process Peter discovered that he was aroused sexually. He never had sex with anyone except three of his closest boy friends, all of whom have since married and have children. He would also like to get married like others and have children.

1. If Peter came to you for help, how would you assist him?

Topic 4

SEXUAL PROMISCUITY

Sexual promiscuity refers to the practice of having sex indiscriminately without a careful selection of partners. Most adolescents are not sexually promiscuous. They have sex with one, or a few, people and only those that they care about. This is more so for females than males. Females usually insist on being loved and going steady, while a larger proportion of males will have intercourse without affection.

Activity 7.5

1. Go through **Reading # 29, Causes of Adolescent Sexual Promiscuity, on page 120.**
2. Discuss with the group the consequences of adolescent sexual promiscuity, contents of Reading #28, and discuss with the group types of sexual addiction behaviour prevalent in their communities.

Reading # 26

MASTURBATION: AN OVERVIEW

A. Who Masturbates?

Just about everybody. Masturbation is a very common behaviour, even among people who have sexual relations with a partner. It tends to be higher among males than females. In one national study, 95 per cent of males and 89 per cent of females reported that they have masturbated. Masturbation is the first sexual act experienced by most males and females. In young children, masturbation is a normal part of the growing child's exploration of his or her body. Most people continue to masturbate in adulthood, and many do so throughout their lives.

B. Why Do People Masturbate?

In addition to feeling good, masturbation is a good way of relieving the sexual tension that can build up over time, especially for people without partners or whose partners are not willing, or available, for sex. Masturbation also is a safe sexual alternative for people who wish to avoid pregnancy, and the dangers of sexually transmitted diseases. It also is necessary when a man must give a semen sample for infertility testing, or for sperm donation. When sexual dysfunction is present in an adult, masturbation may be prescribed by a sex therapist, to allow a person to experience an orgasm (often in women), or to delay its arrival (often in men).

Is Masturbation Normal?

While it once was regarded as a perversion and a sign of a mental problem, masturbation now is regarded as a normal, healthy sexual activity that is pleasant, fulfilling, acceptable, and safe. It is a good way to experience sexual pleasure and can be done throughout life. Among children and adolescents, it is generally considered to be a normal part of growing up and does not have any harmful physical or mental effects, nor does it interfere with normal sexual adjustment in marriage.

Masturbation is only considered a problem when it inhibits sexual activity with a partner, is done in public, or causes significant distress to the person. It may cause distress if it is done compulsively, and/or interferes with daily life and activities.

D. Is Masturbation Harmful?

In general, the medical community considers masturbation to be a natural and harmless expression of sexuality for both men and women. It does not cause any physical injury or harm to the body, and can be performed in moderation throughout a person's lifetime.

as a part of normal sexual behaviour. Some cultures and religions oppose the use of masturbation, or even label it as sinful. This can lead to guilt or shame about the behaviour. The ill effect of masturbation comes not from the act itself but from guilt, fear, or anxiety when the adolescent believes the act will do harm, or create problems in future.

Some experts suggest that masturbation can actually improve sexual health and relationships. By exploring your own body through masturbation, you can determine what is erotically pleasing to you, and can share this with your partner. Some partners use mutual masturbation to discover techniques for a more satisfying sexual relationship, and to add to their mutual intimacy. Masturbation will keep you out of trouble, especially if you are in a long distance relationship, or have a partner who does not have a high sex drive.

Generally, when dealing with adolescents, one should disregard evidence of masturbation, not look for it nor try to stop it.

Reading # 27

SEXUAL ADDICTION

A. Behaviour associated with sexual addiction include:

- Compulsive masturbation (self-stimulation)
- Multiple affairs (extra-marital affairs)
- Multiple or anonymous sexual partners and/or one-night stands
- Consistent use of pornography
- Unsafe sex
- Phone or computer sex (cybersex)
- Prostitution or use of prostitutes
- Exhibitionism
- Obsessive dating through personal ads
- Voyeurism (watching others) and/or stalking
- Sexual harassment
- Molestation/rape

B. How Is Sexual Addiction Treated?

Most sex addicts live in denial of their addiction, and treating an addiction is dependent on the person accepting, and admitting, that he or she has a problem. In many cases, it takes a significant event — such as the loss of a job, the break-up of a marriage, an arrest, or health crisis — to force the addict to admit to his or her problem.

The treatment of sexual addiction focuses on controlling the addictive behaviour and helping the person develop a healthy sexuality. Treatment includes education about healthy sexuality, individual counselling, and marital and/or family therapy. Support groups for people with sexual addictions (i.e., Sex Addicts Anonymous) also are available in some areas. In some cases, medications used to treat obsessive-compulsive disorder may be used to curb the compulsive nature of the sex addiction.

Reading # 28

HOMOSEXUALITY

A. Origins of homosexuality

Theories on the origins of homosexuality, or how one ends up a homosexual, vary widely. Scientific explanations emphasize either the environmental/learning or genetic/hormonal basis of sexual orientation.

(I) The environmental/learning hypotheses.

- According to the environmental/learning hypotheses; sexual orientation is learnt during childhood, and parents may unintentionally contribute to their children's homosexuality. Problems in the environment, such as a domineering mother and/or a weak father, can affect a child's psychosexual development, and thereby cause homosexuality in boys.
- Childhood seduction by an older male or playmate is also considered to contribute to homosexuality. A study by the Kinsey Institute Group in the 1980s found that the first homosexual experiences were with boys of the same age, and the experiences were similar among homosexuals and heterosexuals. What mattered were the feelings accompanying the first experience rather than the first experience itself.
- Sometimes it is argued that unhappy heterosexual experiences, or the inability to attract partners of the opposite sex, can also cause a person to become a homosexual. Again this is not supported by research.
- It is also argued that the acquisition of sex roles during early childhood, such as boys playing with dolls and acting effeminately, will be perceived the way girls are generally perceived, and treated accordingly. Such children come to see themselves as others see them, thereby making a homosexual orientation a part of their self-description.
- However there is no empirical link between what parents did and the sexuality of their children. Parents should not feel guilty that their child's homosexuality was caused by some failure on their part, as this would not be conducive to the development of a positive

- relationship between the homosexual child and the parents.
- Mental health specialists view homosexuality as an adjustment problem requiring psychological help. Although some homosexuals claim to have changed, generally efforts to change have met with little success.

(II) Genetic/Hormonal Explanations

- Some researchers have speculated that hormone levels in adults can contribute to homosexuality.
- Others have speculated that prenatal hormone imbalances can alter the masculine and feminine development of the foetal brain, and that this may contribute to a homosexual orientation.
- Other research has explored the possibility that genetic factors may contribute to male homosexuality

Although research seems to suggest that there is a biological predisposition to exclusive homosexuality, the causes of sexual orientation in general, and homosexuality specifically, remain speculative. It appears a complex combination of genetic/hormonal and environmental factors, operating prior to birth, largely determine an individual's sexual orientation, and the orientation awaits the onset of puberty and may not stabilize until early adulthood.

B. Are Body types or Physical Mannerisms Indicators of Homosexuality

Studies have shown that early effeminate behaviour is a predictor of later homosexuality. However, not all homosexuals are effeminate, and not all effeminate males are homosexual.

While it is true that some homosexual individuals dress and act according to commonly held stereotypes, many do not.

The same is true of bodily gestures or mannerisms. Some homosexuals make a studied attempt to conform to the male or female homosexual stereotypes, but generally speaking, movement characteristics are merely those learned as a child on the basis of imitating older persons' movements.

C. Challenges for Homosexual Adolescents

Realization that one is a homosexual usually becomes clear during adolescence. Sex education should equip adolescents with the necessary information to enable them to make their own moral judgments in sexual as in other matters. Providing only negative perspectives on homosexuality as an immoral form of sexuality is not a sensitive

approach. It is a form of indoctrination which perpetuates homophobia, and will cause distress in many adolescents.

After realizing that their sexual feelings are not 'socially proper', the adolescent usually has no one to talk to about this. Telling parents about their homosexuality may be the biggest challenge. Parents may be aware that something is different about their child, but conveniently avoid talking about it.

Parental support enriches the lives of homosexuals, and helps them develop greater self-acceptance, high self esteem, and self worth and the courage to face an often hostile world.

Reading # 29

CAUSES OF ADOLESCENT SEXUAL PROMISCUITY

- Usually sexual promiscuity is a symptom of the disturbed and immature adolescent. Those who feel rejected by parents and those who feel isolated are likely to engage in loveless sexual relations.
- Peer pressure may drive boys and girls into promiscuous sexual encounters.
- Sometimes girls may be seeking only cuddling, but have to pay for it with intercourse. Among girls, promiscuity may be one way to try to find love. Others may use sex to punish parents who do not have any love for them.
- Some boys may play their hostilities against females by using the penis as a weapon. However, other boys may not necessarily be hostile but have feelings of inadequacy that they try to hide by playing as "studs". Sexual experiences may also be used to reassure boys who are not very sure about their manhood.
- Promiscuity is thus not always a result of a strong sex drive, but may be an attempt to cope with other emotional problems.

REFERENCES :

1. Counselling Skills Training in Adolescent Sexuality and Reproductive Health, A Facilitator's Guide, Adolescent Health Programme. Division of Family Health, World Health Organization, Geneva, Switzerland, August 1993.
2. Adolescents' Education, Physical Aspect Module One
UNESCO Regional Office for Asia in the Pacific, Bangkok, 1991.
3. Adolescents' Education, Social Aspect Module Two
UNESCO Regional Office for Asia in the Pacific, Bangkok, 1991.
4. Teacher Training Manual on Population and Family Life (Reproductive Health) Education, National Institute of Education, Sri Lanka, UNFPA Project, 1998.
5. Messages to Parents, a booklet produced by the Population and Family Life Education (Reproductive Health) Project, National Institute of Education, UNFPA Project, 1996.

ANNEX

ALTERNATIVE RITES OF PASSAGE

An example by World Vision Kenya FGM eradication projects

It has been estimated that 85-114 million women and girls undergo circumcision worldwide. In Kenya alone, more than 51 per cent of the communities practise it.

Circumcision amongst the practising communities is treated just like any other rite of passage from childhood to adulthood.

This particular practice is viewed as having several 'advantages' for the community and the girls. It is considered to guarantee marriage, increase dowry amount, prepare the mother-to-be for labour pains among other things. It is not surprising that there are several myths that justify this practice in these communities. To name a few, the girl becomes 'clean', and is not smelly like the uncircumcised, The clitoris would touch the ground if not cut, and any traditional birth attendant (TBA) who assists an uncircumcised girl to deliver is expected to turn blind.

These communities also see female circumcision as a practice that supports tribal cohesion, and brings much honour to the family, the girl, and the circumciser herself.

The alternative rite of passage is a modern practice that serves as a substitute for FGM. It borrows positive cultural meaning from the coming of age ceremony without the excision. It incorporates traditional and customary symbolism, and instructions on the need to take over responsibility as adults. The girls go into seclusion for a week, or longer, to receive training in preparation for 'graduation'.

Some of these positive cultural aspects include, counselling on how to take up adulthood roles, personal hygiene, and the community's culture.

Through this ritual the girl becomes part of the community. There are songs and dances and maturity is displayed. In ARP, all these good cultural aspects are upheld, with additions, such as modern family education, education on HIV/AIDS, and career choice education. Feasting and celebration, religious education, other harmless rituals, socialization, new clothing and presents are provided during graduation ceremony.

In order for it to be a success, all sectors of the community need to be involved as much as possible. The parents of the girl, the larger community, church blessings, the traditionally recognized leaders for blessings, former circumcisers, role models in the community and government representatives.

The girls peers and society accept the rites and recognize their passage to adulthood after this ceremony. In fact, it is highly regarded, and is becoming acceptable in modern times with several communities opting for this practice, and adopting it to their needs and making it as affordable as possible.

The ARP unlike excision, contributes to freedom from trauma for the initiates, prevents transmission of HIV/AIDS and STIs and reduces the maternal and child mortality rates that result in complications in child bearing. It suffices to state that it contributes to the recognition of women s rights, the value of the human race, and for the girls, an enriched education package with an opportunity to diversify roles and career choices in the future.

The males have also started to appreciate these alternative rites and to support them. They are able to tell the difference between no excision as excision. Birth complications, the deaths of spouses and children, and sexual responses are all remarkably different.

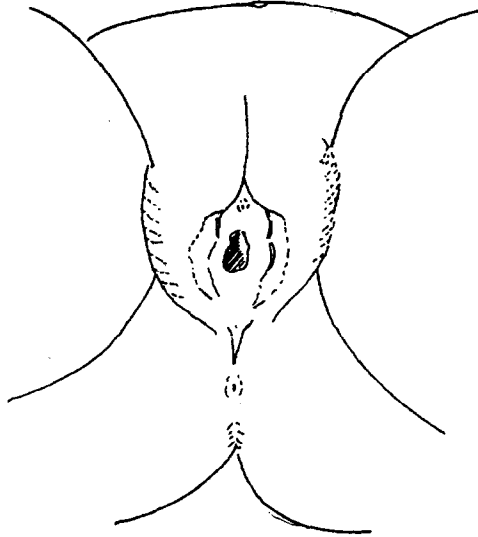
The support from the local leadership for FGM is important, as FGM is deeply rooted in culture, and there is a strong resistance to change. The reasons vary, as do the beliefs of the practising communities. Among the reasons, is general illiteracy, religious influence (some sects uphold excision), the economic value and prestige to the circumciser and belief in myths. Girls who refuse the cut risk being rejected and ostracized by parents and the community. Those who cannot stand the pressure yield and accept the cut. When the community, or an individual, feels they must do it, they do it secretly.

From March 2002, the Children s Act became law in Kenya, and part of what it condemns is the negative cultural practices, like early marriage and female circumcision. To avoid the punishment, those who practise it go underground.

The other challenge and dynamism of this practice is the medicalization. This is where the medical practitioners do it in hospitals, under the pretext that the girl is unwell and is hospitalized. As such, it becomes hard to detect, and continues unabated.

The ultimate victory in the fight against this practice is only realized when there is a complete change of attitude. When the community is aware of the dangers of female circumcision, and are able to go for a harmless alternative, then we can talk of success. This is why ARP is very crucial in this fight, and is the result of the education given to the community.

Excision



Infubilation

