CHRISTIAN FAMILY LIFE EDUCATION:
A Guide for Teaching about Adolescent Sexuality and Reproductive Health

Written by Shirley Miller for Margaret Sanger Center International © 2001
This guide was written especially for Christians and others who value the importance of talking comfortably and effectively with young people and adults about issues related to healthy sexuality and reproductive health.

It provides state of the art information on a variety of topics related to human sexuality, gender, adolescents, growth and development, parenting, domestic violence, STIs, HIV/AIDS, sexual abuse, substance abuse, conflict resolution, goal setting and other important life issues.
CONTENTS

<table>
<thead>
<tr>
<th>SECTION</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFACE</td>
<td>9</td>
</tr>
<tr>
<td>INTRODUCTION: Why Christian Family Life Education?</td>
<td>10</td>
</tr>
<tr>
<td>Important Issues Concerning Adolescents</td>
<td>13</td>
</tr>
<tr>
<td>PART ONE: CHRISTIAN FAMILY LIFE EDUCATION</td>
<td></td>
</tr>
<tr>
<td>About This Guide</td>
<td>16</td>
</tr>
<tr>
<td>Objectives of the Christian Family Life Education Programme</td>
<td>18</td>
</tr>
<tr>
<td>Characteristics of an Effective Christian Family Life Educator</td>
<td>20</td>
</tr>
<tr>
<td>Providing Support for Parents</td>
<td>22</td>
</tr>
<tr>
<td>Communicating with Young People about Sex</td>
<td>23</td>
</tr>
<tr>
<td>Clarifying Values</td>
<td>25</td>
</tr>
<tr>
<td>Talking about Sex</td>
<td>27</td>
</tr>
<tr>
<td>Who Needs Christian Family Life Education?</td>
<td>28</td>
</tr>
<tr>
<td>PART TWO: TEACHING AND FACILITATING TECHNIQUES</td>
<td></td>
</tr>
<tr>
<td>What Facilitators Need to Know</td>
<td>33</td>
</tr>
<tr>
<td>Group Leadership Skills</td>
<td>35</td>
</tr>
<tr>
<td>Some Learning Principles</td>
<td>36</td>
</tr>
<tr>
<td>Important Steps for Making Seminars Work</td>
<td>38</td>
</tr>
<tr>
<td>Tips for Facilitating Discussions</td>
<td>41</td>
</tr>
<tr>
<td>Always Remember Your Role!</td>
<td>44</td>
</tr>
<tr>
<td>Building Group Cohesion</td>
<td>45</td>
</tr>
<tr>
<td>Resource Materials and Handouts</td>
<td>46</td>
</tr>
<tr>
<td>A Seminar Check List</td>
<td>47</td>
</tr>
<tr>
<td>Seating Arrangement / Ready... Set... Let’s Do It!</td>
<td>49</td>
</tr>
</tbody>
</table>
PART THREE: WORKSHOPS FOR PARENTS

A SIX PART SERIES ON COPING WITH PARENTING

Session I  Discovering Your Own Parenting Style ......................51
Session II Discovering Your Child’s Personality Type ..................61
Session III Overcoming Barriers That Destroy Families ..............66
Session IV Setting Boundaries and Disciplining Children ..........72
Session V  Motivating Children for Positive Results ...............78
Session VI  Maintaining a Healthy Family Life .......................83
Couple Communication ................................................................90
How to Talk to Children and Adolescents about Sex ..................94

PART FOUR: WORKSHOPS FOR ADOLESCENTS & ADULTS

“Heaven’s Grocery Store” (Poem) .............................................107
Christian Family Life Education .................................................108
Introduction to Human Sexuality ..............................................113
Psychosocial/Sexual Development and the Life Cycle ...............119
Puberty and Adolescent Development ....................................123
Population, Education and Health ..........................................130
Reproductive Anatomy/Physiology, Males and Females ...........136
Family Planning and Contraception .....................................141
Premarital Education .................................................................148
Sexually Transmitted Infections .............................................156
HIV and AIDS Prevention .......................................................166
Families Working Together ......................................................175
Domestic Violence ...................................................................181
Sexual Abuse, Rape, Child Molestation .................................192
Protecting Children against Child Molestation .......................200
Self-Esteem and Decision-Making .........................................209
Drug and Alcohol Abuse .......................................................214
Dispelling Myths and Telling the Facts ..................................220
Conflict Resolution .................................................................226
Goal Setting ..............................................................................233
PART FIVE: RESOURCE MATERIALS

SECTION 1: ICE BREAKER EXERCISES
Workshop Ground Rules ................................................................. 240
Adjective Name Game ................................................................. 241
Get That Autograph ................................................................... 242
Things We Have in Common ....................................................... 243
Myth or Fact .............................................................................. 244
Myth Activity Questionnaire ....................................................... 249
Myth Activity Answer Sheet ....................................................... 250
Word Exercise .......................................................................... 252
Did Anyone Ever Tell You About...? ........................................ 253
Training Session Workshop Evaluation Form .......................... 254
Teen Questionnaire ................................................................... 255
Parent Questionnaire ............................................................... 257
Things to Remember When Conducting Trainings/
   Workshops/Seminars ............................................................. 259
Four Important Things to Avoid at All Cost .............................. 260
Experience and Learning ............................................................ 261
Working with Guest Speakers ................................................... 262
Teaching Techniques ............................................................... 265
Glossary of Terms ..................................................................... 267

SECTION 2: PARENT EDUCATION RESOURCE MATERIAL
A Parent’s Prayer ........................................................................ 271
Parents Teach in the Toughest School in the World.................... 272
Children Learn What They Live ................................................ 273
How Well Do You Know Your Child? ...................................... 274
How Well Do You Know Your Parent? ..................................... 275
Tips on Talking to Children and Young People about Sex ........ 276
Coping with Parenting Session III: Parent/Child-Evaluation Handout... 279
“Condom Sense” ..................................................................... 280
Talking about Sex Isn’t Easy (A Discussion Guide for Facilitators/Trainers) ................................................................. 282
SECTION 5: PERSONAL AND SEXUAL HEALTH

Sexually Transmitted Diseases ............................................................... 374
Essential Facts about Sexually Transmitted Infections ............................ 387
STI/STD Chart ...................................................................................... 389
Sexually Transmitted Infections: Quiz and Answer Key .......................... 391
HIV/AIDS ............................................................................................... 393
Nutrition and HIV Infection .................................................................. 397
Myths and Facts on HIV (including correct answers) .............................. 400
HIV/AIDS: Ice Breaker Exercise ............................................................... 402
Eight Steps to a Healthier and Safer Sex Life ......................................... 403
Mother’s Milk ......................................................................................... 405
Breast-Feeding and AIDS ....................................................................... 408
Guard against Breast Cancer: Have You Examined Your Breasts This Month? ................................................................. 411
How to Examine Your Breasts ................................................................. 412
Drug and Alcohol Abuse Outline ............................................................ 413
Six Steps to Prevent Drug and Alcohol Use ........................................... 416
Domestic Violence Myth/Fact Sheet ......................................................... 417
Battering of Adult Women ...................................................................... 418
Power and Control Cycle Chart ............................................................... 419
Controlling Behaviour Checklist ............................................................. 420
Effects of Family Violence ...................................................................... 421
Why Women Stay .................................................................................. 422

SECTION 6: FORMS OF SEXUAL ABUSE

Cultural Factors Contributing to Rape ..................................................... 424
Forms of Sexual Abuse: Rape and Sexual Abuse ..................................... 425
Myths and Facts about Rape .................................................................. 426
Quiz on Facts about Rape ....................................................................... 430
Reactions to Sexual Assault ..................................................................... 431
Touch Continuum .................................................................................... 432
Ori and Kori Help Adults and Children Learn ......................................... 433
Preventing Sexual Abuse of Children ..................................................... 434
Children Are Empowered When They .................................................... 436
Definitions of Sexual Abuse .................................................................... 437
Sexual Abuse Indicators ......................................................................... 438
Child Sexual Abuse: Intervention and Prevention ................................. 440
SECTION 7: FAMILY PLANNING ISSUES
Teaching about Family Planning..........................................................442
Traditional Methods of Fertility Control .............................................443
Benefits of Family Planning...............................................................446
Men’s Role in Family Planning ..........................................................450
Methods of Family Planning (picture of sterilisation) .......................451
The Contraceptive Process ................................................................457
Consequences of Early Childbearing ...............................................458
Pregnancy, Childbirth and Parenting ...............................................461
The Importance of Medical Care during Pregnancy and Childbirth ....463
Myth or Fact ......................................................................................465
Attitude Survey ...............................................................................467
Questions to Ask When Choosing a Method of Family Planning .......468
Why People Use Family Planning Methods ........................................469

SECTION 8: SELF-ESTEEM, DECISION-MAKING, VALUES CLARIFICATION
Positive Based Self-Esteem .................................................................471
Self-Esteem Exercise ........................................................................472
My Declaration of Self-Esteem ..........................................................473
Self-Esteem and Decision-Making: Values List Questionnaire ..........474
What Should I Know about Making up My Mind? ..............................475
Seven Value Indicators ....................................................................476
Issues We Face in Real Life ...............................................................477
Decision-Making Model ....................................................................478
Questions You May Ask Yourself about Dating .................................479
Sexual Decisions ..............................................................................480
The Perfect Mate ...............................................................................481
Hints for Better Communication about Sex (and Other Matters) ......482
How Well Do You Know Your Partner? ..........................................483
Differences between Love and Infatuation ......................................484
The Different Kinds of Love ...............................................................485
Values Clarification ...........................................................................486
Values Questionnaire ........................................................................487
Values Clarification: Forced Choice Exercise ....................................488
People Say (Attitude Survey) ............................................................489
Values Clarification: Earthquake Exercise ........................................490
Chief Executive Game ......................................................................491
Values Clarification: A Moral Dilemma (group exercise) .................492
Tips for Living (S.C.O.R.E.) (handout) ..............................................493
PREFACE

There is growing awareness of the important role religious communities play in educating the church about sexuality. After all, sexuality was created by God and is a glorious gift that embraces the total expression of who we are as human beings. Our loving Heavenly Father is not only concerned with man’s redemption and eternal salvation but with his tripartite nature of spirit, soul and body. Hence, sexuality concerns our spiritual, emotional and physical makeup.

From Genesis to Revelation, the Bible provides important insights and guidance on all aspects of life including faith, hope, love, forgiveness, the family, patience, sex, gender, interpersonal relationships, communication, illicit behaviour, incest, rape, prostitution, violence, alcohol abuse, disease, marriage, divorce, life, death and much more.

For over 25 years, the Christian author of this guide has worked to improve the quality of family life for thousands of people around the world including Africa, Asia, the South Pacific, Latin America and the Caribbean.

This guide was written especially for Christians and others who value the importance of talking comfortably and effectively with young people and adults about issues relating to healthy sexuality and reproductive health. It provides state-of-the-art information on a variety of topics including puberty, adolescence, parenting, population education and health, anatomy and physiology, family planning, contraception, STIs and HIV/AIDS prevention, substance abuse, sexual abuse, domestic violence, conflict resolution, self-esteem, decision-making, sexual myths, goal setting and many other important life issues.

Each section of this guide begins with scriptures selected from the Bible that relate specifically to thematic content, allowing the facilitator and the participants time to reflect on their meaning. The format of each workshop is designed for participatory learning and provides a variety of teaching techniques, measurable objectives, clear instructions on how to prepare for a workshop, group activities, effective facilitation approaches, and resource materials. The instructions walk the user through each session from beginning to end.

May this guide glorify God and richly bless everyone who uses it!

Shirley Miller  
Author
INTRODUCTION
WHY CHRISTIAN FAMILY LIFE EDUCATION?

“Train a child in the way he should go, and when he is old he will not turn from it.” Proverbs 22:6

For too long churches have either maintained silence about sexuality issues or when they have spoken, it has most often been to link sexuality with sin or immorality. It is the duty of the church to teach about every aspect of family life, not just one. Evil does not come from sex but from the misuse of sex.

Sexuality is a wonderful gift from God that begins at birth and ends at death. It is like a fine string of pearls, each pearl represents an important part of who we are. Sexuality includes our physical makeup, our emotions, our spirituality, gender, attitudes, values, personality and all of the other aspects that make up our personhood. Sexuality does not diminish as we develop spiritually. Rather it evolves throughout our life cycle.

God’s concern for wholeness in human relationships is addressed throughout the Bible. There are numerous biblical passages that focus on family life issues, marriage, parent/child relationships and sexual behaviour.

How the church talks about sexuality is very important. The church shapes intentionally and unintentionally the values and attitudes about family life and sexual self-understanding. Sexuality is a total expression of who we are as human beings created by God and it should be discussed in a positive light.
Although the church advocates against premarital sex, adultery and fornication, every day young girls become pregnant out of wedlock, rape occurs and the incidence of STIs and AIDS is increasing at alarming rates. Hence, the religious community and parents must find a way to integrate accurate information about sexuality within the context of biblical teachings.

Both proponents and opponents of family life and sexuality education will agree that, ideally, children should receive sexuality information from their parents and that the church community should take an active role in providing assistance for parents as well as programmes for young people. Despite this concurrence, it is evident that most churches are hesitant to assume this role.

Most parents are uneasy talking with young people about issues relating to sexuality. They want to be involved in educating children about sex but they don’t know how to go about it.

Much of the discomfort comes from inadequate information. Many parents feel that they themselves do not understand sexuality well enough to be comfortable talking about it. They often lack facts about anatomy, physiology, menstruation, puberty, wet dreams, masturbation, conception, contraception and other reproductive health issues.

Contributing to this anxiety are cultural taboos, traditional beliefs, values, attitudes, fears and misinformation. Some parents do not discuss sexuality with their children because they believe that too much information leads to experimentation. Some think that if they ignore the topic, it will go away. Others use myths and scare tactics to discourage their children from early sexual experiences.
Unfortunately, neither silence nor scaring works. In fact, studies indicate that misinformation or lack of information about sex simply increases sexual confusion and vulnerability. It stimulates curiosity and leads to more, not less, early experimentation – often resulting in a premarital pregnancy, rape, sexually transmitted infections or AIDS.

What does work is honest, informed communication. When parents and other adults responsible for rearing children have access to the facts, when they have the chance to clarify their own values within the context of their Christian beliefs and when they learn to express them and to become comfortable talking about these subjects in groups with other adults, then their task as sex educators becomes easier.
IMPORTANT ISSUES CONCERNING ADOLESCENTS

“For the Kingdom of God is not a matter of eating and drinking, but of righteousness, peace and joy in the Holy Spirit.” Romans 14:17

There is a growing awareness among reproductive health providers throughout the world that adolescent programmes are vitally needed if young people are to be adequately informed about reproductive health.

Significant social changes that affect all societies to some degree have prompted programme planners, health providers and educators to consider specialised programmes for people in the adolescent or young adult age group. Some of the changes relate to broadened opportunities for women who are now staying in school longer and entering the workforce in larger numbers. The age of marriage is rising in some countries. Combined with the decreasing age of menarche, these years create a longer time period when young women are single and are capable of becoming pregnant. Sexual activity during this non-marital time has increased, fostered by other social changes such as mass media, alcohol and substance abuse, urbanization and other factors which create a new level of need for adolescents.

Another impetus for placing priority on adolescents is the alarming increase of sexually transmitted infections including HIV/AIDS and premarital pregnancy. Young people are contracting STIs/AIDS out of proportion to their numbers.
As the transition years from puberty to adulthood, also called the stages of adolescence, become better understood, efforts to meet this group’s age-specific needs have emerged. This Christian Family Life Education Programme is designed to address the myriad needs of adolescents, parents, professionals and others. The programme provides factual information about adolescent biological development, sexuality and psycho-social issues, positive based self-esteem, responsible decision-making, prevention of STIs/AIDS, premarital pregnancy, premarital education, parenting, alcohol and substance abuse, domestic and external violence, goal setting and other topics related to enhancing the quality of family life.

In today’s world, young people face formidable challenges in the transition from childhood to adulthood. Lack of information and misinformation about a subject can have devastating and even fatal consequences.

<table>
<thead>
<tr>
<th>Young people desperately need help in sorting out…</th>
</tr>
</thead>
<tbody>
<tr>
<td>• spirituality and sexuality</td>
</tr>
<tr>
<td>• personal relationships</td>
</tr>
<tr>
<td>• negative sources of sexual learning</td>
</tr>
<tr>
<td>• love vs. infatuation</td>
</tr>
<tr>
<td>• peer pressure</td>
</tr>
<tr>
<td>• myths from facts</td>
</tr>
<tr>
<td>• gender roles</td>
</tr>
<tr>
<td>• sexual orientation, gender identity</td>
</tr>
<tr>
<td>• consequences of poor decisions</td>
</tr>
<tr>
<td>• sexual abuse; e.g., incest, rape</td>
</tr>
<tr>
<td>• substance abuse, smoking, drugs</td>
</tr>
<tr>
<td>• marriage, divorce</td>
</tr>
<tr>
<td>• communicating with parents</td>
</tr>
<tr>
<td>• valuing education</td>
</tr>
<tr>
<td>• personal values</td>
</tr>
<tr>
<td>• sexually transmitted infections</td>
</tr>
<tr>
<td>• HIV/AIDS</td>
</tr>
<tr>
<td>• dysfunctional family life</td>
</tr>
<tr>
<td>• dating issues</td>
</tr>
<tr>
<td>• reproductive anatomy &amp; physiology</td>
</tr>
<tr>
<td>• self-esteem and decision making</td>
</tr>
<tr>
<td>• sexual behaviours</td>
</tr>
<tr>
<td>• growth and development issues</td>
</tr>
<tr>
<td>• economic pressures</td>
</tr>
<tr>
<td>• setting goals</td>
</tr>
<tr>
<td>• and much more…</td>
</tr>
</tbody>
</table>

Margaret Sanger Center International, Copyright 2001
PART ONE

CHRISTIAN FAMILY LIFE EDUCATION
ABOUT THIS GUIDE

“I have hidden your word in my heart that I might not sin against you.” Psalms 119:11

Christian Family Life Education addresses a myriad of issues that confront young people. This resource guide is divided into sections that contain particular aspects of Christian Family Life Education. Each of the workshops is informal, practical and participatory in structure.

The sessions in this resource guide are intended solely as guides; there are no requirements. Different audiences will have widely different needs, so feel free – in fact, be prepared – to adapt your materials and activities to suit your audience. Exercises that involve reading or writing can be done orally with participants who cannot read or write. Information handouts can also be read aloud. Whenever possible, use the local language in your explanations.

Some workshops recommend using a relevant video. The facilitator may wish to pre-select an appropriate video from his or her programme or perhaps arrange to borrow one from another organization or programme.

Facilitators need to make the necessary plans well in advance for workshops that suggest inviting guest speakers.

A one-day seminar can be compacted into three hours or a three-hour seminar enriched to last all day. The times suggested for individual activities are similarly flexible. An activity proposed for one seminar may work better for you in another.
Switch, Combine … Improvise!

This manual was designed for trained facilitators working with adolescents, parents, professionals and other adults who are committed to:

✧ Enhancing the quality of family life for all members of society.

✧ Helping to contribute to young people’s growth and development.

✧ The development of young people’s health, happiness and prosperity.

✧ Helping parents to become better FLE educators of their children.

✧ Helping young people make informed choices and to behave responsibly.

✧ Enhancing communication skills.

✧ Helping young people develop positive self-esteem and weigh the value of abstinence.

✧ Helping young people to understand their own feelings and to recognize what is important to them.
OBJECTIVES OF THE CHRISTIAN FAMILY LIFE EDUCATION PROGRAMME

“Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God’s will is – his good, pleasing and perfect will.” Romans 12:2

† Enhance awareness of sexuality in relationship to their Christian values.

† Help appreciate the spiritual aspects of sexuality.

† Enhance knowledge about health, moral and spiritual reasons for abstaining from sexual activity until marriage.

† Increase knowledge about sex and sexuality.

† Help develop positive attitudes toward family life education.

† Enable adolescents to develop healthy attitudes about sexuality.

† Dispel myths regarding sex and sexuality.

† Improve communication skills between parents and their children.

† Help reduce the chance of a premarital pregnancy or sexually transmitted infections.
† Encourage parents to think of themselves as their children’s primary sex FLE educator.

† Challenge adolescents to develop a sense of purpose and direction for their lives.

† Strengthen the family socio-economically and improve its quality of life by helping reduce the incidence of premarital pregnancy.

† Educate about the effects of population growth on family life, to help regulate rapid population growth in the society.

† To enhance parenting skills so that families can maintain a healthy family life.

† Create an atmosphere where everyone feels free to exchange ideas and ask questions.

† Help others to clarify their own values about issues relating to sexuality.

† Provide communication techniques that will help parents and other adults talk more comfortably and effectively about issues related to sexuality.
CHARACTERISTICS OF AN EFFECTIVE CHRISTIAN FAMILY LIFE EDUCATOR

“He restores my soul. He guides me in paths of righteousness for his name’s sake.” Psalms 23:3

Effective CFL Educators:

✝ believe that Christian Family Life Education helps improve the quality of life.

✝ believe the Bible provides important insights for the Christian about sexuality.

✝ are comfortable with their own and others’ sexuality.

✝ are sensitive to differences, e.g., religious, ethnic, cultural, social, etc.

✝ have been in a comprehensive training programme in sexuality and family life education, enjoy working with people and have good communication skills.

✝ are motivated, responsible, enthusiastic and are positive leaders.

✝ are well informed about sexuality, reproductive health and other family life education topics.

✝ can be non-judgemental and provide positive and thoughtful feedback.
belief young people need to have sexual facts interrelated with values in order for them to make sound personal decisions about sexual relationships.

belief that parents are the primary (first) FLE educators of their children.

belief that positive self-esteem enhances sound decision making and want to help parents and other responsible adults develop good communication skills.

All the seminars in this manual deal with important and sensitive issues that many people find difficult to discuss. If you’re relaxed, it will help others to be. If you’re friendly and cheerful, your manner will set a tone for the seminars and encourage those who feel shy. Remember, the more careful your planning is, the more likely the seminar is to go well.
PROVIDING SUPPORT FOR PARENTS

“Sons are a heritage from the LORD, children a reward from him. Like arrows in the hands of a warrior are sons born in one’s youth.” Psalms 127:3,4

Parents need to realize that they are naturally the primary FLE educators of their children. That does not mean they have to have a great deal of technical information; children hardly ever ask technical questions. But to avoid passing on misinformation, parents should have certain basic facts about puberty, menstruation, wet dreams, masturbation, hormonal influences, sexual behaviour, family planning, pregnancy, sexually transmitted infections, HIV/AIDS, etc.

Most parents need assurance. As a parent educator or facilitator, you can help them gain self-confidence by pointing out that:

♥ nobody can be a perfect parent at all times.

♥ it’s all right to be a little nervous or embarrassed. Just don’t let it immobilize you.

♥ sexuality continues throughout our lifetime. They needn’t feel pressured to tell everything at once.

♥ they have already begun their children’s sex education without realizing it through their natural parental actions of loving, cuddling, hugging, teaching, etc.

♥ by encouraging their children to develop and use decision-making skills in childhood, they have also begun preparing their children to make thoughtful decisions about sexual involvement.
Most parents want to be involved in their child’s sex education but feel they don’t know how to go about it. As a facilitator, you can help them by emphasizing these 10 important messages for parents:

1. Despite the difficulty and discomfort many parents experience, they can be effective sexuality educators.

2. Parents are the primary (first) sex educators of their children.

3. Parents can initiate conversations by using “teachable” moments from everyday life situations.

4. If children are old enough to ask, they are old enough to know the answer.

5. Parents do not have to be experts to be able to educate their children about sex.

6. The most important thing parents can convey to their children is that no question is ever “wrong” to them as parents.

7. Parents can learn to be “askable” by creating an atmosphere that encourages communication.
It is wiser in the long run to be factual and honest about everything.

Silence conveys powerful messages of discomfort and taboos about sex.

Children acquire behavioural patterns and values largely by observing others, especially their parents.
CLARIFYING VALUES

“Love must be sincere. Hate what is evil; cling to what is good.” Romans 12:9

Parents need to be clear about their own values if they want to pass them on to their children. This may mean that they will need to work through a number of issues first to establish their own “comfort level” with certain subjects. They should also know the best or most appropriate ways to transmit values. As a facilitator, you can help by identifying the areas parents should look at with special care.

Parents need to:

❖ lay the foundation for healthy sexual behaviour by setting clear boundaries and expectations in all areas of life starting at an early age.

❖ consider their religious beliefs and if they have doubts or questions, get the uncertainties resolved before communicating the beliefs to their children.

❖ define the kind of sexual values and behaviour they expect from their children.

❖ compare their values with those expressed in the culture, so they can prepare their children to handle differences or conflicts they encounter outside the home.

❖ decide what sexual subject matter they consider essential for their children to learn.
• be prepared to cope with what their children want to know and be confident that they are meeting their children’s needs.

• sort out their feelings about premarital sex, family planning, drugs, alcohol, rape, etc., so they can convey their values clearly.

• sort out their feelings about nakedness and privacy, so they can establish basic rules and explain the limits of behaviour they wish to set for their children.

• sort out their feelings about sexual slang and how using it affects them as parents.

• sort out their feelings about sexual literature, videos, music, magazines, etc., so they can decide what they want to convey to their children.

• consider how they feel about their children receiving sexuality education outside of the home rather than in the home.
“Teach me to do your will, for you are my God; may your good Spirit lead me on level ground.”  Psalm 143:10

Fathers and mothers need to explore the roles each of them will take in the sex education of their children. They may also need to give some thought to their own relationship as partners.

As a facilitator, you may want to point out that:

- parents whose parents found it difficult or impossible to talk with them about sexuality are likely to have the same difficulty with their own children.

- the easiest time to start basic sex education is when children are very small and are less likely to make parents feel uncomfortable or at a disadvantage.

- when parents feel uncomfortable talking about sex with their children, the best thing is to admit it frankly and explain why they feel that way, perhaps because of their upbringing, family background, whatever. Honesty will not eliminate discomfort but it can improve communication between parent and child.

- if one parent is more at ease with the subject of sex, that parent can take the lead role in sex education. The other parent may stay silent or join in when he/she feels comfortable.
WHO NEEDS CHRISTIAN FAMILY LIFE EDUCATION?

“Do your best to present yourself to God as one approved, a workman who does not need to be ashamed and who correctly handles the word of truth.” 2 Timothy 2:15

Children and Adolescents

The Christian Family Life Education Programme aims to empower young people with the necessary tools they need to lead healthy, happy and productive lives.

Young people live in a world riddled with HIV/AIDS, illicit behaviours, drugs, incest, rape, child molestation, crimes, unintended pregnancies, abortions and much more. Everyday, adolescents make life and death choices with little or no knowledge about the consequences. Now more than ever before, adolescents need to be armed with facts about sexuality and reproductive health in order to protect themselves and others. They need positive reinforcement, positive self-esteem and the confidence to make responsible decisions.

Adolescence is meant to be a wonderful experience, a time for young people to discover who they are.

Parents

Since time began, in every country and culture, parents have been the first and most influential source of all knowledge, beliefs, attitudes and values for their children. They can be ideal sex educators as well as role models for their children.
They provide unspoken sex education by the way they act toward each other and toward their children. They are there at every stage of a child’s development to answer questions, give information and advice and discuss concerns. They can make understanding about sexuality a natural, normal and progressive experience.

Unfortunately, many parents cannot (or do not) adequately answer their children’s questions at home, so most of what adolescents know about sexual reproduction, anatomy, pregnancy, etc. has been picked up from their peers and is either wrong or incomplete.

Education about sexuality and about communicating with one’s child on the subject can help parents do a better job. They need to know that when children come to them with questions related to sexuality, not responding is in itself a response. Nonresponse communicates its own message – a negative message.

Some parents find it particularly hard to show love and affection and communicate to their children the kind of caring necessary for effective sex education to take place. Therefore, parent education programmes need to stress openness, understanding and consideration for children as essential to promoting responsible sexual behaviour.

**Grandparents**

Grandparents often play an extremely close, nurturing role in a child’s life. They, too, are influential in shaping the child’s values and knowledge. The way in which they and other close relatives relate to the child contributes to the child’s sexual development. Their warmth and love help develop the child’s
capacity for affection and love, important aspects of healthy sexuality.

Grandparents can add significantly to the sex education of their grandchildren both directly and indirectly by discussing it with the child’s parents so they can all work together in educating the child.

**Guardians**

Stepparents, aunts and uncles, baby-sitters, teachers and other adults responsible for children play the same powerful, influential role as parents. From them, children derive their attitudes, values and knowledge of facts.

**Men**

Too often, fathers and other adult men in a child’s life withdraw from any role in the child’s education about sex. They see sex education as “women’s work,” the mother’s responsibility.

This is unfortunate. Children – girls and boys alike – need the presence, strength and love of a man to help define their own sex roles.

A man being a man does not mean he cannot be loving. In fact, caring for and nurturing a child requires a special strength and sense of responsibility. Women both need and welcome men’s involvement in educating their children. Fathering does not end after the sperm cell fertilizes the egg. That should be just the beginning of a lifelong process of loving, growing and sharing the joys of parenting.
Parents of Children with Physical, Emotional or Mental Disabilities

Mentally retarded and physically handicapped children with disabilities, even adults, are too often treated as if they were, or should be, nonsexual beings, with no need to know about sex, reproduction or family planning. Educators, and especially doctors, tend to focus on the child’s affliction and put off or ignore all psychosocial concerns; sex education has the lowest priority of all.

This is unfortunate, because people who have disabilities are sexual beings. They have exactly the same needs as anyone else to feel attractive, to be close to others, to love and be loved.

There are two common stereotypes about the sexuality of the mentally retarded; that their childlike level of intellectual development equates with a childlike “innocence” about sex and that their sexuality is primitive and stronger than “normal” people’s. Both ideas are inaccurate and harmful in their inaccuracy. However, retarded children do have special educational needs and their parents do face special difficulties in meeting these needs. These children must learn, early and well, the basics of conventionally acceptable social and sexual behaviour and should be enabled, to the fullest extent possible, to make their own informed choices.

It is important that both men and women provide sex education.
PART TWO

TEACHING AND FACILITATION TECHNIQUES
“Wisdom is supreme; therefore get wisdom. Though it cost all you have, get understanding.” Proverbs 4:7

1) They should first be comfortable with their own and others’ sexuality. This can be accomplished through guided exploration of both their upbringing and their values about a range of sexuality topics. It is critical that educators be able to talk about sexuality and sexual conduct without imposing their own values. This takes practice.

2) They should have appropriate knowledge of human development, sexuality and related concepts. Facilitators need to know and understand basic information about anatomy, physiology, psychosexual development, the life cycle, puberty, sexually transmitted infections, HIV/AIDS, sexual abuse, drug/alcohol abuse, decision-making, contraception and parent/child communication. It would be unreasonable to expect facilitators to be sexuality experts, but they do have to know the basics. They also need to be aware of what they don’t know and where they can go for additional information.

3) Skills building is another important component of training. Facilitators need to be skilled in group facilitation techniques supportive of adult learning styles. The sensitivity of the subject matter and complexity of the social and emotional barriers to sexuality and family life education requires a skilled facilitator to manage the process.
Facilitators work at stimulating discussion by encouraging trust and openness, creating two way communication with and among the target audience, asking open-ended questions and conducting focused activities that encourage parents to learn from each other’s experiences.

4) Facilitators also need to learn how to use correct, appropriate and relevant language for explaining sexual anatomy and functions. Therefore, they need both the knowledge and comfort to communicate such language and new vocabulary to their target audience.

5) Training educators in effective facilitation is very important. The facilitator is the most important variable in determining programme success. For most educators, comprehensive training – exploring one’s values, gaining accurate and relevant knowledge, learning group facilitation techniques and practicing methods of answering questions about sexual matters – increases comfort with the whole process. At the end of the day, some may still be nervous. These are natural jitters that are likely to disappear as the facilitator gains experience implementing the programme.
GROUP LEADERSHIP SKILLS

“Search me, O God, and know my heart; test me and know my anxious thoughts. See if there be any offensive way in me, and lead me in the way everlasting.” Psalms 139:23,24

Throughout this resource manual, the term “facilitator” is used to describe those persons responsible for developing and implementing the Christian Family Life Education Programme. The facilitator helps the learning process by:

1. presenting activities that draw on participants’ experiences, knowledge, attitudes and skills.

2. encouraging active participation in these activities to master new concepts and skills.

Facilitators need to establish two-way communication between themselves and participants. Facilitators are resource people, sharing responsibility for learning with participants. Their role is to facilitate the transfer of information and skills within the group through the learning process.
“But as for you, continue in what you have learned and have become convinced of, because you know those from whom you learned it.” 2 Timothy 3:14

There is a difference in the approach we take when teaching children and teaching adults. This distinction is made because, in a learning situation, adults behave differently from children. Most adults cannot be forced to learn. They become motivated to learn when they perceive that the learning will help them to deal with current problems. Usually, they want to be consulted about what and how they are going to learn. In addition, adults may be more willing to take responsibility for their own learning. Modern Adult Learning Theory grows out of three basic observations:

♥ **Adults learn best when they are treated as equals.**
Adults consider themselves to be mature, capable and responsible human beings. They react more favourably to learning situations in which they are treated as equals. It is important that the facilitator involve parents in the identification of their own learning needs. It establishes an atmosphere of mutual respect that validates and encourages parents to contribute their opinions, knowledge and concerns. Where equality exists, differences can be supported rather than judged. Hence the importance of creating an environment in which differing points of view are accepted. This will allow parents to feel secure and empower them to participate freely.

♥ **Adults learn best when learning incorporates their previous experiences, knowledge and skills and supports their existing values.**
Adults have many life experiences that can be utilized in
co-operative learning. They do not come to the training as empty vessels waiting to be filled with wisdom. Rather, they come as individuals with different kinds of knowledge and skills all relevant to finding the right approach to educating their own children about sexuality and family life. Your role as facilitator is to create the conditions that allow the group to address their own concerns.

Adults come to training with well-established attitudes and values. Perhaps your greatest challenge as a facilitator will be to understand and respect the values participants hold, even while facilitating their exploration of new viewpoints and perspectives. Since people’s ability to change is related to many complex factors, the degree of trust and respect that you establish within the group will be significant in influencing participants’ willingness to explore change.

♥ Adults learn best when they are actively learning. If parents are actively involved in the learning process (instead of listening passively), they will learn more effectively and become self-motivated. If the objectives of your programme are to support a parent’s ability to be an effective sexuality educator, you will need to use different techniques – i.e., role plays – which provide parents with ample opportunities, both in the sessions and throughout the programme, to actively practice the skills and knowledge they are learning. Your role as an educator is to facilitate a process for learning and change.

The adult learning style is also appropriate for adolescents.

Note: Make sure that everyone can read before using an exercise that requires reading. If you think there may be people who cannot read, try using another exercise that does not require reading or read the exercise out loud yourself. Remember…always avoid embarrassing the participants.
IMPORTANT STEPS FOR MAKING SEMINARS WORK

“Finally, brothers, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable – if anything is excellent or praiseworthy – think about such things.” Philippians 4:8

1. Create a comfortable atmosphere by:
   ♦ greeting each person cordially.
   ♦ providing refreshments when possible.
   ♦ preparing readable name tags.
   ♦ asking someone to lead the group in a prayer.
   ♦ starting with an ice breaker exercise to put participants at ease.

2. Introduce yourself by:
   ♦ briefly describing your own background including your training in family life education, human sexuality, reproductive health, your experience as a facilitator and any other relevant facts.
   ♦ explaining your role as a facilitator. Include a little personal information such as “I’m a parent of four children,” etc.

3. Ask participants to introduce themselves.
   ♦ Depending on the size of the group and time allocation, you may want to ask them to provide personal information as well.
   ♦ If time allows, do the “Name Game Exercise.” Everyone chooses an adjective (descriptive) word before their first name, e.g., “I am ‘Silly’ Sarah, I am married with three children,” etc.
4. State the purpose of the Christian Family Life Education Programme.

♦ The CFLE Programme aims to empower young people with the necessary tools they need to lead healthy, happy, moral and productive lives.

♦ Explain that the Adolescent Sexuality and Reproductive Health Programme is committed to reducing the incidence of unintended adolescent pregnancy, sexually transmitted infections and HIV/AIDS by:
  → increasing participants’ knowledge about sexuality and reproductive health.
  → helping participants to clarify their own values in a period of societal change.
  → enhancing participants’ communication skills when talking about matters relating to sexuality and reproductive health.
  → enhancing moral and ethical values.

5. Explain the objectives of the seminar by:

♦ discussing what you hope to accomplish together.

♦ letting the group know the topics you hope to cover in the session.

♦ agreeing on the starting and ending times, e.g., whether and when there will be any breaks or whether there will be any outside resource persons.
6. Establish ground rules for:

- smoking.
- responding to questions, e.g., raising hands, etc.
- respecting everyone’s right to be heard.
- maintaining confidentiality of comments made in the session.
- nonparticipating spectators (bystanders can inhibit discussions, encourage them to be part of the group).
- anything else affecting the comfort of the group.

7. Stress that:

- this workshop is not a lecture and that the success of the session will depend on everyone’s participation.
- there should always be courtesy and respect among participants, especially where there are differences of opinion.
- everyone has something of value to contribute.
- if we totalled up the age of each person in the group, we would have hundreds of years of experience; therefore, we are a collective body of rich experiences, knowledge and resources.
TIPS FOR FACILITATING DISCUSSIONS

“Guide me in your truth and teach me, for you are God my Saviour, and my hope is in you all day long.” Psalms 25:5

♥ Respect everyone’s right to be heard and to express personal feelings.

♥ Encourage active participation by praising the comments they make.

♥ Ask open-ended questions; e.g., “What do you think about...?” “How can we...?”

♥ Use active or reflective listening. This technique involves paraphrasing speakers’ comments (without inserting opinions or judgments) so that people knows that they have been heard. Paraphrasing shows the participants that the facilitator is listening attentively and allows the facilitator to clarify her/his understanding of what was said.

♥ Don’t lecture. Instead, ask questions that invite participants to offer their knowledge as well as their concerns. This lets you determine their level of sophistication about sexuality while giving them practice in discussing sex related topics.

♥ Remember that humour can often be highly effective in relieving tension. If a light touch is your style, don’t hesitate to use it whenever appropriate. But if it’s not your style, don’t force it.

♥ Speak in a loud and clear voice. Use short concise instructions for activities, making sure that the person farthest from you can also hear you clearly.
Use “I” messages and encourage participants to do the same. Encourage participants to speak for themselves and not for the group; e.g., “I’m warm” as opposed to, “It’s too warm in here.”

Use language that most people understand. Don’t try to impress with your words or be condescending. Stay away from “slang.” You need to communicate using language that is comfortable for everyone in the group. Equally important, you need to remain open to various uses of language within the group.

Be aware of “body language” or nonverbal messages. Be sensitive to unspoken feelings and statements hidden in the speaker’s body language. As facilitator, be aware of your own body language. Your gestures and posture should not only agree with your words, they should encourage positive interactions between you and the group. Positive nonverbal communication includes: facial expressions which invite interaction, tone of voice which welcomes sharing, direct eye contact and postures which communicate openness.

Learn to relax with silence. You don’t need to rush in to fill up the silence. A certain amount of silence is actually a stimulus for the group. It may be an indication that they are seriously considering a question or topic you just covered.

Maintain group focus on task or content. When introducing a topic, link it to the topic that preceded it; e.g., “This morning we reviewed the male and female reproductive systems. This afternoon we’ll have the opportunity to use this information in distinguishing myths from facts.”
Help the group make necessary decisions. Make sure each suggestion is heard and considered. Help group members to educate each other, to provide supportive assistance, to think critically and to become confident in their ability to solve problems.

Know when to stay with the schedule and when to be flexible. If participants are benefiting from a particular activity, it may be a good idea not to stop in order to stay on schedule. Weigh that against the objectives for the next activity – it may be possible to incorporate those objectives into the current activity.

Manage conflict when it arises. Sometimes it is necessary to bring hidden conflicts out in the open. You can do this by stating, “I noticed that some people seem upset about what occurred earlier today. I’d like to get this cleared up. What would help us to do that?” By doing this, you show the group that you are open to disagreements and are able to work out differences. It is sometimes necessary to address feelings and put aside the “task” when group functioning is affected by unresolved tensions. The maintenance of group cohesion is a priority.

Be aware of your own values and feelings. Distinguish between personal needs and the needs of the group. Do not use your authority as facilitator to impose your own values and opinions. When expressing your personal opinions and feelings, identify them as such.

Be genuine. Be patient, trusting, empathetic, non-judgemental, enthusiastic, humorous, humane – but be genuine.
“If it is possible, as far as it depends on you, live at peace with everyone.” Romans 12:18

As an educator, your job is to facilitate – stimulate discussion, supply facts, provide necessary tools to enhance communication – never to dominate.

A good facilitator creates an atmosphere in which information and ideas flow freely within the group, making sure that every member of the group has a chance to participate, that the statements are accurate and that myths are examined and discarded.

The result is a workshop that is fun, exciting and educational and one in which everyone present is involved. Nothing is more boring than listening to someone lecture all the time. And nothing is surer to block the learning exchange you want to achieve.
BUILDING GROUP COHESION BY:

“Blessed are the peacemakers, for they will be called sons of God.” Matthew 5:9

- sustained positive feedback to participants; e.g., “That sounds like a good idea.”

- recognizing shared vulnerability; e.g., “How many of you have experienced this?”

- confidentiality; e.g., “Let’s all remember that we agreed to keep conversations about what a person shares within the group.”

- encouraging others to participate; e.g., “I noticed a puzzled look on your face. How does your experience differ?”

- discouraging individuals from monopolizing the sessions; e.g., “Thanks for all your interesting comments. Are there others who would like to share?”

- responding positively to criticism; e.g., “I’m glad you brought that to my attention.”

- seeking and providing clarification as needed; e.g., “Did you say that you felt the young woman was sending a mixed message?”

- recalling feelings, ideas, opinions or questions; e.g., “Earlier, several of you felt…”
RESOURCE MATERIALS AND HANDOUTS

“It was he who gave some to be apostles, some to be prophets, some to be evangelists, and some to be pastors and teachers, to prepare God’s people for works of service, so that the body of Christ may be built up.” Ephesians 4:11,12

This manual contains an entire section of resource materials. These materials support the content of each workshop topic and should be used by the facilitator as needed. Some of the materials may also be used as handouts for participants.

The facilitator will need to refer to the Materials Needed section of each workshop to determine what he/she will need beforehand. The loose-leaf format of this resource manual allows for information to be added or removed as necessary.

REMEMBER!!! There is much new information coming out every year on subjects related to Family Life Education, Human Sexuality and Reproductive Health. For example, we know a lot more today about HIV/AIDS than we did just a few years ago.

It is wise to stay informed on the latest information as much as possible. Look out for articles and newspaper reports on issues related to STIs/AIDS, pregnancy rates, etc. Visit a local clinic, health facility, or talk to a medical professional who can update you on the latest information. Sit in on seminars or other related training sessions that will further enhance your knowledge.

You will find that participants and other adults place a great deal of trust and confidence in what you tell them. A good educator/facilitator should always strive towards excellence and endeavour to be well informed on issues relating to family life, sexuality and reproductive health.
A SEMINAR CHECK LIST

“He guides the humble in what is right and teaches them his way.” Psalms 25:9

✔ Whenever possible, make sure you have seen your meeting room beforehand; know where the light switches are, where the restrooms are and know that the building will be unlocked.

✔ Before doing a seminar, review the subject matter. Make sure you know it thoroughly and can deliver the information clearly.

✔ Make sure you have all the resource materials and equipment you need, including enough copies of materials you want to hand out. If duplicating materials is a problem, make one enlarged copy on a chalkboard or chart paper ahead of time.

✔ Arrive at least 15 minutes early to get organized and welcome people as they come.

✔ Arrange seating to accommodate the size of the group. A semi-circle is usually best.

✔ As people arrive, welcome them, give out nametags and introduce yourself.

✔ At the start of the session, introduce yourself more fully and say something about Christian Family Life Education.

✔ Before you do an exercise or invite discussion, explain why you are doing so and invite everyone to join in.

✔ Near the end of each session, review what its goals and objectives have been. Cover in a few sentences any subject the group was interested in that you didn’t have time to discuss. Remind the group of the time, date and site of the next session if there is one.
Always have reference material with you. If you don’t know or can’t immediately locate the answer to a question, tell the group where else to go for the information. Don’t be afraid to say, “I don’t know.” Never give an answer you’re not certain about but be sure you know what resources are available in the community and where you can refer the group.

If refreshments are served, make sure they don’t interfere with seminar time.

Near the end of the session:
- review the goals and objectives.
- ask participants to share one new thing they learned from the session.
- remind the group of the date, time and location of the next session.

End the seminar on time and thank everyone for coming.

Make notes to yourself about the session. This will assist you in other sessions.

Stay until everyone has left.

If the session were held indoors, close the meeting room in whatever way you arranged with the organization that provided the space. Unless the organization specifies otherwise, chairs should be straightened, trash discarded, windows closed, lights turned off and doors locked.

You may want to send a note of thanks to the organization that invited you and when appropriate, thank them for the use of the space.
SEATING ARRANGEMENT

“I will instruct you and teach you in the way you should go; I will counsel you and watch over you.” Psalms 32:8

It’s better if participants can sit in a circle or semicircle, so that everyone can see each other’s face. Classroom seating arrangements tend to be formal and can interfere with group dynamics and other exercises that may require people to move around.

READY . . . SET . . . LET’S DO IT!!!

“Teach me your way, O LORD; lead me in a straight path because of my oppressors.” Psalms 27:11

After you’ve checked your list, you’re now ready to conduct your workshop. May the grace of God anoint your spirit, soul, and body, and may you be a blessing to all the people that you come in contact with.

God Bless!
PART THREE

WORKSHOPS FOR PARENTS

CONTENTS:

A Six Part Series on Coping With Parenting
Couple Communication
How to Talk to Children and Adolescents About Sex
A SIX PART SERIES ON COPING WITH PARENTING

Session I:
Discovering Your Own Parenting Style

“Fathers, do not embitter your children, or they will become discouraged.” Colossians 3:21

Purpose: To help parents and other caretakers of children be the best they can be.

Objectives: Parents will know the four basic types of parenting styles.

Parents will be able to identify their own parenting style.

Parents will be able to determine the kind of parent they would like to be.

Workshop Steps/Time | Materials Needed
--- | ---
1. Devotion (3 min) | Index cards, markers, tape, flipchart, large sack/box, pens
2. Icebreaker Exercise: Shoe Races (10 min) | 
3. Introduction to Parenting Series/ Discussion (20 min) | 
4. Group Exercise/Parenting Styles (60 min) | 
5. Summary/Wrap-Up (7 min) | 

Advance Preparation:

- Have a sack or box large enough to hold everyone’s shoes.
- Have enough magic markers for group exercise.
Write on four pieces of flipchart paper the following headings:
“The Dominant Parent,” “The Neglectful Parent,”
“The Permissive Parent,” “The Balanced Parent”

Write on flipchart paper the following headings: “Things I like
most about parenting,” “Things I like least about parenting.”

Have enough handouts on the “Four Types of Parenting
Styles” (see following charts on Parenting Styles).

Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (Galatians 6:7) or
some other form of inspirational meditation.

IMPORTANT! Explain that this is the first session of a six
part series on “Coping With Parenting.” Ask if there is anyone
who will be unable to attend all six sessions. If parents cannot
attend a minimum of four sessions, encourage them to consider
participating in the next scheduled parenting series.

Explain the importance of everyone attending each session.
The series will lay a foundation for other topics. In order to get
the most out of the series, it is really important for everyone to
attend all six sessions if possible.

This is a unique opportunity for parents to talk about all kinds of
issues with other parents who share similar concerns around
parenting.

Note: As an added incentive, consider making up
certificates which you can give to those parents who
complete the series.
2) **Icebreaker: Shoe Race.** Have everyone get into two groups. Explain the object of this game is to see which team can get all of their shoes on first. Instruct everyone to take off their shoes and place them in a sack, box or some other type of bag large enough to hold everyone’s shoes. Afterwards, allow five minutes for both groups to find their shoes and put them on. (Shoelaces do not have to be tied as long as the shoes are on the right foot.) See which group wins. Have Fun!

3) **Introduction to the Parenting Series/Discussion.**

The Bible teaches us about the important role the parents play in a child’s life; however, there are no formal schools that prepare parents to cope with the many challenges we face in raising children. In fact, much of our parenting information comes from our own experiences as children and from observing others.

In today’s world, there are so many new challenges that parents and children face. Now, more than ever before, parents are struggling to raise their children in a world filled with immorality, HIV/AIDS, promiscuity, violence, alcohol, wars, substance abuse, rape, poverty, etc. Traditional norms that governed behaviour are eroding. Parents are realizing the need to talk to their children about issues relating to sex and sexuality in order to protect them.

The purpose of the “Coping With Parenting” series is to help parents be the best they can be and to raise healthy, happy, morally upright and productive human beings.

Explain that the six sessions will include:
Put up the flipchart paper that reads: “Things I like most about parenting,” “Things I like least about parenting.” Ask parents for their responses. List and discuss.

Explain that parents rarely, if ever, have an opportunity to talk about what they don’t like about being a parent. This may be because parenting is thought to be sacred and we are supposed to love everything about being a parent. Just because we may not like certain things about parenting doesn’t mean that we don’t love our children or that we are bad parents. It simply means we are normal. The more aware we are of our feelings, the better we will understand ourselves.

Ask parents to close their eyes and think back to when they were children. Allow a couple of minutes for this. Now, have parents open their eyes and answer the following questions. List responses and discuss.

Questions...
... What was growing up like for you as a child?
... How many siblings did you have?
... Who raised you?
... Were your childhood memories happy, unhappy, just okay, etc.? 
... If you could change how you were raised, what would you do?
... Do you think your style of parenting is similar to your parents’?
... Do you think you are a better parent, worse, unsure?
... Were there outward displays of love in your home?
... Were your parents strict?
... Were there any advantages to being a male or female?
4) **Group Exercise/Parenting Styles.** Divide parents into four small groups. Give each group a piece of flipchart paper listing one of the four parenting styles. Have each group list all of the things they can think of to define that particular style of parenting: dominant, neglectful, permissive and balanced. Allow 15 minutes for this, then have each group report their findings to the larger group. Compare the list to your facts about parenting styles and discuss. Ask parents what describes their style of parenting.

Review the following information on parenting styles with participants. Explain that a study conducted at the University of Minnesota in the United States found that there are **four** basic categories of Parenting Styles:

<table>
<thead>
<tr>
<th>Parenting Style</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dominant</td>
<td>Controlling, little warmth, lots of rules, hitting, strict boundaries</td>
</tr>
<tr>
<td>2. Neglectful</td>
<td>Few rules given or enforced, little warmth, no set boundaries</td>
</tr>
<tr>
<td>3. Permissive</td>
<td>Few rules, high display of warmth and acceptance</td>
</tr>
<tr>
<td>4. Balanced</td>
<td>Maintains clearly defined rules, high display of warmth and acceptance, sets boundaries</td>
</tr>
</tbody>
</table>

The study concluded that **dominant and neglectful** parenting styles tend to cause children to:

- resent authority.
- dislike themselves and others.
- perform poorly in school.
- believe that they will never be successful.
The permissive and balanced parenting styles tend to produce more positive results in children who:

- tend to maintain higher self-esteem and respect.
- tend to do better in school.
- are more responsible as adults.

Although most parents tend to fall within one of the four parenting styles, it is important to understand that parents can display varying degrees of the four parenting styles in a single day.

Explain that there is no such thing as a “perfect parent.” However, most parents can endeavour to be more like the fourth parenting style that balances love and limits.

THE DOMINANT PARENT MAY SAY THINGS LIKE:

- “You don’t need a reason, just do what I say!”
- “Because I said so, that’s why.”
- “You better, or else.”
- “I don’t care if Mary’s mother said she can go, you’re not going anywhere.”
- “I don’t want to hear it.”
- “Don’t ask questions.”
- “Don’t bother me.”

DOMINANT PARENTS TEND:

- to be stressed out.
- to spend little quality time with their children.
- to have grown up with dominant parents.
- to hit, spank or abuse their children.
- to be insecure.
- to feel overwhelmed by life’s circumstances.
- to have short tempers.
- to have limited resources.
- to be preoccupied with making ends meet.
- to have too many children.
- to get little or no support from partner.
- to come from dysfunctional families.
- to have little respect for children’s intelligence.
- to spend a disproportionate amount of time at work.
CHILDREN OF DOMINANT PARENTS TEND TO:
- have low self-esteem and little self-respect.
- withdraw and refuse to communicate.
- engage in disruptive behaviour in the classroom in order to gain attention.
- have difficulty sticking to rules or obeying authority.
- attract and associate with other children of dominant parents, often engaging in illegal and dangerous activities.

The NEGLECTFUL PARENTS fail to give loving support to their children and have difficulty controlling them. These parents often display an uncaring or immature attitude, lashing out at a child when pushed or irritated. Children are viewed as a bother and are “to be seen and not heard.” Neglectful parents rob their children of one of the most important factors in their lives – emotional accessibility.

NEGLECTFUL PARENTS MAY SAY THINGS LIKE:
- “Can’t you see I’m busy?”
- “What do you want me to do about it?”
- “Figure it out yourself.”
- “That’s your problem, I’ve got other things to worry about.”
- “Do whatever you want.”
- “Get out of my sight.”

NEGLECTFUL PARENTS TEND TO:
- be overwhelmed with responsibilities.
- avoid parental responsibilities.
- leave their children unattended.
- not set boundaries.
- spend little or no quality time with their children.
- blame others for their problems.
- have little education.
- lack affection and warmth.
CHILDREN OF NEGLECTFUL PARENTS TEND TO:

- be rebellious.
- feel insecure, worthless and may have low self-esteem.
- perform poorly in school.
- be out of control and behave inappropriately.
- engage in destructive behaviours.
- disregard rules, laws, boundaries.
- be neglectful parents with their own children.

The PERMISSIVE PARENT provides continual expressions of loving support but is highly inconsistent and unassertive when it comes to rules and limits.

Permissive parents give their children warmth and support that, in turn, gives children confidence and the ability to express thoughts and feelings; however, they often struggle with rules and placing limits on their children. They fear that being too strict will harm them emotionally.

It is important to realize that the fear of confronting your children may hinder them from developing uniqueness and confidence. Permissiveness can produce negative behaviour patterns such as fighting with other children, promiscuity, etc. Children need to have set boundaries that protect them, limit inappropriate behaviour and guide them toward making sound choices.

PERMISSIVE PARENTS SAY THINGS LIKE:

- “Well, Okay, you can stay up late, I know you like this program.”
- “Please don’t get angry with me, you’re making a scene.”
- “I hate to see you under all this pressure. I’ll call tomorrow and tell them you’re sick.”
- “Here’s five dollars, but I don’t understand what you did with the money I gave you yesterday.”
- “I really need your help. I guess I’ll have to do it myself.”
CHILDREN OF PERMISSIVE PARENTS TEND TO:
- manipulate them.
- develop insecurity because of parents’ lack of firmness.
- expect others to put up with whatever they do.
- throw temper tantrums.
- associate “softness” with “weakness.”
- act out rough, harsh behaviour in search for some kind of balance.

BALANCED PARENTS express love and warmth with clearly defined rules, limits and set standards for living in the home. They take time to train their children and allow them to understand the reasons behind rules. This causes children to feel a sense of ownership for the rules they’re obeying. Balanced parenting styles lend support to the effectiveness of rules and limits by expressing physical affection and spending time with each child individually. Their firmness needs to be tempered by proper flexibility, loving attitudes and actions.

BALANCED PARENTS SAY THINGS LIKE:
- “You’re late again, honey. How can we work this out together?”
- “I wish I could let you stay up longer but we agreed on this time.”
- “When we both cool off, let’s talk about what needs to be done.”
- “You say all the girls will be there. Could you get me a little more information?”
- “I will do everything I can to help you but you must do your part.”

CHILDREN OF BALANCED PARENTS TEND TO:
- have a healthy sense of self-respect and self worth.
- be secure and stable.
- obey rules and authority.
- perform well in school.
- handle pressure.
- be good parents.
- raise children who will be balanced parents.
- be fair and objective.
- communicate well with others.
After reviewing the four types of parenting styles, ask parents to think about the points raised and decide which ones they identify with or which ones they would like to become and why?

5) Summary/Wrap-Up

Ask parents to:

☑ name and describe each of the four parenting styles.

☑ describe at least three characteristics of a balanced parent.

☑ identify at least three consequences that the dominant and neglectful parenting styles can have on children.

☑ evaluate if this session has been helpful? If so, how? If not, why?

☑ review other points covered during the session.

☑ Remind parents that the next “Coping With Parenting” series will be Part II on Discovering Your Child’s Personality Type. Encourage everyone to attend.
Session II: Discovering Your Child’s Personality Type

“How great is the love the Father has lavished on us, that we should be called children of God! And that is what we are! The reason the world does not know us is that it did not know him.” 1 John 3:1

Purpose: To help parents better understand the interacting influences that help shape the personalities of children as they grow to maturity.

Objective: Parents will be able to identify at least three “natural” and “nurturing” factors that influence children’s personality.

Parents will be able to appreciate the full meaning of personality.

Parents will appreciate the impact that gender has on a child’s personality.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Index cards, markers, flipchart, pens, VCR/TV/Video</td>
</tr>
<tr>
<td>2. Icebreaker Exercise: “Contest” (10 min)</td>
<td></td>
</tr>
<tr>
<td>3. Review of Session I (5 min)</td>
<td></td>
</tr>
<tr>
<td>4. Defining Terms/Brainstorming (45 min)</td>
<td></td>
</tr>
<tr>
<td>5. Video/Discussion (30 min)</td>
<td></td>
</tr>
<tr>
<td>6. Summary/Wrap-Up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

- Draw a line down the middle on one piece of flipchart paper. Label one column “natural,” and the other “nurturing.” Write on other sheets of flipchart paper the following headings: “What Are Gender Roles/Scripts?” “What is Gender Equity?” “What is Personality?”

- Have relevant videos already set up in the VCR.

- Have plenty of flipchart paper for brainstorm discussions.

- Prepare handouts based on the following pages about genetic and social influences on personalities.

Facilitator’s Notes:

1) Devotion. Have a prayer, a song, reading (Psalm 119:4) or some other form of inspirational meditation.

2) Icebreaker: Laughing Contest. Explain that laughter is the best medicine. Have the group create two lines that face each other. One side has to try to keep a straight face while the other side tries to make them laugh without physically touching them. Switch, repeat and see who wins. Have fun!

3) Review Session I. Take a few minutes to review Session I. Explain that the Parenting Series began by looking at various parenting styles.

   Children do not have a specific category or type of personality as such; however, their personalities are influenced by many factors. Today’s session will help us to discover our child’s personality type or tendencies.
4) **Defining Terms/Brainstorming.** First, ask parents to define what “personality” means. List and discuss responses. Afterwards, write on chart paper a working definition for personality.

**Personality** is the distinctive qualities, traits and behaviours of an individual.

Explain that there is a widespread notion that parents are to blame for everything that goes wrong with a child’s development, leaving many loving mothers and fathers with feelings of undeserved guilt.

Parents do play a central role, of course, but there are many other interacting influences that shape the personalities of children as they grow to maturity.

Explain that there are two influencing factors, one is “heredity,” what the child naturally inherits from his or her parents and the other is “nurturing,” where and how the child is reared. Both heredity and nurturing factors help to shape the temperament of child from birth onward.

For example, genes can account for the marked difference between infants in attention span, responsiveness to people, excitability and mood. Mothers of more than one child can see a difference in the personalities of their children from infancy.

Put up the flipchart paper that says “natural” and “nurturing.” Ask parents to brainstorm some of the natural factors and nurturing factors that can influence a child’s personality type. List and discuss.
Examples:

<table>
<thead>
<tr>
<th>“Natural” Factors</th>
<th>“Nurturing” Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic make-up</td>
<td>Gender, Family, Religion, Class Teachers</td>
</tr>
<tr>
<td>Physical make-up</td>
<td>Culture, Education, Beliefs</td>
</tr>
<tr>
<td>Certain diseases that are inherited</td>
<td>Gender Roles, Peers, Teachers</td>
</tr>
<tr>
<td>Hormones</td>
<td>Politics, Technology, Drugs</td>
</tr>
<tr>
<td>Sickness, Disease</td>
<td>Economics, Race/ism, Media</td>
</tr>
<tr>
<td>Allergies</td>
<td>Environment, Sexual Abuse</td>
</tr>
<tr>
<td>Sex (Male or Female)</td>
<td>Music, Fashions, etc</td>
</tr>
</tbody>
</table>

Explain that “natural” means existing in or produced by nature, “nurturing” means sustenance, upbringing or training. It can be positive or negative.

Positive nurturing means teaching children by example. Ask, “What does this mean?” Ask, “What can parents do to ensure that their children grow up in positive, nurturing environments?” List and discuss responses.

Ask parents to give examples of a positive nurturing environment. List and discuss. Now, ask parents to give examples of negative nurturing environments. Again, list and discuss.

Put up the chart paper on “gender.” Ask, “What are gender roles?” “Is there gender equity in your country?”

“Do gender roles/scripts impact children’s personalities?” “If so, how?” “If not, why?” List and discuss.
Facts:

**Gender roles/scripts** are the set of rules and roles given to males and females at birth as laid down by society. These roles and scripts provide early programming and can limit growth and choices.

**Gender equity** is the quality or state of being fair, just and impartial in dealing with individuals, regardless of gender.

5) **Video Show/Discussion.** Show excerpts (a section) of two different videos. Show one that depicts a positive nurturing environment and another depicting a negative environment. If videos are not available, use role-plays to illustrate both types of environments. Discuss parents’ responses.

Ask, “What can parents do to ensure that children grow up in a positive, nurturing environment, whatever their circumstance?” List and discuss responses.

6) **Summary/Wrap-Up**

Ask parents to:

- ☐ discuss if this session has been helpful. If so, how? If not, why?

- ☐ identify three natural and nurturing factors that can influence a child’s personality.

- ☐ discuss how gender roles influence a child’s personality.

- ☐ What can parents do to ensure that their children develop positive and healthy personalities?

- ☐ Remind parents when the next Session III of the “Coping with Parenting” Series will begin. Encourage everyone to attend all sessions.
Session III:
Overcoming Barriers That Destroy Families

“This is what you are to say to Joseph: I ask you to forgive your brothers the sins and the wrongs they committed in treating you so badly.” Now please forgive the sins of the servants of the God of your father.” When their message came to him, Joseph wept. Genesis 50:17

Purpose: To help parents recognize barriers that can destroy communication in the home.

Objectives: Parents will know the meaning of a “Closed Spirit.”

Parents will be able to identify at least three manifestations of a child’s “Closed Spirit.”

Parents will be able to communicate more effectively without closing their children’s spirits.

Workshop Steps/Time | Materials Needed
--- | ---
1. Devotion (3 min) | Parent/Child-Evaluation
2. Icebreaker Exercise: “My Shoes” (15 min) | Handouts (around p. 280), markers, flipchart, pens, index cards
3. Parent/Child Evaluation (15 min) | 
4. A “Closed Spirit”/Discussion (45 min) | 
5. Role Plays/Discussion (30 min) | 
6. Summary/Wrap-Up (7 min) |
Advance Preparation:

▷ Have enough of the “Parent/Child-Evaluation Handouts” available for each participant (they’re in the Parent Education Resource Material section, around page 280)

▷ Have several skits in mind for role-plays.

▷ Have enough markers and pens.

▷ Write on flipchart paper the following headings: “What is a “Closed Spirit?” “What are barriers?”

▷ Have enough flipchart paper for group exercise.

Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (1 John 5:13) or some other form of inspirational meditation.

2) Introduction/Icebreaker: Walk in My Shoes. Have parents look down at their shoes and tell the group three things their shoes say about them.

Take a few minutes to review Session II, Discovering Your Child’s Personality Type. Ask parents if they have any comments or questions before beginning Session III. Again, remind parents how important it is for them to attend all six sessions in order to get the most from the series.
3) **Parent/Child Evaluation.** Hand out the Parent Child Evaluations. Explain that this evaluation is **not** a test. Rather it is a tool for parents to examine their own personal relationships with their children. Tell them that they will score their own evaluations. Allow about five minutes for parents to answer questions. Now give each parent a score sheet to see how he/she scored. Allow about five minutes for them to score themselves. Ask parents for their comments about the evaluation exercise.

Ask parents to define the term “barrier.” Give your own definition.

A **Barrier** is something that hinders or restricts. Today’s session will examine one important barrier that can destroy family relationships. Explain that when it comes to parenting, a child’s “Closed Spirit” is the single most prevalent cause of persistent disharmony within a home that creates a “barrier” between a parent and child.

Put up the flipchart paper headed “What is a “Closed Spirit?” Ask parents to define what they think it means. List responses and discuss.

Explain that a **Closed Spirit** is often the result of an injustice our children suffer because of an offence we’ve committed as parents. And as a result of the action, children withdraw from the intimacy they once shared with us.

Ask parents to think about different ways we can close a child’s spirit? List responses and discuss.
Example: A child’s “Closed Spirit” may come from:

- not letting your children know how much you love them.
- embarrassing them in front of their friends.
- comparing them to another sibling or to another child.
- saying things like, “you never do things right.”
- not looking after them properly.
- threatening your children.
- yelling at them or making fun of them.
- constantly beating them for everything they do.
- cursing at them or calling them stupid.
- telling them that you wish they were never born.
- arguing with your spouse/partner in front of your children.
- acting inappropriately; e.g., being drunk, beating your wife, etc.
- lying, stealing or cheating.
- not keeping your promise.
- not spending quality time with your children or communicating with them.

Ask, “How we can tell when our child has a “Closed Spirit”?” List and discuss.

Facts:

Some manifestations of a “Closed Spirit” are when your child:

- looks to others for love and support instead of you.
- doesn’t look at you when you talk to her.
- may argue and resist when you ask him to do something.
- may refuse to like anything you like.
- may withdraw and withhold affection.
- stops speaking to you.
- begins to lie and steal from you.
- keeps important information from you.
- does not communicate with you about school, friends, etc.
- will choose not to like certain friends that you like.
- will choose to like certain friends that you don’t like.
- may use abusive, disrespectful language.
- may become involved in alcohol, drugs, smoking and sex.
- may run away from home or attempt suicide.
- etc., etc., etc.
Ask parents to think about “What can parents do if a child’s spirit is closed?

Tell parent to remember that, “No one rises to low expectations.”

Some ways to overcome a “Closed Spirit” may be to:

- become tender-hearted.
- increase understanding.
- recognize the offence.
- practice what you preach.
- seek forgiveness.

provide loving support by:
- communicating unconditional love.
- verbalizing your feelings of love, pride and affection.
- helping your child visualize a positive future.
- recognizing each child’s uniqueness.
- never comparing your child to anyone else.

5) **Role Plays/Discussion.** Ask parents to reflect on how we close our spirits to God our father in some of the same ways. Have parent’s role-play different situations so that they can practice how to respond to children’s “Closed Spirit.”
You may want to make up your own skits or, you can use the following:

1. Your 13 year-old daughter is suddenly not doing well in school. You have a feeling that something is troubling her but whenever you ask her how things are going, she just says “okay.” What can you do?

2. Your 9 year-old son spilled tomato sauce all over your new rug. What do you do?

3. Your youngest daughter failed math but your oldest daughter scored a 100 on her exam. What do you do?

4. You’re not feeling well and your children are making a lot of noise. Several times you have asked them to play quietly. You lose your temper and scream at them. Later on, you feel badly about how you handled it. What can you do?

**Remember!** Parents are extremely resourceful. Encourage them to find the best approach to the problem. After each role-play, discuss how each parent handled the problem. When appropriate, make your own comments.

6) **Summary/Wrap-Up**

- Review today’s session and ask if there are any other questions or comments.

- Ask parents to identify three ways parents can close a child’s spirit.

- Ask parents to explain how they can tell if their child has a “Closed Spirit.”

- Encourage parents to attend Session IV on “Coping With Parenting.”
Session IV:  
Setting Boundaries and Disciplining Children

“Discipline your son, and he will give you peace; he will bring delight to your soul.” Proverbs 29:17

Purpose: To help parents understand the importance of setting boundaries and how to give appropriate discipline.

Objectives: Parents will be able to recall at least three advantages to setting boundaries.

Parents will be able to identify at least three appropriate forms of disciplinary actions.

Parents will know when discipline becomes abuse.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Markers, flipchart, pens,</td>
</tr>
<tr>
<td>2. Icebreaker Exercise:</td>
<td>index cards, tape</td>
</tr>
<tr>
<td>“Lie Detector” (15 min)</td>
<td></td>
</tr>
<tr>
<td>3. Setting Boundaries/Disciplining Children - Group Exercise (60 min)</td>
<td></td>
</tr>
<tr>
<td>4. Role Plays/Discussion (30 min)</td>
<td></td>
</tr>
<tr>
<td>5. Summary/Wrap-Up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>

Margaret Sanger Center International, Copyright 2001
Advance Preparation:

- Invite a guest speaker; e.g., social worker, to talk about disciplining children.
- Have enough index cards and pen/pencils for each participant.
- Write on flipchart paper the following headings: “What are boundaries?” “When do we begin setting boundaries?” “How do we set boundaries?” “What is discipline?” “What forms of discipline should parents use?” and “When does discipline become abuse?”
- Have enough flipchart paper and markers.
- Prepare handouts based on following pages about boundaries and disciplining children.

Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (Proverbs 15:5) or some other form of inspirational meditation.

2) Introduction/Icebreaker: Lie Detector. Have each parent tell the group two true statements about themselves and one false one. See if the group can tell which statement was false. Continue until everyone has had a turn.

3) Setting Boundaries/Disciplining Children/Group Exercise. Ask parents to define “boundaries.” List responses and discuss. Give a working definition for “boundaries.”
A Boundary is something that marks a limit or border.

Explain that in today’s world, society is becoming more lenient about setting appropriate boundaries for children. Consequently, in many homes, children learn to do whatever “feels good.” With the rise in teen pregnancy, crime, AIDS, STIs, suicides, rapes and violence, more children lack respect for morality and authority. Parents need desperately to establish boundaries with their children.

Here are a few facts:

- **Boundaries help children know they are loved by providing them with security.**
  
  Two groups of early grade-school children were studied during recess (break period). One played on a fenced playground, the other in an open field. The children in the fenced playground were found to have had fewer incidences of fighting, lower levels of anxiety and exhibited more cooperation and control.

- **Boundaries protect children from jumping too far ahead.**
  
  In today’s world, children are exposed to more and more at a younger and younger age. Each day, they are bombarded with messages that claim they should be, act and dress older than they are. By establishing boundaries, we protect them from experiences in life with which they are not old enough to cope.

- **Boundaries add productive days to children’s lives.**
  
  By learning to say “no” we protect our children from situations that might be a cause of major embarrassment, threaten their lives or get them into serious trouble. We help minimize frustration and anxiety and help prepare them for life’s challenges from a solid platform of stability and peace.

- **Boundaries help children understand there are absolutes.**
  
  Parents must establish clearly defined boundaries for acceptable behaviour with their children. There is no better way of learning to uphold responsibility and adhere to a system of rules than in the family.
Break parents into small groups of five. Give each group a piece of the prepared chart paper with the following headings:

...When should we begin setting boundaries?
...How do we set boundaries?
...What is discipline?
...What forms of discipline should parents use?
...When does discipline become abuse?

**Explain that abuse** is to use improperly, mistreat, misuse, pervert, etc.

Allow them 20 minutes to list their responses. Have them select someone from within the group to report their findings back to the larger group. Allow each reporter approximately five minutes. See if the group agrees with each other’s findings.

Read the scripture from Proverbs 22:15 “**Foolishness is bound in the heart of a child but the rod of correction shall drive it far from him.**” Ask parents to explain what this scripture means. Does it refer to corporal punishment, the use of excessive force or to any of the following behaviours and why?

- verbal abuse
- talking
- punishing
- spanking (slap on the buttocks)
- hitting (to deal a blow, smack, bash, knock, sock or strike forcefully)
- beating (to strike with force repeatedly)
- torture (to inflict severe physical pain as punishment)
- use of excessive force, etc.
Ask parents to discuss the most effective way to discipline children: what, when, where and how? Who should discipline children?

Ask parents to discuss some of the consequences of incorrectly disciplining children? List responses and discuss.

**Consequences of abuse:**
- death
- internal and external fractures
- emotional scars, e.g., low self-esteem, nervousness, antisocial behaviour
- physical scars, e.g., broken bones, bruises,
- breakdown in family units
- tendency for child to abuse his own children (cycle of abuse continues)
- wife battering, etc.

Introduce the guest speaker. Have him/her address the issue of child abuse. What does the law say about this problem? What are the legal penalties? What are the rights of the child?, etc.

4) **Role Plays.** Have parents role-play different situations that deal with disciplining children.
You may want to make up your own skits or you can use the following skits:

1. Your 3-year-old daughter keeps trying to touch the hot stove. What method of discipline should you use?

2. You catch your 9-year-old son stealing money from you. What do you do?

3. You suspect that your 15-year-old son may be sexually active. What can you do?

4. Your 13-year-old daughter is caught telling you a lie. What do you do?

5. Your 10-year-old son talks back to you. What do you do?

😊 **Remember**, parents are extremely resourceful. Encourage them to find the best approach to the problem. After each role-play, discuss how each parent handled the problem. When appropriate, provide your own comments.

5) **Summary/Wrap-Up**

- Review today’s session and ask for other questions and comments.

- Ask parents to define “boundaries” and explain why setting them is so important.

- Ask parents to identify three effective methods of disciplining children.

- Remind parents about Session V on Motivating Children for Positive Results.
Session V:  
Motivating Children for Positive Results

“Train a child in the way he should go and when he is old he will not turn from it.” Proverbs 22:6

**Purpose:** To help parents create a positive environment in which their children will develop spiritually, emotionally and physically.

**Objectives:** Parents will be able to identify at least three ways to help motivate their children.

Parents will be able to understand the power of praise.

Parents will practice using positive motivation techniques.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>VCR, TV, video, index cards, pens, markers, tape, flipchart</td>
</tr>
<tr>
<td>2. Introductions/Icebreaker</td>
<td></td>
</tr>
<tr>
<td>Exercise: “Reflections” (15 min)</td>
<td></td>
</tr>
<tr>
<td>3. Motivation/Group Exercise/</td>
<td></td>
</tr>
<tr>
<td>Discussion (30 min)</td>
<td></td>
</tr>
<tr>
<td>4. Role Plays/Discussion (30 min)</td>
<td></td>
</tr>
<tr>
<td>5. Summary/Wrap-Up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>

**Advance Preparation:**

- Prepare handouts on motivating children (see pages below).
- Have enough flipchart paper, markers, pens, index cards for group exercises.
If available, show a video on parent/child communication.

Write on flipchart paper the following headings: “What is motivation?” “What is praise?” and “How can we motivate children?”

Facilitator’s Notes:

1) **Devotion.** Have a prayer, song, reading (Job 42:2) or some other form of inspirational meditation.

2) **Icebreaker: Reflections on Family.** Give each parent three index cards and a pen or pencil. Explain that this exercise is designed to make us think about family. Even though not everyone present may have a family, they have thoughts about what they think a family is. Ask parents to close their eyes for a few moments and reflect on the following three questions that you will read:

♥ **What does my family mean to me?**
♥ **What do I wish for my family?**
♥ **What do I want for my children?**

After a few minutes, have parents number each card 1, 2, 3 and write down their answers. They should not put their names on the cards. After everyone has written his/her responses, collect the cards, shuffle them around and redistribute them to the group at random. Read the first, second, then the third question and have parents read their answers from the cards. Ask parents if the responses were similar. Were there any surprising responses?
3) **Motivation/Exercise/Discussion.** Put up the prepared chart paper on motivation. Ask participants to define “Motivation” and then “Praise.” List their comments and discuss.

| ☺ Motivation is the desire to act or cause motion. |
| ☺ Praise is to express approval of or admiration for something. |

Explain to parents that the desire to become motivated begins early in life. It may, and often does, become sidetracked – especially during adolescence when there are so many problems of self-image and growth to deal with and at other times in life when economic difficulties, illness, death, family discord, unemployment or just the need for a “vacation” takes temporary precedence. Nonetheless, what goes on in infancy and early childhood in interpersonal relationships strongly affects later motivation.

**Techniques that help motivate children**

When motivating children, it is important to learn what children’s basic interests and talents are. By doing this, we become more in touch with our children and can work with, not against, their personalities.

Ask parents to brainstorm ways that parents can motivate children. List responses on flipchart paper and discuss.
Techniques for Motivating Children

♥ **The power of praise.** You’ll be amazed at the results.

♥ **Expect Children to do things right.** Children have more confidence in themselves when they know that you have faith in their abilities to achieve certain things or behave a certain way.

♥ **Believe your children can achieve great things.** Let them know that all it takes is knowledge of what to do – and the skilful use of that knowledge.

♥ **Expose your children to people whom you admire.** In doing so, you motivate them to achieve what these people have. Make sure it’s someone to whom they can relate and look up to as well. You turn “hero worship” into a powerful motivator.

♥ **Be enthusiastic.** It’s contagious. When your children see you excited, they are much more likely to hop on the old bandwagon. Don’t be discouraged if they don’t respond with enthusiasm as you do. You can bet your efforts have paid off in some positive way.

♥ **Create positive experiences.**

♥ **Encourage your children with tender touching and listening.** A gentle hand and understanding heart can work miracles when our children are discouraged and need a boost to “get back on track.”

Break parents into small groups of five. Give each group chart paper and markers. Have each group come up with a list of ten ways to motivate children. Allow 15 minutes for this. Encourage parents to think about some special characteristics in their own children while they are preparing the list. Have someone from the group report their findings. Allow each reporter about three minutes. Discuss other points that parents may have.
4) **Role Plays/Discussion.** You may have developed your own skits or you can use the following skits to demonstrate how to motivate children.

**Situations:**
1. Although MaryAnn (15 years old) is doing well in school, she thinks that she is not attractive. Her father notices that she’s always criticizing herself or picking herself apart. What can he do?

2. Matthew is failing math and science. He doesn’t believe that he will ever understand it. His mother senses that he has given up on himself. What can she do?

3. Sylvia (13 years old) didn’t make the score on her sports team. Now her teammates are angry with her. She’s thinking about giving up the sport. What can her parents do?

4. Juma is 16 years old and very short for his age. He’s starting to show signs of being insecure. Both his parents are short. What can his parents do?

After each skit, ask the group how effectively the parents handled the situation. Did they motivate that child? If so, how? If not, why? Discuss.

5) **Summary/Wrap-Up**

- Review today’s session. Ask if there are other comments or questions.

**Ask parents to:**
- name three ways that we can motivate our children.
- explain the power of praise.
- explain how they plan to use what they learned in their own homes.
- Remind parents about the next and final Session VI on the Coping With Parenting Series. Encourage everyone to attend.
Session VI:
Maintaining a Healthy Family Life

“And the things you have heard me say in the presence of many witnesses entrust to reliable men who will also be qualified to teach others.” 2 Timothy 2:2

Purpose: To help parents understand that good communication is the key to a healthy family life.

Objectives: Parents will be able to identify at least three important aspects of communicating with children.

Parents will be able to appreciate the value of using emotional word pictures when they communicate with children.

Parents will be able to create word pictures that foster healthy communication in the home.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Index cards, markers, tape, flipchart, pens</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker Exercise: “The Truth” (15 min)</td>
<td></td>
</tr>
<tr>
<td>3. Communication/Discussion (30 min)</td>
<td></td>
</tr>
<tr>
<td>4. Word Pictures/Discussion (45 min)</td>
<td></td>
</tr>
<tr>
<td>5. Role Plays/Discussion (30 min)</td>
<td></td>
</tr>
<tr>
<td>6. Summary/Wrap-Up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

- Prepare a few skits for role-plays about positive communication in the home (see pages below).
- Prepare handouts on positive communication.
- Prepare flipchart paper with these headings: “What is Communication?” and “What are Word Pictures?”
- Have enough index cards for “Word Picture Exercise.”

Facilitator’s Notes:

1) **Devotion.** Have a prayer, song, reading (Proverbs 1:7) or some other form of inspirational meditation.

2) **Introduction/Icebreaker: To Tell The Truth.** Ask each parent to finish this statement, “To tell the truth...” For example, “I’m tired of having to pickup after my children.” After everyone has had a turn to finish the statement, you also finish the statement.

3) **Communication/Discussion.** Ask parents to define “communication.” List responses and discuss.

You may want to use this as a working definition.

**Communication** is the exchange of ideas, messages or information. Now, ask parents to think back when they were children:

- What has happened to change how we communicate in the home?
- Is it easier for the mother/father to communicate with children today?
Is there a certain age when fathers/mothers communicate more with children?
What other ways do we communicate with children besides talking to them?

List responses and discuss.

Explain that good communication is the key to a healthy family life. If people are going to be motivated to attend a workshop, they have to get excited or interested in what the workshop is about. Before we do a workshop, we tell people what the topic will be so that they will be interested in attending. When it comes to communicating with children, especially teens, the same thing holds true. We must make them interested and thirsty for what we have to say.

**Six helpful guidelines to follow when communicating with children:**

1. Clearly identify what you wish to communicate, before you have your child’s attention.
2. Identify your child’s/listener’s most important interests.
3. Using their areas of highest interest, share a few thoughts to stimulate their curiosity to hear more.
4. Ask questions to increase curiosity, like “Did I ever tell you about the worst date in my life?” or “Did I ever tell you how I met your mother/father?” or “Did I ever tell you about what happened when I met someone I really liked?”
5. Communicate your important information or idea only after you see you have your child’s full interest and attention.
6. Any time you lose their attention, pause and create more thirst. Then continue with what you want to share.

Educators report that the average adult remembers only 7% of the words spoken in a lecture – a half-hour after the speech was given. By creating an interest in the subject you want to discuss, you can multiply the effect of your words.
**Good communication** in the home helps in guiding children towards meaningful goals and enables them to acquire information that is needed to help make good decisions in life.

Many parents have been left heartbroken when, after years of rearing their children in families they believed to be loving, their children **feel unloved**.

In many situations love was never communicated in a manner that was understood and accepted by the children.

4) **Word Pictures/Discussions.** Ask parents if they have ever said to themselves, “Why can’t he understand what I’m feeling?” For many women in particular, their words seem to bounce off their husband as though he were wearing armour plating. But wives who know how to use a powerful communication tool – **emotional word pictures** – can see their words crumble the barriers to a man’s heart.

**Examples of Word Pictures:**

When I turned 46 and was feeling a little insecure, my husband gave me just the word picture I needed. He said, “Honey, when you live with a brand new shiny Mercedes, there’s no desire to rush out to drive a Volkswagen!”...Get the Picture?

“After struggling through the heat all day, I come to a place where there is a beautiful summer breeze. That’s what it’s like having a daughter/son like you. Like coming home to an oasis.”...Get the Picture?

*Mother:* “Honey, how does it make you feel when you raise your hand in class and the teacher ignores you and calls on someone else? *Child:* “Like I’m invisible.” *Mother:* “Well that’s a little like I feel when you don’t listen to me when I’m talking to you.”
“Mary, remember how much you hated it when we had to move,” the mother said. Mary said, “Yeah, I remember the kids in my class were not very friendly, I failed two subjects, I started my period, I had to make new friends.” The mother said, “You know, sweetheart, that first year here was really rough and you worked real hard in school and brought your grades up. You know, life is a lot like that first year we moved here; unexpected things happen that can really be frustrating and discouraging. Just like you overcame those challenges in the first year, I know you will always overcome any challenge facing you and that you will always be victorious. I’m so proud of you.”

😊 Five Reasons to Use Emotional Word Pictures

1. **Word Pictures have the power to dramatically change lives.**
   All of us are born with an innate sense of curiosity and word pictures have a way of tapping into that curiosity and drawing us in. When someone hears a word picture, a theatre of the mind is created. It’s like inviting a person to mentally take a journey that will exercise his intellect, emotion and will.

   For all of us, a significant emotional event is at the heart of a changed life. And using word pictures can help parents into their children’s emotions and see the greatest change. Word pictures tap into a person’s emotions and open the door to significant changes.

2. **Word pictures grab and direct a child’s attention.**
   TV, videos, and radio can all be sly thieves of communicating with our children. They also have the power of forming word pictures. Advertisers have known its effect for years. They constantly bombard us. In today’s world, there is a lot of competition for a person’s attention: with a barrage of word pictures, skillfully crafted to get our attention on a message or product.

3. **Word Pictures Bring Our Conversations to Life.**
   Researchers have discovered that experiencing a picture or event – real or imagined – gets all our five senses involved to almost the same degree as if it were real life! When we awaken a person’s emotions with a word picture, we add richness, depth, impressiveness, intensity and clarity to our communication. What’s more, we plant within a listener a lasting seed that can grow into a changed life – even if they reject our words at first hearing.
4. **Word Pictures Lock Our Words In to Another Person’s Memory.**
   Emotional word pictures leave a sweet after-taste to your words, long after the words themselves have been savoured. Public speakers from pastors to politicians know the value of a well-timed word picture; they skillfully use these powerful building blocks of communication to construct pictures in our mind that stand tall and unwavering in our memories.

5. **Word pictures provide the gateway to intimacy.**
   Many families find it difficult (some say impossible!) to communicate meaningfully. The different ways parents and children think can make what’s being said like talking to someone who speaks a foreign language. Parents and their children need a tool that can act like an interpreter and create a language of love that fosters healthy family life. Word pictures can do just that.

Get a volunteer from the group to read the following examples of word pictures. See how many parents get the word picture.

Explain to parents that there are many resources for creating word pictures. You can use almost anything to create a word picture: elements of nature, experiences, everyday objects, imagination, stories, memory, animals, weather, mountains, water, a fable or bedtime story, etc.

**Word Picture Exercise:**
Give each parent some index cards. Tell them to make up their own word pictures and write them down on the cards. Afterwards, get volunteers to share what they wrote.

**5) Role-Plays/Discussion.** Have parents practice role-play situations where they can use a word picture. Tell them to pay more attention to what they say and how they say it.
Instruct them when they go home to listen more intently to their children. Tell them to ask themselves if they are:

♥ clearly conveying their thoughts and feelings in a loving way?
♥ moving towards more understanding of their children and other members in the home.
♥ praising or encouraging their children and other members in the family.
♥ lovingly correcting their children without yelling or screaming.

6) **Summary/Wrap-Up**

☐ Review today’s session and ask if there are any questions or comments.

☐ Briefly review the last six session topics, highlighting key points.

☐ Ask parents if this series has been helpful. If so, how? If not, why?

☐ Ask parents to explain “communication.”

☐ Ask parents to explain the meaning of word pictures and how they can help when communicating with children.

☐ Answer any unanswered questions.

☐ Ask parents to think about other topics that should be included in the Coping With Parenting Series.

☐ How has the Coping With Parenting Series impacted your relationship with your children or family?

☐ Are you more willing now to talk to your children about sensitive issues like sex since attending this series?

☐ Encourage parents to participate in other Christian FLE Programmes.
COUPLE COMMUNICATION

“Many waters cannot quench love; rivers cannot wash it away. If one were to give all the wealth of his house for love, it would be utterly scorned.” Solomon’s Song of Songs 8:1

Purpose: To help married couples communicate more effectively with their children about issues relating to sexuality.

Objectives: Parents will appreciate the importance of effective communication within the family, especially on sensitive issues related to sex.

Parents will see the value in sending uniform messages about issues relating to sexuality to their children.

Parents will learn how to resolve conflicts, using compromise and communication.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>TV, VCR, index cards, markers, tape, flipchart, pens</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker Exercise: “Feeling Good” (15 min)</td>
<td></td>
</tr>
<tr>
<td>3. Brainstorming/Discussion (20 min)</td>
<td>Values Clarification (around page 486)</td>
</tr>
<tr>
<td>4. Video/Discussion (20 min)</td>
<td>“Forced Choice Exercise” (around page 488)</td>
</tr>
<tr>
<td>5. Values Exercise (30 min)</td>
<td></td>
</tr>
<tr>
<td>6. Role Plays/Discussion (60 min)</td>
<td></td>
</tr>
<tr>
<td>7. Summary/Wrap-Up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

- Have a pack of index cards, plenty of flipchart paper, pens and markers.
- Have a video (if available) depicting couple conflicts.
- Have a pack of Feeling Good Cards.
- For the “Forced Choice Exercise,” write on three sheets of paper, “Agree,” “Disagree” and “Unsure” and tape the paper to three separate walls in the meeting room.
- Have enough copies for each parent of the “Values Clarification: Earthquake Exercise” (around page 490).
- Select at least five couple conflict skits for role-plays.

Facilitator’s Notes:

1. **Devotion.** Have a prayer, song, reading (Matthew 18:19) or some other form of inspirational meditation.

2. **Introduction/Icebreaker.** Introduce the Feeling Good Card Game. Invite everyone to take a Feeling Good Card from the deck. Explain that there are no right or wrong answers. Tell the group not to show their card to anyone. After everyone (including the facilitator) has a card, ask each person to read his or her card out loud and respond. Select another icebreaker if this one is not available.

Distribute index cards to all participants. Tell them to write down unanswered questions that may come up during the workshop. Tell them that you will try to answer them at the end of the workshop, if time permits.
3) **Brainstorming/Discussion.** Ask parents to define the terms “couple” and “communication.” Explain that within the Christian context, a “couple” refers to a man and a woman who are married. However, in the secular world, it refers to two people who are closely associated. There are many unmarried couples, including common law partners living together, who share parental responsibilities. Ask parents to think of other couple situations. List and discuss.

Ask couples to define “communication.” List and discuss. Explain that communication is the exchange of ideas, messages or information.

**Effective Communication** is the ability to exchange ideas, messages or information so that the sender understands it as intended. It can be verbal or nonverbal.

**Ask the following questions:**
“What factors hinder good communication?”
“What factors enhance good communication?”
“What are some of the common causes for couple conflicts?”
“What messages do couples in conflict send to their children?”
“How can we minimize conflict between couples so that children will benefit?”

4) **Show a relevant video.** Show a relevant video depicting couples in conflict. After showing the video, discuss. What caused the conflict? What should the couple (man or woman) have done to avoid the conflict?

5) **Forced Choice Exercise.** Have five or six statements expressing positions on various childrearing issues. Example, “My children can stay up as late as they want to.” or “My daughter should never ask me about sex.” Read the statement, then tell parents to stand by the sign that best reflects their position on that issue. Repeat the exercise, this time telling
each couple they must come up with a joint position. Discuss the results.

**Values Clarification Exercise: Earthquake.** Review the instruction with the group and read the story out loud. Have parents rate in order which characters should be saved. Then have each couple compare their results and agree on a joint rating. Discuss with the couples how they reached an agreement.

6) **Role Plays/Discussion.** Assign each couple a conflict situation to resolve. Ask one couple to come to the centre of the room and role-play the scene while the other parents watch on. When the scene is over, ask the group for comments. What did the couple in the scene do, or not do, that was helpful in resolving the conflict? Go on to the next couple’s scene. Continue until each couple has had a turn.

7) **Summary/Wrap-Up**

☐ Ask the couples if this workshop has been helpful. If so how? If not why?

☐ Ask couples to:
  a) give two reasons why it is important for couples to effectively communicate about child rearing issues.
  b) give two reasons why it is important for a couple to send their children uniform messages.
  c) describe two techniques for compromising.

☐ Briefly review the purpose and objectives of the workshop. Read and answer questions from the index cards. If there are any questions that you can’t answer, suggest another source of information.

☐ Commend the couples for their participation and encourage them to participate in other *Christian FLE* Programmes.
HOW TO TALK TO CHILDREN AND ADOLESCENTS ABOUT SEX

“The man and his wife were both naked, and they felt no shame.” Genesis 2:25

Purpose: To help parents talk more comfortably and effectively with their children about issues that relate to sex and sexuality.

Objectives: Parents will know when it is the best time to start talking with their children about sex.

Parents will be able to explain sex and sexuality to their children.

Parents will be aware of some of the emotional and physical changes that occur during the life cycle.

Parents will be able to name at least three things children need to know about sexuality.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>3 “life cycle” handouts (around page 300)</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker:</td>
<td>Video, TV, VCR, index cards, markers, tape, flipchart, pens</td>
</tr>
<tr>
<td>“Remember When” (15 min)</td>
<td></td>
</tr>
<tr>
<td>3. Sex and Sexuality Discussion (10 min)</td>
<td></td>
</tr>
<tr>
<td>4. Life Cycle/Group Exercise (60 min)</td>
<td></td>
</tr>
<tr>
<td>5. Video Presentation/Discussion (25 min)</td>
<td></td>
</tr>
<tr>
<td>6. Role Plays/Discussion (30 min)</td>
<td></td>
</tr>
<tr>
<td>7. Summary/Wrap-Up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

➤ Arrange the chairs in a semi-circle.

➤ Make sure you have enough index cards, pens/pencils for each participant.

➤ On separate pieces of flipchart paper, write the following headings: “Remembering” “What is Sex?” “What is Sexuality?” and “Helpful Hints for Parents”

➤ On five pieces of flipchart paper, draw a line down the middle of the paper. Label one side “Physical” and the other side “Emotional.” At the top of each sheet put the appropriate age range, beginning with 0-2 years, 3-5 years, 5-7 years, 8-12 years (preteens), 13-20 years (teens).

➤ Have enough copies of the “life cycle” handouts and markers for group exercise.

➤ Have a relevant video already set up in the VCR.

Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (1 Timothy 6:12) or some other form of inspirational meditation.

2) Introduction/Icebreaker: Remembering When. Have all attendees introduce themselves to the group and tell how many children they have and their ages. Afterwards, ask parents to close their eyes and think back to when they were young. Ask them to remember how they first learned about where babies came from. Encourage each parent to share his or her experience.
Give parents an index card and encourage them to write down any unanswered questions relating to the topic. During the break, glance through the cards to determine if some of the questions asked will be covered in today’s session. If not, at the end of the workshop, try to respond to the unanswered questions.

Explain that most of us feel uncomfortable talking about sex to our children. Many of us were taught that sex is dirty. Most parents are afraid that they don’t have any or all of the answers, or find it difficult to admit their children are sexual beings. Some even find it hard to admit that they are sexual. However, sex is a gift from God and a wonderful part of our lives. “Sex is like a river. It is powerful and beautiful; it gives life and is a source of blessing to all humankind. But if the river overflows its banks, it can cause great destruction. God designed sex to be a blessing. He has given clear guidelines about the right use and enjoyment of sex. These guidelines are like the banks of the river. If we go outside these guidelines and misuse the gift of sex, the blessing becomes a curse, a source of destruction.”

In today’s world, messages about sex are all around us – on the radio, TV, videos, music, magazines, newspapers, etc. Sex is used to sell everything from soap to cars. Politicians and religious leaders have a lot to say about sex. Young people talk amongst themselves about sex in the locker rooms, in school and on the phone. Unfortunately children today hear a lot about sex but not enough to stay out of trouble.

Despite all the talk about sex, our children don’t get much useful information. What they do get is misinformation and dangerous myths about sex that can put them at risk for an STI, unwanted/premarital pregnancy, rape and even AIDS.
Most children grow up thinking that having sex will:

...make a boy into a man  ...be fun
...make a girl into a woman  ...repay an obligation
...make them popular    ...feel good
...prove their love to someone  ...be okay because
...cure loneliness, etc.     everyone’s doing it

We all want our children to have healthy and rewarding lives. And we all know that teaching them about sex is very important. However, most parents find it hard to talk about sex – especially with their own children. This is due to cultural taboos, fears and other things.

In today’s world of AIDS, teen pregnancy, STIs, rape, child molestation and other sexual abuses, parents must be armed with factual information about sex and be able to talk with their children about important aspects related to sex.

❤ This workshop is designed to:
  help parents to be better sex educators of their children.

❤ What we hope to accomplish:
  - Arm parents with factual information about sex and sexuality.
  - Support parents family/religious values.
  - Provide parents with the skills they need to talk to their children about sex.

It is vital that children receive factual information about sex along with their parents’ values. Values help young people to be responsible and to know what is expected of them. Combining positive values along with facts about sex helps young people to make better decisions about their lives, relationships and sexuality.
What doesn’t work:
- fire and brimstone tactics
- scare tactics
- threats
- myths
- lying
- ignoring the topic, etc.

Children are wonderfully made by our loving Heavenly Father. Children are naturally inquisitive. When they ask questions, it lets us know that they are intelligent and developing normally. Asking questions is an important part of how we learn about life.

When a child is two years old and wants to touch a hot pot, we tell the child the pot is hot and it can burn. However, if that same two-year-old asked where do babies come from, we panic and tell lies – babies come from the hospital or the garden, etc.- instead of saying babies come from mommies and daddies.

Remember, children are only interested in how things work. They are not interested in all of the emotions. As they get older, they will ask more specific questions that will require more detailed information.

Information does not encourage kids to be sexually active. Children make better decisions about sex when they have all the information they need and when there are no taboos on what to talk about at home.

3) **Sex and Sexuality/Discussion**. Put up the prepared chart paper headed “What is Sex?” and “What is Sexuality?” Ask parents to define what these two terms mean.

List their responses and discuss.
Facts:

**Sex** refers to biology, whether you are a male or female. **Sexuality** is the total expression of who we are as human beings. It includes our spirituality, emotions, physical development, gender, attitudes and values, personality, sexual orientations and sexual identity. Sexuality begins at birth and ends at death and influences how we feel about life, love, relationships, compassion, joy and sorrow.

Be sure to get group consensus on these two terms.

4) **Life Cycle/Group Exercise.** Break the group up into five small groups. Give each group the prepared flipchart paper listing specific age groups, beginning with:

<table>
<thead>
<tr>
<th>Age Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 2 years</td>
</tr>
<tr>
<td>3 to 5 years</td>
</tr>
<tr>
<td>5 to 7 years</td>
</tr>
<tr>
<td>8 to 12 years (preteens)</td>
</tr>
<tr>
<td>13 to 20 years (teens)</td>
</tr>
</tbody>
</table>

Explain that the life cycle refers to the multitude of physical and emotional changes we experience throughout life. Explain that this exercise draws from parents’ wealth of knowledge about anatomy, physiology and life experiences.

Instruct each group to list all the physical and emotional changes that occur in that age category. Each group should select a recorder and someone to report back to the larger group. Allow 20 minutes for small group work.

Afterwards, allow each reporter about five minutes to report findings. If time permits, allow comments and questions from the larger group. Be sure to add any important information that might have been overlooked.
**Why Do Children Need to Know About Sexuality?**

**Children who understand their sexuality are:**

... better able to take charge of their lives.
... better able to cope with their feelings.
... able to handle peer pressure.
... less likely to be either sexually abused or become sexual abusers.
... more secure.
... less likely to experiment with unsafe behaviours.
... more informed about the facts about AIDS, STIs, premarital pregnancy.
... likely to make sound decisions about their sexuality and personal relationships.
... more likely to come to their parents for help.
... more confident.
... more likely to respect themselves and others.
... etc.

Remember, our children listen to the music with lyrics that are all about sex. They watch thousands of sexual messages on TV and videos, however, much or most of the information they get from music and videos is harmful. It only romanticizes sex and never addresses the dangers.

It’s up to parents to give our children useful information. It’s our job to warn them about sexually transmitted infections and AIDS. We have to help them understand why it’s important to avoid teen pregnancy. We can help them learn to say “No!” and how to take “No!” seriously.
When’s the best time to start?

- Relax, you have already begun teaching your children about sexuality by your nurturing, hugging and loving.
- It’s always best to start as soon as children begin getting sexual messages which is as early as three years.
- Don’t worry if you haven’t started yet. It’s better late than never.
- Don’t try to catch up all at once. Sexuality is a lifelong process.
- The most important thing is to be open and available whenever a child wants to talk. The rest will take care of itself.

Important Facts:

0-2 years: We give babies a sense of themselves from birth. We make them feel secure or insecure by:
- the way we hold and touch them.
- the way we feed, wash and diaper them.
- the tone of our voices.
- letting them feel comfortable with their bodies and emotions.

Babies develop healthier feelings about their sexuality if parents do all these things in a pleasant, loving and caring way.

3-5 years: By the time children are three, kids are ready to know that boys and girls have different sex organs. They may have already wondered about it for a while.
- Talk about it the same way you talk about noses, fingers and toes.
- Introduce biologically/culturally appropriate names for sex organs, e.g., say “vulva,” “penis” and “breasts” instead of nicknames. Otherwise, children may get the idea that something is wrong with these parts of the body.
- Toddlers are curious about the bodies of their parents and other children.
- Three-year-olds want to know, “Where do babies come from?”
- If your children ask this question, the first thing that you should do is to let them know that their question is a good one. For example, “That’s a good question sweetheart, do you know where babies come from?” After you hear their response, you can say something like “Babies grow in a special place inside the mother.”
- As children get older, you can slowly add other details as the child becomes able to understand them.
5-7 years: It is common for children to become less attached to parents and caregivers at this time. They are beginning to realize their own femininity and masculinity. They:
♥ sometimes say they hate children of the opposite gender.
♥ don’t like to be teased.
♥ may be shy about asking questions but that doesn’t mean they don’t have questions.
♥ Most children at this age have heard about such things as AIDS, sex or drugs and they wonder about these things even if they don’t say anything. We need to keep talking with them.

8-12 (preteens): This age group needs all the facts about menstruation, wet dreams and other signs of maturing. Preteen(s):
♥ worry a lot about whether they are normal.
♥ boys worry about their penis size.
♥ girls worry about their breast size.
♥ need reassurance that no two people are the same and it is normal to be different.
♥ need to fit in with their peers.
♥ need to be encouraged to think for themselves and not get carried away by the crowd.
♥ are fascinated with the way their bodies change.
♥ are ready to know about sex and reproduction.
♥ want to know about sexual and social relationships.
♥ need to know about STIs, birth control, rape, drugs, alcohol and the consequences of teen pregnancy.
♥ need to know how poor choices can affect their lives.

13-20 years: All teens have to make sexual decisions. They:
♥ should be told that there are good reasons to abstain from sex.
♥ must learn how to protect themselves against pregnancy and infection.
♥ must learn how to say “no” without feeling guilty or pressured.
♥ must know how to have healthy relationships.
♥ must know they are responsible for their choices.
♥ are easy targets for peer pressure and bad advice.
♥ should be told about the emotional, physical and financial consequences of pregnancy and disease.
**Helpful Hints For Parents:**

- Always put God first.
- Set good examples that show kids how our lives are enriched by our values.
- Reassure them that they are normal.
- Build their self-esteem and credit them for their talents, personalities and accomplishments.
- Respect their privacy as much as you value your own.
- Use biological names for sex organs and sexual behaviour.
- Practice saying the words out loud or in front of a mirror to help get over the embarrassment.
- You don’t have to know all the facts.
- There is no such thing as a perfect parent.
- Always be honest.
- Admit when you don’t know the answer.
- Accept questions at face value. For example, “How old do you have to be to have sex?” doesn’t mean that your child is thinking about or having sex. Questions about sex are often attempts to understand a family’s values more clearly.
- Be an “askable” parent. Let your child know that you are available and make it a habit to share what you think and feel.
- Ask questions even if they don’t – questions about what they think, what they know and how they feel.
- Be clear about your own feelings and values and figure out what you want to say about them before you speak.
- Talking with a spouse, friend or with other parents can help clarify your message. It can also give you the confidence you need to talk with your children.
- Use “teachable” moments; e.g., a TV commercial, movie, article in the newspaper, a pregnant woman, etc. to have a discussion about sex.
- Let your body language, facial expressions and tone of voice support what you say with words.
- Get to know the world in which kids live today. What pressures they feel, what they want for themselves, etc.
- Showing interest in their activities and friends lets them know that you care and want to be a part of their lives.
- Practice what you preach.
- Live what you teach.
It is wise for single parents to recommend to their child a mentor of the opposite sex to answer his or her questions.

5) **Video/Presentation/Discussion.** Show a relevant film on parent child communication and discuss.

6) **Role Plays/Discussion.** Explain that it is very important that parents practice responding to sensitive questions. Encourage each participant to take turns responding to the following questions:

<table>
<thead>
<tr>
<th>Age</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 to 5</td>
<td>“Where do babies come from?”</td>
</tr>
<tr>
<td></td>
<td>“Why do boys stand and girls sit when they go to the bathroom?”</td>
</tr>
<tr>
<td>5 to 8</td>
<td>“What is AIDS?”</td>
</tr>
<tr>
<td></td>
<td>“What is sex?”</td>
</tr>
<tr>
<td></td>
<td>“What is a period?”</td>
</tr>
<tr>
<td>9 to 12</td>
<td>“When are my breasts going to grow?”</td>
</tr>
<tr>
<td></td>
<td>“Why am I shorter than the other boys my age?”</td>
</tr>
<tr>
<td></td>
<td>“What does homosexual mean?”</td>
</tr>
<tr>
<td></td>
<td>“What are condoms used for?”</td>
</tr>
<tr>
<td>13 to 20</td>
<td>“How far should a single person go in an intimate relationship?”</td>
</tr>
<tr>
<td></td>
<td>“How do you know when you are in love?”</td>
</tr>
<tr>
<td></td>
<td>“What are contraceptives?” etc.</td>
</tr>
</tbody>
</table>

Ask parents if they can think of other questions of a sensitive nature that children sometimes ask. List them on flipchart paper and discuss.
7) **Summary/Wrap-Up**

**Ask parents:**

- ☑ if they have any questions.
- ☑ if this workshop has been helpful. If so, how? If no, why?
- ☑ to explain when is the best time to start talking to children about sex.
- ☑ to define “sex,” “sexuality” and why children need to know about it.
- ☑ to name at least three physical and emotional changes which occur during the life cycle, e.g., during puberty.
- ☑ to recall at least three things parents can do to become an effective sex educator for their children.
PART FOUR

WORKSHOPS FOR ADOLESCENTS & ADULTS
HEAVEN’S GROCERY STORE

I was walking down life’s highway, a long time ago.
One day I saw a sign that read “Heaven’s Grocery Store.”
As I got a little closer, the door came open wide.
And when I came to myself, I was standing just inside.

I saw a host of angels. They were standing everywhere.
One handed me a basket and said, “My Child, please shop with care.”

Everything a Christian needed was in that Grocery Store.
And all you couldn’t carry, you could come back the next day for more.
First, I got some PATIENCE, and LOVE was in the very same row.
Further down was UNDERSTANDING, you need it wherever you go.

I got a box or two of WISDOM, a bag or two of FAITH.
I just couldn’t miss the Holy Spirit, for He was all over the place.

I stopped to get some STRENGTH and COURAGE to help me run this race.
By then my basket was getting full but...I remembered I needed some GRACE!
I didn’t forget SALVATION that was free.
So I tried to get enough of that to save both you and me.

Then I started up to the counter to pay my grocery bill,
for I thought I had everything now to do my Master’s will.
As I went up the aisle I saw PRAYER and I just had to put that in.
For I knew when I stepped outside, I would run right into sin.

PEACE and JOY were plentiful; they were on the last shelf.
SONGS and PRAISES were hanging near, so I just helped myself.
Then I said to the Angel, “How much do I owe?”
He just smiled and said, “Just take them everywhere you go.”

Again I smiled at him and said, “How much do I owe?”
He smiled again and said, “My child,
JESUS PAID YOUR BILL A LONG, LONG TIME AGO!!!”

Author Unknown
CHRISTIAN FAMILY LIFE EDUCATION

“And how from infancy you have known the Holy Scriptures, which are able to make you wise for salvation through faith in Christ Jesus.” 2 Timothy 3:15

Purpose: To provide participants with an overview of what the Christian Family Life Education Programme is all about.

Objectives: Participants will understand the broad meaning of Family Life Education.

Participants will be able to identify at least three external and internal factors that impact young peoples’ values.

Participants will appreciate the importance of talking about issues relating to life, loving and growing up.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Black/white board, chalk, markers, tape, flipchart, pens</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker:</td>
<td>Handouts of “CFLE Questionnaire” (around page 284 in Resource Materials section)</td>
</tr>
<tr>
<td>“Name Game” (20 min)</td>
<td></td>
</tr>
<tr>
<td>3. Discussion/Defining Terms</td>
<td></td>
</tr>
<tr>
<td>(10 min)</td>
<td></td>
</tr>
<tr>
<td>4. Brainstorming/Discussion</td>
<td></td>
</tr>
<tr>
<td>(30 min)</td>
<td></td>
</tr>
<tr>
<td>5. Summary/Wrap-up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

✓ Arrange the meeting room in a circle or semi-circle.

✓ Have two Icebreaker Exercises – “Get That Autograph” and the “Adjective Name Game” (see around page 240 for both).

✓ Bring enough flipchart paper and markers.

✓ Write on separate pieces of flipchart paper definitions for: “What is Family Life Education?” “What is Sex?” “What is Sexuality?” (see following pages for definitions).

✓ Prepare on flipchart paper headings on external factors that impact individual family member and internal factors that impact individual family members.

✓ On a separate piece of flipchart paper or board, write down this definition: Family Life Education is an all encompassing topic which includes both internal and external factors that impact on the quality of life of the individual, the family and the community.

✓ On another piece of flipchart paper write, Sex refers to biology, whether you are a male or female, and Sexuality is the total expression of who we are as human beings. Sexuality includes our spiritual, emotional and physical development.
Facilitator’s Notes:

1) **Devotion.** Have a prayer, song, reading (Romans 12:1,2) or some other form of inspirational meditation.

2) **Introduction/Icebreaker.** Choose either the “Get that Autograph “ or the “Adjective Name Game” icebreaker exercise found in the Resource Materials section. Follow the instructions carefully. Both exercises can be done in 10 to 20 minutes depending on the size of the group and the amount of time you have. After the exercise, talk a little about your background and about the *Christian Family Life Education* Programme. Handout “CFLE Questionnaire” (around page 284).

**Example:**
Make reference to the growing numbers of AIDS cases and out of wedlock pregnancies. Say that so many things are changing in the world today and that now, more than ever before, parents need to have the facts and the skills to talk to their children about all of these things.

Explain that the *Christian Family Life Education* Programme was created to provide factual information about sexuality, STIs, reproductive health, clarify values and provide communication skills.

3) **Defining Terms.** Put up the prepared flipchart paper with the headings: “What is Family Life Education?”, “What is Sex?”, “What is Sexuality?” Ask participants to give their own definitions. List responses and discuss.
**Facts:**

**Family Life Education** is an all-encompassing topic that includes both internal and external factors that impact on the quality of life of the individual, the family and the community.

**Sex** refers to biology, whether you are a male or female.

**Sexuality** is the total expression of who we are as human beings. Sexuality includes our spiritual, emotional and physical development.

Discuss and be sure to get group consensus on your definitions.

4) **Brainstorming/Discussion.** Use the flipchart paper prepared for “External Factors.” Ask participants to think about some of the External Factors which impact us as individuals; e.g., religion, society, traditions, culture, war, politics, rape, drugs, technology, climate, weather patterns, economy, etc. List and discuss each of these factors.

Use the flipchart paper prepared “Internal Factors.” Ask participants to think of some of the Internal Factors impacting our lives; e.g., puberty, hormones, menstruation, wet dreams, masturbation, pregnancy, drugs, AIDS, STIs, rape, nutrition, etc. List and discuss each of these factors. Highlight those factors that relate to sexual growth and development.

Once again, emphasize the focus of *Christian FLE Programme.*
5) **Summary/Wrap-Up**

Ask participants:

- to explain why Christian Family Life Education is important.
- if this workshop has inspired them to want to talk with their children about issues related to sexuality.
- to recall at least three external and internal factors which impact their lives.
- if they would like to learn more information about sexuality and about how to talk with others about sex and sexuality.
- Explain that parents have an important role to play in helping to shape their own children’s future, especially as it relates to growth, development and decision-making.
- Explain the importance of young people taking responsibility for their own choices.
- Encourage participants to attend other *Christian FLE* Programmes.
INTRODUCTION TO HUMAN SEXUALITY

“Search me, O God, and know my heart: try me, and know my thoughts.” Psalms 139:23

Purpose: To help participants understand the various components of sex, sexuality and the variations in sexual behaviours.

Objectives: Participants will appreciate the full meaning of sexuality.

Participants will know at least three sources of sexual learning that can impact them negatively or positively.

Participants will appreciate the importance of clarifying their own values about issues relating to sexuality.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Handouts: “Introduction to Human Sexuality” (around page 289)</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker: Questionnaire (15 min)</td>
<td>8 1/2” x 11” heavy stock paper (3 sheets in bright colours), markers, tape, flipchart, chalk</td>
</tr>
<tr>
<td>3. Discussion/Defining Terms (40 min)</td>
<td></td>
</tr>
<tr>
<td>4. Brainstorming/Discussion</td>
<td></td>
</tr>
<tr>
<td>5. Brainstorming/Card Exercise/ Discussion (30 min)</td>
<td></td>
</tr>
<tr>
<td>6. Summary/Wrap-up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

▷ Arrange the meeting room in a circle or semi-circle.

▷ Make enough copies of handouts for each participant on “Sex and Sexuality.”

▷ Have enough of the 8 1/2” x 11” heavy stock paper, pens (pencils) and markers for each participant.

▷ Write on three coloured sheets of paper, “OK for me,” “OK for others,” and “Not OK,” then hang each sheet on three separate walls in the meeting room.

▷ Write on two pieces of flipchart paper, both headed: “Sources of Sexual Learning,” one that says “50 Years Ago” and the other “Today.”

▷ Make sure you have extra flipchart paper to write on.

Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (Proverbs 3:6) or some other form inspirational meditation.

2) Introduction/Icebreaker. Select an icebreaking exercise that suits you from the resource section. Handout the “FLE Questionnaire.” Explain to participants that this is an anonymous questionnaire, not a test. Say, “This information will assist you in knowing how much information you will need to cover.” Allow 15 minutes.

3) Discussion/Defining Terms. Introduce the topic by asking participants to define sex and sexuality. List their responses and discuss. Explain that the term “sex” is used to
mean different things including; sexual intercourse, making love or male and female. However, sex really refers to one’s biology, whether we are male or female.

Facts:

Sexuality is a broad term that describes our full personhood that begins at birth and ends at death. It is a gift from God that is a natural and positive part of our lives and is unique and individual. Say, “Sexuality is constantly evolving as we grow and develop. It is the total expression of who we are as human beings. It includes the physical, emotional and spiritual part of our being and encompasses our personality, values, attitudes, gender, race, sexual orientation, etc.”

The methods which people use to express their sexuality are many, varied and shaped by many things: culture, tradition, society, religion, politics, beliefs, etc. Ask parents why the term “sex” makes some people feel uneasy. List responses and discuss.

Gender refers to the psychosocial and cultural aspects of maleness and femaleness.

Gender roles are the set of rules/scripts laid down by society. These rules are established at birth, as soon as it is announced “It’s a Boy” or “It’s a Girl.” For example, we assign certain colours and toys to boys and to girls. Ask parents what these things denote; e.g., the colour blue is thought to mean masculine, strong while the colour pink is associated with feminine, soft. Guns are for boys and dolls are for girls. Ask participants, “What other things are girls and boys taught concerning their genders?”
Gender identity is the personal or private conviction each of us has about being a man or being a woman. For example, no two men feel exactly the same about being a man and no two women feel exactly the same about being a woman. Gender identity is at the core of how we feel about who we are.

Sexual (gender) orientation refers to a preference for sharing emotional and sexual expressions with members of the opposite (heterosexual) sex, same sex (homosexual) or both sexes (bisexual).

Sexism is the confusion between biology and culture; e.g., some men are socialized to believe that women are inferior to them. In some places, men are given more opportunities to develop themselves academically and are put into positions of leadership. It should be understood that gender roles are largely influenced by the culture, not biology.

4) **Brainstorming/Discussion.** Put up the two sheets listed “Sources of Sexual Learning” and ask participants to think of some of the sources of sexual learning 50 years ago. List their responses and discuss. Now, ask them to think of some of the sources of sexual learning today. List responses, have them compare the list and discuss. Ask participants to discuss how these changes have positively or negatively impacted young people today.

**Remember!** to mention school curriculum as a possible source of sexual learning and to address any misconceptions about the *Christian Family Life Education* Programme.

5) **Brainstorming/Card Exercise/Discussion.** Explain that the purpose of this exercise is to explore some of the wide range of sexual behaviours and to examine our own values and attitudes about these behaviours. Get two volunteers to record
each behaviour on an 8”X11” paper while you record the same responses on flipchart paper.

Ask participants to think of all of the sexual behaviours they can, both acceptable and unacceptable. List them and discuss. You may want to add a few on the list that are less common in their environments (see Resource Section: Sex and Sexuality: Defining Terms.) Make sure the list is long enough so that everyone can get at least one sexual behaviour sheet of paper.

**Card Exercise:**
Mix the sheets up and distribute them randomly to each parent. (Each participant should have at least one sheet. Two per participant is ideal.) Tell participants to think about how they feel about the behaviour recorded on the sheet of paper they have been given and decide if that behaviour is okay for them personally, okay for others but not okay for them personally or not okay at all, not for anyone. After they have decided, give all participants a piece of tape and have them tape their paper on the wall underneath the appropriate label they have chosen. When they are done, they should stand back and examine the sheets on the wall, to see if they agree or disagree with how others have labelled other behaviours. Discuss. If group is small, you may remain standing for the discussion. If the group is large, have participants return to their seats and discuss.

Ask participants to share their reactions to how others have rated different behaviours.

Specific questions could include:

⇒ “Are you surprised by any of the categories chosen?”

⇒ “How would it feel to be given these as a list of what is right or wrong?”
“How would you feel if you did one of the things on the ‘not okay’ wall?”

“How did the body language and reactions of others affect your choices?”

6) **Summary/Wrap-Up**

- Review the topics you covered. Ask participant to define sex and sexuality?

- Ask participants to identify three sources of sexual learning which can have a positive/negative impact on young people and why

- Ask if talking to others about sexuality issues in an open forum has helped them to feel more comfortable.

- Say that it is important for parents to know how sources of sexual learning can impact what our children believe about themselves and others. One of the many advantages in talking to our children about sex is that we can share our values along with the facts.

- Ask participants if this experience has helped them clarify their own values about sexual behaviours.

- Encourage participants to attend other *Christian FLE* Programmes.
PSYCHOSOCIAL/SEXUAL DEVELOPMENT AND THE LIFE CYCLE

“Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God’s will is – his good, pleasing and perfect will. Romans 12:2

Purpose: To help participants understand the psychosocial/sexual development process and identify emotional, physical aspects of sexual development throughout the life cycle.

Objectives: Participants will appreciate the eight stages of our psychosocial/sexual development.

Participants will be able to identify some of the emotional and physical aspects of sexual development throughout the life cycle.

Participants will understand sexual development throughout the life cycle.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Handout: “Psychosocial Development” (around page 288)</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker: “Shoe Race” (10 min)</td>
<td>“Life Cycle” materials (around page 300)</td>
</tr>
<tr>
<td>3. Psychosocial Development (15 min)</td>
<td>Transparencies: Life Cycle</td>
</tr>
<tr>
<td>4. Life Cycle Exercise (20 min)</td>
<td>overhead projector, big box, markers, flipchart</td>
</tr>
<tr>
<td>5. Group Presentations/ Discussion (45 min)</td>
<td></td>
</tr>
<tr>
<td>6. Summary/Wrap-up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

▷ Have a box or sack large enough to hold everyone’s shoes.

▷ Arrange meeting room in a semi-circle.

▷ Prepare overhead transparencies on Psychosocial and Sexual Development.

▷ Review all materials on psychosocial/sexual development and the life cycle.

▷ Review the Human Sexual Response Cycle.

▷ Prepare five sheets of flipchart paper. Draw a line down the middle of the paper. Label one side “Physical” and the other “Emotional.” At the top of each sheet put the appropriate age range beginning with: “Birth to 3 years,” “4 to 12 years,” “13 to 20 years,” “21 to 50 years,” and “51 years to death.”

Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (Proverbs 22:6) or some other form of inspirational meditation.

2) Introduction/Icebreaker: Shoe Race. Have everyone get into two groups. Explain the object of this game is to see which team can get all of their shoes on first. Instruct all participants to take off their shoes and place them in a sack, box or some other type of bag large enough to hold everyone’s shoes. Afterwards, allow five minutes for both groups to find their shoes and put them on. (Shoelaces do not have to be tied, as long as the shoes are on the right foot.) See which group wins. Have fun!
3) **Psychosocial Development.** Using an overhead projector (if one is available) introduce Erik Erikson’s 8 stages of Psychosocial Development. Review each stage: infancy, toddler, early childhood, childhood, adolescence, young adulthood, middle age and old age. Talk about the sexual development at each stage; e.g., erections and genital exploration during infancy stage, etc. Summarize by saying that our psychological development is closely linked to how we develop sexually. The process of psychosexual development continues throughout our lifetime. Allow 15 minutes for this discussion.

4) **Life Cycle Exercise.** Explain that the life cycle refers to the multitude of physical and emotional changes we experience throughout life. Break participants up into five small groups. Give each group a sheet of prepared chart paper listing an age range. Explain that this exercise is participatory and draws from participants’ wealth of knowledge about anatomy, physiology and life experiences. Instruct each group to list all the physical and emotional changes that occur in that age category. Each group should choose a recorder and someone to report back to the larger group. Allow 20 minutes for small group work.

5) **Group Presentations.** Beginning with the first age range (birth to 3 years, 4 to 12 years, etc.) have each group report their findings to the larger group. Allow each reporter approximately seven minutes to report group findings. If time permits, allow for comments and questions from the larger group. Allow about 40-45 minutes for all presentations.

Remember!!! People tend to overlook sexual development after puberty. Be sure to include important points which may have been missed in the presentations; e.g., hormonal impact on genital growth and functions, libido (sex drive), vaginal lubrication, menopause, male climacteric, etc. Explain that our bodies are constantly changing and that our need for love and affection continues long after we reach old age.
6) **Summary/Wrap-Up**

**Ask participants:**

- ☐ if the Life Cycle exercise refreshed their own memories about growing up.

- ☐ if the information presented helped to enhance their own knowledge about growth and development.

- ☐ to identify at least three emotional and physical areas within the Life Cycle where we develop psychosexually.

- ☐ how they intend to use this information.

- ☐ to identify at least three aspects of the life cycle that they would like to begin talking to their children about.

- ☐ encourage participants to attend other *Christian FLE* Programmes.
"My son, pay attention to what I say; listen closely to my words. Do not let them out of your sight, keep them within your heart; for they are life to those who find them and health to a man’s whole body.” Proverbs 4:20-22

Purpose: To help participants understand the adolescent period of physical and psychological development between puberty and maturity.

Objectives: Participants will be able to define puberty, early, middle and late adolescence.

Participants will be able to explain at least three physical and emotional changes that occur during adolescence.

Participants will be able to define sexual maturity and at least three important factors to consider when forming a long-term relationship.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Handouts: Adolescent Development drawings (starting around page 313); and “Things We Have in Common” (around page 243)</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker: (20 min)</td>
<td></td>
</tr>
<tr>
<td>3. Defining Terms/Discussion (15 min)</td>
<td></td>
</tr>
<tr>
<td>4. Early, Middle and Late Adolescence (30 min)</td>
<td>Men/Boys, Women/Girls Relationship Game Cards video/VCR/TV, index cards, pens</td>
</tr>
<tr>
<td>5. Relationship Card Game (60 min)</td>
<td></td>
</tr>
<tr>
<td>6. Video/Discussion (30 min)</td>
<td></td>
</tr>
<tr>
<td>7. Summary/Wrap-up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

➔ Have enough flipchart paper and markers.

➔ Make enough handouts for everyone on: “When I Was 11!” and “When I Was 18!”

➔ Have enough copies of “Things We Have in Common” Ice-breaker Activity.

➔ Have enough pens/pencils and index cards for each participant.

➔ In bold letters, write the following words on index cards (make three sets) or you can make up your own words to be used in the Relationship Game Card Exercise: “Being Faithful,” “Money,” “Good Looks,” “Sex,” “Honesty,” “Communication,” “Respect,” “Trust,” “Love,” “Freedom.”

➔ Have an appropriate video already set up for viewing.

➔ Have enough handouts on “Adolescent Development” and drawings of the Male and Female to hand out to participants.
Facilitator’s Notes:

1) **Devotion.** Have a prayer song, reading (James 4:7) or some other form of inspiration meditation.

2) **Introduction/Icebreaker:** After your introduction, give out index cards to all participants and encourage them to write down any questions related to the topic they wish to have answered. This helps the facilitator know what issues and concerns the group may have. It also allows shy participants an opportunity to ask questions anonymously. During the Ice-breaker Exercise, be sure to review the cards and try to address the questions during the session.

Distribute a sheet of the “Things We Have in Common” to each person. Explain the object of this exercise is to see how many things people have in common with other members in the group. Ask the group to mingle with each other using the sheets and get signatures from the persons with whom they have things in common. Allow 15 to 20 minutes for this exercise. Afterwards, ask participants to return to their seats and tell what things they learned about others.

3) **Defining Terms/Discussion.** Ask participants to define puberty and adolescence. Record responses on flipchart paper and discuss.

**Puberty** is the stage of human physical development in which individuals can reproduce.

**Adolescence** is the period of physical and emotional change between puberty and adulthood.
Ask the group to brainstorm some of the different physical and emotional changes that occur during puberty. List on flipchart paper and discuss.

Ask if physical maturity means that a person is emotionally mature. If not, why? If so, why? List responses and discuss. Be sure to point out that just because people are able to physically reproduce does not mean that they are sexually mature. For example, ask “Although a 12-year-old girl has reached puberty and can become pregnant, does this mean that she is ready to become a parent?” Ask the group to define sexual maturity and discuss. Be sure to emphasize that being sexually mature includes accepting and handling responsibilities.

4) **Early, middle, late adolescence.** Explain that too often the information we learn in school about our bodies is scientific and doesn’t include our feelings. This gives the impression that our genitals function independently from the rest of us. Our genitals don’t have a mysterious life of their own. Making the link between our bodies, sexual health care, relationships and our feelings is really important. Having an understanding about our bodies assists us in understanding ourselves as whole persons.

An understanding of contraception, safer sex and sexual health are not possible without this information. If young people are to have some control over their sexuality, it is vital that they understand the functions of their bodies. Lack of information can lead to fear and this can stop people from feeling good about themselves. Having information will enable them to make better decisions.

Give participants handouts on “When I Was 11!” and “When I Was 18!” Have them fill them out. Allow 10 minutes for this. Then ask:
How did you feel about…
- yourself
- your body
- menstruation/wet dreams
- sexual relationships
- males/females
- moving into adulthood
- being responsible
- other …

Early Adolescence (11-14 years)
- puberty, rapid physical changes
- concerns about body image
- mood swings
- conflict with parents
- early independence and “testing”
- lowered self-confidence
- same sex relationships
- “crushes”
- menarche (first period) can begin as early as 8.5 years
- spermarche (beginning of sperm production) can begin as early as 13.8 years

Middle Adolescence (15 – 17 years)
- abstract thinking begins to develop
- rites of passage; e.g., circumcision, voting, etc.
- sexual attraction to others
- attachment to peers
- moral or reasoning begins to develop
- experimentation and “testing out”
- sexual relationships
Late Adolescence (18 – 20 years)
- relationships based on own values
- clearer perception of desirable body image
- clearer establishment of sexual, political, moral and vocational identity
- interdependence from parents
- increased self-esteem and confidence with greater independence

5) **Relationship Card Game.** Begin by asking the group “Do men and women have different expectations about relationships?” If so, why? List and discuss responses.

Ask the group to define a “long-term relationship.” List responses on flipchart paper and discuss. Allow about five minutes for this. Afterwards, divide the group into three smaller groups. If possible, form a female group, a male group and a mixed group. Give each group a set of the duplicated cards that read, “Money,” “Honesty,” “Sex”, etc. Ask each group to arrange the cards in order of priority beginning with the most important quality in a “lasting relationship” to the least important. Once the cards have been arranged ask each group to move their cards to a central position so that everyone can view the cards. Facilitate a discussion around the card sequences. Ask:

- Was it difficult to get a group consensus? Why?
- Do men and women view relationships differently? If so, how?
- How does a person affect how she/he views relationships?
- If the sex card is removed, what role do the remaining qualities play in the development and maintenance of a successful relationship?
- Who in the relationship needs to possess these qualities?
- Would it be different for a casual relationship?
- If the communication card is removed, what is the impact on the relationship?
Ask: How long does it takes to establish a long-term relationship? At what age is it better to consider forming a long-term relationship? Do young people who engage in serial monogamy (multiple sexual partners) really understand what it means to be in a long-term relationship? If not, why? If so, why?

6) **Video/Discussion.** Show a relevant video that illustrates how people value relationships and discuss.

7) **Summary/Wrap-Up**

**Ask participants to:**

- define puberty, adolescence and name three physical and emotional changes that occur during early, middle, and late adolescence.

- explain the difference between physical and emotional maturity.

- explain the important factors to consider in forming long-term relationships.

- encourage participants to attend other *Christian FLE* Programmes.
“But my God shall supply all your need according to his riches in glory by Christ Jesus.” Philippians 4:19

**Purpose:** To help participants understand the relationship of population education and health.

**Objectives:** To help participants recognize at least three aspects of population education and three factors affecting health.

To help participants identify at least two ways they can help to reduce problems related to population and improve health.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>TV/VCR/Video, flipchart,</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker:</td>
<td>Markers, pens, pencils, tape</td>
</tr>
<tr>
<td>Selective Listening (10 min)</td>
<td></td>
</tr>
<tr>
<td>3. Population &amp; Health</td>
<td></td>
</tr>
<tr>
<td>Brainstorming (20 min)</td>
<td></td>
</tr>
<tr>
<td>4. Video/Discussion (60 min)</td>
<td></td>
</tr>
<tr>
<td>5. Summary/Wrap-up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

✧ Have at least six markers (one for yourself and five for group leaders.)

✧ Prepare the following headings on flipchart paper:
  “Definition of population” “What are growth rates?”
  “What does dependency ratio mean?”
  “What are birth/death rates?” “Life expectancy”

✧ Have ready the Icebreaker exercise: “I Heard It Through The Grapevine.”

✧ Set up the video in the VCR

Facilitator’s Notes

1) Devotion. Have a prayer, song, reading (John 1:1-3) or some other form of inspirational meditation.

2) Introduction/Icebreaker: Selective Listening Explain that messages sometimes change as they are passed on from one person to another. People have a tendency to hear what they want to hear. Begin this exercise by telling the participants you are going to whisper a message in the ear of a person; e.g., “Parents are the primary sex educators of their children” and that person will pass along the message to the next person until it reaches the person on the end. When the last person has received the message, ask him/her to repeat the message out loud for everyone to hear. Determine if anything was lost in the transmission process. If so, ask what others heard. Ask parents to think about other situations where a message got changed and some of the reasons why things get added or deleted. Explain the importance of active listening. If time permits, send another message to see if it changes.
3) **Population & Health/Brainstorming.** Break the group into five small groups. Give each group a marker and the prepared flipchart paper listing the questions on population. Have each group fill in as many responses as they can and have them select someone from their group to report their findings to the larger group. Allow 10 minutes for this exercise. Beginning with, “Definition of Population,” have each group present their findings. Be sure to add on information that may not get covered. If time permits, go over some of the other terminology related to population issues.

**Facts:**

| **Birth rate** is the number of live births per 1,000 in a given year. |
| **Death rate** is the number of deaths per 1,000 in a given year. |
| **Demography** is the scientific study of human populations including their size, composition, distribution, density, growth, socio-economic characteristics and the causes and consequences of changes in these factors. |
| **Demographic transition** is described as the period during which a society goes from high fertility and mortality to low fertility and mortality. |
| **Dependency ratio** is the number of people in a population (under 15 years and over 64 years) who are economically dependent on the working or productive part of the population for its survival. |
| **Ethnicity** is the classification of people on the basis of cultural characteristics such as language, race, nationality, etc. |
**Fecundity** is the physiological capacity of a woman or a man to produce a live child.

**Fertility** is the actual reproductive performance of an individual, couple, a group or population.

**Growth rate** is the rate at which populations increase or decrease in a given year, taking into account births, deaths and migration.

**Infant mortality** is the mortality of live-born infants who have not reached their first birthday, divided by the number of live births in the period and usually expressed per one thousand.

**Life expectancy** is the average number of additional years a person of a given age can expect to live, if current mortality trends were to continue.

**Morbidity** is the state of illness and disease in a population.

**Mortality** is deaths as a component of population change.

**Natality** is births as a component of population change.

**Parity** is the number of children previously born alive to a woman. For example, “two-parity” women are women who have had two children at present while “zero-parity” women have had no live births up to now.

**Population** is the total number of people inhabiting a specific area.

**Population density** is the population per unit of land area; e.g., the number of persons per square mile.
**Population momentum** is the tendency for a population to keep growing even if fertility declines because of the large group of people able to bear children.

**Population policy** is the set of explicit or implicit measures instituted by a government to influence the size, growth, distribution or composition of a population.

**Pregnancy rate** is the number of pregnancies per 1,000 women of reproductive age (about 15-44).

**Race** is the classification of a population on the basis of physical characteristics such as skin colour or facial features. Census data often mix ethnic groups and races together under the general category of “race.”

**Sex ratio** is the number of males per 100 females in a population.

**Types of populations** may include rural, urban, sedentary, migrant, nomadic, squatters, etc.

**Zero population growth** is a population in equilibrium with a growth rate of zero, achieved when the combination of births and immigration equals the combination of deaths and emigration.

Ask participants to think about some of the factors affecting population growth rates; e.g., AIDS, unplanned pregnancies, drugs, incest, rape, lack of knowledge, war, etc. List responses and discuss.
Ask participants to think about factors that affect health in their country; e.g., family size, environment, poverty, poor health, unemployment, politics, gender inequities, etc. Again, list responses and discuss.

4) **Video on Population Issues.** Show a relevant video on population and discuss. Ask participants to think of how each person can help to reduce problems that relate to population growth in their country. List each idea and discuss.

Ask if the following issues are important? If so, why? If not, why?

- Planning a family.
- Premarital education.
- Parent/child communication about sexual health.

5) **Summary/Wrap-Up**

**Ask participants to:**

- identify at least three factors affecting population growth in their country and how they can help reduce problems related to poor health.

- define dependency ratio, growth rates, birth and death rates.

- identify at least two topics related to population education that they believe are important to discuss with others.

- encourage participants to attend other *Christian FLE* Programmes.
“He created them male and female and blessed them. And when they were created, he called them "man."” Genesis 5:2

Purpose: To help participants better understand the functions of the male and female reproductive system.

Objectives: Participants will be familiar with the biological names of reproductive organs and how they function.

Participants will be able to explain menstruation, wet dreams (nocturnal emissions), puberty, menstruation, hormones, menopause and male climacteric.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Handouts: “Myth/Fact” sheets (around page 249);</td>
</tr>
<tr>
<td>Myth/Fact (20 min)</td>
<td>TV/VCR/video, flipchart markers, pens, index cards</td>
</tr>
<tr>
<td>3. Defining Terms/Discussion (10 min)</td>
<td></td>
</tr>
<tr>
<td>4. Group Exercise/Discussions (45 min)</td>
<td></td>
</tr>
<tr>
<td>5. Video/Discussion/Questions (45 min)</td>
<td></td>
</tr>
<tr>
<td>6. Summary/Wrap-up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

- Have a video on the reproductive systems of male/females.

- Create about 50 common myths and facts in your community or country related to reproduction. Record them on index cards. For example, “If a girl has sexual intercourse standing up, she won’t get pregnant,” etc. (See Resource Materials section for other myths).

- Write on flipchart papers the following headings: “What is Anatomy?” “What is Physiology?” “What is Reproduction?”

- Have a drawing of the male and female reproductive systems. You can copy the drawings in Section 4 (around pages 348-368) or have someone draw them for you. Draw an arrow pointing to each organ but leave out the names. Have enough Reproductive System Handouts and markers for each participant.

Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (Psalms 119:105) or some other form of inspirational meditation.

2) Introduction/Icebreaker. Introduce the “Myth and Fact Game.” Distribute the Myth/Fact Cards to each participant. Have each participant read his/her card out loud and tell the group if the statement is true or false and why. As a facilitator, be prepared, know the facts and be able to explain why.
**Myths** are opinions, beliefs or fantasies that have no basis in fact. Myths are universal and they vary from country to country.

**Facts** are known truths, events that have actually occurred, things that are real and actual.

Young people tend to discuss reproductive issues with their peers. Much of the information they get is inaccurate. With high rates of sexually transmitted infections, HIV/AIDS and unplanned pregnancies increasing every year amongst adolescents, young people need to understand the facts about reproduction.

3) **Defining Terms/Discussion.** Using the prepared flipchart paper. Ask participants to define “anatomy,” “physiology” and “reproduction.” List responses and discuss.

<table>
<thead>
<tr>
<th>Anatomy</th>
<th>is the study of body parts.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiology</td>
<td>is the study of how those parts function.</td>
</tr>
<tr>
<td>Reproduction</td>
<td>refers to recreation, replicating or producing again.</td>
</tr>
</tbody>
</table>

4) **Group Exercise.** Put up the drawings of both the male and female reproductive systems. Break the group into five small groups. Give each group an opportunity to identify at least five parts of the male and female anatomy and to explain their physiological functions. Allow each group 10 minutes and have someone in the group report back findings to the larger group. Allow each group approximately three to five minutes to report. See which group knows the most.

After each group has reported, ask the larger group if the information is accurate or complete. Be sure to correct and explain the facts clearly. Offer parents simple explanations for the following:
Hormones are the substances produced in the body that are transmitted through the blood and influenced by chemical messengers. Primary sex hormones controlling secondary sex characteristics are estrogens and progesterone (which are produced in the ovaries) and testosterone (which is produced in the testicles).

Preadolescence is the period between eight and 12 years, frequently overlooked but very important. Young people begin to change physically, (some girls begin to menstruate as young as eight years) and their social development is likely to be rapid.

Puberty is the phase of adolescence during which boys and girls develop the physical and sexual characteristics of adults.

Menstruation is a process occurring at approximately 28-day intervals in women, beginning at puberty and lasting through middle age, in which blood and tissue are discharged from the uterus out through the vagina if fertilization has not taken place.

Wet dream (nocturnal emission) is the emission of semen from the penis that occurs when the boy or man is asleep.

Menopause is the cessation (stopping) of the menstrual cycle, occurring approximately 45 to 55 years in a woman.

Male climacteric is the period between 35 years and older when men’s bodies produce less of the hormone testosterone.
5) **Show a relevant video.** Discuss the video. Ask participants if the video helped to clarify their understanding of what was covered in the earlier part of the workshop. Ask if there are any questions and answer them.

**Remember:**
If you don’t know the answer to a question, don’t hesitate to say so. You can respond by saying, “That’s a good question but I don’t have the answer.”

Suggest another source; e.g., a health professional, nurse, doctor or, if you will be meeting with the group again, try to get the answer before the next workshop.

6) **Summary/Wrap-Up**

**Ask participants to:**

- explain at least two important functions that estrogens and progesterone serve in women.
- explain at least two functions of the testicles and ovaries.
- explain the process of menstruation.
- encourage participants to attend other *Christian FLE* Programmes.
FAMILY PLANNING AND CONTRACEPTION

“Suppose one of you wants to build a tower. Will he not first sit down and estimate the cost to see if he has enough money to complete it?” Mark 8:36

Purpose: To increase participants’ knowledge about family planning methods (contraception) and responsible sexual behaviour.

Objectives: Participants will be able to explain at least five family planning methods (contraception), how they work, their advantages, disadvantages and where to go for more information.

Participants will appreciate how prevalent attitudes and values put young people at risk for premarital pregnancy, STIs and AIDS.

Participants will better understand the importance of becoming parents by choice and not by chance.

Participants will better understand the value of responsible sexual behaviour and the consequences associated with poor choices.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Handouts: “Condom Sense” (around page 280)</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker: “Charade”</td>
<td>Samples of contraceptives</td>
</tr>
<tr>
<td>(15 min)</td>
<td>TV/VCR/video, flipchart markers, pens, index cards</td>
</tr>
<tr>
<td>3. Defining Terms/Discussion (45 min)</td>
<td></td>
</tr>
<tr>
<td>4. Contraceptive/Presentation/</td>
<td></td>
</tr>
<tr>
<td>Exercise (40 min)</td>
<td></td>
</tr>
<tr>
<td>5. Video/Discussion/Questions</td>
<td></td>
</tr>
<tr>
<td>(30 min)</td>
<td></td>
</tr>
<tr>
<td>6. Summary/Wrap-up (15 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

- Invite a guest speaker from a local family planning or health clinic to talk about family planning and contraception. The guest speaker may have his/her own exercise/activity for this session so be prepared to compromise your icebreaker exercise before the workshop begins.

- Have samples of contraceptives on hand or ask the guest speaker to bring some. Have enough handouts on “Condom Sense” (around page 280).

- Have a video on contraceptive methods and handouts for each participant.

- Prepare flipchart paper with the following headings: “What is family planning?” “What is contraception?” “Important Considerations?” “Traditional Methods” “Natural Methods” “Modern Methods” “Permanent Methods.”

- Print (in capital letters) each of these words on five index-cards: “Unhappy,” “Sick,” “Confused,” “Lonely” and “Worried.”

Facilitator’s Notes:

1) **Devotion.** Have a prayer, sing a song, reading (John 3:16) or some other form of inspirational meditation.

2) **Introduction/Icebreaker.** Introduce “Charade.” Explain that “Charade” is a game in which each word or phrase is acted out non-verbally by someone playing the game while others try to guess the word or phrase. Whoever guesses the word/phrase wins. Ask for five volunteers to come up and give each of them your prepared index cards. Allow each of the five volunteers approximately three minutes to act out the word.
See who from the larger group guesses correctly.

3) **Definition/Discussion.** Put up your prepared chart paper with the questions: “What is Family Planning?” “What is Contraception?” Ask participants to define family planning and contraception. List their responses and discuss.

**Facts:**

**Contraception** relates to the methods that prevent conception/pregnancy.

**Family planning,** in a broader context, not only considers the method of contraception but also the factors that impact on family life; e.g., number of siblings, mother, father, health, extended family needs, economics, employment, environment, age, education, etc.

Explain that “parenthood is a challenging role, carrying complex and lifelong responsibilities; a role that should not be taken lightly or without careful consideration.”

**Ask participants to think of other important considerations like:**

- When is the best time for a couple to start a family?
- How many children should they have?
- How much does it cost to raise a child?
- What is a good environment for a family to live in?
Discuss:

...Traditional practices vs. today’s practices that govern childbearing. What are the advantages and disadvantages?

...What impact does family size have on society?

...Should both men and women share in the responsibility of family planning?

...Which parent determines the sex of a child?

...Some of the cultural and religious attitudes towards having children.

...Is there a preference for having boys over girls?

...Are there preferences for having a particular number of children?

...How are women and men who cannot have children thought of in your culture?

…How do you feel about raising a child that is not biologically yours?

…What are the advantages and disadvantages of legal adoption?

4) **Contraceptives/Presentation/Exercise.** Explain that since time began, people have used different methods to plan their families. Put up the four prepared chart papers headed: “Traditional Methods” “Natural Methods” “Modern Methods” and “Permanent Methods.”
Break the group into five small groups. Give each group a sheet of chart paper and have them list at least two methods for each category; e.g., under “Traditional Method” – abstinence, etc. Have each group select someone to report their findings. Allow 10 minutes for group discussion. Give each reporter three to five minutes to report group findings.

**Introduce Guest Speaker.** Give a brief background of the speaker. Have the guest speaker share other relevant information about him/herself. Have him/her present on methods of contraception including showing samples of contraceptives to participants.

**Make sure that the guest speaker covers:**

- types of methods
- how they work
- advantages/disadvantages
- effectiveness
- cost
- availability
- questions/concerns. etc.
- attitudes towards contraception
- myths about contraception

**Note:** Eighty-five percent of women who use no contraceptives during vaginal intercourse become pregnant each year. The only guarantee against pregnancy is not having vaginal intercourse. Using a contraceptive method greatly reduces the risk of pregnancy during vaginal intercourse.
### Natural/Fertility

#### Awareness Methods
- Abstinence
- Ovulation/Rhythm/Calendar
- Basal Body Temperature
- Withdrawal
- Lactational Amenorrhoea
- Billing’s Method/Cervical Mucous
- Post Ovulation

#### Traditional Methods
- Withdrawal
- Bush Medicine/Herbs
- Abstinence (after childbirth)

### "Modern" Methods
- Oral Contraceptives
- Emergency Contraception
- Injectables
- IUDs (Intrauterine Devices)
- Diaphragm
- Condom (male and female)
- Spermicides
- Norplant Implants
- Cervical Caps
- Foams, Creams, Jellies
- Suppository Capsules

#### Permanent Methods
- Tubal Ligation
- Vasectomy

5) **Show a video.** Show a video on family planning/contraception and discuss. Ask participants if the video helped to answer questions that they might have had. List and discuss.
6) **Summary/Wrap-Up**

**Ask participants to:**

- Explain the difference between family planning and contraception.

- Identify at least three factors that impact family planning practices today.

- Think about what other information they would like to have about family planning and contraceptive methods.

- Describe five types of contraceptives, their advantages and disadvantages and how they work.

- Encourage participants to attend other *Christian FLE* Programmes.
PRE-MARITAL EDUCATION

“For this reason a man will leave his father and mother and be united to his wife, and they two will become one flesh.” Ephesians 5:31

Purpose: To help participants appreciate important factors to consider before marriage.

Objectives: Participants will be able to identify at least three important factors to consider before choosing a marriage partner.

Participants will be able to identify at least three consequences of a poorly planned marriage.

Participants will be able to understand the importance of premarital education and its relationship to regulating family size, preventing domestic violence, planning pregnancy, alcohol/drug abuse, early marriage, HIV/AIDS and poverty.

Participants will appreciate the importance of premarital education for their own children.
## Workshop Steps/Time

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>TV/VCR/video, flipchart,</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker:</td>
<td>markers, pens, pencils, index</td>
</tr>
<tr>
<td>“About Me” (15 min)</td>
<td>cards, tape</td>
</tr>
<tr>
<td>3. Premarital Education/</td>
<td></td>
</tr>
<tr>
<td>Discussion (15 min)</td>
<td></td>
</tr>
<tr>
<td>4. Tradition Vs Modern/</td>
<td></td>
</tr>
<tr>
<td>Discussion (45 min)</td>
<td></td>
</tr>
<tr>
<td>5) Group Exercise (60 min)</td>
<td></td>
</tr>
<tr>
<td>6. Video/Discussion/Questions</td>
<td></td>
</tr>
<tr>
<td>(30 min)</td>
<td></td>
</tr>
<tr>
<td>7. Summary/Wrap-up (15 min)</td>
<td></td>
</tr>
</tbody>
</table>

## Advance Preparation:

- Set up a relevant video in the VCR before the workshop begins.

- Write on separate pieces of flipchart paper the following headings: “Important Considerations when Choosing a Marriage Partner?” “Factors Influencing Choice of Partner?” “Important Considerations in Deciding When to Get Married?” “Types of Marriages?” “Consequences of a Poorly Planned Marriage?” “Ingredients of a Successful Marriage?”

- Have plenty of flipchart paper and markers for group exercises.

- Have enough index cards and pens/pencils for each participant.
Facilitator’s Notes:

1) **Devotion.** Have a prayer, song, reading (Proverbs 22:12) or some other form of inspirational meditation.

2) **Introduction/Icebreaker: About Me.** Have participants choose an object from their pockets, wallets, etc. Have them tell the group what that object says about them; e.g., a brush, money, pictures, a cross, a bible, etc. Be sure that you also participate in this exercise.

3) **Premarital Education/Discussion.** Ask participants to brainstorm their own definition of what premarital education is. List and discuss. Here is a working definition.

**Premarital education** is the process of educating young people about important factors to consider before marriage and to make them aware of the obligations and responsibilities that go along with marriage.

Ask participants to think of some of the advantages and disadvantages of being married. List them on flipchart paper and discuss.

Ask participants, “What is a good age to get married and why?” List and discuss.

Ask participants to discuss some of the reasons people get married.
4) **Common Law vs. Legal Marriages.** Draw a line down a piece of flipchart paper and head one column “Common Law” and “Legal.” Ask participants to define Common Law and Legal and give examples of both types of marriage. Ask participants to discuss what things are similar and what things are different.

Ask participants to think about factors that impact how people get married in today’s culture compared to 50 years ago; e.g., assimilation, popular culture, foreign influences, politics, etc. List responses on flipchart and discuss.

**Important Points!**

| Personal characteristics and other considerations in choosing partners: |
|---|---|---|
| age | education | religion |
| health | personality | economic standing |
| occupation | physical appearance | ethnicity |
| geography | environment | caring/loving |
| intelligence | kindness | responsible |
| honesty | trustworthy | faithful |
| strong | dependable | family background |

| Factors influencing choice of partner: |
|---|---|---|
| parents | compatibility | extended family |
| elders | religion | friends |
| economics | loneliness | politics |
| looks | occupation | culture |
| society | politics | war |
| environment | education | race/ethnicity |
| language | health | status |
| age | matrilineal | patrilineal |
| fertility/parenthood | endogamy | pre-nuptial agreement |
### Important considerations in deciding when to get married:

<table>
<thead>
<tr>
<th>Age</th>
<th>Economics</th>
<th>Compatibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>Health</td>
<td>Shelter (housing)</td>
</tr>
<tr>
<td>Religion</td>
<td>Maturity</td>
<td>Unselfishness</td>
</tr>
<tr>
<td>Child spacing</td>
<td>Family planning</td>
<td>Number of children</td>
</tr>
<tr>
<td>Premarital counselling</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Types of marriages/ceremonies:

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Common-law</th>
<th>Civil</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal</td>
<td>Modern</td>
<td>Same sex</td>
</tr>
<tr>
<td>Religious</td>
<td>Other…</td>
<td></td>
</tr>
</tbody>
</table>

Ask participants to discuss the meaning of early marriage. List and discuss advantages and disadvantages of early marriage.

Ask participants to discuss what role expectations in marriage they have for themselves and their partner. List and discuss.

Discuss measures to encourage marriage at an appropriate age; e.g., laws raising age of marriage, increasing Family Life Education and employment opportunities, etc.

Discuss some of the short-term and long-term consequences of early marriage for both girls and boys.

### Factors affecting family welfare:

<table>
<thead>
<tr>
<th>Living environment</th>
<th>Employment</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infidelity</td>
<td>Traditions</td>
<td>Gender equity</td>
</tr>
<tr>
<td>Education</td>
<td>Media</td>
<td>Religion</td>
</tr>
<tr>
<td>Fertility</td>
<td>Migration</td>
<td>Economics</td>
</tr>
<tr>
<td>HIV/AIDS, STIs</td>
<td>Compatibility</td>
<td>Culture</td>
</tr>
<tr>
<td>In-laws</td>
<td>Social/relationships</td>
<td>Politics</td>
</tr>
<tr>
<td>Violence</td>
<td>Gambling</td>
<td>Pornography</td>
</tr>
<tr>
<td>Substance abuse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Emotional and physical needs of children:
love  patience  spiritual guidance
food stability motivation
understanding shelter discipline
good health care recreation education
sensitivity clothing positive role models
positive reinforcement quality time spent etc...

5) **Break the group into small groups of six.** Give each group a piece of the prepared chart paper headed:

- Important Considerations When Choosing a Marriage Partner?
- Factors Influencing Choice of Partner?
- Important Considerations in Deciding When to Get Married?
- Types of Marriages?
- Consequences of a Poorly Planned Marriage?
- Ingredients of a Successful Marriage?

Allow each group 20 minutes to discuss and list their responses. Have them select someone from their group to report their findings. Allow each reporter approximately five minutes to report. See if the group agrees with each other’s findings. If time permits, allow the larger group to ask questions or add on the list.

Ask participants to think about when premarital education should begin. Who should provide premarital education and why? List and discuss responses.

Ask participants to recall what type of premarital information, if any, they received.
Should premarital education include sex education? If so why? If not, why?

Ask participants if the religious community should be involved. If so, how? If not, why?

6) **Video/Discussion.** Show a relevant video depicting HIV/AIDS, domestic violence, out of wedlock pregnancy, alcoholism and drug abuse or a family unable to properly feed, educate or provide clothing for their children.

Ask participants to identify possible causes for these problems. Could these problems be avoided if they planned properly for marriage? If so how? If not why?

Ask participants what is meant by over population. Does the term “over population” mean:

- ... there is not enough land for people to live on?
- ... too many mouths to feed and not enough resources to go around?
- ... the quality of life is below standards? Etc...

List and discuss participants’ responses on chart paper.

**Over population** generally refers to a situation in which a country’s population exceeds that country’s ability to provide each individual with the proper resources needed to have a productive and healthy quality of life/lifestyle. This includes good nutrition, shelter, clothing, health care, education, jobs, etc...
**Note:** If a video is not available, have participants role play different situations demonstrating some of the possible consequences that can arise from not planning properly for a marriage.

Role-play skits can illustrate consequences of a poorly planned marriage; e.g., alcohol and substance abuse, wife battering and other forms of violence in the home, poverty, lack of or poor education, etc.

7) **Summary/Wrap-up**

- Review session objectives.
- Ask participants to explain at least three factors to consider before marriage.
- Ask participants to explain at least three consequences of a poorly planned marriage and three ingredients of a successful marriage.
- Ask participants to explain when, what and how they intend to provide premarital education to their own children.
“Do you not know that your body is a temple of the Holy Spirit who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore honour God with your body.”
1 Corinthians 6:19,20

Purpose: To help participants recognize the threat that sexually transmitted infections (STIs) has on personal health and to identify signs and symptoms of common STIs.

Objectives: Participants will be aware of the most common and most dangerous STIs.

Participants will know at least 4 different types of STIs, their modes of transmission, effects, consequences and method of treatment.

Participants will be able to identify at least three factors contributing to increased STI rates.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Handouts on STIs (around page 374 in Resource Materials section)</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker: “Trusting” (10 min)</td>
<td>Pamphlets on STIs</td>
</tr>
<tr>
<td>3. Defining Terms/Discussion (15 min)</td>
<td>VCR/TV/video, markers, tape, flipchart, pens, cards, pens, pencils</td>
</tr>
<tr>
<td>4. Brainstorming/Discussion (45 min)</td>
<td></td>
</tr>
<tr>
<td>5. Video/Discussion (45 min)</td>
<td></td>
</tr>
<tr>
<td>6. Summary/Wrap-up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

◇ Have the instructions for the “Trusting” exercise.

◇ Invite a guest speaker from a clinic to give a talk on STIs/STDs.

◇ Have a video (if available) on Sexually Transmitted Diseases/Infections.

◇ Have enough handouts and or pamphlets on STIs for everyone.

◇ Have enough sheets of flipchart paper for group work and other discussions.

◇ Write on chart paper the following heading: “Types of STIs”

◇ Make sure the VCR/TV is working properly.

◇ Make sure the seating is arranged the way you want it.

◇ Have enough blank index cards for questions parents may have.

Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (Ephesians 6: 10-18) or some other form of inspirational meditation.
2) **Introduction/Icebreaker: Trusting Exercise.** Break group into small groups of threes. The purpose of this exercise is to demonstrate who, what, when and why people trust.

Each person in the group is asked to stand with two persons flanked on the outside of the person in the middle. Instruct the person in the middle to close his/her eyes and to fall backwards and forwards into the arms of the two other individuals in that group. Allow several minutes so that each person has a chance to be in the middle.

Ask each group what they experienced. Find out who kept their eyes closed and who opened them. Ask if the middle person knew the person in the front/back. Did knowing that person make a difference? Explain that trust is the firm reliance in the honesty, dependability, strength or character of someone or something. Ask participants if they believe themselves to be trustworthy and why.

3) **Defining Terms/Discussion.** Ask participants to define sexually transmitted infections (STIs.)

**Begin this discussion by explaining that:**
STIs are also referred to as STDs (sexually transmitted diseases). At one time, STIs were called venereal disease or VD. Today, it is thought that sexually transmitted infections (STIs) is a more accurate description since not all sexually transmitted infections are diseases; e.g., yeast infections (monilia/candida), trichomoniasis, etc. However, the acronyms VD, STD and STI all basically mean the same thing.
**STIs** are infections transmitted by any type of intimate genital, anal or oral contact with an infected person. While a few STIs are only unpleasant, most have serious consequences and require professional medical treatment. Some can cause sterility. Others can affect a developing foetus or newborn and may cause birth defects. Some increase the risk of getting certain cancers. And others such as hepatitis-B, syphilis and the human immunodeficiency virus (HIV) that can cause AIDS, can kill you.

Give all participants an index card along with a pen or pencil. Encourage them to write down any questions that may come up during the workshop. Say that you or the guest speaker will try to answer them at the end of the session.

4) **Brainstorming/Discussion.** Introduce the guest speaker. Have participants name all the types of STIs they can think of. List them on flipchart paper. Review the list, making sure to include other important STIs not mentioned.

**Ask participants:**

...if they know how each of the listed STIs is transmitted?
...what are some of the signs/symptoms?
...how STIs are treated?
...why they think the rates of STIs are increasing?

You can assist by writing down responses while the guest speaker facilitates discussion.

The speaker can present other information on STIs not covered in the brainstorming session and respond to unanswered questions.
Facts:

Types of Sexually Transmitted Infections (STIs)

**Chlamydia** is a bacterium. It can cause sterility in women and men. It infects the cervix and can spread to the urethra, fallopian tubes and ovaries. It can cause bladder infections and serious pelvic inflammatory disease (PID), ectopic pregnancy, reproductive tract infections (RTIs) and sterility. In men, it infects the urethra and may spread to the testicles. Chlamydia can also lead to arthritis. In infants, Chlamydia can cause pneumonia, eye infections and blindness.

**Common symptoms:**
- discharge from the penis or vagina
- pain or burning while urinating
- frequent urination
- excessive vaginal bleeding
- abdominal pain
- nausea, fever
- painful intercourse for women
- inflammation of the rectum/inflammation of the cervix (cervicitis)
- swelling or pain in the testicles.

Seventy five percent of women and twenty five percent of men with Chlamydia have no symptoms. Many women discover they have Chlamydia only because their partners find out they have the disease or when they are treated for infertility. Symptoms usually appear within seven to 21 days.
**Gonorrhoea** is a bacterium that can cause sterility, arthritis, heart problems and disorders of the central nervous system. In women, gonorrhoea can cause pelvic inflammatory disease (PID), which can result in ectopic pregnancy or sterility. During pregnancy, gonorrhoea infections can cause premature labour and stillbirth. To prevent serious eye infections that are caused by gonorrhoea in newborn babies, drops of silver nitrate are routinely put into the eyes of infants immediately after delivery. The symptoms or a smear test is used to diagnose gonorrhoea, not a blood test.

**Common symptoms in women:**
- frequent, often burning urination, pelvic pain, a green or yellow-green discharge from the vagina, swelling or tenderness of the vulva and even arthritic pain. Eighty percent of women with gonorrhoea show no symptoms and if they appear it is usually within 10 days.

**Common symptoms in men:**
- a pus like discharge from the urethra or pain during urination. Ten percent of men with gonorrhoea show no symptoms and if they appear it is usually within 1-14 days.

**Syphilis** is spread from vaginal, anal, oral intercourse, kissing and during pregnancy. Untreated, the syphilis bacterium, "spirochete," can remain in the body for life and lead to disfigurement, mental disorder or death. Syphilis is especially contagious when sores are present early in the disease; the liquid that oozes from them is very infectious.

People are usually not contagious during the latent phase. Untreated syphilis may remain latent for many years or a lifetime but can be spread from a pregnant woman to her foetus at any time.
The effect of syphilis on a foetus is very serious. If untreated, the risks of stillbirth or serious birth defects are high. Birth defects include damage to the heart and brain as well as blindness. Pregnant women with syphilis can be treated to prevent damage to the foetus. Syphilis is diagnosed by doing a blood test.

**Common symptoms:**
Syphilis has several phases that may overlap one another. They do not always follow in the same sequence. Symptoms vary with each phase but there are no symptoms most of the time.

- **Primary Phase:** Sores or chancres often appear from three weeks to 90 days after infection. They last three to six weeks and can appear on the genitals, in the vagina, on the cervix, lips, mouth or anus. Swollen glands may also occur during the primary phase.

- **Secondary Phase:** Other symptoms often appear from three-six weeks after the sore appears. They may come and go for up to two years. They include body rashes on the palms of the hands and the soles of the feet that often last from two to six weeks. There are many other symptoms including mild fever, fatigue, sore throat, hair loss, weight loss, swollen glands, headache and muscle pain.

- **Latent (present but not evident or active) Phase:** No symptoms. Latent phases occur between other phases or can overlap them.

- **Late Phase:** One-third of untreated people with syphilis experience serious damage of the nervous system, heart, brain or other organs and death may result.
During pregnancy, herpes may cause miscarriage or stillbirth. If active herpes infections are present during childbirth, newborn infants may suffer serious health damage including developmental disabilities and, rarely, death.

**Common symptoms.**

- A recurring rash with clusters of blistery sores appearing on the vagina, cervix, penis, mouth, anus, buttocks or elsewhere on the body.
- Pain and discomfort around the infected area, itching, burning sensations.
- During urination, swollen glands in the groin, fever, headache and a general run down feeling.

Symptoms usually appear from 2-20 days after infection but it may be years before the primary outbreak occurs.

Recurrences are sometimes related to emotional, physical or health stresses. During recurrences, it is important to observe strict rules of day-to-day hygiene. Wash hands frequently and do not touch the sores. If the sores are touched inadvertently, wash hands immediately. Be particularly careful when handling contact lenses. There is no cure for Herpes but symptoms may be very mild and need not interfere with daily living.
**Other Types of STIs:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Possible Symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chancrous</td>
<td>boil, ulcer, bubo, pain urination, etc</td>
<td>Antibiotics</td>
</tr>
<tr>
<td>Crabs/Public Lice</td>
<td>intense itching, fever, irritability</td>
<td>Ointment</td>
</tr>
<tr>
<td>Genital Warts</td>
<td>burning urination, pus, discharge</td>
<td>Antibiotics</td>
</tr>
<tr>
<td>Hepatitis-B Virus (HBV)</td>
<td>fatigue, fever, headache, nausea, etc</td>
<td>None</td>
</tr>
<tr>
<td>Human Immuno-deficiency Virus (HIV)</td>
<td>weight loss, diarrhoea, fatigue, fever, etc</td>
<td>No Cure</td>
</tr>
<tr>
<td>Human Papilloma Virus</td>
<td>warts on genitals, tenderness, soreness</td>
<td>No Cure</td>
</tr>
<tr>
<td>Monilia/Candida (yeast infection)</td>
<td>itching, burning</td>
<td>Ointment</td>
</tr>
<tr>
<td>Pelvic Inflammatory Disease (PID)</td>
<td>fever, nausea, vomiting, pain, discharge</td>
<td>Antibiotics/Surgery</td>
</tr>
<tr>
<td>Scabies (mites)</td>
<td>intense itching, bumps, rashes</td>
<td>Ointments</td>
</tr>
<tr>
<td>Trichomoniasis (trich)</td>
<td>smelly vaginal discharge, itching</td>
<td>Antibiotics</td>
</tr>
</tbody>
</table>

5) **Video/Discussion.** Before showing a video on STIs, see if there are any index cards containing participants questions. While the video is showing, you and the guest speaker can read the questions and prepare to answer them afterwards.

After showing the video, ask participants if they learned any new information that was not covered in earlier discussions. Have the guest speaker answer questions (including the ones on the index cards).
Ask participants to role-play the following situations.

A partner has been diagnosed with an STI. How does the other partner respond to this information? Process the role-play and ask participants to give their reaction. Ask if healing can take place in this situation? If so, how?

6) **Summary/Wrap-Up**

**Ask participants to:**

- name at least four common STIs including how they are transmitted, symptoms and if they can be cured.
- identify at least three factors contributing to increased STIs.
- ask participants how they would communicate information about STIs to others.
- encourage participants to attend other *Christian FLE* Programmes.
HIV AND AIDS PREVENTION

“Be self-controlled and alert. Your enemy the devil prowls around like a roaring lion looking for someone to devour.” 1 Peter 5:8

Purpose: To provide participants with factual information about HIV/AIDS, how it is transmitted, its symptoms and how it can be avoided.

Objectives: Participants will know how HIV is transmitted and how to prevent infection.

Participants will be able to identify at least five signs and symptoms of AIDS.

Participants will understand the importance of talking about sexuality issues, especially HIV/AIDS prevention.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Handouts on HIV/AIDS (starting around page 393); “Condom Sense” (around page 280)</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker (15 min)</td>
<td>8 x 10 sheets of white/coloured paper, markers, tape, flipchart, cards, pens, pencils</td>
</tr>
<tr>
<td>3. Defining Terms/Discussion (30 min)</td>
<td></td>
</tr>
<tr>
<td>4. Behaviours/Group Exercise (30 min)</td>
<td></td>
</tr>
<tr>
<td>5. Talking About AIDS /Discussion</td>
<td></td>
</tr>
<tr>
<td>(45 min)</td>
<td></td>
</tr>
<tr>
<td>6. Role Plays (20 min)</td>
<td></td>
</tr>
<tr>
<td>7. Summary/Wrap-up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>

Advance Preparation:

➤ Have enough index cards so that everyone gets four each.
Write on flipchart paper the following headings: “What is HIV?” “What is AIDS?” “What should children be told about AIDS?” “At what age should parents begin to talk to their children about things like sex and AIDS?” “What are the factors contributing to high rates of HIV infection?” “What are some of society’s attitudes toward people living with HIV/AIDS?” “What are some myths associated with HIV/AIDS?”

Write on three (8x10) sheets of white/coloured paper/cards the following: “High Risk Behaviour?” “Low Risk Behaviour?” “No Risk Behaviour?” Tape it high up on the wall. Be sure to leave enough space between the sheets for the placing of index cards later on.

Write (in capital letters and bold print) on index cards the following behaviours so that each participant has a card.

<table>
<thead>
<tr>
<th>Kissing</th>
<th>Oral sex without a condom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body massage</td>
<td>Body piercing</td>
</tr>
<tr>
<td>Sitting on a dirty toilet seat</td>
<td>Mosquito Bites</td>
</tr>
<tr>
<td>Vaginal sex without a condom</td>
<td>Blood transfusion</td>
</tr>
<tr>
<td>Vaginal sex with a condom</td>
<td>Being cut by someone</td>
</tr>
<tr>
<td>Showering/bathing together</td>
<td>Body rubbing</td>
</tr>
<tr>
<td>Sharing needles without cleaning them</td>
<td>Drinking behind a person infected with HIV</td>
</tr>
<tr>
<td>Using someone else’s tooth brush</td>
<td>Anal intercourse without a condom</td>
</tr>
<tr>
<td>Sneezing on someone</td>
<td>Having a physical examination</td>
</tr>
<tr>
<td>Coughing on someone</td>
<td>Getting a manicure</td>
</tr>
<tr>
<td>HIV mother who breast-feeds</td>
<td>Unprotected sex with a person who injects drugs</td>
</tr>
<tr>
<td>Manicure</td>
<td>Masturbation</td>
</tr>
<tr>
<td>Kissing someone who has AIDS</td>
<td>Sharing eating utensils with someone who has AIDS</td>
</tr>
<tr>
<td>Touching someone who has AIDS</td>
<td>Mutual masturbation</td>
</tr>
<tr>
<td>Hugging a person who has AIDS</td>
<td>Sleeping in the same bed with someone who has AIDS</td>
</tr>
</tbody>
</table>

Optional: If available, have a video on HIV/AIDS.

Invite a guest speaker from the health department or other health professional to talk about HIV/AIDS.
Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (Genesis 50:20) or some other form of inspirational meditation.

2) Introduction/Icebreaker Exercise. This exercise does not have a name; however, it is a powerful exercise that helps each participant appreciate the experience of losing control over his/her own body and the things that each values.

Give four index cards to each participant. Ask participants to write down their responses to the following questions:

Card #1 - Who is the most important person in your life?
Card #2 - What is your most important role in life?
Card #3 - What gives you the most pleasure in life?
Card #4 - What is the one thing you like most about yourself?

Have participants shuffle the cards and hold them up. Tell them to select one card to give up. Collect that card from each participant. Now, tell them you are going to take a card except this time participants cannot choose which one. Tell them that you are going to take another card. Again, they cannot choose what card to give up.

After parents are left with only one card, ask them:

...how did it feel to give up a part of their lives?
...how would it change them?
...would they want to go on living without the things they lost?
Explain that people living with HIV/AIDS often feel as though they have no control over their bodies. They feel like things have been taken away from them. They have feelings of isolation, hopelessness, loneliness, denial, fear, anger, bargaining, unhappiness, insecurity, shame, etc.

Say that any one of us could at any time find ourselves in a similar situation and that we should all show compassion for people infected and affected by HIV/AIDS.

3) **Defining Terms/Discussion.** Ask participants to define HIV and AIDS. Write down responses and discuss.

**Facts:**

**HIV (Human Immunodeficiency Virus)** is a virus that weakens the body’s ability to fight disease and causes AIDS. HIV is fragile. It doesn’t survive well outside the body. It can be destroyed by heat, mild household bleach, even soap and water. But it is deadly if it gets into the body. And once it does, nothing can get it out of the body.

**AIDS (Acquired Immune Deficiency Syndrome)** attacks the body’s immune system, destroying the ability to fight off infections. There is no known cure.

4) **Group Exercise: Risky Behaviours.** Explain that this exercise is designed to see how participants rate individual behaviours that put people at risk for HIV infection. Give all participants one index card each and tell them to tape their card underneath the sheet on the wall that best describes what they believe.
After all participants have had an opportunity to tape their card to the wall, ask the group if they agreed with how others rated behaviours. Ask why they disagreed. See what responses you get. Some people may feel that some behaviours are riskier than others, while others may feel that the behaviour has no risk. Be sure to explain the facts when necessary. (See Resource Materials section on HIV/AIDS).

**Note: If you choose not to use the “Risky Behaviour” Exercise, you can do the following “Myth and Fact” Exercise:**

Ask participants if the following statements are myth or fact: (for your information, all statements are myths and require an explanation).

- You can get the HIV virus from hugging or touching someone with AIDS.
- Everyone who gets AIDS dies within five years after becoming infected with HIV.
- Babies born to mothers who are HIV infected will automatically have AIDS.
- Having intercourse with a virgin will cure an HIV infected male.
- You can’t get AIDS if you use a condom.
- You can get AIDS from a mosquito.

Ask the group if they can think of other myths about AIDS. List and discuss.

Using flipchart paper, list and discuss some of the ways HIV is transmitted etc., signs and symptoms of AIDS and prevention.
FOR PARENTS AND OTHER ADULTS

5) **Talking to kids about AIDS.** Explain that young children are very receptive to learning parental values. Now is a good time to pass on family values about sex. In addition, talking makes it clear that sex is something you talk about in your family. Another advantage to talking with your children about issues relating to sex is that as they get older, they are more likely to come to you with questions about sexuality issues instead of relying on their peers for answers.

**Important Reminders!!!**

❤ Before talking to kids about AIDS, be sure you know what AIDS is, how it is spread and how it can be prevented.

❤ Include values along with the facts.

❤ Give age appropriate responses. A child’s intellectual/social development can indicate how much information he or she is ready for.

❤ Answer questions when they come up, don’t put them off.

❤ Old enough to ask is old enough to know.

❤ Just because a child does not ask questions doesn’t mean that he or she doesn’t have them.

❤ It’s okay to be nervous or embarrassed. Just don’t let it stop you from communicating.

❤ You don’t have to feel pressured to give all the information at once.
Very young children (3 to 5 years) have little need to discuss AIDS unless it directly affects their lives. They need only the most basic information; e.g., AIDS is a serious disease and that they are not in any danger of getting AIDS. Children should not be exposed to environments that put them at risk for infection; e.g., sharp objects, used condoms, tampons, syringes, blood, etc. Parents/guardians should be cautious when leaving very young children with house girl/boys, siblings, friends, etc.

Children (5 to 8 years) are more likely to hear about AIDS. Although they’re still not ready to hear all the details, they do need to know that AIDS is caused by a virus. Try to keep your response simple and concrete. Reassure them that they can’t get it from casual contact, hugging, coughing, sneezing, dishes or toilet seats. Listen very carefully to your child’s questions. You can determine how much they are ready to know from their questions.

Children 9 to 12 years need a better understanding of the facts. You will need to be specific about transmission and prevention of AIDS.

By early adolescence, a child should know that AIDS is transmitted mainly through sex, IV-drug use and transfusions, that it is passed through blood, semen, body fluids including vaginal, anal, oral and mother to child.

They need to know that using latex condoms can help prevent AIDS. Most importantly, they need to know they can talk with a trusted adult about AIDS.

Use “teachable moments”; e.g., when you hear something on the radio or TV together, you might ask, “Did you understand what they were talking about?” or “Do you know what AIDS is?”
A good opening statement might be: “We’re hearing a lot about AIDS these days. Have you heard about AIDS?”

**Note:** This may be a good opportunity for parents/guardians to talk about what the Bible has to say about abstinence, marriage, commitment, etc.

6) **Role Plays.** Break the group into small groups of three. One person will be a child (5 to 12 years), one person will be the parent and the third person will look on. Instruct the person pretending to be a child to ask, “How does a person get AIDS?” or “What is AIDS?” Allow five minutes for the parent to respond.

Have the person who looked on tell how well the parent handled the questions. Repeat this exercise until each person has had a chance to be a child, a parent and an onlooker. List and discuss what worked well and what didn’t. If available, you can show a video on HIV/AIDS.

**NOTE:** Facilitator can adapt the role-play to reflect an adolescent to adolescent.

**Glove Exercise.** This exercise helps participants know how we contract HIV/AIDS. Give a latex glove to one person in the group. Tell him/her to put it on his right hand (or hand they use to shake with). Ask participants to shake the hand of at least three other persons in the group. Instruct the person with the latex glove to shake the hand of only one person in the group. When this is done bring the group together. Ask everyone who shook the hand of the person with the glove to stand up. Then ask everyone who shook the hand of the persons standing to also stand. Explain that if all the people wearing gloves were HIV infected, the exercise has demonstrated how people contract HIV/AIDS. Emphasize that you do not have to sleep around to get it. Having contact with just one person who has contact with another person infected with HIV is enough.
It is not the number of people you sleep with that puts you at risk. It is having unprotected sex with someone who is infected. Remember, you do not know about the sexual history of others.

7) **Summary/Wrap-Up**

Ask participants to:

- identify at least three ways that HIV is transmitted and how to prevent infection.
- identify at least three signs of AIDS.
- explain the advantage of talking to children and others about issues related to sexuality including AIDS.
- encourage participants to attend other *Christian FLE* Programmes.
FAMILIES WORKING TOGETHER

“How great is the love the Father has lavished on us, that we should be called children of God! And that is what we are! The reason the world does not know us is that it did not know him.” 1 John 3:1

Purpose: Designed for parents and teens to provide basic information about sex, sexuality, gender roles, sources of sexual learning and to foster good communication around issues related to sexuality.

Objectives: Parents and their teenagers will have accurate information about sex, sexuality, gender roles, sources of sexual learning and local myths.

Parents and their teenagers will recognize how sources of sexual learning impact teenagers’ values, attitudes and sexual behaviour.

Parents and their teenagers will feel more comfortable talking with one another about issues relating to sex and sexuality.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Handouts “How Well Do You Know Your Child/Parent” (around pages 274-275)</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker: “How Well...” (30 min)</td>
<td>markers, tape, flipchart, cards, pens, pencils</td>
</tr>
<tr>
<td>3. Defining Terms/Myth &amp; Fact/Discussion (45 min)</td>
<td></td>
</tr>
<tr>
<td>4. Role Reversal Role-Plays/Discussion (45 min)</td>
<td></td>
</tr>
<tr>
<td>5. Incomplete Sentence Exercise (10 min)</td>
<td></td>
</tr>
<tr>
<td>6. Summary/Wrap-up (10 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

✧ Have enough copies of the “How Well Do You Know Your Child/Parent” questionnaire for participants.

✧ Have enough index cards for each participant.

✧ Have at least five skits for parent/child role-plays.

✧ Write down on flipchart paper: “What is Sex?” “What is Sexuality?” “What is a Gender Role?” “What is Gender Equity?” “What are Myths?” “What are Facts?”

✧ On another piece of flipchart paper, prepare the heading to read: “Sources of Sexual Learning.” Beneath this heading draw a line down the middle. In one column write, “50 Years Ago” and on the other write, “Today.” Be sure to have extra chart paper.

Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (Philippians 3:14) or recite the following:

Recipe for a Happy Home

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>♥ 4 Cups of love</td>
<td>5 spoons of hope</td>
</tr>
<tr>
<td>♥ 2 cups of loyalty</td>
<td>2 spoons of tenderness</td>
</tr>
<tr>
<td>♥ 3 cups of forgiveness</td>
<td>4 barrels of faith</td>
</tr>
<tr>
<td>♥ 1 gallon of patience</td>
<td>1 barrel of laughter</td>
</tr>
<tr>
<td>♥ 1 quart of kindness</td>
<td>2 quarts of understanding</td>
</tr>
</tbody>
</table>

Take love and loyalty, mix in thoroughly with faith. Blend it with tenderness, forgiveness, kindness and understanding. Add patience and hope; sprinkle abundantly with laughter. Garnish with hugs and kisses. Serve generous portions daily.
2) **Introduction/Icebreaker Exercise.** Ask parents and teens to complete the “How Well Do You Know Your Child/Parent” questionnaires. Afterwards, have parents and their teenagers exchange the questionnaires and take turns reading them out loud. See how well parents and children know each other. Hand out index cards to each participant and ask him or her to write down any questions that they wish to have addressed in today’s session.

You can begin by saying that each member of the Family of God has an important role to play. For, example the father has the great responsibility of demonstrating love, encouragement and discipline in the family. He should realize the magnitude of his role; not demanding respect by shouting commands to his children and exacting submission from his wife, but by so ordering his own life, showing sincere love and interest, that he wins the respect, confidence and love of his family. You can ask the group to explore the role of mothers and children.

3) **Defining Terms.** Tape your prepared chart paper on the board or wall. Ask participants to give as many definitions as they can of “sex,” “sexuality” and “gender.” Write them down and discuss.

Explain that sex is used to mean different things. **Sex** refers to biology, whether you are a male or female. **Sexuality** is a much broader term that involves our spirit, soul and body. It is a gift from God that begins at birth and ends at death. Sexuality includes our biology, emotions, intellect, physical make-up, values, attitudes, personality, etc. We can say that sexuality is like a fine string of pearls, each pearl representing an important aspect of who we are. A good definition is **“Sexuality is the total expression of who we are as human beings.”**
Explain that Gender refers to the roles/scripts, attributes and expectations assigned to males and females. These roles are determined by culture and social norms; they are not biological.

Ask the group to think about some of the gender roles for males and females in their community. Is there gender equity (fairness) in how men and women are treated in society? Who controls gender roles? Are gender roles changing? If so, how? Should gender roles change? If so, how? If not, why? List participants’ responses and discuss.

Sources of Sexual Learning. Put up the prepared flipchart paper listing the two columns reading “50 years ago” and “Today.” Ask parents and their teens to think of all of the sources of sexual learning 50 years ago. List them and discuss. Now ask them to think of all of the sources of sexual learning today. List them and discuss. Ask participants to compare how people learned about sex 50 years ago to how people learn about sex today. Ask if the sources of learning have impacted how people behave sexually.

Myths & Facts. Explain that “myths” are opinions, beliefs, stories or idealized fantasies that have no basis in fact yet the members of a group uncritically hold them. The word “myth” comes from the Greek mythos meaning fable or story. Explain that facts are known truths, something that is objectively verified, proven or real.

Ask parents and teens to think about the role that myths play in culture. Can myths be helpful? Can myths be dangerous? If so, why?

Ask participants to think of sexual myths they may have heard. List them and discuss. Ask participants if they believe some of them to be fact and why. Explain the facts if necessary.
4) **Role Reversal Role Plays.** Have parents and teens reverse roles. Have the parents (who are really teens) explain sex and sexuality to their teens (who are really parents.) Now have the teens (who are really parents) ask the parents (who are really teens). “When is the right time to begin dating?” and “When is it okay to kiss?” Afterwards, have participants report how they did.

- Ask participants if the explanations and questions were handled effectively.
- Ask if the parents/teens were nervous or unsure.
- Ask how it felt to reverse roles. Discuss.

Be sure to encourage parents and their teens to continue talking about issues that relate to sex and sexuality. Tell them that it’s all right if they don’t have all the answers. The most important thing is that they are talking.

**Remember!!!** Be sure to mention school curriculum as a possible source of sexual learning. Also, this is a good opportunity to address any misconceptions about the *Christian Family Life Education* Programme.

5) **Incomplete Sentence Exercise**

Ask parents to turn to their teenager/s and complete this statement: “The thing that I want most for you is...”

Now ask teens to turn to their parents and complete this statement: “The thing that I want you to know about me is...”

Allow parents and teens enough time to express how this exercise made them feel.

Collect the index cards given out in the early part of the session. If time permits, answer any questions written on the cards.
6) **Summary/Wrap-Up**

**Ask participants to:**

- define sex, sexuality, gender and gender roles.

- identify at least three sources of sexual learning today that influence how young people behave sexually.

- ask teenagers to identify at least three local myths in their community that put young people at risk for pregnancy, disease, AIDS, etc.

- ask parents and teens if the session has helped them to feel more comfortable talking with each other about issues related to sex and sexuality.

- encourage parents and their teens to participate in other *Christian FLE* Programmes.
DOMESTIC VIOLENCE

“In this same way, husbands ought to love their wives as their own bodies. He who loves his wife loves himself.” Ephesians 5:28

Purpose: To help participants understand the full meaning of Domestic Violence (DV), factors which contribute to DV, its impact on family life and ways to avoid it.

Objectives: Participants will be able to identify at least three forms of DV.

Participants will be able to help their children recognize warning signs of an abusive personality.

Participants will be able to name at least three things that can be done about DV and three techniques that can resolve conflicts.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Handouts “DV Myth/Fact Sheet” (around page 417)</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker: (20 min)</td>
<td>Markers, tape, flipchart, VCR/TV/Video</td>
</tr>
<tr>
<td>3. Defining Terms/Exercise/</td>
<td></td>
</tr>
<tr>
<td>Discussion (45 min)</td>
<td></td>
</tr>
<tr>
<td>4. Conflict Resolution Techniques</td>
<td></td>
</tr>
<tr>
<td>(20 min)</td>
<td></td>
</tr>
<tr>
<td>5. Video/Role Plays/Discussion</td>
<td></td>
</tr>
<tr>
<td>(45 min)</td>
<td></td>
</tr>
<tr>
<td>6. Summary/Wrap-Up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

- Have enough handouts of the “Domestic Violence Myth/Fact Sheets” (around page 417 in Resource Materials section) and other relevant literature on domestic violence.

- Have flipchart paper headed: “What is domestic violence?” “Warning signs of an abusive personality” “Causes of DV” “What is dating violence?” “What can women/children/men do to protect themselves?”

- Write on flipchart paper and place on the walls, “Agree” “Disagree” and “Unsure.”

- Have five statements on DV ready for the “Values Clarification: Forced Choice Exercise” (around page 488).

- Prepare handouts using information from the pages immediately following and from around pages 417-422. Select a relevant video on DV.

Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (Proverbs 18:21) or some other form of inspirational meditation.

2) Introduction/Icebreaker: Myth and Facts on Domestic Violence. Have participants fill out the “Domestic Violence Myth/Fact Sheets.” Tell them not to put their names on the sheets. After they have completed filling them out, collect them and redistribute them randomly. Have someone read each statement out loud. Ask participants to tell the group if they felt the statement was true, false or they didn’t know.
3) **Defining Terms/Discussion.** Put up prepared flipchart paper with headings, “What is DV?”

Have participants brainstorm their own definition for domestic violence. List and discuss. Explain that “Domestic Violence” is the use or threat of physical, emotional, sexual and economic violence against a partner in a primary relationship or a family member, resulting in fear and emotional and or physical suffering. “Abuse” is the mistreatment of one person by another. “Battering” is an abuse of power to create physical and emotional pain. The abuser wants **Power and Control**.

**Group Exercise.** Break the group into five small groups. Explain that each group should select a reporter and that they will have 20 minutes to complete the task.

Assign each group one of the following topics:

<table>
<thead>
<tr>
<th>Group #1</th>
<th>Warning signs of an abusive personality.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group #2</td>
<td>Forms of domestic violence.</td>
</tr>
<tr>
<td>Group #3</td>
<td>What effect does DV have on the family?</td>
</tr>
<tr>
<td>Group #4</td>
<td>Why do women/people stay in an abusive situations?</td>
</tr>
<tr>
<td>Group #5</td>
<td>What can be done about DV and how can, men and children protect themselves?</td>
</tr>
</tbody>
</table>

Allow each group five minutes to report back findings to the larger group. Afterwards, allow the larger group to contribute.
Facts:

**Warning Signs of an Abusive Personality**

Something is just not right in your relationship and you can’t put your finger on it. So, here’s some help if your mate is displaying a combination of these behaviours. You may have a potential batterer on your hands.

**Watch out for:**
1) a push for quick involvement
2) jealousy
3) controlling
4) unrealistic expectations
5) isolation (tries to cut you off from your family and friends)
6) blames others for problems and mistakes.
7) makes everyone else responsible for his/her feelings.
8) hypersensitivity (is easily insulted)
9) cruelty to animals and children
10) “playful” use of force during sex
11) verbal abuse
12) rigid gender roles
13) sudden mood swings
14) past battering (admits hitting in the past)
15) threats of violence
### Forms of Domestic Violence

<table>
<thead>
<tr>
<th>Physical</th>
<th>Psychological</th>
<th>Sexual</th>
<th>Economic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hitting</td>
<td>Name calling</td>
<td>Rape/forced sex</td>
<td>Withholding money</td>
</tr>
<tr>
<td>Slapping, punching</td>
<td>Constant harassment</td>
<td>Unwanted sexual practices</td>
<td>Stealing money</td>
</tr>
<tr>
<td>Kicking</td>
<td>Refusal to speak</td>
<td>Rough sex</td>
<td>Lying about assets</td>
</tr>
<tr>
<td>Burning</td>
<td>Humiliating you with</td>
<td>Child sexual abuse</td>
<td>Keeping her from</td>
</tr>
<tr>
<td>Mutilation</td>
<td>family/friends</td>
<td></td>
<td>getting a job</td>
</tr>
<tr>
<td>Pushing, shoving</td>
<td>Intimidating</td>
<td>Treating you as a sex</td>
<td>Taking her money</td>
</tr>
<tr>
<td>Bitting, choking</td>
<td>Isolating you from</td>
<td>object</td>
<td></td>
</tr>
<tr>
<td>Pulling hair, grabbing</td>
<td>family/friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holding knife to throat</td>
<td>Threats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pushing, shoving</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biting, choking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulling hair, grabbing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holding knife to throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pushing, shoving</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biting, choking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulling hair, grabbing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holding knife to throat</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Abuse is a Pattern of Coercive Control

**What are the effects of abuse on the victim as reported by battered women?**

- It frightens me.
- It controls my life.
- I withdraw and get depressed.
- I lost my self-confidence.
- I’m nervous, get headaches and high blood pressure.
- I lost my furniture.
- I never had a moment’s peace.
- I was always terrified.
- I worry about people finding out.
- I feel alienated from my family.
- I lost my home.
- My kids had to change schools again.
- I can’t hold down a job because of the harassment.

**What does the abuser gain? (Quotes from battered women)**

- He got his way.
- He got control.
- He didn’t have to do anything at home.
- He got taken care of.
- He felt powerful because I was frightened.
- He felt superior to me.
- He got the house.
- He gets pity from others and respect from the guys.
## 3 Stages of Abuse

1. **Tension builds**: A time of minor conflicts and possibly physical abuse. This may last from a few hours to a few months. The victim is aware of the tension and may attempt to defuse it by apologizing, reasoning with or complying with the abuser.

2. **Episodes of violence**: May be triggered by an insignificant quarrel or some other minor problem. Once an attack starts, there’s very little the victim can do to stop it. Apologizing or reasoning seldom works.

3. **Periods of remorse**: Following the abuse, the abuser feels ashamed, guilty and promises it will never happen again. The abuser may lavish the victim with gifts and/or attention. This phase wears off and tension begins to build again. This phase is also called the “Honeymoon Phase.”

### Note:
Be sure to mention dating violence. Example, girls dating boys often find themselves in abusive situations. Many times they are afraid to tell anyone, especially their parents. This might be difficult since girls experience DV in their own families and may feel that they will get little or no support from home. In some cultures, girls believe that if their boyfriend hits them, that means they really love them. This is not true.

## Effects of Domestic Violence on Families

**On adults:**

- emotional stress and deprivation
- disabling injuries
- substance abuse
- depression
- break-up of family unit
- expansion of violence in the community
- death by homicide
- suicide
- difficulty maintaining a job
- etc
### On children:
- low self-esteem
- emotional injuries
- poor school performance
- aggressive behaviour toward others/delinquency
- depression
- runaway episodes
- alcohol and drug experimentation or use
- victim/aggressor roles
- sexual promiscuity
- violent behaviour in their adult relationships
- death by homicide
- death by suicide

### Why Do People Stay in Abusive Relationships?
**Situational Factors:**
- economic dependence
- fear of greater physical danger to themselves and their children if they leave
- fear of emotional damage to children
- fear of what others will think
- lack of alternative housing
- lack of job skills
- social isolation resulting in lack of support from family or friends
- lack of information regarding alternatives
- fear of involvement in court processes
- cultural and religious constraints
- fear of retaliation
- etc.
**Emotional Factors:**
- dependency
- co-dependent behaviour
- fear of loneliness
- insecurity over potential independence and lack of emotional support
- guilt about failure of marriage or relationship
- fear that husband or partner is not able to survive alone
- belief that the husband/partner will change
- feel responsible
- love for husband/partner
- ambivalent about making life changes
- learned helplessness
- dependency

Ask participants if men can also be victims of DV? If so, how and under what circumstances? In not, why? List responses and discuss.

Ask participants if they think men are more reluctant to seek help when they are the victims of abuse? If so, why? If not, why?

**What Can Be Done About Domestic Violence?**
- Educate the public about the effect of DV on families
- Get the church community involved
- Involve the civic associations
- Stiffer penalties
- Talking to children about sexual abuse
- Get the schools/universities involved
- Support gender equity that guarantees human rights for women and children
- More prayer in the home and schools
- Counselling
- Therapy
- Providing shelter
- Family court
- Improve police reporting
- Safe place
- Women’s Crisis Centre
NOTE: Be sure to mention the services available in the community; e.g., Salvation Army, Women’s Crisis Centre, Hotline, etc.

4) **Conflict Resolution Techniques.** Here are a few practical rules to follow for resolving conflicts in a constructive manner.

**Consideration:**
- Don’t belittle, humiliate or use character-degrading words about the other person.
- Don’t dismiss the other person’s issue as unimportant.
- Acknowledge and try to understand the other person’s point of view.
- Don’t talk down to the other person; talk to him or her as an adult.
- Don’t blame the other person unfairly or make unfair accusations.
- Don’t push your own point of view as the only right one; consider the other person.
- Don’t be sarcastic or mimic the other person.
- Try to understand the other person’s faults and don’t be critical or judgmental.
- Don’t hurt the other person.
- Don’t make the other person feel guilty.
- Listen to the other person.
- Don’t talk too much or dominate the conversation.
- Don’t interrupt.

**Self-expression:**
- Keep to the point and don’t get involved in other issues.
- Get to the point quickly.
- Be honest and say what is on your mind.
- Be specific. Don’t generalize.
- Clarify the problem.
- Express your feelings about the topic.
- Explain your reasons for your point of view.
- Don’t exaggerate.
**Conflict resolution:**
- Pray for guidance.
- Explore alternatives.
- Make joint decisions.
- Be prepared to compromise.
- Be able to say you’re sorry.
- Resolve the problem so that both people are happy with the outcome.

**Rationality:**
- Pray for wisdom.
- Try not to get angry.
- Try not to raise your voice.
- Don’t be aggressive or lose your temper.
- Try to keep calm and not get upset.

**Positivism:**
- Try to relieve the tension in arguments (through prayer, jokes, laughter).
- Use receptive body language.
- Remember to be loving.
- Look at each other.
- It’s not the end of the world.
- Be supportive and give the other praise where due.

Ask participants if they can think of other ways that might help to resolve conflicts. List them and discuss.

5) **Show a relevant video and discuss.** If you do not have a video, have the participants role play how they would begin talking to their own children about DV.
Discuss the following:

**Protecting Children and Teens Against Sexual Abuse**

*Children need to know that:*
- no one has a right to abuse them.
- they should pay close attention to the personality of a potential partner/mate.
- they should respect themselves and others.
- they should tell someone they trust if they are being harmed in any way.

Ask participants to think of other ways to protect children against sex abuse. List and discuss.

6) **Summary/Wrap-Up**

**Ask participants to:**

- identify at least three forms of DV.
- recall at least three characteristics of an abusive personality.
- explain at least three empowering points that children should be taught.
- explain at least three ways to avoid conflicts.
- encourage participants to attend other *Christian FLE* Programmes.
SEXUAL ABUSE, RAPE, CHILD MOLESTATION

“But if anyone causes one of these little ones who believe in me to sin, it would be better for him to have a large millstone hung around his neck and to be drowned in the depths of the sea.” Matthew 18:6

Purpose: To help participants better understand sexual abuse and how to protect their children against rape and child molestation.

Objectives: Participants will understand the meaning of sexual abuse, rape, child molestation, sexual harassment and gang rape.

Participants will know at least three factors contributing to rape.

Participants will be able to talk to children about sexual abuse and how they can protect themselves.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Markers, tape, flipchart,</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker:</td>
<td>pens, index cards,</td>
</tr>
<tr>
<td>Charade (20 min)</td>
<td>VCR/TV/Video</td>
</tr>
<tr>
<td>3. Defining Terms/Group</td>
<td></td>
</tr>
<tr>
<td>Exercise (60 min)</td>
<td></td>
</tr>
<tr>
<td>4. Video/Discussion (15 min)</td>
<td></td>
</tr>
<tr>
<td>5. Role Plays/Discussion (30</td>
<td></td>
</tr>
<tr>
<td>min)</td>
<td></td>
</tr>
<tr>
<td>6. Summary/Wrap-Up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

- Have a relevant video set up to show.

- Invite a guest speaker. Ask him or her to be prepared to talk about sexual abuse, rape, child molestation, sexual harassment and gang rapes. Examples of possible speakers include a police officer, a lawyer, a social worker or other relevant professional.

- Review the session to ensure you cover all the facts.

- For the charade exercise, write down on five index cards the following words: “Lost” “Sexy” “Drunk” “Angry” “Worried” (or select your own words).

- Have at least two role play scenarios in mind for your session.

- Write on flipchart paper: “What is Sexual Abuse?” “What is Rape?” “What is Child Molestation?” “What is Sexual Harassment?” “What is Gang Rape/Battery?”

Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (Isaiah 55:7) or some other form of inspirational meditation.

2) Icebreaker Exercise: Charade. Explain that “Charade” is a game in which each word or phrase is acted out non-verbally by someone playing the game while others try to guess the word or phrase. Whoever guesses the word/phrase wins. Ask for five volunteers to come up and give each of them your prepared index cards. Allow each of the five volunteers approximately three minutes to act out the word. See who from the larger group guesses correctly.
3) **Defining Terms/Group Exercise.** Break the group into five small groups. Give each group the flipchart paper you prepared on: “What is Sexual Abuse?” “What is Rape?” “What is Child Molestation?” “What is Sexual Harassment?” “What is Gang Rape/Line-ups?” Give the groups 10 minutes to come up with their responses. Have someone from each group report the findings. Allow each reporter five minutes. Invite feedback from the larger group.

During the discussions, explain that some people do not think *rape* has anything to do with husbands and wives. But in many countries a husband who forces sex on his wife – intercourse, oral or anal sex (also called sodomy) – by physical force or threats of harm is violating her rights as a human being.

Many countries are changing their laws so husbands can be charged with crimes of rape/forced sex.

**Facts:**

**Sexual abuse** involves forced, tricked or manipulated touch or sexual contact, although sexual abuse can occur without touch – obscene phone calls or exposing one’s sexual organs are examples. *Sexual abuse* can also include breaking down barriers to privacy, for instance, harmful exposure of children to information or activities that exploits them and are inappropriate to their age or understanding level.

**Rape** is defined differently in each country. In some countries, *rape* is defined as an act of violence.
**Child molestation** is when an older person exploits a child for sexual gratification. The adult may be a family member, neighbour, acquaintance, authority figure or a stranger. The abuse is generally ongoing rather than a one-time occurrence. The offender is often a person who has influence and power in the child’s life. Children are manipulated, threatened and often forced. *Child Molestation* occurs between infancy and 11 years because children are most vulnerable to sexual exploitation at this age.

**Sexual harassment** is unwanted sexual advances with suggestive gestures, language or touching. This situation is commonly found on the streets, in the workplace and sometimes in the church. For example, the person who is being harassed (employee) is subordinate to the harasser (employer). The person being harassed feels pressure to engage in unwanted sexual relations for fear of losing a job or promotion.

**Gang rape/battery** is sexual assault committed by two or more people. This is common practice in some communities and schools. A girl who consents to have sex with one boy sometimes finds herself gang raped by his friends.

**Incest** is sexual activity between close family relatives; e.g., father and daughter/son, mother and son/daughter, brother and sister, uncle and niece, etc.
After the group has exhausted the list, introduce the guest speaker. Be sure that you have prepared your speaker to address the following areas:

→ What do the laws in your community say about sexual abuse, rape, child molesting, incest, sexual harassment, gang rape, etc.?

→ Are the laws adequate or do they need updating?

→ What are the legal and social consequences to men/boys who rape?

→ Approximately how many cases of rape get reported each year?

→ Are the number of rape cases increasing or decreasing and why?

→ What should a woman, child or man do if he/she is sexually assaulted?

→ What can parents and other responsible adults in the child’s life do to keep him/her from being sexually abused?

→ Should parents talk to their children about sexual abuses?

→ What role should the church play in preventing sexual abuse?

→ How can we increase public awareness about this issue?

→ After the group has exhausted this discussion, move on to the following:
Cultural Factors Contributing to Rape

- Inequality of the sexes
- Media that portrays females as sex objects, property or weak creatures always needing protection.
- Double standards set by society on sexual behaviour that says men must be sexually experienced but women must remain chaste.
- The idea that a man’s sexual needs are more important than a woman’s.
- That after a man is sexually excited to the point of having an erection, it is only natural for him to complete the act of sexual intercourse.
- Cultural ideals that present rigid gender stereotypes of men as aggressive (analytical, etc.) and women as submissive (unthinking, victims, etc).
- If a man spends money on a girl/woman, he may expect sexual favours, even from his daughter.

Explain a study done by an anthropologist named Dr. Sanday found cultures that were high in levels of rape had a number of features in common. Cultures low in levels of rape also had shared characteristics.

<table>
<thead>
<tr>
<th>High-Rape Cultures</th>
<th>Low-Rape Cultures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low respect for women</td>
<td>High respect for women</td>
</tr>
<tr>
<td>Women seen as inherently inferior to men</td>
<td>High value placed on fertility and maternal behaviour</td>
</tr>
<tr>
<td>Women viewed as property</td>
<td>Complementary gender roles</td>
</tr>
<tr>
<td>Much violence in culture</td>
<td>Little violence in culture</td>
</tr>
</tbody>
</table>

Ask participants if they can think of other factors that contribute to rape? List and discuss.

Say that young men should, “Always take a no to mean no, even if he thinks the other person really means yes.”

Say to young women, “Make sure when you say no, that you mean no and that your body language also says no.”
Protecting Children and Teens against Sexual Abuse

Young people need to know that:

• no one has a right to abuse or touch them in a way that makes them feel uncomfortable.
• they should respect themselves, others and expect others to respect them.
• they should pay close attention to the personality of a potential partner/mate.
• they should tell someone they trust if they are being harmed in any way.

Ask participants to think of other ways to protect children against sexual abuse. List and discuss. Ask them to brainstorm ways to avoid rape.

Examples of some ways to avoid rape and other forms of sexual abuse:

✦ Don’t walk alone in dark places.
✦ Stick with the crowd.
✦ Don’t leave your drinks unattended.
✦ Use common sense.
✦ Trust your God given instincts.
✦ Men are stimulated by what they see so be cautious how you dress.
✦ Don’t give the impression that you engage in sexual intercourse.
✦ Avoid taking rides from strangers.
✦ Avoid being alone with a man/men in isolated places.
✦ Don’t drink.
✦ Don’t do drugs.
✦ Don’t feel pressured to say yes, even to a small request.
✦ Always have enough money to get home.
✦ Don’t let people know when you are home alone.
✦ If you think you’re being followed, go to the nearest public facility; e.g., gas station, police station, restaurant, etc.
✦ Always be aware of your surroundings.

4) **Video showing and discussion.** Show a relevant video and discuss.

5) **Role Plays/Discussion.** Get volunteers from the group to role-play a situation around sexual abuse. Afterwards, have the group discuss how they felt about the role-play.
Sample Scenarios

1) A mother tries to talk to her 9-year-old daughter about sexual abuse and how to stay safe. Although the mother is a little embarrassed about saying the word “sex,” she wants her daughter to know that no one has the right to touch her in a manner that makes her feel uncomfortable and that she should always come to her if she has any questions or is unsure about something.

2) A father explains to his 9-year-old son that he should always respect himself and that he should always respect females (girls and women), no matter what other males think.

6) **Summary/Wrap-Up**

Ask participants to:

- name at least three forms of sexual abuses.
- recall at least three factors that contribute to rape and child molestation.
- explain why it is important to talk to children about sexual abuse and what they can do to help keep their children safe.
- Encourage participants to attend other *Christian FLE* Programmes.
PROTECTING CHILDREN AGAINST CHILD MOLESTATION

“Discretion will protect you, and understanding will guard you. Wisdom will save you from the ways of wicked men, from men whose words are perverse, who leave the straight paths to walk in dark ways, who delight in doing wrong and rejoice in the perverseness of evil, whose paths are crooked and who are devious in their ways.” Proverbs 2:11-15

Purpose: To give participants a better understanding of sexual abuse and how to protect children against rape and molestation.

Objectives: Participants will understand the meaning of sexual abuse, rape and child molestation.

Participants will know at least three factors that contribute to child abuse and at least three warning signs that a child is being abused.

Participants will be able to talk to children about sexual abuse and how they can protect themselves.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Handouts “Preventing Sexual Abuse of Children” (around page 434)</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker: Active Listening (20 min)</td>
<td>Index cards, pens, markers, tape, flipchart, VCR/TV/Video</td>
</tr>
<tr>
<td>3. Defining Terms/Group Exercise (30 min)</td>
<td></td>
</tr>
<tr>
<td>4. Protecting Against Sexual Abuse (20 min)</td>
<td></td>
</tr>
<tr>
<td>5. Video/Role Plays /Discussion (40 min)</td>
<td></td>
</tr>
<tr>
<td>6. Summary/Wrap-Up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>

Margaret Sanger Center International, Copyright 2001 200
Advance Preparation:

- Invite a guest speaker to talk about child sexual abuse and molestation; e.g., a policeman, lawyer, health professional, social worker or other relevant professional.

- Have a relevant video set up to show. Make sure VCR/TV is working properly.

- Make enough copies of “Preventing Sexual Abuse of Children” (around page 434 in Resource Materials section) to give participants.

- Have enough index cards, flipchart paper, markers, pen/pencils.

- Have at least two role play scenarios in mind for your session.

- Write on flipchart paper the following headings: “What is Sexual Abuse?” “What is Child Molestation?” “What is Incest?” “Signs of Child Molestation”

Facilitators Notes:

1) **Devotion.** Have a prayer, song, reading (Isaiah 40:31) or some other form of inspirational meditation.

2) **Icebreaker: Active Listening.** Break participants up into groups of twos. Explain that you want them to complete this statement, “What really makes me angry is...” Have one person tell the other person what really makes him/her angry. Allow five minutes for this, then give the other person a chance to complete the same statement. Again, allow five minutes. Afterwards, ask participants to share what made some people
really angry. Ask people if they felt the other person was actively listening. If so, how could they tell? If not, why? Explain the importance of being an active listener. Say, “Too often when children talk, they are not listened to.” In fact, you hear adults saying things like, “Children should be seen and not heard.” This kind of attitude can put children at risk for abuse.

**Discussion Points**
What are some ways in which a child will tell you about a threatening situation? Will they always say directly “Mr. Jones touched my vagina?” or “Mr. Steven’s told me it was okay for people to see each other naked?” If not, why?

What are some possible behavioural signals that could alert you that a child is being or has been abused? List responses and discuss.

**If a child confides in you, reassure him/her that:**
• You are glad he/she told you.
• You believe what she/he told you.
• You know it is not her/his fault.
• You are sorry about what happened.
• You will do your best to protect and support him/her.

**Behaviour Signals:**
✧ Reluctance to be left alone with someone or go to a particular place.
✧ Expresses affection in inappropriate ways.
✧ Has sexual knowledge beyond his/her age.
✧ Exhibits seductive behaviour.
✧ Diagnosed with an STI.
✧ Sleep disturbances (bedwetting, trouble falling asleep, suddenly needs a night light
✧ School difficulties (inability to concentrate)
✧ Change in appetite
✧ Returns to younger, more babyish behaviour
✧ Behaviour shift (was outgoing, now withdrawn or was easygoing/confident, now fearful)

**Note:** Behavioural changes may be a result of other things; e.g., a move, divorce, new baby, etc.
3) **Defining Terms/Group Exercise.** Break the participants into four small groups. Give each group the flipchart paper you prepared on: “What is Sexual Abuse?” “What is Child Molestation?” “What is Incest?” “Sign of Child Molestation” Give the groups 10 minutes to come up with their responses. Have someone from each group report findings. Allow each reporter five minutes. Invite feedback from the larger group.

During the discussions, explain that some people only think of violent assault as child sexual abuse; however, it can take many different forms. In fact, most abusers do not use physical force but rather resort to subtle coercion or threats. Share the following facts and discuss.

**FACTS:**

**Sexual abuse.** We can differentiate between sexual abuse that involves forced, tricked or manipulated touch or sexual contact, although sexual abuse can occur without touch: obscene phone calls or exposing one’s sexual organs are examples. Sexual Abuse can also include breaking down barriers to privacy, for instance, harmful exposure of children to information or activities that exploit them and are inappropriate to their age or understanding level.

**Rape** is defined differently in each country. In some countries, rape is defined as an act of violence.
**Child molestation** is when an older person exploits a child for sexual gratification. The adult may be a family member, neighbour, acquaintance, authority figure or a stranger. The abuse is generally ongoing rather than a one-time occurrence. The offender is often a person who has influence and power in the child’s life. Children are manipulated, threatened and often forced. *Child Molestation* occurs between infancy and 11 years because children are most vulnerable to sexual exploitation at this age.

**Incest** is sexual activity between close family relatives; e.g., father and daughter/son, mother and son/daughter, brother and sister, uncle and niece, etc.

4) **Protecting Children/Teens Against Sexual Abuse.**

Introduce the guest speaker. Be sure that you have prepared the speaker to address the following areas.

<table>
<thead>
<tr>
<th>What we Fear</th>
<th>What is more likely to happen</th>
</tr>
</thead>
<tbody>
<tr>
<td>A dangerous weird stranger</td>
<td>A person they know (85%)</td>
</tr>
<tr>
<td>A violent attack</td>
<td>Bribery &amp; threats rather than extreme physical force</td>
</tr>
<tr>
<td>Out of the blue surprise</td>
<td>A situation that develops gradually over time</td>
</tr>
<tr>
<td>Isolated extreme incident</td>
<td>Frequent incidents taking many forms</td>
</tr>
</tbody>
</table>

A child usually knows and trusts the child molester. Most often the onset of child molesting is gradual. Detecting early warning signs can prevent a sexual assault.
We need to talk about child molestation and equip children with skills so they are not caught by surprise, trapped by shame or immobilized by confusion.

Ask participant to discuss some of the things a molester may say to coerce a child. List responses and discuss.

**Children need to know:**

- what an assault is so that they can recognize behaviour leading up to one.
- that they have the right to control who touches them and how.
- that they can ask us about puzzling adult behaviour.
- that it’s not their fault if something happens.
- that no one has a right to touch them in a way that makes them feel uncomfortable.
- we will protect them by taking them seriously if they share that someone has approached them in a sexual way or made them feel uncomfortable.
- they should not put someone else’s feelings above their own sense of safety and their need to seek protection.
- it is not okay for adults or an older child to ask them to keep a secret from someone they trust.

5) **Video/Role Plays/Discussion.** Show a relevant video and discuss. Get volunteers from the group to role-play a situation around sexual abuse. Afterwards, have the group discuss how they felt about the role-play.
Sample Scenarios

1) A mother tries to talk to her 9-year-old daughter about sexual abuse and how to stay safe. Although the mother is a little embarrassed about saying the word sex, she wants her daughter to know that no one has the right to touch her in a manner that makes her feel uncomfortable and that she should always come to her if she has any questions or is unsure about something.

2) A father explains to his 9-year-old son that he should always respect himself and that he should always respect females (girls and women), no matter what other males think.

Parents and other responsible adults can play the “What If” game with children. Posing certain questions helps to determine that child’s knowledge and understanding of contingency plans.

Example: “What if...?”

... your bicycle broke and someone offered to help you with it?
...someone took your tricycle across the street?
...the neighbour across the street asks you to come in and see the kittens?
...the baby-sitter asks you to keep a secret?

Ask participants to think of other “What if” questions. List and discuss.

Personal Space – Explores the concept of personal body space and teaches children to recognize when someone is invading their personal space.
The Stare Game – Two people stare at each other until one of them breaks eye contact and the other one wins. Talking about how that feels and where each feels it (in the stomach, chest, face) can identify feelings that are clues to being challenged or uncomfortable.

The Face Off – In the simplest version, two people stand face to face, back up from each other and then walk toward each other until one of them becomes uncomfortable with the closeness. Children will goof off with this game and run into each other but they can tell the point at which the other is close enough. We can emphasize the feeling of being close enough as a sign she/he can use to protect her/himself.

No – An exercise to increase the likelihood that children will say “no” to an exploitative approach. One of the reasons that “no” isn’t said more often is that rules and values may make it seem the wrong thing to do. It can be fun to brainstorm with the group what rules seem to encourage us to do things we might not want to do.

“Be nice to people. It’s not nice to hurt people’s feelings.”

“Don’t be rude. If someone speaks to you, answer him.”

“Always have to have a reason for things.”

“Take good care of your things, if someone threatens them, don’t just let them take them away.”

“You are responsible for taking care of other people.”

Adapted from No More Secrets – Protecting Your Child from Sexual Assault by Caren Adams and Jennifer Fay.
6) **Summary/Wrap-Up**

Ask participants to:

- explain child molestation.

- recall at least three factors that contribute to child molestation.

- explain why it is important to talk to children about sexual abuses and what can be done to help keep children safe.

- encourage participants to attend other *Christian FLE* Programmes.
SELF-ESTEEM AND DECISION-MAKING

“I praise you because I am fearfully and wonderfully made; your works are wonderful. I know that full well.”
Psalm 139:14

Purpose: To help young people understand the factors influencing self-esteem and its effect on decision-making.

Objectives: Participants will be able to define self-esteem, self-concept and generalized others.

Participants will be able to understand how self-concept and generalized others help shape our self-esteem.

Participants will be able to understand and appreciate how self-esteem impacts decision-making.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Handouts “Self-Esteem and Decision-Making” (around page 474)</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker: Perceptions (15 min)</td>
<td>Index cards, pens, markers, tape, flipchart, paper clips</td>
</tr>
<tr>
<td>3. Defining Terms (20 min)</td>
<td></td>
</tr>
<tr>
<td>4. Role Plays/Discussion (60 min)</td>
<td></td>
</tr>
<tr>
<td>5. Summary/Wrap-Up (5 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

- Have enough handouts on “Self-Esteem and Decision-Making.” (around page 474 in Resource Materials section.)
- Have enough flipchart paper, markers, pens, paper clips and index cards for group exercises.
- If available, show a relevant video on Self-Esteem and Decision-Making.
- Write on flipchart paper the following heading: “What Is Self-Esteem?”
- On flipchart paper, make two columns, one headed “Good Self-Esteem” and the other headed “Poor Self-Esteem.”
- Write on flipchart paper the following heading: “Factors Influencing Positive/Negative Self-Esteem.”

Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (Psalms 8:3-5) or some other form of inspirational meditation.

2) Introduction/Icebreaker: Perceptions. Give each participant a paper clip. Ask the group to tell something about the paper clip; e.g., “It’s small,” or “It has a beginning and an ending,” etc. If time permits, allow each person a chance to share. Afterwards, ask participants what, if anything, did they learn from this exercise? Explain that we each have our own unique way of looking at things. Some people will look at a piece of land and only see trees and dirt, while another will see a house, a building or a garden. Some people look at a half of
glass of water and see it as half full, others see it as half empty. Ask participants to think about factors (race, religion, economics, education, etc.) that influence our perceptions. List responses and discuss.

3) **Defining Terms.** Ask participants to define self-esteem, self-concept and generalized others.

Explain that:

**Self-esteem** is how you value and feel about yourself.

**Self-concept** is how one sees and evaluates one’s self; one’s self-image.

**Generalized others** is a person’s perception of the expectations for him/her shared by others in the community. When someone says, “What would people think if I did such a thing?” the people he or she is thinking of are their generalized others.

**How Do Positive & Negative Self-Esteem Impact Decision-Making?**

Self-Concept is how one sees and evaluates one’s self. Self-concept is important because what we think of ourselves often determines how we behave. The decisions we make are the results of our self-image.
Examples

- A person who values him/herself will not be easily influenced to take drugs or engage in risky behaviours.
- To win the acceptance of our peers we behave in ways that conform to their standards.
- People who do not believe they will succeed at a task are not likely to try.
- A person who is insecure or has general poor self-esteem is more likely to engage in risky behaviours.

Handout Maslow’s “Hierarchy of Needs” (See Resource Section.) Ask participants to label and discuss.

Put up the prepared chart papers labelled “Good Self-Esteem” and “Poor Self-Esteem.” Ask participants to define good and poor self-esteem. List and discuss.

Example:

<table>
<thead>
<tr>
<th>Good Self-Esteem</th>
<th>Poor Self-Esteem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence (&quot;I can&quot; attitude...)</td>
<td>Insecure (excuses: “I’m too fat/ugly, not smart enough,” etc.)</td>
</tr>
<tr>
<td>Assertive</td>
<td>Poor attitude</td>
</tr>
<tr>
<td>Active involvement</td>
<td>Non-participatory</td>
</tr>
<tr>
<td>Good manners/behaviour</td>
<td>Ill-behaved</td>
</tr>
<tr>
<td>Well groomed</td>
<td>Poorly groomed</td>
</tr>
</tbody>
</table>

Ask participants to brainstorm and come up with factors that influence both positive and negative self-esteem. List responses and discuss.
Examples

- A positive self-esteem is influenced by a healthy, nurturing home environment.
- A negative self-esteem is influenced by verbal abuse, demeaning behaviour.

4) **Role Plays/Discussion.** Explain that a “self-fulfilling prophecy” is a forecast or expectation whose existence creates the conditions for its own fulfillment.

**Skit: Self-fulfilling prophecy**

Have one participant act as a teacher and another act as a student. Instruct the teacher to repeatedly tell the student negative things pertaining to his ability, no matter how hard the student tries. Have the student give in and agree with the teacher. After the skit is over, ask participants to tell how the teacher impacted the student’s self-esteem and what effect it had on his decision.

5) **Summary/Wrap-Up**

- Review today’s session

**Ask participants:**

- if there are any questions or comments.
- to define self-esteem.
- to explain how self-esteem impacts decision-making.
- if they plan to use what they learned in the session.
- encourage participants to attend other *Christian FLE* Programmes.
DRUG AND ALCOHOL ABUSE

“Wine is a mocker and beer a brawler; whoever is led astray by them is not wise.”  Proverbs 20:1

Purpose: To make participants aware of the dangers of drug and alcohol abuse so that they can protect themselves and others.

Objectives: Participants will be able to identify the three categories of drugs.

Participants will understand the effects of drug and alcohol abuse.

Participants will be able to talk about the dangers of drugs and alcohol.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Handouts “Drug and Alcohol Abuse Outline” (around page 413)</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker:</td>
<td>VCR/TV/Video, Index cards, pens, markers, tape, flipchart</td>
</tr>
<tr>
<td>Feeling Good (15 min)</td>
<td></td>
</tr>
<tr>
<td>3. Drugs and Alcohol/Group Exercise</td>
<td></td>
</tr>
<tr>
<td>(60 min)</td>
<td></td>
</tr>
<tr>
<td>4. Video /Discussion (30 min)</td>
<td></td>
</tr>
<tr>
<td>5. Summary/Wrap-Up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

- Invite a guest speaker; e.g., narcotics officer, policeman, etc., to talk about drug and alcohol abuse.

- Have enough index cards and pens for each participant.

- Have plenty of chart paper and markers. Write on flipchart paper, “What are drugs?” “What kinds of drugs are there?” “Why do people use drugs?” “Physical and psychological effects of alcohol and drugs” “What are the economic effects of drug and alcohol abuse on: the individual, the family and the nation?”

- Have enough handouts on: “Drug and Alcohol Abuse Outline” (around page 413) and “Six Steps To Prevent Drug and Alcohol Use” (around page 416).

- Have a relevant video already set up in the VCR.

- Have a pack of the Feeling Good Cards.

Facilitator’s Notes:

1) **Devotion.** Have a prayer, song, reading (1 John 2:15, 16) or some other form of inspirational meditation.

2) **Icebreaker: Feeling Good.** Invite everyone to take a Feeling Good Card from the deck. After the cards are distributed, ask each person to respond to the question on the card in any way he chooses. The aim is to make participants feel more comfortable and at ease with one another and with you.
3) **Drugs and alcohol/group exercise.** Break participants into small groups of five. Give each group markers and the chart paper you prepared with the questions on drugs. Have group select a reporter. Allow 15 minutes.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What are drugs?</td>
</tr>
<tr>
<td>2.</td>
<td>What kinds of drugs/alcohol are there?</td>
</tr>
<tr>
<td>3.</td>
<td>Why do people use drugs/alcohol?</td>
</tr>
<tr>
<td>4.</td>
<td>What are the physical/psychological effects of drugs/alcohol?</td>
</tr>
<tr>
<td>5.</td>
<td>What are the economic effects on the individual, family, and nation?</td>
</tr>
</tbody>
</table>

Afterwards, give each reporter approximately five minutes to report findings. Fill in any important information that may be missing after each group reports.

Introduce the guest speaker to provide additional information on drug and alcohol abuse.
Facts on Drugs:

**Drugs** are defined as substances (other than food) that affect the chemistry and function of the body and that sometimes cause addiction or habituation.

**Drugs of dependence** are drugs that when taken for some time make the user depend on them for energy or for relaxation. Some of these drugs are psychological stimulants, others are depressants. They are in three categories: depressants, stimulants and hallucinogens.

**Depressants** are drugs that restrict the activity of the central nervous system, slowing down the pulse and breathing and lowering the blood pressure; e.g., marijuana, alcohol, opium, heroin, etc. They also reduce the ability to receive information from outside the body through the senses. Thus, vision is impaired, hearing is impaired, the senses of smell, taste and touch are impaired, sexual response is impaired, reactions and judgment are impaired. Drug use creates an inability to control normal behaviour that can lead to aggression, socially unacceptable behaviour, accidents and harm to oneself and others. Marijuana may cause euphoria or feelings of detachment, hallucinations, mental changes and lasting impairment of the mind.

**Stimulants** are drugs that increase the blood pressure and give the user a feeling of power; e.g., cocaine. They may cause loss of appetite, convulsions, hallucinations or terrifying dreams or mental illness.

**Hallucinogens** are drugs that distort perception. An individual thinks objects or events are there that are not; e.g., LSD. LSD stands for lysergic acid diethyl amide and may cause euphoria or feelings of detached well-being, hallucinations, mental changes and lasting impairment of the mind.
Facts on Alcohol:

Alcohol is the most common mood-altering drug used throughout history. In every age, drunkenness has been condemned. Alcohol is any of a series of compounds that cause intoxication. Alcoholic drinks include home brew, beer, gin, wine, rum, vodka, whisky, etc. Many people think beer is food because it is made from grains, sugar and yeast. In fact, the brewing process destroys nearly all food values.

Ask participants to brainstorm ways to prevent drug and alcohol abuse. List responses and discuss. After discussion, be sure to hand out copies on the “Six Steps To Prevent Drug and Alcohol Use” and “Outline on Drug and Alcohol Abuse” (see Resource Section).

Ask participants to explain what the legal age is for purchasing alcohol? Ask if this information is posted in liquor stores.

Ask them to brainstorm ways that young people acquire alcohol; e.g., at parties, home, etc. List responses and discuss.

Ask participants to list ways young people can readily obtain drugs. Ask which drugs are common. List and discuss.

Ask participants to mention some of the factors influencing drug availability; e.g., a geographical location that is a port, tourism, media influence, widespread cultivation and use of marijuana, etc. List responses and discuss.

4) Video/Discussion. Show a relevant video on drug or alcohol abuse and discuss. Ask participants if it is important to talk to children about drugs and alcohol abuse. If so, why? If not, why?

Ask participants at what age children should be engaged in discussions about issues related to drugs, sex and alcohol. List responses on flipchart and discuss.
Explain that it is very important that young people talk about these issues in order to understand what they mean. Young people learn a lot about drugs and alcohol largely from their peers. Much of the information is incorrect and is sometimes presented in a manner that entices them to experiment.

One of the many advantages in talking about sex, drugs and alcohol when children are young is that when they are older, they will be well armed with the facts and be able to avoid dangerous experimentation.

Use this quote from A. Ernest Wilder-Smith’s book, *The Causes and Cure of the Drug Epidemic*: “Drug availability then, is only a relatively minor cause behind the present epidemic. It may cause aggravation of the epidemic once the epidemic is established. A much more important cause of the drug epidemic is not the physical availability of drugs to people but rather the physical availability of people to the drug.”

5) **Summary/Wrap-Up**

☐ Review today’s session. Ask participants if they have any additional comments or any unanswered questions.

☐ Ask participants to name the three categories of drugs and their adverse effects on the body and mind.

☐ Ask participants to talk about what they will tell young people about drugs and alcohol.

☐ Ask participants to give three reasons why people do drugs.

☐ Thank participants for attending and encourage them to attend other *Christian FLE* Programmes.
DISPELLING MYTHS AND TELLING THE FACTS

“Have nothing to do with godless myths and old wives’ tales; rather, train yourself to be godly.” 1 Timothy 4:7

Purpose: To explore myths and facts regarding sex and sexuality and provide factual information on puberty, conception, pregnancy, drugs, alcohol, rape, AIDS and sexually transmitted infections.

Objectives: Participants will better understand myths, their origins and their implications for the health of individuals and society.

Participants will be able to distinguish common myths from facts on issues related to sex and sexuality.

Participants will better understand the role that myths play in culture and the potential danger in accepting myths unquestioningly.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Myth or Fact Cards</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker: Myth/Fact Game (20 min)</td>
<td>VCR/TV/Video, Index cards, pens, markers, tape, flipchart</td>
</tr>
<tr>
<td>3. Defining Myth/Facts: Group Exercise (60 min)</td>
<td></td>
</tr>
<tr>
<td>4. Video/Discussion (60 min)</td>
<td></td>
</tr>
<tr>
<td>5. Role Play Scenarios (30-45 min)</td>
<td></td>
</tr>
<tr>
<td>6. Summary/Wrap-Up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

- Have enough flipchart paper, markers and tape for group exercise.

- Write the definition for “Myths” and “Facts” on flipchart paper:

  - **Myths** are opinions, beliefs, idealized fantasies, traditional stories that have no basis in fact yet are critically held by the members of a group. The word “myth” comes from the Greek word *mythos* meaning fable or story.
  
  - **Facts** are known truths, events that have actually occurred, something objectively verified, things with real demonstrable existence.

- Select a relevant video and set it up for viewing.

- Create on index cards 40 myths and facts that relate to sex and sexuality. Below are some local myths you may wish to use:

  1. If you kiss someone with HIV you will get the disease.
  2. If a woman is loyal to her partner she will not get AIDS.
  3. Having sexual intercourse with a virgin will rid a man of an STI or AIDS.
  4. Having sexual intercourse at a very early age can physically hinder one’s growth, especially in boys.
  5. A woman who is menstruating should not do any cooking because she is unclean.
  6. A man’s sexual drive is more important than a woman’s.
  7. When a woman reaches menopause, her sexual desire diminishes.
  8. Black men have larger penises than white men.
  9. Sexual intercourse the night before will decrease athletic performance.
 10. As a man grows older, he can no longer have erections.
 11. A large penis means the man is sexually more potent.
 12. The penis must ejaculate inside the woman’s vagina for pregnancy to occur.
 13. Menopause begins when all of the eggs in the ovaries have been discharged.
 14. Sexually compatible couples have simultaneous orgasms.
 15. The size of a man’s penis depends on his body build.
 16. A pregnant woman should refrain from sexual intercourse, especially near the end of her pregnancy.
17. Children who ask questions about sex do so because they are sexually active or planning to have sex.
18. Women who have large breasts are more sexually aroused than those with small breasts.
19. A baby’s sex depends on which side of the ovaries the egg comes from.
20. Women prefer a large penis to satisfy them.
21. Breast milk from a breast-feeding mother is good medicine for sore eyes/red eyes.
22. No woman is raped who doesn’t want to be raped.
23. When a girl or woman says no to sex, she doesn’t really mean it.
24. If a person does not become sexually active by a certain age, he or she will become ill.

Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (1 John 4:1) or some other form of inspirational meditation.

2) Introduction/Icebreaker: Myth and Fact Game. Distribute to each participant the Myth and Fact (index) Cards you have prepared. Have each person read the statement out loud and tell the group if the statement is true or false and why. As the facilitator, you should know what is myth, what is fact and be able to explain why.

Explain that young people tend to discuss sex primarily or only with their peers. Much of the information they get is inaccurate. This workshop will explore myths and facts regarding sexuality and provide reliable information on topics related to sex and reproduction.

3) Defining Myths and Facts/Group Exercise. First, ask participants to define “myths.” List responses on flipchart paper and discuss. Now, ask them to define “facts.” Again, list responses on flipchart paper and discuss. Put up your own definition for “myths” and “facts” that you prepared before the workshop.
Myths are opinions, beliefs, idealized fantasies, traditional stories that have no basis in fact, yet are critically held by the members of a group. The word “myth” comes from the Greek word *mythos* meaning fable or story.

Facts are known truths, events that have actually occurred, something objectively verified, things with real demonstrable existence.

Explain that myths are universal and vary from country to country. Myths can play an important role in society; however, there are some myths that are dangerous. Some myths can become self-fulfilling prophecies, especially if they are believed to be true.

⚠️ Examples of Dangerous Myths:

- “If an HIV infected man has sexual intercourse with a virgin, he will not get AIDS.”
- “Marijuana increases the sex drive.”
- “Having sexual intercourse with a virgin will cure a Sexually Transmitted Infection.”
- “Alcohol increases sex drive.”
- “Women provoke men to rape them.”
- “If a woman urinates immediately after having unprotected sexual intercourse, she will not get pregnant.”
- “Wife battering is necessary to keep women in their place.”
- “Birth control pills will make you sick and cause cancer.”
- “A girl cannot get pregnant if she has sex standing up.”
Break participants into five small groups. Give each group chart paper and markers. Have them select a reporter and a recorder. Ask the group to think about some of the dangers and health risks associated with myths related to the following topics:

- drugs
- conception/pregnancy
- domestic violence
- rape
- contraception

Allow approximately 20 minutes for the groups to come up with myths and their health implications. Each reporter should be given approximately five minutes to report findings. If time permits, allow the other groups to ask questions and make comments. Afterwards, ask the participants if this exercise forced them to think about myths differently. If so, how? If not, why?

4) **Video Presentation.** Show a relevant video and discuss the main theme of the film. Ask participants if they think myths played a role in how men and women behaved. If so, how? If not, why?

In the absence of a video, you can engage participants in role-play situations that bring out behaviours that are influenced by myths within their culture.
5) **Role Play Scenarios:**

- A man is caught having an extra-marital affair with his baby sitter.
- A man beats his wife in front of all his neighbours.
- A group of young men decide to gang rape a young girl.
- A young woman decides to have unprotected sex with her boyfriend who she suspects is fooling around with other girls.
- Etc.

**NOTE:** Be aware of the appropriate time to intervene in each role-play situation.

6) **Summary/Wrap-Up**

**Ask participants to:**

- define myths and facts and give examples of each.
- explain at least three myths about sex and sexuality that can have dangerous health implications.
- explain the value of giving children the facts about issues related to sex and sexuality.
- Thank everyone for coming and encourage him or her to participate in other *Christian FLE* Programmes.
CONFLICT RESOLUTION

“Blessed are the peacemakers, for they will be called sons of God.” Matthew 5:9

Purpose: To help participants understand the elements of conflict and different methods of resolving conflicts within the context of the family.

Objectives: Participants will be able to recognize positive and negative conflicts.

Participants will be able to identify at least three “Communication Blockers” that contribute to family conflict; e.g., parent-child, partners, siblings and extended family.

Participants will know at least three basic strategies to use in conflict resolution.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Peacemaking Rules, transparencies</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker:</td>
<td>pens, markers, tape, flipchart rope</td>
</tr>
<tr>
<td>Tug of War Game (7 min)</td>
<td>or sheet, a ball</td>
</tr>
<tr>
<td>3. Session I (1 hr 40 min)</td>
<td></td>
</tr>
<tr>
<td>4. Role Plays (45 min)</td>
<td></td>
</tr>
<tr>
<td>5. Conflict Resolution (30 min)</td>
<td></td>
</tr>
<tr>
<td>6. Summary/Wrap-Up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

- Prepare four separate sheets of flipchart paper with information on the following topic areas: “Communication Blockers” “Peacemaking Rules” “Core Values in Conflict Resolution” “Options for Resolving Conflict Disputes”

- Arrange meeting room in a semi-circle.

- Write down four role-play scenarios on index cards or paper to dramatize three family conflicts and one external conflict.

- Have transparencies prepared on this topic.

Facilitator’s Notes:

1) **Devotion.** Have a prayer, song, reading (Roman 12:18) or some other form of inspirational meditation.

2) **Introduction/Icebreaker: Tug of War Game.** Divide participants into two groups by having participants count off 1, 2, 1, 2, etc. Explain the object of the game is to see how conflict arises. Place an object on the floor between the two groups that represents a border. Using a long rope, twisted sheet or cloth, have each group pull on opposite ends of the rope to see which group is forced to cross the border. Whoever crosses the border loses. Allow approximately three minutes for this. Afterwards, ask participants to explain why their group won or lost. Ask if there were any conflicts within the group. If so, what was it? Was it resolved? If so, how?
3) **Positive and Negative Conflict.** Explain that in life we experience both positive and negative conflicts. Give an example of a positive conflict; e.g., having to choose between what to wear or what to eat, etc. Explain that a negative conflict may be something like choosing to fight over talking it out. Both are conflicting dilemmas, but the negative example has serious consequences that may even be life threatening.

Ask participants to think about negative conflicts that can occur within family relationships and how they impact the individual, family, community, etc. List responses and discuss.

4) **Role Play.** Using role-play situations ask for eight volunteers. Two people will be needed for each role-play; e.g., conflict scenarios between a parent/child, partners, siblings, and external conflict between two motorists. Give players their assignment and allow them three minutes to prepare outside the workshop room.

Allow three to five minutes for each role-play. Afterwards ask the group to:

- identify the relationship between the two persons.
- explain the nature of the conflict.
- evaluate if the role-play was realistic.
- think about other conflicts that may arise.
- Could this situation be avoided or handled differently? If so, how?
- Determining the impact of the conflict on the individual, family, community, etc.

List responses and discuss each point.
Ask participants to define “Communication Blockers.” Explain “There are things that interfere with good communication; e.g., name-calling, cursing, insulting, accusations, etc. Ask the group to think of other blockers. List them on flipchart paper and discuss.

**Communication Blockers:**
- interrupting
- ignoring
- sarcasm
- insulting
- threatening
- stereotyping (statements which label people and make them angry/resentful)
- judging
- blaming
- stating opinion as fact
- expecting someone to read your mind
- hitting, punching, slapping, etc.
- screaming, etc.

Explain that communication blockers can lead to violence. In fact, violence is increasing in many countries. The environments in which many young people grow up do not encourage peacekeeping attitudes and behaviours. Hence, conflict resolution is like a retraining process.

Parents and other adults are quick to criticize young people without really understanding the sub-culture norms and pressures they are confronted with. Most young people develop coping skills (positive or negative) by and large from the environments in which they live.
While young people need to know *how to avoid conflicts* and *how to resolve them peaceably*, it is equally important for them to know how to survive in a hostile climate. They need to practice different methods of resolving conflicts to see which ones are more effective.

5) **Conflict Resolution Strategies and Peacemaking Rules.**

Divide participants into four groups. Give each group flipchart paper and markers. Assign one of the above role-play scenarios already prepared to each group. Have each group select a recorder. Tell them they will have 15 minutes to respond to the following:

- specific steps that could be taken to resolve the conflict
- resource persons and/or places that could be helpful
- possible obstacles or blocks to resolving the conflict
- strategies to get around the blocks

Note: Have groups report on specific blocks that the group could not get around.

Afterwards, have each group report back findings. Allow the presenter about five minutes to give his or her report, then ask others if they have any comments. Allow several minutes for larger group discussion. Remember participants are very resourceful. Your role is not to be a fountain of wisdom and information but to facilitate discussion, draw on the knowledge in the group, bring together information on the issues, summarize findings and, where necessary, add important information that may have been overlooked.
Put up the three sheets of prepared flipchart paper or use transparencies on:

**Peacemaking Rules**
1. Identify the problem
2. Focus on the problem, not the person
3. Attack the problem, not the person
4. Listen with an open mind
5. Treat the other person’s feelings with respect
6. Take responsibility for your own actions

**Core Values in Conflict Resolution**
1. Cooperation
2. Affirmation
3. Empowerment
4. Neutrality
5. Confidentiality

**Options for Resolving Conflict Disputes**
1. Adjudication
2. Negotiation
3. Mediation

Using the four role-play scenarios, have participants practice how they would use the Peacemaking Rules to resolve conflicts. Allow the group to practice this. Discuss.

Ask participants to throw a ball in the air to the height that shows how much they liked the session. The higher the ball, the better they liked the session.
6) **Summary/Wrap-Up**

**Ask participants to:**

- explain the difference between a *positive* and *negative* conflict.
- name three “Communication Blockers” that contribute to negative conflicts
- identify three strategies to avoid conflicts and three methods of resolving conflicts.
GOAL SETTING

“Commit to the Lord whatever you do, and your plan will succeed.” Proverbs 16:3

Purpose: To help participants discover short-term and long-term goals; how to set realistic goals; and resources that will help achieve your goals.

Objective: Participants will be able to differentiate between short-term and long-term goals.

Participants will be able to explain how to set realistic goals.

Participants will be able to identify resources that will help them achieve their goals.

<table>
<thead>
<tr>
<th>Workshop Steps/Time</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Devotion (3 min)</td>
<td>Handout: “Tips for Living”</td>
</tr>
<tr>
<td>2. Introduction/Icebreaker:</td>
<td>(around page 493)</td>
</tr>
<tr>
<td>&amp; GO for the Goal (15 min)</td>
<td>pens, markers, tape, flipchart</td>
</tr>
<tr>
<td>3. Achieving Goals</td>
<td>blank sheets of 8 1/2” x 11”</td>
</tr>
<tr>
<td>&amp; Exercise/Discussion (60 min)</td>
<td>paper</td>
</tr>
<tr>
<td>4. Techniques and Review (45 min)</td>
<td></td>
</tr>
<tr>
<td>5. Summary/Wrap-Up (7 min)</td>
<td></td>
</tr>
</tbody>
</table>
Advance Preparation:

- Have enough handouts on “Tips for Living.”

- Have enough markers, flipchart paper, pens, and blank sheets of paper for individual and group exercises.

- Write on four separate pieces of flipchart paper the following headings: “Goal” “Realistic Goals” “Resources” “Trade-Offs” “Short/Long Term Goals” “Setting Priorities”.

Facilitator’s Notes:

1) Devotion. Have a prayer, song, reading (Psalm 23) or some other form of inspirational meditation.

2) Introduction/Icebreaker: Go For the Goal. Give each participant a sheet of blank paper and a pen or pencil. Explain that this exercise is designed to make us think about our goals. Even though everyone may not have a long-term goal, knowing what you want to do makes life more interesting and rewarding. It gives purpose to your life and helps you do your best. Give out the “Tips for Living” handout, along with some writing paper and pens/pencils.

Ask participants to list skills they have tried to master in the last year/few years. For example, students may list trying to learn how to use the computer. Ask participants to close their eyes for a few minutes and reflect on the following three questions. Write responses on flipchart paper and discuss.
1. What do you want to achieve in life?
2. What occupation would you like to have; e.g., architect, plumber, teacher, etc.
3. Would you like to be self-employed or employed by someone else?

Ask participants if their responses were similar to others. Ask if there were any surprising responses. Ask what are some of the factors in society that may contribute to how people choose careers? Explain that the skills we want to master and the things they want to accomplish are “goals.”

Put up the prepared flipchart paper on ”Goals” “Realistic Goals” “Resources” “Trade Offs” “Setting Priorities” and “Short/Long-Term Goals”. Now give out paper and pens to participants. Ask the group to write down the definitions for each word and put them into a sentence. Ask participants to give examples of Goals, Short/Long-Term Goals, Realistic Goals, Resources and Trade-Offs. List responses and discuss. Be sure to correct any misconceptions.

**Setting personal goals** is something you want to achieve. **Setting priorities** may involve making Trade-Offs. **Short and long term goals** relate to the amount of time that it takes to achieve a particular goal. For example, a short-term goal may be to complete a CPR Course that will prepare you for a long-term goal of becoming an emergency medical technician. **Realistic goals** are goals that you can achieve. **Resources** are the things required for obtaining a particular goal.
**Trade-Off** is something that you give up in order to get something more important. For example, you may decide to finish a college degree instead of getting married.

3) **Achieving Goals/Exercise/Discussion.** Ask participants to brainstorm factors that impact how one achieves his or her goals; e.g., an individual’s attitude (the way you feel about something). List and discuss.

Write on flipchart paper, “Nothing Succeeds Like Success.” Ask participants what they think this means. Record responses on chart paper and discuss. Say, “Having successful experiences as a young person will help them achieve success throughout their lives.” Ask participants if they agree or disagree with that statement and why. Again, list responses and discuss.

Ask participants to review the “Tips for Living” handout. Ask them if they think these tips are important. If so, how? If not, why? List responses and discuss.

Explain that planning is an important step in achieving goals. Emphasize that unrealistic goals can lead to frustration.

4) **Techniques in Applying Concepts and Review Exercise.**

- Have participants write down a long-term goal that they are interested in achieving. List all the short-term goals that can help you achieve your long-term goal.

- Talk to your family members about the goals you have as a family. Choose one of your family’s goals and design a newspaper type ad for the goal. Use the title “Go for the Goal” for your ad. Ask for permission to display the ad in your home.
Review Exercise
Ask each person to respond to the following:

**Compare**
What is the difference between a long-term goal and a short-term goal?

**Vocabulary**
Define the term “realistic goal” and use it in a sentence.

**Identify**
List five resources that can help you achieve your goals.

**Explain**
Why is it important to set priorities for your goals? Why is it important to set goals?

**Illustrate**
Give an example of a trade-off you have had to make.

5) **Summary/Wrap-Up**

- Remind participants that to be successful, you must set realistic goals throughout life. You will have both long and short-term goals.

**Ask participants to:**

- define short and long term goals.

- give examples of a realistic goal and an unrealistic goal.

- explain what is meant by “Trade-Off.”

- identify at least three important resources that can help achieve goals.
PART FIVE

RESOURCE MATERIALS
SECTION 1

Topic: Ice Breaker Exercises

CONTENTS

Workshop Ground Rules
Adjective Name Game
Get That Autograph
Things We Have In Common
Myth or Fact
Myth Activity Questionnaire
Word Exercise
Did Anyone Ever Tell You About…?
Training Session Workshop Evaluation Form
Teen Questionnaire
Parent Questionnaire
Things to Remember When Conducting Training & Workshops
Experience and Learning
Working with Guest Speakers
Teaching Techniques
Glossary of Terms
WORKSHOP GROUND RULES

1. **Always begin with a prayer or some other form of inspirational meditation.** This invites God into your workshop/session.
2. **Participate** – Everyone, even the facilitator, is a participant. No spectators!
3. **Punctuality and attendance** – Encourage everyone to be on time and not to miss sessions.
4. **Respect the opinion of others** – Nobody’s opinion can be considered right or wrong. An opinion is just that – someone’s own personal way of looking at an issue.
5. **Be considerate of others’ feelings** – There are no “stupid” questions. All questions are valid. Members of the group can express personal thoughts only if they feel sure they will not be criticised or “put down” for opinions that are not widely shared or for any questions they might ask.
6. **Respect everyone’s confidence** – If someone shares something of a personal nature, it must be kept confidential.
7. **Everyone has the right to be heard** – Some people find it easy to express their ideas while others find it difficult. It is important for the entire group to value each member’s contribution to the discussion.
8. **No topic is “taboo”** – Anything that you would sincerely like to know more about, you could bring up at this session (as long as you bring it up in a respectful manner).
9. **All rules apply to everyone** – No one is an exception.
10. **Talk loud enough for everyone to hear you** – Whenever possible create “eye contact” with whomever you are speaking.
ADJECTIVE NAME GAME

This game works extremely well with all-day sessions or when you will be seeing the same participants more than once. The object of this game is for each participant to think of a descriptive game name for him/herself and to memorize other participants’ game names.

This exercise is an excellent way for people to learn about other members in the group and at the same time have fun with remembering other peoples game names.

Explain that people tend to remember much better when they have to rely solely on their memory. Therefore, no one is allowed to write down game names. It’s also much more fun to remember people by the descriptive words they choose to call themselves. Follow these simple instructions.

Give your correct name, then drop your surname and put an adjective (descriptive word) before your first name. Example, “My name is James Lawson, call me ‘Jammin’ James.” That person tells the group a little about himself (where he is from, number of children, why he is here) and then the next person has a turn.

The next person begins by saying “Hello, ‘Jammin’ James, my name is Sandra Sally, call me ‘Shy’ Sandra... “I come from the city, I have five children ages two to 14 years, I came because I want to be a better parent...” Then the next person has a turn.

The process continues until all participants have had a turn at introducing themselves. Obviously persons nearest to the end are challenged with trying to remember all of the game names starting with the first name; ‘Jammin’ James... then ‘Shy’ Sandra, etc., etc., etc.

Have Fun!
GET THAT AUTOGRAPH

Hand out copies of this exercise to each participant. Have them go around the room to see if they can get people to put their initials next to the statement that is true for them or one with which they agree. Allow about 7 to 10 minutes for this game. Whoever has the most signatures when time is up wins the game.

1. I think schools should educate students about sexuality.
2. I can name three alternatives to sexual intercourse.
3. I have talked with my children about sex and AIDS.
4. I get nervous when my children bring up the subject of sex.
5. I know how to put on a condom properly.
6. I personally know of someone who has died of AIDS.
7. I can name three types of sexually transmitted infections.
8. I would be embarrassed to buy a condom.
9. I think it is useless to try to get people to practice safer sex.
10. I think people with AIDS should not socialize with other people.
11. I believe that masturbation is a sin.
12. I believe male children are more important than female children.
13. I believe that a woman is never responsible for her own rape.
14. I believe parents are the primary sex educators of their children.
15. I believe religious communities should not be involved in teaching parents and children about sexuality.
**THINGS WE HAVE IN COMMON**
**(ICE BREAKER EXERCISE)**

Make copies of this exercise. Have participants go around the room and get signatures from people who have the following things in common:

- Same colour eyes
- ____________________________
- Same height
- ____________________________
- Same age
- ____________________________
- Wears same shoe size
- ____________________________
- Got most sex education from peers
- ____________________________
- Raised in a single parent home
- ____________________________
- Worry too much
- ____________________________
- Have trouble sleeping at night
- ____________________________
- At least 10 lbs. over desired weight
- ____________________________
- Have an out-going personality
- ____________________________
- A morning person
- ____________________________
- Only require 5 hours of sleep
- ____________________________
- Hates to swallow pills
- ____________________________
- Have more than 3 siblings
- ____________________________
MYTH OR FACT

DIRECTIONS: Facilitator can duplicate this page and cut out the underlined statements into strips. Have participants select one of the strips, read the statement out loud and say if it’s a Myth or Fact and why.

1. **A girl can become pregnant before she has her first period.**
   **FACT** – Pregnancy occurs when a man’s sperm fertilizes the female’s egg. Even before a girl has her first period (menarche), her ovaries release the first egg. If a girl has sexual intercourse at the time her egg is released, she can become pregnant.

2. **It is unhealthy for a girl to bathe or prepare food during her period.**
   **MYTH** – There are no physical reasons why girls should not bathe or prepare food during menstruation. Bathing is important for good hygiene. Blood and tissues come from the lining of the uterus when an egg is not fertilized. Hence the blood is not bad or contaminated in any way.

3. **Abstinence is the only method of contraception that is 100% effective.**
   **FACT** – Abstinence is not engaging in sexual intercourse of any kind. Avoiding sexual intercourse is the only way that a couple can be sure to prevent a pregnancy. Abstinence requires discipline.

4. **In males, one testicle usually hangs slightly lower than the other one.**
   **FACT** – All bodies are uneven – one hand or foot is usually larger, one of a woman’s breasts is usually slightly larger and one testicle hangs slightly lower than the other. This is completely normal. Some doctors believe that it eliminates chafing.
5. **A couple can avoid a pregnancy if they have intercourse in certain positions.**
   **MYTH** – Intercourse in any position – sitting, standing, lying down – can lead to a pregnancy.

6. **Males need to have sexual intercourse in order to be healthy.**
   **MYTH** – While it is normal and healthy for both men and women to have sexual feelings and a desire to express them, males will not get sick without regular sexual intercourse.

7. **Alcohol and marijuana increase sexual arousal.**
   **MYTH** – Actually, these substances are depressants. Although these drugs can reduce inhibitions (up tightness or hang-ups) and make people feel at ease or sexy, they can actually reduce sexual performance. They decrease the flow of blood to the genital area, making it more difficult for men to have or even maintain an erection and can make it more difficult for men and women to experience orgasm. More importantly, the influence of these drugs can result in poor decision-making and risky behaviour; i.e., having sexual intercourse without using a condom.

8. **Cancer of the testicle typically affects older men, those fifty and above.**
   **MYTH** – Cancer of the testicle is a rare but serious form of cancer usually found in young men. Boys and men should be encouraged to feel for any unusual lumps in their testicle (testicular self-exam) while bathing on a regular basis.

9. **The pill (oral contraceptives) causes cancer.**
   **MYTH** – The pill has been tested for many years and is now considered to be safe for most women. Although the pill can sometimes lead to minor side effects such as breast tenderness, headaches and slight weight gain, there is no
evidence that the pill causes cancer. In fact, the pill helps prevent some forms of cancer.

10. **There is one absolute “safe” time between menstrual periods when a woman cannot get pregnant.**
    **MYTH** – There are no absolutes when it comes to safe. Even though a woman monitors her cycle for signs of ovulation, she cannot be certain she won’t get pregnant if she has unprotected sex.

11. **Men’s penises are more similar in size when they are erect than when they are flaccid (soft or non-erect).**
    **FACT** – Men’s penises vary quite a bit when they are flaccid but less so when they are erect. The size of a man’s penis has nothing to do with masculinity or the ability to be a good lover or father children.

12. **Once a man is aroused and has an erection, he must ejaculate in order to avoid harmful effects.**
    **MYTH** – A man may feel discomfort and heaviness in his testicles. However, that feeling will go away. There are no harmful effects.

13. **Women should begin having pelvic exams in their mid to late teen years.**
    **FACT** – Girls should begin having an annual pelvic exam by the age of 18 years and even younger if she is sexually active to ensure that her genitals and reproductive organs are healthy.

14. **Males always have symptoms when they have a sexually transmitted infection (STIs).**
    **MYTH** – Certain STIs such as Chlamydia and Gonorrhoea typically show no symptoms in women and often show no symptoms in men as well. HIV infection can go undetected without symptoms for many years. It is important for males or females to be examined regularly by a health professional if they are engaging in sexual intercourse.
15. **A girl or woman with a heavy discharge from her vagina probably means she has a sexually transmitted infection.**
   **MYTH –** After puberty, vaginal discharge is normal. The vagina has a natural process of cleansing itself. The amount of discharge varies from woman to woman and is usually heaviest around the time she ovulates. If the discharge causes itching, burning or has an odour or colour than usual, that may be a sign of a common vaginal infection. If she is sexually active, it may indicate an STI. In case, the woman should consult a health professional.

16. **Condoms used correctly are effective in preventing STI/HIV.**
   **FACT –** Condoms are not 100% effective. However, for people who are having intercourse, they are the most effective way of preventing STIs including HIV infection that causes AIDS. Used correctly and consistently, condoms are 98% effective and will pregnancy 90% of the time based on actual use. When are combined with a spermicide, they are extremely in preventing pregnancy and HIV/STIs.

17. **Teenagers in the United States can be treated for STIs without their parents’ permission.**
   **FACT–** Clinics and health professionals are prohibited by law from asking for parental consent to test or treat a teenager with an STI.

18. **A woman cannot get pregnant while she is nursing a baby.**
   **MYTH –** It is true that regular and on demand breast-feeding suppresses ovulation in most women. However, some women continue to ovulate and have gotten pregnant while breast feeding on demand.

19. **There is no known cure for herpes.**
   **FACT –** Herpes is a virus that can cause painful sores on the mouth, genitals or anus; and once contracted, it cannot be cured. Women with herpes may have a greater risk of developing cancer of the cervix; they should have a Pap Smear every year without fail.
20. **Having a sexual experience with someone of the same sex means you are gay or lesbian.**

**MYTH** – Having a same sex experience does not mean a person is a homosexual. Many young people have a sexual experience as a way of exploring their sexuality. What determines whether people are gay, lesbian or bisexual are their feelings, not their sexual behaviour. People who come to recognize that they are gay have had primary feelings of attraction for the males/females throughout their adolescent and adult lives, even if they denied those feelings initially.

21. **A woman can get pregnant even if a man doesn’t ejaculate or “come” inside her vagina.**

**FACT** – If a man ejaculates near the opening the vagina or touches her vulva while he has semen on his fingers, it is possible for sperm to find their way inside and fertilize an ovum. Women have become pregnant without actually having intercourse.

22. **In homosexual or gay relationships, one person usually takes the “male” role and the other takes the “female” role.**

**MYTH** – In the past, gay men and women were more likely to adopt roles of “husband” and “wife.” However, today people express themselves as individuals rather than in specific roles.

23. **A woman will always bleed and feel pain when she has vaginal intercourse for the first time.**

**MYTH** – Most women have a hymen, a thin membrane partially covering the entrance of the vagina. However, hymens vary in size and thickness. Some women may see blood while others may not.
## MYTH ACTIVITY QUESTIONNAIRE

<table>
<thead>
<tr>
<th></th>
<th>MYTH</th>
<th>FACT</th>
<th>UNSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Negative body image can affect a man/woman's relationship.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>2. The absence of the hymen proves that a girl is not a virgin.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>3. You can always tell if someone is homosexual.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>4. All men should be circumcised.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>5. Orgasm and ejaculation are separate processes.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>6. Nocturnal emissions (wet dreams) are indications of sexual disorders.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>7. A woman’s sexual desire declines after menopause.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>8. Homosexual encounters during childhood or adolescence usually do not interfere with heterosexual relations later on in life.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>9. Alcohol is a sexual stimulant.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>10. Women should refrain from sexual intercourse during pregnancy, especially near the end.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>11. Marijuana is a sexual stimulant.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>12. Women can have orgasms during their sleep.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>13. A healthy elderly person can continue to have sexual intercourse and orgasms.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>14. Transvestites, transsexuals and transgender people are all homosexuals.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>15. A woman who has had a hysterectomy loses interest in sex and is unable to experience an orgasm.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>16. Intercourse the night before decreases athletic performance.</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
</tbody>
</table>
MYTH ACTIVITY – ANSWER SHEET

1. Truth – A person’s self-concept can definitely affect her/his interactions with the opposite sex.

2. Myth – Girls are not always born with hymens or they may be torn in the process of growing up. Some hymens are small and flexible and may still be partly intact after intercourse.

3. Myth – Knowing if someone is homosexual is not really possible unless you ask that person and he or she tells you directly. People sometimes look at feminine looking men and masculine looking women and make the assumption that they are homosexual. In reality, this may or may not be true.

4. Myth – There are various views on the subject. For health reasons, a male needs to clean behind the foreskin if he is not circumcised. Some religious groups require circumcision and some cultures see circumcision as the entrance into manhood.

5. Truth – Orgasms are experienced by both sexes and at all ages including very young children. Ejaculation only occurs in males after puberty when the prostate and accessory gland becomes functional. Females do not ejaculate. Both handicapped men and women with spinal cord injuries have reported being able to experience orgasms.

6. Myth – Kinsey found almost all men have erotic dreams that end in an orgasm. They occur primarily in single males in their teens and 20’s. They are beyond the conscious control of a sleeping male and the cause is attributed to there being an insufficient number of other sexual outlets to reduce built up sperm/semen and sexual tension.

7. Myth – A woman’s ability to achieve an orgasm is not affected by menopause. Some women may actually respond more since the risk of pregnancy is over. Emotionally, women deal with menopause in many different ways.

8. Truth – Same sex experiences are common during the process of growing up. According to the Kinsey studies, 60% of males and 33% of females have engaged in at least one act of overtly homosexual sex play by the age of 15.
9. **Myth** – Although alcohol may lower inhibitions, it actually has the opposite effect of a stimulant. In men, it may lower erectile and ejaculatory capacity and lengthen the refractory period before response is possible. It may lower responsiveness and lengthen the time necessary for orgasm.

10. **Myth** – Providing there are no medical problems, women can have sexual intercourse right up to the point when labour begins as long as there is no pain or bleeding and the membrane is not broken.

11. **Myth** – Although marijuana induces euphoria, it is actually a depressant.

12. **Truth** – Women can have orgasms in their sleep. Sometimes they may remember an erotic dream, other times they may not.

13. **Truth** – People can remain sexually active throughout their entire lives providing they have a good attitude about sex and aging and have no severe health/medical problems.

14. **Myth** – A *transvestite* is a woman or man who dresses in clothing associated with people of the opposite gender because it gives them sexual pleasure. Many transvestites are heterosexual and have no interest whatsoever in sexual encounters with same sex members. A *transsexual* is a woman or man who fully identifies with the gender other than their biological one. Oftentimes, *transsexual* people are unhappy with their female or male anatomy and prefer to live full-time as the other gender. Many use hormone and surgery to change their sexual anatomy so it matches their gender identity. *Transgender* people are women or men who dress in the clothing associated with the other gender because they enjoy being treated as if they were of the other gender. Transgender people typically have two different identities and may even have two names for themselves – one female and one male. For them, cross-dressing is like acting, playing a role, trying to see what it’s like to walk in a woman’s or a man’s shoes. Many transgender people are also heterosexual.

15. **Myth** – Medically, a hysterectomy should not produce change in a woman’s sex drive or capacity for orgasm.

16. **Myth** – Intercourse does not affect athletic performance. Drinking, partying and late hours that may go along with having sex, can lower performance.
WORD EXERCISE

Make copies of this list and hand them out to participants. Ask them to identify the words they would find most difficult to talk about with their children or with another person.

Head       Nose       Ear
Vagina     Anus       Love
Kissing    Dating     Penis
Shoulder   Vulva      Hips
Menstruation Mouth Tongue
Orgasm     Intercourse Foot
Breasts    Testicles  Buttocks
Scrotum    Thighs     Uterus
Clitoris   Masturbate Urinate
Did your parent/s or other caretaker talk to you about any of these subjects when you were growing up? If so, what? If not, how did you learn about them? How much do you know about them?

Difference between love and infatuation
Hormones and how they affect the body
Sexual feelings and how to control them
Puberty and adolescence
Menstruation
Wet dreams
Where babies come from
Abstinence
Sexual intercourse
Masturbation
Homosexual
Lesbians, gays, bisexuals or transgender
Sexual abuse: rape, child molestation, sexual harassment
Condoms
AIDS
Sexually Transmitted Infections/Diseases
Family planning and contraceptives
Oral sex
Orgasm
Menopause
Dating
Breast-feeding
TRAINING SESSION WORKSHOP
EVALUATION FORM

Your Name_____________________________ Today’s Date_________________
Topic____________________________  Trainer/Facilitator __________________

Circle the number that best reflects your view.

Too Simple  Just Right  Too
Simple  Right  Sophisticated

1. How clear was the presentation?  1  2  3  4  5
2. How did you rate the level of material covered?  1  2  3  4  5
3. How knowledgeable was the instructor?  1  2  3  4  5
4. How enthusiastic was the instructor?  1  2  3  4  5
5. How much did you learn?  1  2  3  4  5
6. Overall, how would you rate the session?  1  2  3  4  5

7. What did you like most about the session?

8. What did you like least about the session?

9. Other comments?

Margaret Sanger Center International, Copyright 2001
TEEN QUESTIONNAIRE

Trainer/Facilitator/s Name___________________________________________

Today’s Date_______________ Your Birth Date (day/month/year) ___/___/___

PART 1: Please tell us how you feel about each of the following statements. Circle ‘A’ if you agree, ‘D’ if you disagree and ‘?’ if you are unsure or don’t know.

1. Most boys mature physically earlier than girls do. A  D  ?

2. Physical changes during puberty happen to different teenagers at different times. A  D  ?

3. Girls begin to menstruate at the same age and have identical cycles. A  D  ?

4. Boys are born with all the sperm cells they will ever use. A  D  ?

5. Female release thousands of eggs each month from their ovaries. A  D  ?

6. Male testes produce millions of sperm for each ejaculation. A  D  ?

7. Once a girl starts menstruating, she is able to get pregnant. A  D  ?

8. A man must have a large penis in order to satisfy a woman sexually. A  D  ?

9. Wet dreams are a sign of a sexual disorder. A  D  ?

10. Abstinence or not having sexual intercourse in old fashioned. A  D  ?

11. Using a condom properly will prevent an STI/HIV infection. A  D  ?

12. Oral contraceptive pills can cause cancer in young women. A  D  ?

13. You can tell if a woman is asking to be raped by the way she dresses and acts. A  D  ?

14. At present, there are no cures for herpes II or HIV. A  D  ?

15. If left untreated, syphilis can cause blindness, insanity and even death. A  D  ?

16. Women who have Gonorrhoea or Chlamydia often don’t know it. A  D  ?
17. A person experiencing itching, discharge or burning in the penis or vagina should see a doctor or nurse immediately. A D ?

18. It’s natural for children to be curious and ask questions about sex. A D ?

19. Young people should always consider their family values and religious beliefs before getting involved with another person. A D ?

20. There are lots of ways to express romantic feelings toward a partner without having sexual intercourse. A D ?

21. Holding hands, talking, kissing, snuggling or writing love letters can be very romantic and satisfying for both males and females. A D ?

22. Mass media; e.g., videos, music, advertisement, use sex to sell products. A D ?

23. Young people and older people alike need to develop more skills to say No to Sex. A D ?

24. Sexuality embraces the physical, emotional and spiritual part of human beings. A D ?

25. All human beings deserve respect, regardless of their sex or sexual orientation. A D ?

26. I’m confused about what is right and wrong when it comes to having sexual intercourse. A D ?

27. I believe that people should wait to have sex until after they are married. A D ?

28. Having sexual intercourse is okay, just as long as people practice safer sex. A D ?

29. I wish my parents were more open about talking to me about sex. A D ?

30. I would like to know more about sexuality and reproductive health. A D ?

I am a female _________________________ male _________________________

My religion is _______________________________________________________

My ethnic identity is ___________________________________________________

My school level is ___________________________________________________
PART 1: Please tell us how you feel about each of the following statements. Circle ‘A’ if you agree, ‘D’ if you disagree and ‘?’ if you are unsure or don’t know.

1. Most boys mature physically earlier than girls do. A D ?
2. The physical changes of puberty happen to different teenagers at different times. A D ?
3. Girls begin to menstruate at the same age and have identical cycles. A D ?
4. Boys are born with all the sperm cells they will ever use. A D ?
5. Female release thousands of eggs each month from their ovaries. A D ?
6. Male testes produce millions of sperm for each ejaculation. A D ?
7. Once a girl starts menstruating, she is able to get pregnant. A D ?
8. A man must have a large penis in order to satisfy a woman sexually. A D ?
9. Wet dreams are a sign of a sexual disorder. A D ?
10. Abstinence or not having sexual intercourse in old fashioned. A D ?
11. Using a condom properly will prevent an STI/HIV infection. A D ?
12. Oral contraceptive pills can cause cancer in young women. A D ?
13. You can tell if a woman is asking to be raped by the way she dresses and acts. A D ?
14. At present, there are no cures for herpes II or HIV. A D ?
15. If left untreated, syphilis can cause blindness, insanity and even death. A D ?
16. Women who have Gonorrhoea or Chlamydia often don’t know it. A D ?
17. A person experiencing itching, discharge or burning in the penis or vagina should see a doctor or nurse immediately. A D ?
18. It’s natural for children to be curious and ask questions about sex. A D ?
19. Young people should always consider family values and religious beliefs before getting romantically involved with another person. A D ?
20. There are lots of ways to express romantic feelings without having sex. A D ?
21. Holding hands, talking, kissing, snuggling or writing love letters are acceptable romantic expressions for my teenage son/daughter. A D ?
22. Mass media – e.g., videos, music, advertisement – use sex to sell products. A D ?
23. Young people and older people need to be taught how to say "No" to sex. A D ?
24. Sexuality is the physical, emotional and spiritual part of being human. A D ?
25. Everyone deserves respect, regardless of his/her sexual orientation. A D ?
26. Both partners should take responsibility for preventing an STI/pregnancy. A D ?
27. Parents don’t have to have all the answers to talk to children about sex. A D ?
28. Having sexual intercourse is okay, just as long as people practice safer sex. A D ?
29. I would like to know more about sexuality and reproductive health. A D ?
30. Parents are the primary (first) sexuality educators of their children. A D ?
31. Parents should make it easy for their children to ask them questions about sex. A D ?
32. Talking about sex will encourage teens to be sexually active. A D ?
33. Premarital sex is always wrong. A D ?
34. All human beings deserve respect, regardless of their sex or sexual orientation. A D ?
35. Adolescents should learn about family planning, contraception and condoms. A D ?

I am a mother _______ father_______ guardian ________

My religion is _______________________________________________________

My ethnic identity is _________________________My school level is __________
THINGS TO REMEMBER WHEN CONDUCTING TRAININGS/WORKSHOPS/SEMINARS

Remember people need to:
- bond with one another
- know that they have something of value to contribute to the training experience
- be validated/acknowledged for past accomplishments
- know what to expect from the training
- know what is expected of them
- know particular time frames for training, breaks, exercises, videos, etc.
- feel comfortable and know what the trainer’s role will be
- know what they are expected to do with the training they receive

Questions trainers should ask themselves before and during training:
- Do I have all of the resource materials including handouts, newsprint, markers, videos and audio equipment, etc.
- Do I have the right number of guest speakers?
- Does the guest speaker know what to focus on?
- Are resource materials substantive, relevant and culturally appropriate?
- Is the training venue or general environment conducive for learning?
- Have I given a rationale for why the training is important?
- Have I given a clear outline of what the goals and objectives are?
- Have I clarified participants’ questions or concerns?
- Does the training have a variety of learning activities?
- Am I being encouraging and supportive of participants?
- Am I talking too much?
- Am I opinionated or judgmental?
- Is there a good balance between presentation and processing?
- Do I encourage critical thinking amongst participants?
- Am I giving participants enough time to process information?
- Does the training allow for free time?
FOUR IMPORTANT THINGS TO AVOID AT ALL COST

✧ Ending later than your scheduled time (unless negotiated before time)
✧ Trying to pack everything that’s left over into the last few moments of training
✧ Letting people drift off without bringing closure or a definite end to the training
✧ Looking harried, exhausted, hurried or bored

Ending Your Session/Training
✧ Briefly summarize major points or accomplishments of the group.
✧ Give an inspirational ending.
✧ Give participants a way to say good-bye to each other, to you and to the training process.
✧ If you finish your work early rather than stretching to fill time, finish early.
## EXPERIENCE AND LEARNING

<table>
<thead>
<tr>
<th>We Tend to Remember</th>
<th>Means</th>
<th>Our Level of Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 10% of what we read</td>
<td>Reading</td>
<td>Verbal Receiving – Passive</td>
</tr>
<tr>
<td>2. 20% of what we hear</td>
<td>Hearing Words</td>
<td>“</td>
</tr>
<tr>
<td>3. 30% of what we see</td>
<td>Looking at Pictures</td>
<td>“</td>
</tr>
<tr>
<td>4. 50% of what we see and hear</td>
<td>Watching a Movie</td>
<td>Visual Receiving – Passive “</td>
</tr>
<tr>
<td></td>
<td>Looking at an Exhibit</td>
<td>“</td>
</tr>
<tr>
<td></td>
<td>Watching a Demonstration</td>
<td>“</td>
</tr>
<tr>
<td></td>
<td>Seeing it done on location</td>
<td>“</td>
</tr>
<tr>
<td>5. 70% of what we say</td>
<td>Participating in a Discussion</td>
<td>Participating – Active “</td>
</tr>
<tr>
<td></td>
<td>Giving a Talk</td>
<td>“</td>
</tr>
<tr>
<td>6. 90% of what we say and do</td>
<td>Doing a Dramatic Presentation</td>
<td>Doing – Active “</td>
</tr>
<tr>
<td></td>
<td>Simulating the Real Experience</td>
<td>“</td>
</tr>
<tr>
<td></td>
<td>Doing the Real Thing</td>
<td>“</td>
</tr>
</tbody>
</table>
WORKING WITH GUEST SPEAKERS

Just as an additional second trainer/facilitator can help maintain interest, using guest speakers can further energize groups. Besides providing another way to change the style and pace of the training, guest speakers can:

1. Provide information about a subject for which trainers are unqualified; e.g., specialist on STIs or HIV/AIDS.

2. Present a variety of points of view about a controversial subject; e.g., religious attitudes towards using condoms.

3. Familiarize participants with local referral agencies and services; e.g., FP and STI clinics.

4. Give the message you want the participants to see through presentation of him/herself; e.g., if you are trying to break a stereotype, don’t get a speaker who personifies that stereotype.

5. Whenever possible, utilize guest speakers whose views and training ability are known to you through direct, first-hand experience. Select persons who are:

   • knowledgeable about the subject
   • interesting speakers
   • able to stimulate discussion and to hear a variety of points of views
   • willing to respond to your specific request; e.g., will discuss the needs of the sex worker as requested rather than use the time to promote agency values.
   • available to make presentations.
Since matching the best speakers with your training dates is always complicated, contact guest speakers as early as possible. During this first conversation, discover whether they are interested in and available on the training dates.

6. If yes, explain what you want him/her to do including:
   (a) date, time and place of training
   (b) length of presentation
   (c) specific topics to be discussed; explain the content which is to proceed and follow his/her presentation.
   (d) format of training (formal lecture series, participatory workshops, etc.)
   (e) size, composition, background of the group. Share your understanding of participants’ level of sophistication about the topic (s) that the guest speaker will address.
   (f) When several persons will appear on a panel, inform each speaker of who the other panelists will be and their topics.

7. Clarify amount (if any) of money you are able to pay for:
   • fee for preparation time; fee for presentation time
   • reimbursement for duplication costs for handouts
   • donation to his/her sponsoring agency
   • daily expenses and travel expenses

8. Check to see whether guest speaker needs:
   • AV equipment
   • materials (handouts) duplicated
   • special room set-up
   • assistance with travel or accommodation arrangements
9. Schedule a specific time/date to discuss the presentation prior to training.

Follow-up the initial conversation with:

a) a letter outlining the above. Keep a copy for yourself.

b) enclosures consisting of: a map to the training facility including instructions for parking and how to find the training room, an agenda, specific training objectives for his/her presentation, pre/post test questions which he/she is expected to cover, two copies of a contract clarifying monetary agreement, one copy to be signed and returned to you.

Prior to the training, meet with the guest speaker or converse over the telephone.

10. At this time you can answer any remaining questions. Discuss how the trainer and guest speaker will work together; e.g., can the trainer add additional information during the speaker’s presentation? Are there questions the participants have which can be shared with the speaker? Should the trainer intervene if speaker is having difficulty?

11. Review the objectives of the programme and the amount of time allowed for the presentation and follow-up activities.
TEACHING TECHNIQUES

The more open and honest educators/facilitators appear, the more willing the learners will be to disclose their feelings, ask questions and participate in discussions. Similarly, the atmosphere educators create when they meet for an activity affects the quality of the activity and the extent to which the participants retain information or change their behaviour.

Many different teaching techniques can be used to teach any unit in this resource guide. Some of you will feel more comfortable with a few strategies; others will use a wider variety of techniques.

Whatever your choice, you should remember that the exercises presented in the guide are meant only to be suggestions – frameworks for your own creativity. Feel free to alter, edit, add to or subtract from the material contained here. Your personal style as an educator/trainer/facilitator will come through, regardless of what technique you choose.

You may feel that certain techniques work consistently well with your class. One of your crucial tasks in training is to function as a barometer, sensing which exercises and activities will work best for groups of adults, groups of adolescents, single-sex or mixed groups or for specific ages. You are the experts as educators and only you can decide what will best achieve each unit’s goals and objectives. One exercise or activity may seem more appropriate than another because of the size of the group, the subject matter, time constraints or other variables. It is up to you to decide.
A number of the exercises/activities in the guide provide opportunities for participants to bring out and recognise their own values and attitudes on a variety of subjects. This is extremely important. Young people must be given the chance to realise what their own values and the values of their society really are before they can learn to make choices, carry out decisions and change ways of behaving.

It is also important to allow as much participant interaction as possible. In this way, everyone can share ideas and information and myths can be dispelled.
GLOSSARY OF TERMS

Brainstorming
Brainstorming is a free-flowing exchange of ideas on a given topic. The process generates an unlimited range of ideas and concepts. All responses are acceptable and no evaluation takes place. Brainstorming is a time for any and all contributions. It validates individual responses since anything and everything “goes.”

Rules are few and simple:

- Don’t criticise anyone’s suggestions during brainstorming.
- Don’t alter or edit ideas. Take them just as they come.
- Encourage far-fetched ideas. They may trigger practical ones.
- The more ideas, the better. Keep up until everyone runs out.
- Record all ideas as they are presented on newsprint or a chalkboard where everybody can read them.

Discussion
Discussions have defined topics and can be teacher directed or learner-led. Through discussion, participants share facts and thoughts to clarify their own ideas and better understand the feelings and values of others. A well-informed group makes for a more fruitful exchange. Stimulating questions add direction.

Lecture/Lecturette
A lecture is a structured and orderly presentation of information, opinion, theory or fact delivered by an individual speaker or a panel. It is a fairly formal teaching technique. However, lectures can involve audience interaction and participation by allowing time for comments, questions and feedback. The creative use of visual aids can help capture audience attention.
**Processing**
This technique requires allocating meeting time for reflection and open discussion following the presentation of information or concepts. It is used to elicit personal feelings and impressions. The processing of a learning activity or video can take a great deal of time. It can be stimulated by open-ended questions.

**Role-Play or Drama Performance**
This technique provides an opportunity for people to assume the role of another person – to feel like, act like and sound like someone else. Role-playing has no set outcome but is built on a set scenario. Drama performances use scripts and have specific roles. Both techniques allow participants to “try out” a kind of behaviour and are an effective and entertaining method of making a point.

**Values Clarification**
This is a process that enables one to examine ideas, feelings and concepts in a systematic manner. It involves the individual in making decisions and evaluating consequences. The values clarification process is accomplished through a series of exercises or activities based on the following principles:

- considering alternatives
- examining consequences
- making choices
- discovering what is cherished
- publicly affirming a belief, feeling, action
- acting consistently

Values clarification exercises can include forced choices, moral dilemmas and rank order exercises. All of these employ basic valuing principles and are supported through value clarification questions.
Videos
Videos are very effective in providing information about a variety of different topics. They reach a lot of people, they reinforce a subject matter and they can be entertaining. Careful selection, review and preparation are essential. In selecting a video, it is important to consider the following:

- Does the video fulfill a particular purpose?
- Are the situations relevant?
- Are the characters realistic?
- Are the facts accurate?
- Are the content and the required comprehension level appropriate for your audience?
- Could the major points of the video be addressed more effectively through another medium (book, chart, etc.)?

To make video use most helpful, be sure to:

- preview the selected video
- prepare supplementary material for pre and post video discussions
- learn how to use portions of films to highlight specific concepts. Evaluate the effectiveness of the video.
SECTION 2

Topic: Parent Education Resource Material

CONTENTS

“A Parent’s Prayer”
Parent’s Teach in the Toughest School in the World
Children Learn What They Live
How Well Do You Know Your Child?
How Well Do You Know Your Parent?
Tips on Talking to Children and Young People About Sex
Coping With Parenting: Session III Evaluation and Handout Form
Condom Sense Handout
Talking About Sex Isn’t Easy (A Discussion Guide For Facilitators and Trainers)
“A PARENT’S PRAYER”

O Heavenly Father, make me a better parent. Teach me to understand my children, to listen patiently to what they have to say and to answer their questions kindly.

Keep me from interrupting or contradicting. Help me to be as courteous to them as I want them to be to me.

Forbid that I should ever laugh at their mistakes or resort to shame or ridicule. May I never punish them out of anger or spite or to show my power.

Help me, dear Lord, to demonstrate by all that I say and do that honesty does produce happiness. Reduce, dear Lord, the meanness in me. And when I am out of sorts, help me to hold my tongue.

May I be ever mindful that my children are merely children and that I should not expect them to have the maturity and judgment of adults.

Let me not rob them of the opportunity to do things for themselves or to make their own decisions.

Help me to grant them all reasonable requests and give me the courage to deny them the privileges that I think may be harmful.

Help me to be fair, just and kind, O Lord, so that I will earn their love and respect and that they will want to imitate me. This is the supreme compliment… Amen
Parents Teach in the Toughest School in the World

“The School for Making People.”
You are the Board of Education, the principal,
the classroom teacher and the janitor....
You are expected to be experts on all subjects
that pertain to life and loving....
There are few schools to train you for your job,
and there is no general agreement on the curriculum,
you have to make it up yourself.
Your school has no holidays, no vacations, no unions,
no automatic promotions or pay raises.
You are “on duty” or at least “on call”
24 hours a day, 365 days a year,
for at least 18 years for every child you have....
Within this context, you carry on your people making.
I regard this as the hardest, most complicated,
anxiety-ridden,
blood-and-sweat-producing job in the world.

Virginia Satir
CHILDREN LEARN WHAT THEY LIVE

If a child lives with criticism, he learns to condemn.

If a child lives with hostility, he learns to fight.

If a child lives with ridicule, he learns to be shy.

If a child lives with shame, he learns to feel guilty.

If a child lives with tolerance, he learns to be patient.

If a child lives with encouragement, he learns confidence.

If a child lives with praise, he learns to appreciate.

If a child lives with fairness, he learns justice.

If a child lives with approval, he learns to like himself.

If a child lives with acceptance and friendship, he learns to find love in the world.
HOW WELL DO YOU KNOW YOUR CHILD?

See how many questions you can answer about your son or daughter. Remember, only your child can grade this for you, since only he or she really knows the right answers.

• Given the choice, which would your child pick for dinner – hamburger and French fries, steak and potatoes, fish and chips, rice and chicken, etc.?

• Which would your child rather eat – potato chips, fruit, French fries, ice cream or candy?

• How many boyfriends/girlfriends has your daughter/son had?

• How much does your child weigh (within five pounds)?

• What’s your child’s favourite game?

• What’s the name of your child’s best friend?

• What’s your child’s favourite sport?

• After school, which would your child rather do – go for a walk or play outside?

• What’s your child’s favourite musical group or singer?

• Which would your child rather do – wash the dishes, iron, go shopping or wash clothes?

• What does your child want to do when he/she grows up?

• What subject in school does your child like best?

• What was the last nice thing that your child did for you that was a real surprise?

• Would your child rather-spend time with friends, read or listen to music?
HOW WELL DO YOU KNOW YOUR PARENT?

See how many questions you can answer about your mother/father. Remember, only your parent can grade this, since they alone will know the right answer.

• What household task does your parent dislike the most?
• Does your parent feel comfortable talking to you about sex?
• Does your parent believe in love at first sight?
• Does your parent usually carry a photo of you?
• How old were your parents when they got married?
• What’s the name of your parent’s best friend?
• Which of these can your parent not do – touch his/her toes, cook, wash the clothes, sing or do the latest dance?
• Which would your parent prefer to eat – fish, steak, fruit, nuts, vegetable or chicken?
• Where was your parent born?
• What’s the last present your parent gave you?
• Does your parent attend religious services?
• Does your parent attend a family planning clinic?
• Does your parent enjoy sports?
• Who is your parent’s favourite singer?
• What’s your parent’s idea of having fun?
TIPS ON TALKING TO CHILDREN AND YOUNG PEOPLE ABOUT SEX

♥ Sexuality lasts throughout a lifetime; don’t feel pressured to tell everything at once.

♥ It’s better in the long run to be honest and frank.

♥ Acknowledge your feelings and if you don’t know the answer, say so. Then find out.

♥ Remember… “If a child is old enough to ask, he is old enough to know.”

♥ Give simple age appropriate responses; e.g., when children ask “Where do babies come from?” you don’t have to describe sexual intercourse at this point, just give a simple answer. You can respond by saying something like, “That’s a good question. Where do you think babies come from?” This helps you to know how much they know and where you should start. You can say something like “Babies grow in a special place inside the mother.” Remember…don’t confuse them with too much information they cannot understand.

♥ You don’t have to be an expert on the subject of sex. Just be an “askable” parent.

♥ By the time children reach three, they are ready to know males and females have different sex organs.

♥ When a child asks a question about sex, be sure to let him/her know that they did the right thing by coming to you.

♥ Talk about genital organs the same way you talk about elbows, noses, fingers and toes.

♥ Always use the correct names for sex organs. Say “vulva,” “penis,” and “breasts” instead of cute nicknames that give children the idea that something is “wrong” with certain parts of the body.
♥ Three and four-year-olds are curious about their bodies and they may also want to see parents without their clothes on. Parents or caregivers should set limits that make their families comfortable. However, children should not be punished for being curious.

♥ By the age of five to seven, children may be shy about asking questions. This doesn’t mean they don’t have questions about things like pregnancy, AIDS, rape or child abuse. So parents and caregivers need to keep talking with children and use ‘teachable’ moments; e.g., TV or newspaper to start up a conversation.

♥ Pre-teens (eight to 12 years) worry a lot about whether they are “normal.” Boys worry about their body size; e.g., penis, etc. Girls worry about their breast size or about the shape of their bodies. They should be reassured that no two people are the same and that it is normal to be different.

♥ Pre-teens need all the facts about menstruation, wet dreams and other facts about maturing. They should be encouraged to think for themselves and not get carried away by the crowd.

♥ Most 12-year-olds are ready to know the facts about sex, reproduction, sexually transmitted infections, etc. They also want to know about sexual and social relationships. Include family values; e.g., Christian, etc. – along with the factual information you give them.

♥ Set good examples that show young people how our lives are enriched by our values.

♥ Build young people’s self-esteem – credit them for their talents, personalities, and accomplishments.

♥ Respect adolescents’ privacy as much as we value our own.

♥ Give accurate, honest, short and simple answers.
Let young people know that we’re available and make a habit of sharing your thoughts and feelings about issues related to sex. Be clear about your feelings and values about sex and think about what you want to say before you speak.

Becoming agitated conveys a negative message and is a sure way to stop your child from asking you questions about sex in the future.

What if your child doesn’t ask questions about sex? The general rule is that if your children do not ask questions about sexual issues by the time they are six years old, you should initiate discussions using “teachable moments.”

Remember! … It’s never too late to start talking about sex with young people, even if they are already teenagers or young adults.
How Open Is Your Child’s Spirit?
Test yourself with each of your children to see how open his/her spirit is. This is a simple, yet very helpful evaluation that can detect whether or not your child’s spirit is closing. Score each question from one (1) to Five (5).

1 = never    2 = seldom     3 = sometimes    4 = usually    5 = always

1. Does my child enjoy touching me?  ___
2. Does my child respect what I respect in life?  ___
3. Are my child’s friends the ones I’d choose for him/her?  ___
4. Does my child wear clothing and hairstyles I approve of?  ___
5. Does my child agree, generally, with my opinions?  ___
6. Is my child wise about the activities he/she’s involved in?  ___
7. Do I approve of the music he/she listens to?  ___
8. Does my child enjoy conversations with me?  ___
9. Does he/she enjoy going places with me?  ___
10. Does my child display affection to me?  ___
11. Does my child enjoy looking into my eyes?  ___

TOTAL  ___

Total Up Your Score!
14-20 Danger! Resolve anger immediately! (Seek help from a family counsellor)
21-30 Warning! Investigate possible hidden resentment towards you
31-40 Be Careful! Actively listen for signs of hurt feelings
41-50 Some turbulence may exist. However, things are proceeding well overall
51-70 Smooth sailing. But stay on the alert to keep up your excellent loving and sensitive behaviour
Let’s face it. Like it or not, people all around the world, religious or not, engage in sexual behaviours which put them and their partners at risk for STIs and AIDS. One stupid mistake can result in illness and death. And while “abstinence” and “fidelity” should be encouraged, we must provide information about condoms to help save lives. According to the World Health Organization (WHO), women and girls are the most vulnerable to AIDS and other STIs simply because their partners do not use condoms.

Facts

Condoms:

…protect the spouse from being infected with STI/AIDS from a partner who may be having extra-marital affairs.

…protect the postpartum woman from infection during the first three months after delivery, the time in her life when she is most likely to develop a pelvic infection.

…protect both the woman and her foetus against AIDS, gonorrhoea, herpes, chlamydia, warts, etc.

…protect women against infertility and cervical cancer.

…protect against sexually transmitted infections including the HIV virus that causes AIDS.

…help prevent an unwanted pregnancy.

…can increase sexual enjoyment during intercourse by helping men maintain erections.

…rarely cause side effects.

…are one of the cheapest methods of contraception.

…are accessible and do not require examination, prescription or fitting.
Seven Important Steps for Using a Condom:
1. Check the expiration date and store condoms in a cool, dry place.
2. Open the package containing the condom carefully so that the condom does not tear.
3. Make sure the tip on the condom is upright. Do not unroll condom before putting it on.
4. Squeeze the tip on the condom to get rid of air pockets.
5. Hold the tip of the condom while rolling condom over the erect penis.
6. After ejaculation, hold the rim of condom and pull the penis out before it becomes soft.
7. Tie a knot in the condom, making sure contents do not spill out, then carefully discard in a safe place away from children and animals.
Communicating about sex and sexuality is not always easy. There are many reasons for this including cultural taboos, family values, social upbringing, religious beliefs, lack of information, etc.

Here are some suggestions that will help participants overcome their uneasiness.

Begin by asking participants to define “sex.” Write down responses and review them. Explain that most people think about sexual intercourse whenever they hear the word sex. However, the fact is that sex refers to biology whether or not we are male or female.

Now ask participants to define “sexuality.” Again write down responses. Explain that sexuality begins at birth and ends at death. It is the total expression of who we are as human beings. It includes the physical, emotional and spiritual makeup of each individual.

Divide participants into small groups and give them newsprint and markers. Ask each group to list and discuss their own sources of sexual learning. Allow approximately 30 minutes for this. Have one member of each group report findings back to the larger group.

Lead a discussion about the findings.

Ask participants to identify topics that were hardest to discuss and why. Ask if the group exercise helped them to talk more easily about sex.
SECTION 3

Topic: Christian Family Life Education and Human Sexuality

CONTENTS

Christian Family Life Education Questionnaire
Human Sexuality Questionnaire
Family Life Education Questionnaire
History of Sexual Attitudes
Psychosocial Development
Introduction to Human Sexuality
Sexual Patterns/Pair Bonding/Orientations
Sexual Behaviours
Sexual Scripts
A Message to Adolescent Girls and Young Women
CHRISTIAN FAMILY LIFE EDUCATION (CFLE) QUESTIONNAIRE

Please print your answers to the following questions:

What is Family Life Education (FLE)?
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Is it important? If so, why? If not, why?
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

List at least 4 critical areas related to sex and sexuality that FLE addresses?
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

What role, if any, should Churches play in CFLE? Explain.
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Margaret Sanger Center International, Copyright 2001
HUMAN SEXUALITY QUESTIONNAIRE

Match the terms on the left with the definitions on the right by writing the letter in the space provided.

1. ___ Sex  a. the choice to refrain from sexual intercourse with others, also called abstinence
2. ___ Sexuality  b. set of rules laid down by society that tell us what is appropriate behaviour for people of our sex
3. ___ Gender Role  c. prejudice and fear against homosexuals
4. ___ Gender Identity  d. preferring emotional/sexual partners of the opposite sex
5. ___ Sexual Orientation  e. total expression of who we are as human beings
6. ___ Homophobia  f. sexual contact between mouth and vulva, vagina, clitoris
7. ___ Asexual  g. refers to biology being male or female
8. ___ Bisexual  h. preferring emotional/sexual partners of the same sex
9. ___ Heterosexual  i. conscious or unconscious assumption that one’s sex on the whole is superior
10. ___ Celibacy  j. personal conviction that each of us has about being male or female
11. ___ Homosexual  k. gratifying oneself sexually
12. ___ Fellatio  l. preferring emotional/sexual partners of both sexes
13. ___ Cunnilingus  m. sexual contact between mouth and penis/testes/scrotum
14. ___ Masturbation  n. no sex drive
15. ___ Sexism  o. socially and or biologically determined preference for emotional and sexual pair bonding
FAMILY LIFE EDUCATION QUESTIONNAIRE

Please print the answers to the following questions:

I. When does sexuality begin?

II. When does it end?


IV. List at least 4 characteristics of a sexually healthy adult:
   1. 
   2. 
   3. 
   4. 

V. List at least 4 sources of sexual learning:
   1. 
   2. 
   3. 
   4. 

VI. What is Reproductive Health?

VII. Is Reproductive Health the same as Sexual Health?
HISTORY OF SEXUAL ATTITUDES

**Judeo-Christian:** The **Judaic** monotheistic (belief in one God) religion of Jewish People traces its origins back to Abraham, having its spiritual and ethical principles embodied chiefly in the Old Testament Bible and the Talmud (the collection of ancient Rabbinic writings, the religious authority for traditional Judaism).

**Christianity:** The Christian religion, founded on the teachings of Jesus – belief that Jesus is the son of God, the Christ (the Messiah foretold by the prophets in the Old Testament) and following the religion based on Jesus’ teachings, having its spiritual beliefs embodied in the Old and New Testament Bible.

**Puritan:** Protestant precepts (any Christian belonging to the sect descending from the Church of Rome at the time of the Reformation-a 16th century effort to reconstitute the life and teaching of Western Christendom – resulting in the separation of the Protestant Churches from the Roman Catholic Church), especially one who regards luxury or pleasure as sinful. Many missionaries were puritans, hence the missionary position (position for sexual intercourse which a man and woman lie facing each other, with the woman on the bottom and the man on the top).

**Victorian:** Is the period of Queen Victoria’s reign in the 19th century in England – moral severity, hypocrisy, middle-class stuffiness, pompousness, conservatism, being highly ornamented, massive architectural style and decorations, etc.

**Modern/Current:** Belonging to the time we live in now, what we are experiencing today, prevalent, in vogue, etc.
PSYCHOSOCIAL DEVELOPMENT

Theory of Psychosocial Development attributed to Erik Erikson, a German-born American psychoanalyst, maintains that “sexuality” is a birth to death expression of who we are rather than an “adolescent problem.”

Psychosocial Development Process

Stages

1 – Infancy
   Trusting, touching

2 – Toddler
   Beginning of Independence

3 – Early Childhood
   Cognitive learning, venturing

4 – Childhood
   A sense of achievement

5 – Adolescence
   The identity crisis, who am I?

6 – Young Adulthood
   Questions of marriage, intimacy

7 – Middle Age
   Responsibilities, procreation

8 – Old Age
   Resolutions, summing up
INTRODUCTION TO HUMAN SEXUALITY

Sex – refers to one’s reproductive system (biology) and gender behaviour as male and female. It has to do with biology, anatomy and physiology.

Gender – refers to the psychosocial and cultural aspects of maleness and femaleness.

Sexuality – is the total expression of who we are as human beings. It encompasses our whole psychosocial development – our values, attitudes, spirituality, physical appearance, beliefs, emotions, personality, likes and dislikes, feelings, preferences, our entire self-concept and all the ways in which we are socialized. Sexuality begins at birth and evolves throughout our lifetime until death.

Masculinity and Femininity – relate to sexuality as “male” and “female” relate to sex. Generally, they are defined in the light of particular stereotyped gender roles. A stereotype is something conforming to a fixed pattern, a pattern built up in our minds by the myths, values, attitudes, traditions and practices of the culture/society we grow up in.

Sources of Sexual Learning – are all the factors that contribute to our psychosexual development via parental teaching, experience, family values, media, school, literature, religious beliefs, peers, societal norms, etc.

Gender Roles – are the set of scripts, rules or norms laid down by society that say what is and is not appropriate behaviour for being feminine or masculine. These rules are established by culture/society, not biology and are usually assigned to us at birth as soon as someone announces “It’s a boy” or “It’s a girl.”
The colour blue is usually associated with boys and pink with girls. Most boys are taught early on to suppress their feelings through sayings like “big boys don’t cry” while girls are encouraged to express their feelings. Even the toys we buy help to teach children gender role expectations. Dolls, tea sets, cooking utensils teach girls about nurturing while boys play with guns, cars, toy trucks and model airplanes. In school, boys tend to excel more in the sciences while girls tend to excel more in language and the arts.

Men are thought to be stronger than women, both physically and emotionally, while women are thought to be weak. In some cultures, strict gender roles are reflected in local customs and traditions that exploit women and girls and prevent them from reaching their full potential.

**Gender Identity** – is the personal, private conviction each of us has about being male or female. It is at the core of how we feel about who we are. It probably becomes fixed around the age of two years. It is also called sexual identity.

**Sexual Identity** – is feelings about one’s own sexual orientation, gender, gender role and gender identity.

**Sexual Orientation** – refers to a preference for sharing sexual expression with members of the opposite sex, members of our own sex or members of both sexes. These preferences may be socially determined, biologically determined or both – we cannot be certain.
SEXUAL PATTERNS/
PAIR BONDING/ORIENTATIONS

**Heterosexual** (Straight) – preferring emotional/sexual partners of the opposite sex.

**Homosexual** (Gay) – preferring emotional/sexual partners of the same sex. (The term “gay” is commonly used for men who prefer same-sex partners, though it can refer to women as well. The more usual term for women who prefer same-sex partners is lesbian.)

**Bisexual** – enjoying emotional/sexual partners of both sexes.

**Celibate** – one who remains unmarried for religious reasons or takes an oath of celibacy. One who abstain from sexual intercourse.

**Asexual** – lack a libido (sex drive) Although asexual persons are physically and psychologically male or female, neither sex stimulates them sexually.
SEXUAL BEHAVIOURS

**Sexual Behaviours** – cover a wide range of sexual expressions including holding hands, sexual intercourse, kissing, masturbation, hugging, singing, dancing, rubbing noses, etc. Society and culture plays an important role in determining what is acceptable and unacceptable sexual behaviour.

**Paraphilia** – a sex practice that becomes necessary for sexual arousal to occur but is not approved by social norms. Once considered paraphilias, oral and anal sex are now increasingly common sexual practices for many people.

The following sexual behaviours are considered by many cultures to be non-standard or deviant:

**Bestiality/Zoophilia** – sexual pleasure derived from intercourse with animals.

**Coprophilia** – deriving sexual pleasure from soiled underwear, filth, dirt, etc.

**Drag Queen** – a male homosexual who dresses flamboyantly in exaggerated imitation of a woman.

**Exhibitionism** – sexual pleasure from exposing one’s genitals to others.

**Gerontosexual** – sexual pleasure derived from having sexual relations with an old woman or man.

**Incest** – sexual intercourse between blood-related family members; e.g., father-daughter, sister-brother.

**Narratophilia** – sexual arousal from listening to erotic narratives in a song, story, etc.
Necrophilia – deriving sexual pleasure from intercourse with a corpse.

Nymphomania – an excessive desire in a woman to have frequent sex with many different partners.

Oral Sex – sex play involving the mouth and sex organs. Cunnilingus or mouth-to-vulva, Fellatio or mouth-to-penis, Annilingus or mouth to anus.

Paedophilia – deriving sexual pleasure from children (child molestation).

Pederasty – deriving sexual pleasure from young boys.

Pictophilia – sexual arousal dependent on sexy pictures.

Sado-Masochism – sexual arousal from inflicting and receiving pain.

Satyriasis – an excessive desire in a man to have frequent sex with many different partners.

Sodomy – anal intercourse.

Somnophilia – dependent on the fantasy or actually intruding on and fondling a sleeping stranger for sexual arousal.

Transgender – women and men who dress in the clothing associated with the other gender because they enjoy being treated as if they were of the other gender – not for sexual pleasure.

Transsexuals – men or women, most often men, who believe themselves trapped in the wrong body and seek an operation to make their bodies look more like that of the opposite sex. They fully identify themselves with the opposite gender.
Transvestites – women and men who dress in clothing associated with people of the other gender because it gives them sexual pleasure.

Transvestophilia – a paraphilia in which sexual arousal becomes dependent on wearing clothing, especially underwear, associated with the other gender.

Troilism – two people engaged in sexual activities while a third person observes.

Voyeurism – deriving sexual excitement from observing others undressing, having sexual intercourse, kissing, masturbating, etc. Voyeurs are sometimes called “Peeping Toms.”
SEXUAL SCRIPTS

The idea of a script, a device for guiding action and for understanding it, is a metaphor drawn from the theatre. Viewing conduct as scripted is a way of organising our thinking about behaviour. Scripts are also plans that people may have in their heads for what they are doing and what they are going to do as well as being devices for remembering what they have done in the past. Scripts justify actions that are in accord with them and cause us to question those which are not. Scripts specify, like blueprints, the who, what, when, where and why for given types of activity. As we act, we think about what we are doing, the people we are doing it with, the places where we do it, the times when it is done and the reasons why we – the people we are with – are doing it. We use scripts to choose courses of action, to check our behaviour against our plans and to recall the prior concrete steps in our behaviour through thinking about the elements in the script.

A script is simpler than the activity we perform, often more limited. It is like a blueprint or roadmap or recipe, giving directions but not specifying everything that must be done. Regardless of its sketchiness, the script is often more important than concrete acts. It is our script that we carry from action to action, modified by our concrete acts but not replaced by them. Scripts do change as new elements are added and old elements are reworked but very few people have the desire, energy or persistence to create highly innovative or novel scripts – and even fewer people can convert a private idiosyncrasy into a socially or culturally important event – i.e., create a really new script that becomes a part of the social code.
All social behaviour is scripted. All cultures have scripts or perhaps levels of scripts. There are official public scripts (law and religion); the scripts of various subgroups; and the idiosyncratic and variable scripts of individuals. The less complex the society, the fewer are the scripts and the less variability there is among individuals. The less stable and more complex and heterogeneous the society, the more scripts there are which may have some public support and the greater is the variety of individuals’ scripts and conduct.

Sexual scripts are a subset of social scripts, formulated in the same ways and with the same purposes. However, no individual’s sexual script or actual pattern of sexual activity is an exact replica of the sexual script that is offered or preferred by the culture. Scripts and the sexual conduct that they guide do not emerge fully formed either at birth or at puberty or at the moment of marriage – there is no automatic connection between the penis and the vagina, between the man and the woman, between love and sex. Rather, they are accumulated rapidly, sometimes slowly, sometimes directed, sometimes accidental, in simple and in complex circumstances. From these sources we build our scripts, what goes with what and in what order (the cognitive schemes that we carry in our heads) and our actual sexual conduct, in situations with real people and with real consequences.

(Adapted from Human Sexualities by John Gagnon, 1977)
A MESSAGE TO ADOLESCENT GIRLS AND WOMEN

Sexuality is a precious gift from God that’s given to us at birth. Sexuality comprises man’s tripartite nature as spirit, soul and body. Each of us has our own unique sexuality that is expressed in many ways – e.g., personalities, gender identity, values, attitudes, biology, intellect, preferences, etc.

Gender roles are social scripts that are assigned to us from the moment we are born. These roles come from many sources including parents, family, culture, society, and religion and carry powerful messages about what it means to be male or female. As we mature, gender roles continue to influence our preferences, sexual expressions, lifestyles, behaviours and even our taste in clothing.

In today’s world, young girls receive harmful messages about body image, beauty, how to be valued and appreciated. Unfortunately, many young women fall victim to negative images projected by the media that basically reduce women to sex objects. Women spend countless hours trying to conform to unrealistic images of beauty and spend disproportionate amounts of money on clothing, jewellery, make-up, fancy hair-dos, perfumes, nail sculptures and plastic surgery. Some sell their bodies in return for attention, affirmation and material things. Some will allow themselves to be mistreated, abused and even take health risks that may be life threatening.

Clearly, negative gender messages create feelings of inadequacy, insecurity, vulnerability and gender-based-violence. Furthermore, they perpetuate low-self esteem in women and girls.
Promoting healthy messages that affirm girls and women will help them to value themselves. Whenever a girl feels good about herself and valued, she makes positive choices that reflect her self-image.

Both girls and women must be made aware of the sources that promote negative messages. They should be encouraged to love, respect and value themselves. They need to know that they are uniquely crafted and packaged by a wonderful God who designed their bodies into sacred vessels attached to a spirit and soul. Their bodies should only be shared with a partner who will love, cherish and honour them for who and what they are, the image of God.
SECTION 4

Topic:
Sexual and Reproductive Health Issues

CONTENTS

Life Cycle Chart/Life Cycle (blank) Form
Sexual Development Throughout the Life Cycle
The Life Cycle: Preadolescence, Adolescence, Puberty, Adulthood, Mid-life, The Later Years
Adolescent Development: Early, Middle and Late
Physical Changes in Boys (including illustrations)
Physical Changes in Girls (including illustrations)
Traditional Gender Prescriptions – Part 1
Traditional Gender Prescriptions for Sexuality – Part 2
Pre-Development of Male and Female Genitalia
Development of Reproductive Function: Female
Development of Reproductive Function: Male
The Fertility Cycle
Information About Reproductive Anatomy and Physiology
Female/Male
Reproductive Anatomy and Physiology – Male
(including diagrams)
Quiz on Male Reproductive System
Reproductive Anatomy & Physiology – Female (including diagrams)
Quiz on Female Reproductive System
Sexual Development in Young People – Some Key Facts (T or F)
Human Sexual Response Cycle (illustration graph)
Sexual Dysfunctions
### LIFE CYCLE FORM

<table>
<thead>
<tr>
<th>Birth to 3 Years</th>
<th>4 to 12 Years</th>
<th>13 to 20 Years</th>
<th>20 to 50 Years</th>
<th>51 Years to Death</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SEXUAL DEVELOPMENT THROUGHOUT THE LIFE CYCLE

Infancy (0 – 2 years)
1. Family encourages either a male or female identity.
2. Child explores genitals and other body parts unless stopped by parents or other adults.
3. Child begins to develop an attitude (positive or negative) toward body parts, including genitals.
4. Child experiences genital pleasure (from birth, boys have erections, girls lubricate vaginally).
5. Family either builds or discourages the development of trust and self-esteem.
6. Child is completely dependent upon caretakers.

Early Childhood (3 – 6)
1. Child becomes aware of and very curious about gender and body differences.
2. Child will probably masturbate unless taught not to.
3. Child may participate in sex play with other children.
4. Child may wish for special relationship with parent of opposite sex.
5. Child becomes more independent.
6. Child’s gender identity is fixed.

School Age (5 – 8)
1. Child may participate in sex play with other children.
2. Child may be very curious about pregnancy and birth.
3. Child will probably continue to masturbate unless taught not to.
Pre-adolescent (9 – 12)
1. Child begins to separate from parents but parents are still the primary sources of values.
2. Peers become more important.
3. Child begins to experience body changes due to puberty.
5. Children may develop romantic crushes.
6. Child may feel awkward and wonder “Am I Normal?”
7. Child may experience sexual fantasies.
9. Child will probably develop romantic relationships.

Late Adolescence (12 – 23)
1. Adolescent is becoming increasingly independent from parents.
2. Body image is more realistic.
3. Relationships involve more intimacy.
4. Mature social activities and friendships.
5. Sexual activity.
6. Many are considering marriage and/or parenthood.

Young Adulthood (24 – 34)
1. Young adults have many choices about life options: career, relationship, parenting, etc.
2. Managing relationships: dating, marriage, outside relationships, etc.
3. Many adults choose to be single longer than in the past.
4. Some adults choose to be single parents.
5. Issues for single adults include meeting people, how to get sexual needs met and loneliness.
Middle Adulthood (35 – 45)
1. By this age, many adults are married, coupled, separated or divorced.
2. Issues in marriage/coupling include:
   - Handling dual careers
   - Dealing with changing sex roles
   - Possible disenchantment with sex
   - Extramarital sex
   - Heightened sexuality from women
   - Divorce/Separation
3. Many adults have become parents by this age. Issues in parenting include:
   - Postpartum sex
   - Balancing parenting demands and partner’s demands
   - Parenting teenagers
   - Dividing parents roles and tasks
   - Dealing with children’s sexuality
4. Many adults have become single again as a result of separation, divorce or being widowed.

Mid-Life (45 – 60)
1. End of fertility for women – menopause.
2. Possible increased interest in sex for women.
3. Possibility of male menopause (psychological).
4. Children are usually living independently, which requires adjustment on the part of the parent/s.

Older Adulthood (60+)
1. Possibility of deeper intimacy in marriage or other relationships.
2. Slowing down of sexual responsiveness – more so in men than in women. (Erection may be less firm and take longer to achieve. Women may have more difficulty lubricating).
3. Interest and desire for sex continues until death, depending on the health and attitudes of the individual.
4. Increased medical problems.
5. Women frequently outlive men.
THE LIFE CYCLE

All female and male organs, including sexual and reproductive organs, are similar in origin, homologous (meaning they are developed from the same embryonic tissue) and analogous (meaning similar in function). During the first six weeks, female and male fetuses appear identical in the uterus.

**Corresponding Sex Organs**

<table>
<thead>
<tr>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>outer lips (labia majora)</td>
<td>scrotum</td>
</tr>
<tr>
<td>inner lips (labia minora)</td>
<td>bottom side of penis</td>
</tr>
<tr>
<td>glans of clitoris</td>
<td>glans of penis</td>
</tr>
<tr>
<td>shaft of clitoris</td>
<td>corpus cavernosum</td>
</tr>
<tr>
<td>ovaries</td>
<td>testes</td>
</tr>
<tr>
<td>bulb of vestibule</td>
<td>bulb of penis and corpus spongiosum</td>
</tr>
</tbody>
</table>

**Preadolescence**

This frequently overlooked period between the ages of about seven to 12 years is, in fact, very significant. It is a time of rapid social development for most young people. “Best friends” become very important as youngsters begin to move away from their dependence on parents and towards peer groups.

**Adolescence**

The teen years. Adolescence is expressed differently in different cultures and there are variations among subgroups within the same culture. A number of physical changes occur along with emotional development influenced by the adolescent’s social environment and the attitudes of the adults around him or her. It is important that parents and other adults help the adolescent to understand the physical and emotional changes going on to encourage a positive self-image.
Dramatic body changes and personal feelings about these changes can be confusing and scary. This period of observable rapid change is called “puberty.”

**Puberty**

The phase of adolescence during which boys and girls develop the sexual characteristics of adults. The sequential changes for boys take about five years, beginning at 12 or 13 years of age. For girls, the changes take about six years, beginning at 11 or 12. Major changes and events include:

- onset of menstruation (menarche) in girls
- breast development and growth of pubic hair in girls
- enlargement of the labia and clitoris in girls
- enlargement of scrotum, testes and penis in boys
- development of pubic hair and facial hair in boys
- first ejaculation (spermarche) and often nocturnal emissions (wet dreams) for boys
- gain in muscular strength for boys
- voice changes in both girls and boys
- growth in body height in both boys and girls
- body shape takes on adult characteristics/patterns in both boys and girls
- skin problems (acne) develop for some boys and girls

These changes generate concern on the part of both girls and boys about how their bodies appear to others and sensitivity to remarks by parents and peers about their changing appearance. These changes in adolescents are triggered by enormously increased production of hormones: testosterone in males, oestrogen and progesterone in females.

Some adolescents feel inadequate and inferior if their personal development is not in step with their peers. These feelings can produce defensive behaviour that makes adolescents’ lives painful and affects their parents and other adults in ways that make living together stressful.
Parents have to be very understanding and supportive of their children during this period. They can do a good deal to alleviate the extreme stress that young people generally suffer throughout adolescence. During this period young people become increasingly independent and sexual interest surfaces. Today, adolescents have to face many social and cultural pressures that previous generations were not aware of; yet they still have to struggle with their emergent adult identities. Young people are increasingly hyper-sexualised through many sources including advertisement, music, videos, fashion and society’s cavalier attitudes towards sex. In fact, sexual intercourse has been disassociated from responsibility, commitment and love. Many young people view sex as some sort of “rite of passage,” a ritual that everybody engages in. Hence, young people need and want direction and guidance.

**Adulthood**
Essentially achieved by the end of the second decade of life.

**Midlife – Women**
The years between 40 and 65, called the climacteric in men and menopause in women. In women, there are essentially four phases of reproductive maturity:

I. *Menarche/Menstruation* – the period when a woman has regular periods or menstrual cycles.

II. *Climacteric* – when the ovaries start to produce less oestrogen. This is usually when the woman is about 35. As time goes on, she may experience symptoms of breast tenderness, premenstrual syndrome (PMS), night sweats or other signs of imbalance in oestrogen and progesterone.
III. *Pre-Menopause or Peri-Menopause* – when the woman’s periods become irregular. Some women experience hot flashes, lasting 30 seconds to 15 minutes. These usually occur between 6 and 8 in the morning or 8 and 10 at night.

IV. *Menopause* – when the woman has not menstruated for a full year. This signals the end of the reproductive years. The average age at which this happens is 51 years.

Note: Before birth, a female foetus has about 7 million eggs in her ovaries. Five million are lost before she is born. By the time she reaches puberty, she has approximately 300,000 undeveloped eggs left in her ovaries. By the time she reaches menopause most – though not all – have disintegrated.

**More About Menopause**

At one time, menopause was believed to be an oestrogen deficiency disease. Today, some women choose to take oestrogen/progesterone supplements or hormone replacement therapy (HRT) to lessen bothersome symptoms.

The signs and symptoms approaching menopause may include vaginal dryness, overall tingling sensations, more frequent urinary tract infections, less strength in the hands, insomnia, hot flashes, less secure sense of balance, osteoporosis (brittle or soft bones), fomication (itching under the skin) and psychological symptoms (which may be physiological or emotional).

There are two (2) types of menopause. *Natural menopause* occurs when the ovaries decrease production of certain hormones, including oestrogen. The average age at natural menopause is 51 years; however, it can begin as early as age 35 or as late as after age 60. *Surgical menopause* occurs when the ovaries are surgically removed – often in conjunction with a hysterectomy (an operation to remove the uterus).
Oestrogen is a female sex hormone that fulfils many important roles in a woman’s body. It is responsible for many functions including the development of the breasts, the vagina and the uterus. But the role of oestrogen is not restricted to the reproductive process. It controls other important functions throughout your body in a variety of ways.

The drop in oestrogen can have many short-term and long-term effects on your body. In both natural and surgical menopause, similar events occur.

**Symptoms that may occur during Menopause:**

- Hot flashes/night sweats – affect an average of 86% of women. Hot flashes, as the name suggests, are brief, uncomfortable feelings of intense heat, flushing and possibly sweating. A hot flash can last anywhere from 30 seconds to 15 minutes or longer. Hot flashes/night sweats are one of the most common symptoms of oestrogen loss. Many women view menopause as a healthy and natural part of the life cycle. Some feel that it has a positive effect on sex – no more worries about contraception and pregnancy can lead to an increased sense of sexual freedom. For others, it may have no effect at all. Some women refer to hot flashes as having a “power surge” or “private summer.”
- Vaginal discomfort can occur due to drying and thinning of the vaginal lining caused by progressive loss of oestrogen.
- Monthly periods become irregular and gradually stop. In the case of surgical menopause, periods stop abruptly at the time the uterus is removed.
- Bone loss occurs at an increased rate that can lead to osteoporosis in women at risk.
- Interrupted sleep
- Vagina becomes shorter and narrower.
- Fatigue
- Vaginal lining becomes thin and dry.
- Vaginal atrophy (loss of elasticity and irritability)
- Vaginal burning/irritation/itching
- Mood changes
- Memory loss
- Increased risk of vaginal infection
- Bleeding after intercourse
- Negative attitude about aging

For many women, hot flashes and night sweats will subside after approximately two years. However, for some women hot flashes and night sweats can last for five to 10 years. The good news is there are therapies such as hormone replacement therapy (HRT), oestrogen replacement therapy (ERT), natural progesterone creams and other things that can help. Women should be encouraged to take charge of their health at menopause. They should have regular checkups, especially if they have any of these symptoms.

Some alternatives to HRT may be maintaining a healthy attitude about aging; eating a well-balanced diet, getting appropriate exercise, joining a self-help or support groups, having sex regularly, using vaginal lubricants or saliva to counteract vaginal dryness during sex, increasing intake of calcium, vitamin E, ginseng or bee pollen, herb teas and cranberry juice and, equally important, understanding the physiological changes going on.

Many women sail through menopause without any problems. Studies suggest that a woman who has a healthy attitude towards life and aging will probably experience little or no difficulties. However, women who do experience symptoms should try to maintain a positive attitude as the symptoms will eventually subside. Positive thinking is powerful medicine.
What can women do to protect their health:

• Stop smoking!
• Take calcium supplements
• Maintain a healthy weight
• Exercise regularly
• Reduce stress
• Eat a diet low in saturated fats
• Eat a diet high in fruits and vegetables

It is important to note that sexuality is an important part of life and that it continues to play a vital role long after menopause. In fact, evidence suggests that continued sexual activity plays a positive role in maintaining vaginal health.

Mid-life – Men

Just as oestrogen production diminishes in women during mid-life, testosterone levels are also reduced in men. Since men do not menstruate, the term “menopause” is inappropriate.

The male climacteric is a better term than “male menopause” for describing the kind of emotional and psychological changes that some men experience during mid-life.

Mid-life crisis is a term commonly used to describe men in conflict with growing older. Some men who are insecure about their masculinity react with something near panic. Some may question their virility and seek to prove they are as “good” as ever by pursuing the maximum possible number of sexual encounters. Some men indulge in all sorts of excessive behaviours to prove they are still desirable, strong and virile. It is this group that has given rise to the myth that middle-aged men look for younger partners. Many men never experience a mid-life crisis by seeking multiple women for sex.
As men get older, their testosterone levels drop with age. This decline can begin as early as the mid-30s. The average decline in testosterone levels from the mid-20s to the mid-40s could be as much as 17%, going up to 32% by the mid-60s. While such a decline in testosterone levels is a natural transition and for most men not associated with any adverse events, symptoms such as erectile dysfunction, decreased libido, fatigue and depressed mood may indicate the need for testosterone replacement. A standard blood test is all it takes to diagnose it.

Low testosterone levels can result in decreased sexual function, decreased sexual desire, diminished energy and mood swings. Millions of men may suffer from testosterone deficiency yet only a small percentage are currently being treated. However, with the availability of convenient, user-friendly testosterone replacement, testosterone deficiency may be easily treated once it is diagnosed.

**Treating Testosterone Deficiency:**

Once testosterone deficiency is diagnosed, choosing a treatment is just as critical in getting the desired results. Some of the therapies available for testosterone replacement are:

- Injections
- Oral testosterone
- Scrotal Patches
- Non-scrotal Patches

It is important for men to discuss the advantages and disadvantages of each therapy to determine the one that best suits the individual’s needs and lifestyle.

It is normal for men to reflect on the direction their lives have taken and on what the future holds. It is also common for them to feel a profound sadness or depression for no obvious reason. Some may show some personality changes that may put a strain on his relationships. The duration of this period is highly variable. It may be concentrated in a few months or it may last for several years, on and off, during a man’s 40s, 50s or 60s.
However, many men sail through mid-life without any problems. Men who have a healthy attitude towards life and aging will probably not experience any difficulty.

**The Later Years**

The most likely change in people’s sexual expression in later years is a slowing-down to some degree. Many cultures do not expect older people to have sex, so to conform to what is expected, many try to avoid it. The greater risk of significant physical impairments that may occur during aging sometimes affects sexual expression. Partners die and, for many reasons, new ones are hard to find. However, we all need to be aware that sexual interest and pleasure are not related to age. The changes that occur during menopause and the male climacteric do not signal the end of sexual expression or desire.

The frequency of sexual activity in later years seems to be most closely related to the frequency of it earlier in life.

A person who had a high level of sexual activity when young is likely to desire sexual activity as they get older.

Caressing, fondling and kissing, as well as genital acts, are important expressions of love and affection at every stage of the life cycle.

Physical problems may necessitate some modification in the manner of sexual expression but they need not end it.

Barriers to active sexual expression in later years may include boredom. Overindulgence in food, drink and fatigue due to poor physical condition may lead to reduced sexual activity in later years. It is more likely to be due to lack of a partner than to lack of interest.

(Adapted from the Parent Education Programme, Planned Parenthood of New York City)
Early Adolescence (11 –14 years)

- Puberty, rapid physical changes
- Concerns about body image
- Lowered self confidence
- Same sex relationship “crushes”
- Concern for privacy
- Mood swings
- Conflict with parents
- Early independence and “testing”

Middle Adolescence (15 – 17 years)

- Identity formation
- Experimentation – “testing out”
- Sexual relationships
- Attachment to peer group
- Moral reasoning begins to develop
- Abstract thinking begins to develop

Late Adolescence (18 – 20 years)

- Clearer establishment of sexual, political, moral and vocational identity
- Interdependence with parents
- Clearer perception of desirable body image
- Relationships based on own values
- Increased self-esteem and confidence with greater independence
There are lots of changes that happen at puberty. Some of these are the same for both young women and men, others are different.

**Genitals**
Your testes and penis will get bigger. Your internal organs mature and you start producing sperm and semen (the white, sticky fluid that comes out of your penis when you come). This means you are physically able to get a woman/girl pregnant. As you begin to mature you may start having wet dreams that occur when you ejaculate (come, have an orgasm) while asleep. This is normal and nothing to worry about.

**Body Odour**
This changes and you sweat more.

**Skin**
Skin and hair gets more oily and some people get pimples. This usually clears as you get older.

**Voice**
Gets deeper.

**Height**
You will grow taller.

**Hair**
This grows under your arms, around your genitals and on your legs, face and body.

**Body Shape**
Shoulders broaden and you put on weight. This usually disappears as you get older, especially if you do regular exercise and eat well.

All of these changes are triggered by hormones that are chemical messengers inside our bodies. Because everyone is different, the age at which these changes begin and end varies from person to person.
PHYSICAL CHANGES: GIRLS

There are lots of changes that happen at puberty. Some of these are the same for both young women and men, others are different.

**Body shape**
Shoulders broaden and hips usually do too. Some girls put on weight although this usually disappears as they get older, especially if they do regular exercise and eat well.

**Hair**
This grows under your arms, around your vulva and on your legs, face and body. Girls don’t usually get as much hair on their body and face as boys. It is normal for girls to have a few hairs around their nipples.

**Skin**
Skin and hair gets oilier and some people get pimples. This usually clears as you get older.

**Body odour**
This changes and you sweat more.

**Height**
You will grow taller.

**Voice**
This can deepen although it is not always noticeable in girls.

**Breasts**
These develop and grow to various sizes.

**Genitals**
The lips of your vulva (the labia) get larger and change shape slightly. Inside, the labia and vagina will become moist from vaginal mucous. You may notice a clear/white discharge (mucous) from your vagina certain times of the month. This is normal and healthy.
**Periods**

Starts some time between the ages of eight and 17-years. Blood comes from the vagina over a few days. Everyone’s period is different. It is normal for bleeding to last between two and seven days. A cycle can be 19 to 35 days apart and longer when you first start. In the beginning, your periods may be irregular. Your body is physically able to get pregnant after your period starts and just before you see your first period (menarche).

All of these changes are triggered by hormones that are chemical messengers inside our bodies. Because everyone is different, the age at which these changes begin and end varies from person to person.
## TRADITIONAL GENDER PRESCRIPTIONS: PART 1

<table>
<thead>
<tr>
<th>Aspects of Power</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Strong, Touch, Powerful, Muscular</td>
<td>Weak, Gentle, Helpless, Dainty, Demure, Petite, Vulnerable, Cute</td>
</tr>
<tr>
<td></td>
<td>Ruggedly Handsome</td>
<td>Graceful, Sensual, Sexy, Pretty</td>
</tr>
<tr>
<td>Status</td>
<td>Ownership, More entitled Dominant, in authority Front-seat Leader Independent, Free Protector</td>
<td>Property, Less entitled Submissive, Deferring Back-seat Follower Dependent Protected</td>
</tr>
<tr>
<td>Interpersonal Style</td>
<td>Active, Doer Direct, Assertive</td>
<td>Passive, Receiver Responder to male, Indirect, Female wiles</td>
</tr>
<tr>
<td></td>
<td>Worldly, Experienced Bold, Adventurous, Daring</td>
<td>Inexperienced Retiring, Modest, Self-conscious</td>
</tr>
<tr>
<td></td>
<td>Aggressive – win at all costs</td>
<td>Easily intimidated, Shy, Patient</td>
</tr>
<tr>
<td></td>
<td>Conqueror, Victor Competitive</td>
<td>Be conquered, Prize Non-competitive</td>
</tr>
<tr>
<td></td>
<td>Ambitions Outer world</td>
<td>Unambitious Inner world</td>
</tr>
<tr>
<td></td>
<td>Performance</td>
<td></td>
</tr>
</tbody>
</table>
### TRADITIONAL GENDER PRESCRIPTIONS:
#### PART 1 (continued)

<table>
<thead>
<tr>
<th>Aspects of Responsibility</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Roles</strong></td>
<td>Economic provider</td>
<td>Economic dependence</td>
</tr>
<tr>
<td></td>
<td>Work:</td>
<td>Work:</td>
</tr>
<tr>
<td></td>
<td>• outside family</td>
<td>• within family</td>
</tr>
<tr>
<td></td>
<td>• breadwinner</td>
<td>• nurturer</td>
</tr>
<tr>
<td></td>
<td><strong>Economic dependence</strong></td>
<td><strong>Relationship</strong></td>
</tr>
<tr>
<td></td>
<td>Work:</td>
<td>• maintenance and repair</td>
</tr>
<tr>
<td></td>
<td>• within family</td>
<td>• support provider</td>
</tr>
<tr>
<td></td>
<td>• nurturer</td>
<td>• child rearing</td>
</tr>
<tr>
<td></td>
<td>• relationship</td>
<td>• domestic duties, tidy</td>
</tr>
<tr>
<td></td>
<td>• maintenance and repair</td>
<td>• sexual partner</td>
</tr>
<tr>
<td></td>
<td><strong>Support provider</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Child rearing</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Domestic duties, tidy</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Sexual partner</strong></td>
<td></td>
</tr>
<tr>
<td>Head of the family</td>
<td>Neck that turns the head</td>
<td></td>
</tr>
<tr>
<td>Separateness, space</td>
<td>Togetherness</td>
<td></td>
</tr>
<tr>
<td><strong>Emotional Style</strong></td>
<td>Unemotional, insensitive</td>
<td>Emotional, sensitive, warm</td>
</tr>
<tr>
<td>Cool, aloof</td>
<td>Expressive, caring, understanding</td>
<td></td>
</tr>
<tr>
<td>Calm in crises, stoic</td>
<td>Easily distressed</td>
<td></td>
</tr>
<tr>
<td>Level-headed</td>
<td>Irrational – intuitive</td>
<td></td>
</tr>
<tr>
<td>Rational</td>
<td>Impractical – outer world</td>
<td></td>
</tr>
<tr>
<td>Practical</td>
<td>Frivolous, vain, gossipy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sentimental</td>
<td></td>
</tr>
<tr>
<td>Clever</td>
<td>Dumb</td>
<td></td>
</tr>
<tr>
<td>Non-verbal communication</td>
<td>Verbal communication</td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>Words</td>
<td></td>
</tr>
</tbody>
</table>
## TRADITIONAL GENDER PRESCRIPTIONS: FOR SEXUALITY – PART 2

<table>
<thead>
<tr>
<th>Aspects of Responsibility</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Roles</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsibility to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• act on desire</td>
<td></td>
<td>• be object of desire</td>
</tr>
<tr>
<td>• initiate</td>
<td></td>
<td>• be available, oblige, satisfy</td>
</tr>
<tr>
<td>• orchestrate</td>
<td></td>
<td>• be seduced</td>
</tr>
<tr>
<td>• perform</td>
<td></td>
<td>• be responsive to male</td>
</tr>
<tr>
<td>• provide female sexual</td>
<td></td>
<td>• protect male ego</td>
</tr>
<tr>
<td>turn on</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limit testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• be attracted to bodies</td>
<td></td>
<td>• attract but not provoke</td>
</tr>
<tr>
<td>• provide self conquests</td>
<td></td>
<td>• avoid leading on/ teasing</td>
</tr>
<tr>
<td>• performance</td>
<td></td>
<td>• responsible for consequences</td>
</tr>
<tr>
<td>Emotion Style</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsibility –</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sexual intimacy</td>
<td></td>
<td>• avoid appearing easy</td>
</tr>
<tr>
<td>Sex → Intimacy</td>
<td></td>
<td>• set limits, moral guardian</td>
</tr>
<tr>
<td>Sex separate from</td>
<td></td>
<td>• take care of contraception</td>
</tr>
<tr>
<td>relationship context</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotions highly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sexualised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• closeness/caring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• aggression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexuality → self-esteem</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Margaret Sanger Center International, Copyright 2001*
### TRADITIONAL GENDER PRESCRIPTIONS: FOR SEXUALITY – PART 2

<table>
<thead>
<tr>
<th>Aspects of Power</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical</strong></td>
<td>Locus of male sexuality</td>
<td>Locus of female sexuality</td>
</tr>
<tr>
<td>Penis</td>
<td>• Penis as object</td>
<td>Whole Body - Broader</td>
</tr>
<tr>
<td></td>
<td>• Big</td>
<td>• Body as object</td>
</tr>
<tr>
<td></td>
<td>• Touch, Weapon</td>
<td>• Sex = young, firm, vulnerable</td>
</tr>
<tr>
<td></td>
<td>• Performance</td>
<td>• Attract males through sexual display</td>
</tr>
<tr>
<td></td>
<td>• erection at will</td>
<td>• Cultivate [AT ALL</td>
</tr>
<tr>
<td></td>
<td>• ever ready</td>
<td>• Maintain [COSTS</td>
</tr>
<tr>
<td></td>
<td>• ever lasting</td>
<td></td>
</tr>
<tr>
<td>Virile = Penile</td>
<td>action Actor on desire</td>
<td>Sexy – Body attraction</td>
</tr>
<tr>
<td>Status</td>
<td>Own partner’s body</td>
<td>Submit to ownership</td>
</tr>
<tr>
<td></td>
<td>Sexual entitlement</td>
<td>Sexual obligation</td>
</tr>
<tr>
<td>Interpersonal Style</td>
<td>Active sexuality – doer</td>
<td>Responsive sexuality - receiver</td>
</tr>
<tr>
<td></td>
<td>Initiate – direct</td>
<td>Attract – indirect</td>
</tr>
<tr>
<td></td>
<td>Seduction</td>
<td>Seduction</td>
</tr>
<tr>
<td></td>
<td>Orchestrate turn females on</td>
<td>Be turned on</td>
</tr>
<tr>
<td></td>
<td>Experienced, Knowledgeable, Bold</td>
<td>Inexperienced, Naïve, Virginal, Modest</td>
</tr>
<tr>
<td></td>
<td>Predatory, Aggressive Make conquests, score Rate</td>
<td>Prey, Defensive, Guard Reputation, Surrender</td>
</tr>
<tr>
<td></td>
<td>Gain Access</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Take Opportunities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overcome Resistance</td>
<td>(resistance = desires)</td>
</tr>
<tr>
<td></td>
<td>(resistance = desires)</td>
<td>Double Standard</td>
</tr>
<tr>
<td></td>
<td>Performance: quantity vs. quality</td>
<td></td>
</tr>
</tbody>
</table>

Margaret Sanger Center International, Copyright 2001
Differentiation of the Gonads

This begins about the sixth week after the conception. Genetic male and genetic female embryos look alike at this point, although sex was determined at the moment of conception. Differentiation begins with gonads, then proceeds to the internal reproductive structures and is completed with differentiation of the external genitals as male or female. Each process overlaps.

The ovary and testis have a common beginning in a primitive bipotential structure that can differentiate in either direction as male or female.

In structure, the gonad may develop either of two portions – a medulla (inner or core portion) or a cortex (outer or rind portion).

If the medullary portion of the primitive gonad proliferates under the influence of directives programmed in the genetic code of the XY (male) pair of chromosomes, then a testis is formed. At the same time, the cortical portion of the gonad begins to regress and soon largely disappears.

In the differentiation of the ovary, the opposite occurs. The medullary portion of the original sex-neutral gonad regresses and the cortical portion proliferates. This process begins later than the differentiation of the testis, sometimes as late as the 12th week. It is complete at around the sixth month of gestation. At birth, a normal pair of ovaries contains 300,000 to 400,000 ova, of which about 300-400 will eventually mature and be released. (The billions of sperm that a male will ejaculate in his lifetime are not present at birth but are produced constantly throughout life.)
The mechanism by which the X and Y chromosomes regulate gonadal differentiation has not yet been empirically demonstrated. It is assumed that there are gonad-determining genes on the XY and XX chromosome pair.

Gonads do not attain full maturity until after puberty.

**Differentiation of the Internal Genitalia**

At about the seventh week of intrauterine life, when gonadal structures have still not completely differentiated into either testes or ovaries, the embryo has both male and female genital ducts.

In normal female development, the mullerian ducts develop into the uterus, the fallopian tubes and the upper part of the vagina. In normal male development, the wolffian ducts have the potentiality of differentiation into the Vas Deferens, the seminal vesicles and the ejaculatory ducts. During the third foetal month, either the mullerian or wolffian ducts proliferate, while the opposite structures disappear except for small remnants.
When a girl begins to menstruate she is usually considered “a woman,” although she may not feel much different. Menstruation has a lot of names; the most common is “period.” It is the result of at least a month’s activity inside the female body.

Let’s start with what we see. Usually between the ages of nine and 18 years, a girl begins menstruating. Menstruation is made up of blood and tissue that come from the uterus and are no longer needed. It dribbles out of the female body through the vagina for two to eight days. Although the discharge is called “bleeding” and looks like blood, not much of it is blood (usually less than ¼ cup). Also, the girl isn’t bleeding as if she had a cut. The self-cleaning lining of the uterus no longer has fresh new blood flowing through it because its blood supply has been shut off. So a girl isn’t bleeding to death. During this time, she wears either a sanitary napkin or a tampon to catch the discharge so it won’t stain her clothes. She should change this every eight hours or more often, even if she’s not flowing heavily.

The first day menses (men-seez), a shorter word for menstruation, is called the first day of that menstrual cycle. A cycle can last from 20 to 40 days but the duration is usually about a month. When a young girl first starts having periods, she may not have regular monthly cycles for a year or more. (Some women are never regular – never have cycles or a consistent length.) The cycle ends the day before the next period starts.
What’s happening when the female isn’t menstruating? Her body is very active. While the uterus is cleaning itself out during menses, an egg is actively developing in the ovary. This usually takes about two weeks but it may be as short as a few days or as long as a month – the process may be affected by stress, illness and many other factors.

As the egg is maturing, a blister forms on the ovary. When the egg is mature, a blister pops the egg out of the ovary. This is called ovulation. The finger-like ends of the oviducts swim around the ovary, pick up the egg and draw it into the oviduct. Inside the oviduct are tiny little hairs that pass the egg along into the uterus. This usually takes three to five days. If fertilisation (a union of sperm and egg) takes place, it happens here in the widest part of the oviduct.

During the few weeks all this is going on, the uterus is building up its lining with fresh tissue and blood. By the time the egg arrives, the lining is rich and soft, ready in case the egg is fertilised and needs to implant itself in the lining. That would start a pregnancy. If the egg isn’t fertilised, the lining dissolves and dribbles out of the vagina as the menses.

The time from ovulation to the next menses is a very consistent length – 12 to 16 days – controlled by hormones. So the two weeks or so before ovulation and the two weeks after make a menstrual cycle about four weeks or a month in length. The cycle is a normal function for a woman until she reaches her 50s, when it slows down and eventually stops. During the 30 to 40 years a woman menstruates, she can get pregnant if she has sex. If she does not want to be pregnant, she can either not have sex or use a method of family planning when she does.
DEVELOPMENT OF
REPRODUCTIVE FUNCTION: MALE

While the female has a cycle that generally (about 97 percent of the time) produces only one egg per month, the male can produce about 150 million sperm per day. There is no monthly cycle for sperm. They begin to develop in the two testes when the hormones become active in the male body, which can be anywhere from age ten to age 16 but is usually around 12 to 14. The same hormones that cause female eggs to start developing are active in the male and cause sperm to be produced in the testes.

Sperm start out in each testis (the plural is testes) where it’s cool (one to eight degrees lower than normal body temperature). The scrotum keeps the testes outside the body so they’re cool. It takes about six weeks for sperm to develop in the testis.

From there, they move into a coiled tube called the epididymus where they get lots of nourishment and mature so they can fertilise; this takes 10 to 20 days. Now they are ready for a long journey to the outside of the body.

Sperm move through the vas deferens by muscle contractions of the tube. They can’t swim until they get into liquid. They travel from the scrotum into the body and to a holding area at the end of the vas deferens.
When the male is sexually aroused, some sperm, some sugary liquid from the *seminal vesicle* and a little milky fluid from the *prostate gland* mix in the area called the *ejaculatory duct*. When the sperm (only about 5% of the mixture) and the liquid mix together, the sperm are able to swim. This mixture is called *semen*.

Now the semen is ready to come out the *penis*. By this time, the male has an erection (the penis is filled with blood and sticks out straight).

Before the semen comes out – called *ejaculation* – little glands called *Cowper’s glands* send out a few drops of liquid that clean out the pathway. (Both urine and semen use the same tube to cleave the body.) A muscle closes off the bladder, the Cowper’s glands squirt out their cleaning fluid and the *urethra* is clean and ready for semen. When the male ejaculates, the semen (with sperm in it) shoots out the penis. This can happen during wet dreams, during masturbation or during sexual intercourse.

(Adapted from a publication of Planned Parenthood of Northern New England)
THE FERTILITY CYCLE

This is a sequence of events within a woman’s body that keeps repeating itself every 28 days or thereabouts from the time she is 12 or so until she is 40 or 50.

It is begun and controlled by a series of hormones – messenger chemicals – travelling back and forth through the bloodstream between the ovaries, the uterus and a small gland at the base of the brain called the pituitary gland.

The cycle has two main phases. The first prepares an egg cell to be released. The second prepares the uterus to receive and nourish a fertilised egg.

Phase One

The pituitary gland starts each cycle off by producing what is called FSH – Follicle Stimulating Hormone.

This hormone travels to the ovaries where the immature eggs are stored, each in a tiny follicle or egg container. Several eggs in both ovaries start to grow and mature. Then, after a few days, one egg in one ovary keeps growing while the rest regress. (It is rare but possible for more than one egg to go on to be released. This is one of the ways multiple births occur.)

FSH also causes the swelling follicle to start producing oestrogen.

Oestrogen stimulates female physical development generally but it has specific effects on the reproductive organs. As the days go by, the lining of the uterus becomes thicker and more velvety. There begins to be more moisture at the cervical opening and its consistency gets thinner, easier for sperm to penetrate.
Then, as the oestrogen in the bloodstream approaches its peak, it signals the pituitary to release a surge of LH – *Luteinising Hormone*.

This causes the follicle to burst and push the mature egg out. Some women actually feel this as a cramp on one side of the lower abdomen; some have a slight bloody discharge at this point. Most women notice nothing at all. But the event – *ovulation* – is the climax of Phase One.

**Phase Two**

As soon as the egg cell is released, it starts down the Fallopian tube. If fertile sperm are present in the tube – or if they reach it during the next 24 hours – the egg can be fertilised. Meanwhile, the egg’s empty follicle – now called the *corpus luteum* – continues to produce oestrogen but less and less of it and more and more of the other major hormone, progesterone. These two hormones now work together to prepare the whole system for a possible pregnancy.

Within 18 to 24 hours after ovulation, the woman’s body temperature goes up one-half to one degree. As progesterone builds up in her system over the next week or so, her kidneys and body tissues may retain more water, so that she feels ‘fatter’ and her breasts may be uncomfortable. The lining of her uterus becomes still thicker and softer. It starts secreting a special sugar-rich solution that would help a fertilised egg implant and would provide its first nourishment. There is less cervical moisture and what there is thicker, beginning to seal the cervical opening.

Of course, all these preparations are unnecessary if the egg has not been fertilised in the first 24 hours after ovulation but it takes about 10 days for the message – pregnancy or no pregnancy – to reach the ovary.
If the message is no pregnancy, the corpus luteum simply dries up. Its hormone production stops. Without the stimulation of oestrogen and progesterone, the lining of the uterus cannot sustain itself. The extra thickness dissolves. It drains away in a little flow of blood, perhaps four to six tablespoonfuls over a period of four or five days. This is *menstruation* – the one part of the cycle most women are aware of.

Meanwhile, the drop in the level of oestrogen and progesterone in the bloodstream has signalled the pituitary to start the whole cycle over again.

All of this usually takes about 28 days, with the first day of menstruation counted as Day 1 of the cycle. But some women normally have longer cycles and others have shorter ones and any woman’s individual cycle may vary from month to month. A cycle can be as short as 21 days; it can be as long as 35 days.

One part of the cycle is consistent – Phase Two, from ovulation to the onset of menstruation, is almost always 14 days. It is Phase One that contains the variable – the interacting build-up of hormones (FSH, oestrogen, LH) that leads to ovulation.

If this build-up takes place at the rate usual for most women, ovulation will occur on Day 14 and the whole cycle will last the typical 28 days. If the build-up is unusually quick, the woman may ovulate as early as Day 7 and that cycle will be short – 21 days. If the build-up is slow, perhaps because the woman is tired or ill, she may not ovulate till Day 21 and it will be a 35-day cycle.
Introduction: Adolescence

Adolescence, also called puberty, is the period between childhood and adulthood when people’s bodies undergo remarkable hormonal and physical changes.

- Physical, sexual and emotional development occurs during puberty.
- Girls may begin maturing by age eight.
- Boys begin maturing at ten or later.
- Most of the changes of puberty have occurred by ages 16-18.

Physical growth is one of the obvious changes during adolescence.

- Each person has his or her own rate of growth.
- Some people start this growth – as much as five or six inches and gain 30 to 40 pounds or more – in a short period.
- Some people start maturing later, at age 13, 14 or even older.
- Whenever it happens, this spurt of growth can make one feel somewhat uncoordinated at times but coordination will return as the body reaches its mature height and weight.

In addition to physical growth, adolescents experience sexual development.

- In males, the penis and testicles grow larger.
- In females, the breasts begin developing, menstruation begins and cervical mucus begins to be produced.
- Internally, in both males and females, the reproductive organs mature, making the person capable of producing babies through sexual intercourse.

Some people discover that their emotions change during puberty. They’re maturing sexually as well as physically and may find that some emotional changes have to do with their sexual development.
Sexual dreams are common during adolescence (as well as during adulthood). It is also common not to have sexual dreams.

These changes may worry an adolescent, particularly if he is the last boy in his class whose voice hasn’t changed or if she’s a girl who hasn’t started her menstrual periods. They’ll catch up with their friends soon but if they are really worried, they should talk it over with someone they trust.

**Similarities Between Males and Females**

We often think of anatomy as a way of understanding the differences between males and females, yet both sexes are very similar physiologically before birth.

The following male and female sex organs develop from the same tissue in the foetus during the first six weeks of foetal life:

- The glans (head) of the penis in the male and the clitoris in the female.
- The penis and the vagina.
- The testicles and the ovaries.
- The vas deferens and the Fallopian tubes.

When we are born, we are equipped with sex organs that grow and mature as we grow older. It is not until adolescence, however, that we begin to get signals that our sexual organs are maturing – for example, a boy’s first ejaculation or a girl’s first menstrual period.

It’s important for both boys and girls to know about their bodies and how they function. Misinformation or lack of information is often responsible for a lot of needless worry and can sometimes cause serious problems.
Female Anatomy

One difference between males and females is that in males the organs responsible for the male role in reproduction are the same organs that provide sexual pleasure but in females there is one organ that seems to have no other function than to help a woman have sexual pleasure. This organ is the clitoris.

- The clitoris is located in the soft folds of skin in front of a woman’s vagina.
- Because the clitoris comes from the same tissue that develops into the glans of the penis in the male, it has the same number of nerve endings as the glans and because it is so much smaller, about the size of a pea, it is very sensitive.
- Direct or indirect stimulation of the clitoris is the main way a woman reaches a climax or orgasm.

Below the clitoris is the opening to the urethra, which is the passageway for urine from the bladder to the outside of the woman’s body.

Just below the urethral opening is the entrance to the vagina.

The vagina is the elastic muscular passage extending from the woman’s outer sexual organs (the vulva) to the uterus.

- The vagina is about four inches long and can receive a man’s penis during sexual intercourse.
- The vagina, also called the birth canal, is the passage through which a baby is born.
- It is also where tampons are inserted to absorb menstrual discharge.
- The vagina is not a hollow tube. The walls are collapsed when empty but it can stretch to accommodate a tampon, a penis or a full-term baby.
- The vagina is designed to clean itself by periodically shedding mucus and dead cells.
Often, but not always, a small web of skin called the *hymen* partly covers the opening of the vagina.

- For centuries people mistakenly believed that if this web were torn or missing, a woman was not a virgin.
- Actually, the hymen hardly exists in some women. In others it is very easily stretched.
- For some women in whom the hymen is still intact, first sexual intercourse may be uncomfortable.

The clitoris, the urethral opening, and the vagina are surrounded by the *labia minora* (inner lips) and the labia majora (outer lips).

All of the woman’s reproductive organs are located inside her body.

The neck of the uterus, which is called the *cervix*, protrudes down into the back of the vagina.

- The cervix is the entrance to the uterus and contains mucus-producing glands.
- The cervix feels like the end of a nose with a dimple in it.
- 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.

The *uterus*, also known as the womb, is a pear-shaped muscular organ in which the fertilised egg grows and develops into a foetus.

- Normally, the uterus is about three inches long and two inches wide. During pregnancy, it stretches and grows with the foetus.
- In a pregnant woman, the lining of the uterus, called the *endometrium*, nourishes the foetus.
- In women who are not pregnant, the lining is shed about once a month if an egg is not fertilised. This shedding is called *menstruation*.
- Menstruation, or a period, comes about once a month for most women.
• In the beginning, periods may be irregular – every three, four, five or six weeks. Gradually the body develops its own pattern of regularity.
• Periods last three to seven days in most women but this also varies.
• Some women feel uncomfortable the first or second day of their periods but for most women there is no reason for menstruation to interfere with normal activity.

Tampons or sanitary napkins usually are used to absorb the menstrual discharge. The total amount of menstrual flow for an average period is approximately a quarter of a cup.
• Tampons fit inside the vagina and many women find them more comfortable than sanitary napkins.
• Sanitary napkins are absorbent pads worn outside the body.

The occurrence of Toxic Shock Syndrome (TSS) has been associated with tampon use. TSS is believed to be caused by a toxin (poison) released by staphylococcus aureus bacteria. The symptoms are sudden high fever, diarrhea, vomiting, muscle ache, inflamed eyes and a widespread rash that looks like sunburn. If these occur, the woman should stop using tampons and call her physician or clinic.

The risk of TSS is virtually eliminated if sanitary pads are used rather than tampons. A woman who chooses to use tampons can minimise her risk of TSS by:
• changing tampons at least every eight hours.
• avoiding use of tampons with super absorbent fibres.
• washing her hands before inserting a tampon and inserting it carefully to avoid carrying bacteria from the skin or rectum into the vagina.
• having a tampon-free interval every day – for example, using pads at night.
• seeing a physician if she thinks she may have had TSS in the past.
• not using tampons if she has had TSS, until she is sure that she no longer has *staphylococcus aureus* in her vagina.

It’s common for young women to experience some discomfort when they begin having periods.
• They may experience cramps in the pelvic area, headaches, backaches or nausea.
• The individual girl’s preparation for and attitude toward menstruation may be a factor in the amount of discomfort she feels.
• These problems also can be affected by changes in hormone levels.
• There are medications available to relieve cramps.
• Exercise and a balanced diet may help.

*Premenstrual tension* can also be produced by monthly changes in hormone levels. There may also be nutritional causes.
• Premenstrual tension can occur during the ten days before menstruation.
• Some women experience tension with such symptoms as fatigue, anxiety, irritability, headache, a feeling of puffiness in the pelvic region, craving for sweets, breast tenderness and depression.
• Exercise and a balanced diet are thought to help alleviate this syndrome.

*Menstruation* occurs only in female humans, some apes and some monkeys.

The *menstrual cycle* begins on the first day of bleeding and ends on the day before the next bleeding.
• Most cycles range from 26 to 34 days in length.
• Cycles can be affected by emotional stress or changes in diet or illness since any of these can affect the hormones that control the cycle.
• It is not unusual for cycles to change in length at any point in a woman’s life.
The menstrual cycle is controlled by hormones, which are chemical messengers that travel through the bloodstream.

During the first part of the menstrual cycle the pituitary gland in the brain secretes a hormone called Follicle Stimulating Hormone (FSH). This stimulates an ovary to develop a number of follicles.

As the follicles are developing, they secrete an increasing amount of oestrogen into the bloodstream.

The oestrogen then signals certain changes to occur. The uterine lining (endometrium) begins to build and the mucus-producing glands in the cervix begin to secrete mucus.

As oestrogen increases, the mucus becomes fertile, facilitating sperm travel through the cervical opening into the uterus and Fallopian tubes.

When oestrogen reaches its peak level, the pituitary gland responds by sending out another hormone, Luteinising Hormone (LH).

LH acts on the ovary by causing one follicle (rarely, two) to develop fully and burst from the ovary, a process called ovulation.

Ovulation marks the beginning of the second phase of the menstrual cycle. It occurs 12 to 16 days before the next menstrual bleeding.

The egg cell dies if it is not fertilised within 12-24 hours after ovulation.

Fertilisation occurs in the outer third of the Fallopian tube. If fertilisation does not occur, the egg cell will dissolve and be absorbed by the body.

After ovulation, the ovary secretes progesterone along with more oestrogen.
The progesterone maintains the uterine lining.
If fertilisation does not occur, the ovary will stop producing oestrogen and progesterone after about two weeks.
This decline in hormone levels signals the uterus to shed its lining which is menstruation.
If fertilisation 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.
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.
Connected by ligaments to the uterus are two ovaries, one on each side of the uterus.
These are the organs that store egg cells. They also produce some of the female sex hormones that regulate the menstrual cycle and are responsible for the development of female secondary sex characteristics.
At birth, a girl’s ovaries contain all the eggs she’ll ever have – about 400,000. However, she’ll probably use only about 400 of the eggs in her lifetime.
The eggs or ova (which are about the size of a dot made by a sharp pencil) are among the largest cells in the human body.
- When an egg is expelled from one of the ovaries, it travels to the uterus in one of the Fallopian tubes. This takes from three to five days.
- If the egg is not fertilised, it will disintegrate and be absorbed into the body.
Male Anatomy

The *testicles* and the *penis* are the male external sex organs.

The penis is made up of spongy erectile tissue.

- Most of the time it is soft and limp.
- But when a man becomes sexually excited, his penis stiffens and grows larger in width and length.
- An erect penis is about five to seven inches long and an inch to an inch-and-a-half in diameter, regardless of its size in a normal (flaccid) state.
- The entire penis is highly sensitive, particularly the *glans* or head of the penis.

The *testicles*, which produce sperm and the male hormone called *testosterone*, are located in a wrinkled-looking pouch called the *scrotum*, which hangs behind the penis.

- Adult men have two testicles about the size and shape of plums.
- The testicles contain hundreds of thousands of chambers where sperm develop.

The *scrotum* controls the temperature of the testicles. Scrotal temperature is about six degrees below body temperature. This is ideal for producing sperm.

- In warm weather, the scrotum becomes somewhat larger and more limp to expose and cool a larger skin area.
- In cold weather, the scrotum contracts to conserve heat.

As sperm are produced, they pass through two fine tubes, each called a *vas deferens*, on their way to the *seminal vesicles*, where they mix with semen.

*Semen*, or seminal fluid, is the whitish fluid that carries the sperm and is ejaculated during intercourse.
Each ejaculation contains from 100 million to 600 million sperm in about a teaspoon of fluid.

After passing through the seminal vesicles, the vas deferens also goes through the prostate gland where additional fluid is added to nourish the sperm.

Then the vas deferens joins with the urethra, which becomes the sperm’s passage through the penis to the outside of the body.

*Sperm*, which are the microscopic male reproductive cells, make up less than two percent of the total ejaculate.

- They are much smaller than the egg
- Each has a head and tail, like a tadpole.
- When ejaculated during sexual intercourse, they swim through the vagina, through the cervical opening into the uterus and on up into the Fallopian tubes.
- Sperm can live for six to eight hours in the vagina.
- Once they get up into the uterus and tubes they can live for three to five days.
- They usually reach the tubes within an hour to an hour-and-a-half after ejaculation.
- On reaching the top of the uterus, half go into one Fallopian tube and half go into the other.
- They swim against strong currents set up by the cilia in the Fallopian tubes, which act to draw the egg down toward the uterus.
- Of several hundred million sperm ejaculated, only about 2,000 reach the tubes.
- Even though the egg must be totally surrounded by sperm in order to be fertilised, only one sperm is able actually to penetrate it. The body absorbs the rest.
**Circumcision** is the removal of the hood of skin called the foreskin, which covers the end of the penis.

- This is a simple surgical procedure done in the hospital a few days after the baby’s birth.
- Among Jews, Moslems and some African cultures, it is done to comply with religious laws and traditions.

Currently in the U.S., almost all baby boys are circumcised if the parents consent, though there is a growing trend to leave boy babies uncircumcised.

In Europe, circumcision is much less common and uncircumcised males are the norm.

In boys and men who are not circumcised, the foreskin can be pulled back to reveal the glans. The glans and the foreskin should be washed carefully, because perspiration, urine and glandular secretions called *smegma* can become trapped underneath and cause an unpleasant odour and possibly an infection.

**Wet dreams**, also known as seminal or nocturnal emissions in males, are erotic dreams that cause sexual excitement during sleep and lead to orgasm (climax). Because males ejaculate fluid during orgasm such dreams have come to be known as “wet dreams.”

- Females also have erotic dreams that can lead to orgasm.
- Wet or erotic dreams are common for both sexes at all ages and are a way in which sexual tension is relieved.
- It is also common not to have wet or erotic dreams.
Androgens: Male sex hormones produced mainly in the testicles, though some are produced by the adrenal glands. Small amounts of androgens are produced by the adrenal glands in females.

Bladder: The organ that collects and stores urine produced by the Kidneys. The Bladder is emptied by the urethra.

Castration: The process by which testicles are removed.

Cilia: Hair-like structures on the inner walls of the vas deferens/ Fallopian tubes that help move the sperm toward seminal vesicles and the egg (ovum) toward the uterus.

Circumcision: The surgical removal of the foreskin from the penis.

Corona: The rim of the glans or head of the penis.

Couvade: The parallel physical and psychological responses some men experience during their wives' pregnancies.

Cowpers Gland: (named after William Cowper, English surgeon, 1666-1709) Also referred to as the bulb urethral gland (a rounded or enlargement). Two glands located on either side of the urethra, below the prostate. During arousal and before ejaculation they secrete a small amount of fluid into the urethra that appears at the tip of the penis. This fluid may contain sperm and can cause a pregnancy.

Ejaculate/Ejaculum: Consists of the secretions of the Cowper’s gland, epididymis, vas deferens, seminal vesicles and prostate and contains the spermatozoa (sperm).

Ejaculation: The release of semen from the penis.

Ejaculatory Ducts: Located within the prostate, the passages where the seminal vesicles join the vasa defentia.
**Epididymis:** Tightly coiled tubes that adhere to the surface of each testicle and act as a maturation and storage chamber for newly developed sperm as they move out of the seminiferous tubules.

**Erection:** The process whereby the soft spongy tissue in the shaft of the penis is filled with blood, causing the penis to enlarge and stiffen.

**Foreskin:** The tissue that covers the glans of the penis.

**Genes:** A segment of a DNA molecule that contains all the information required for synthesis of a product including coding and non-coding sequences. It is the biological unit of heredity and is self-reproducing and transmitted from parent to progeny. Each gene has a specific position on the chromosome map. Man normally has 46 chromosome components that define our biological characteristics including (XX female or XY male) which determines the sex of a child.

**Glans Penis:** The head of the penis, also known as the glans.

**Interstitial Cells:** Cells in the testicles that produce the male sex hormone testosterone. Also called Leydig's cells (named after Franz von Leydig, a German anatomist, 1821-1908).

**Nocturnal Emissions:** Involuntary ejaculation of semen while a boy/man is asleep. Common name is *wet dream*.

**NREM (Non-Rapid Eye Movement):** The dreamless period of sleep consisting of four stages of succeeding depth, during which the brain waves are slow and of high voltage, the automatic activities such as heart rate and blood pressure are low and regular. Brief episodes of REM sleep occur at intervals during this type of sleep. (In adults, about 80% of sleep is NREM sleep).

**Oedipus Complex:** Sigmund Freud (1856-1939), an Austrian physician and pioneer psychoanalyst, had a *theory* that described part of the psychosexual development of boys between the ages of three and six years in which they fear their fathers will castrate them for competing for the mother’s affection.
Penis: The male organ of copulation and of urinary excretion, comprising a root, body and extremity or glans penis. The root is attached to the descending portions of the pubic bone by the crura (leg like part), the latter being the extremities of the corpora cavernosa. The body consists of two parallel cylindrical bodies, the corpora cavernosa and beneath them the corpus spongiosum, through which the urethra passes. The glans is covered with mucous membrane and ensheathed by the prepuce or foreskin. The penis is homologous with the clitoris is the female. Therefore the penis is made up of a head, called the glans and the shaft or body/root. The shaft is made up of soft spongy erectile tissue into which extra blood can flow (vasocongestion) causing the penis to become erect.

Prepuce: A covering fold of skin also called the foreskin.

Prostate Gland: The gland located near the bladder that produces the majority of the fluid which, combined with sperm and other secretions, constitutes semen.

REM (Rapid Eye Movement): The period of sleep during which the brain waves are fast and low voltage and automatic activities such as heart rate and respiration are irregular. This type of sleep is associated with dreaming, mild involuntary muscle jerks and rapid eye movements. REM usually occurs 3 to 4 times each night at 80 to 120 minute intervals, each occurrence lasting five minutes to more than an hour. (In adults, about 20% of sleep is REM).

Scrotum: The soft muscular pouch, containing the testicles and their accessory organs.

Semen: The fluid that leaves a man’s penis when he ejaculates. It is made up of fluids from the prostate gland (95%) and the seminal vesicles (4%). Only about (1%) of semen is sperm.

Seminal Vesicles: Two pouches located on either side of the prostate gland that contributes fluid to semen.

Seminiferous Tubules: Structures within each testicle were sperm is produced.

Smegma: A natural secretion under the foreskin of the penis. Without regular washing, smegma may collect and cause odour, discomfort and possibly infection.
**Sperm**: The microscopic cells produced in the testicles and ejaculated as a very small portion of semen. If a single sperm unites with an ovum (egg), fertilisation occurs and pregnancy may follow. *Sperm* can live six to eight hours in the vagina and travel at a rate of 1/8 inch per minute after reaching the uterus. But once in the uterus and Fallopian tubes, they can live up to five days. Sperm usually reach the Fallopian tubes within an hour to an hour and a half after ejaculation. The sperm swim against strong currents set up by the cilia in the Fallopian tubes, which acts to draw the egg down towards the uterus. Of the several hundred million sperm ejaculated, only about 2,000 reach the tubes.

**Spermatogenic Cords**: The cords that connect each testicle to the abdominal cavity.

**Spermatogenesis**: The process of formation of spermatozoa including *spermatocytogenesis* (*first stage* of formation of spermatozoa) and *spermatogenesis* (*second stage* in the formation of spermatozoa).

**Sphincter Muscle**: A valve-like muscle at the base of the bladder and prostate gland which opens and closes.

**Testosterone**: The most important male androgen or male hormone produced in the testicles.

**Urethra**: The tube and opening from which women and men urinate. The urethra empties the bladder and carries urine to the urethral opening. In men, the urethra runs through the penis and also carries ejaculate and pre-ejaculate during sex play.

**Vasa Differentia**: Two narrow tubes, conveying sperm to the point where it can mix with the other constituents of semen. Each vas deferens is approximately 16” to 18” inches long.
Reproductive Anatomy: Male

MALE SECONDARY SEX CHARACTERISTICS
Reproductive Anatomy: Male

Tube through which semen and sperm are released from body is the URETHRA.

Urine coming from BLADDER leaves body through same tube. But never at same time as semen.

PENIS. Tip especially sensitive to touch. Sexual stimulation (physical or mental) causes erection—increase of blood supply to penis, making it bigger and harder, standing out from body. Penis has to be erect to enter woman's vagina easily in intercourse.

Climax of sexual intercourse brings on EJACULATION here. Semen is released in explosive spurts, not under the man's control. Each ejaculation releases about a teaspoonful of semen, containing 100 million to 500 million sperm. (The longer since the last ejaculation, the higher the count.)

SEmen PRODUCING GLANDS. Semen, the fluid in which sperm cells travel, is product of three different glands located here. The most important is the largest, the PROSTATE gland.

VAS DEFERENS. Tube sperm travel through to merge into semen—milky fluid in which they leave body.

EPIDIDYMIS. Where sperm cells are stored.

SPERM CELLS. One of these must meet and join with a woman's egg cell to start a pregnancy.

TESTICLE. Where male sex hormone, testosterone, is produced. This chemical, circulating in the blood, is what chiefly makes a man 'male.' Testicles are also where sperm cells are made. Sperm production, stimulated by testosterone, starts when boy is between 12 and 15, then goes on for rest of his life.

SCROTUM. Sack of thin loose skin that holds the two testicles. Temperature is lower here than inside the body itself. This is better for sperm production.
MALE REPRODUCTIVE SYSTEM

In a simple statement, please write the function for each part of the male reproductive system listed below.

Scrotum: ____________________________________________________________
__________________________________________________________________

Testes: _____________________________________________________________
__________________________________________________________________

Epididymis: _________________________________________________________
__________________________________________________________________

Sperm: _____________________________________________________________
__________________________________________________________________

Vas Deferens: _______________________________________________________
__________________________________________________________________

Penis: _____________________________________________________________
__________________________________________________________________

Glans Penis: _______________________________________________________
__________________________________________________________________

Erection: __________________________________________________________
__________________________________________________________________

Ejaculation: ________________________________________________________
__________________________________________________________________

Testosterone: ______________________________________________________
__________________________________________________________________

Circumcision: _____________________________________________________
__________________________________________________________________

Corona: __________________________________________________________
__________________________________________________________________
MALE REPRODUCTIVE SYSTEM (continued)

Foreskin (prepuce): ____________________________________________________
__________________________________________________________________

Semen: ______________________________________________________________
__________________________________________________________________

Epididymis: __________________________________________________________
__________________________________________________________________

Smegma: _____________________________________________________________
__________________________________________________________________

Seminal Vessicles: ____________________________________________________
__________________________________________________________________

Bladder: ______________________________________________________________
__________________________________________________________________

Sphincter Muscle: ____________________________________________________
__________________________________________________________________

Prostate Gland: ______________________________________________________
__________________________________________________________________

Cowpers Gland: ______________________________________________________
__________________________________________________________________

Urethra: _____________________________________________________________
__________________________________________________________________

Vasectomy: __________________________________________________________
__________________________________________________________________

Nocturnal Emission (Wet Dream): ______________________________________
__________________________________________________________________

R.E.M. Sleep: _________________________________________________________
__________________________________________________________________
Amniocentesis: Surgical removal of a sample of amniotic fluid from a pregnant woman, especially for use in determining the sex or genetic disorder in the foetus.

Amniotic sac: Thin fluid-filled membrane that surrounds and protects the developing foetus.

Anus: The orifice in which faecal matter is excreted.

Bartholin’s Gland/Duct: (Named after a Danish anatomist, Caspar Thomeson Bartholin, Jr. 1655-1738). Two small reddish yellow bodies in the vestibular bulbs, one on each side of the vagina orifice. They are the homologues of the Cowpers glands (bulb urethral glands) in the male. These glands at the opening or mouth of the vagina secrete small amounts of fluid when a woman in sexually aroused.

Blastocyst: The cluster of cells formed after fertilisation that attaches itself to the endometrium lining of the uterus.

Breech Birth: When the baby emerges feet or buttocks first.

Caesarean Section: Surgical delivery of a baby through an incision in the abdominal wall.

Cervix/Neck of Uterus: The lower and narrow end of the uterus.

Cilia: Hair-like follicles on the inner walls of the Fallopian tubes that help move the ova (eggs) towards the uterus.

Clitoris: The female sex organ located at the anterior of the vulva consisting of a head called the glans (similar to the glans penis of a male) and a body or shaft (about the size of a cherry pit). The clitoris has a protective covering or hood that is formed by the meeting of the labia minora. Clitorises vary in sizes.

Ectopic Pregnancy: An implantation of the embryo in a location other than the uterus.
**Embryo:** A fertilised egg three to eight weeks inside a sac filled with amniotic fluid connected by the umbilical cord to the placenta to nourish the baby.

**Endometrium:** The innermost lining of the uterus that nourishes the foetus during pregnancy and also sheds about once monthly if an egg is not fertilised. The thickness and structure of the endometrium vary with the phase of the menstrual cycle. It is divided into three layers: the *stratum basale* or deepest layer of the endometrium which contains the blind ends of the uterine glands (the cells of this layer undergo minimal change during the sexual cycle), the *stratum spongiosum* (spongy layer) or middle layer of the endometrium and the *stratum compactum* together form the *stratum functionale*.

**Fallopian Tubes/Oviducts:** (named after an important Italian anatomist, Gabriel Fallopius, 1850-1911). Two thin tubes approximately 4” long that convey eggs (ova) from the ovaries into the uterus.

**Fertilisation:** When the ripe egg cell of a woman is fertilised by the sperm cell of a male. Most fertile time lasts several days, half way between menstruation. It takes about six (6) days for the fertilised egg to implant itself in the lining of the uterus. It takes three to eight weeks for the fertilised egg cell to form an embryo inside a sac filled with fluid (amniotic sac) connected by the umbilical cord to the placenta for nourishment.

**Fibroids:** A benign *neoplasm* (any new and abnormal growth) of smooth muscle, especially in the uterine wall. A tumour composed mainly of fibrous or fully developed connective tissue.

**Fimbria:** A fringe edge or finger like structure at the end of each Fallopian tube that encloses around each ovary to channel the ovum (egg) into the Fallopian tubes.

**Foetus:** A developing baby from seven to eight weeks after fertilisation until birth.

**Follicle Stimulating Hormones (FSH)** – Chemical message from the brain that influences the ovaries to produce/secrete *oestrogen* into the blood stream and ripen an egg in the ovaries.

**Follicle:** A sac or pouch like cavity.
**Gamete:** A germ cell like a mature sperm or ovum (egg) capable of participating in fertilisation.

**Gonads:** A bodily organ that produces gametes.

**Hormones:** A chemical substance produced in the body by one organ and conveyed, by the blood stream, to another which it stimulates to function by means of its chemical activity.

**Hymen:** A membrane structure that partially covers the entrance to the vagina.

**Hypothalamus:** Part of the brain that lies below the thalamus and helps to regulate activities such as bodily temperature and certain metabolic processes. When the cycle begins (Follicular Phase) the hypothalamus produces gonadotropin-releasing hormone (GnRH) that is necessary for the release of follicle-stimulating hormone (FSH) from the pituitary gland.

**Hysterectomy:** The partial or complete surgical removal of the uterus.

**Hysterotomy:** The surgical incision of the uterus.

**Labia Majora/Outer Lips:** The larger lips of the vulva where pubic hair grows.

**Labia Minora/Inner Lips:** The inner lips of the vulva where no pubic hair grows.

**Leutenising Hormones (LH):** Chemical message from the brain that influences the secretion of progesterone into the blood stream and causes ovulation.

**Lochia:** The normal discharge of blood and mucus from the uterus after childbirth, lasting for 2 to 6 weeks and sometimes longer.

**Menarche:** The onset of menstruation. First menstruation or period.

**Menstruation:** A monthly discharge of blood filled with tissue (about ¼ cup) from the uterus (womb). It occurs if a mature egg cell is not fertilised by the sperm cell of a male.

**Milk Ducts:** Tubes in the breasts that convey milk from the glands to the nipples.
**Milk Glands:** There are 15 to 25 milk-producing sacs in each female's breast.

**Mon Pubis:** The soft fleshy mound that forms the upper end of a woman’s external sex organ where pubic hair grows. Also called pubic mound.

**Monilia:** The vaginal infection caused by an overgrowth of a yeast fungus found in the vagina.

**Myometrium:** The muscular outer layer of the uterus that gives the uterus its strength and elasticity. It is the smooth muscle coat of the uterus that forms the main mass of the uterus.

**Oestrogen –** The female sex hormone produced in the ovaries responsible for secondary sex characteristics and during the menstrual cycle, it acts on the female genitalia to produce a suitable environment for the fertilisation, implantation and nutrition of the early embryo.

**Os:** A general term describing any orifice (opening) of the body; the mouth, vagina, urethra, uterus, anus, etc.

**Ovarectomy:** The surgical removal of one or both ovaries.

**Ovaries:** The female gonad. Two sexual glands located on each side of the uterus connected by ligaments in the abdomen. They produce ova (eggs) and the female hormones oestrogen and progesterone.

**Ovulation:** The release of an egg (ovum) from a graafian follicle in the ovaries. Ovulation occurs around 12 hours after Luteinizing Hormone production reaches its peak. As LH peaks, oestrogen levels temporarily drop. This can cause midcycle bleeding in some women. As the ovarian follicle ruptures (corpus luteum), some women experience abdominal pain.

**Ovum:** Tiny egg cells in the ovaries that begin to mature during puberty. Girls are born with immature egg cells.

**Oxytocin:** A hormone involved in the production of breast milk. When released into the bloodstream, it causes the milk to move from the milk glands to the nipples.
**Pap Smear:** (named after George Papanicolaou 1883-1962, its inventor). Also referred to as a *Pap Test*. It is a test in which a smear of bodily secretion, especially from the cervix or vagina, is immediately examined for exfoliated cells to detect cancer in an early stage or to evaluate hormonal condition.

**Perineum:** The space between the vulva and the anus of a woman and the scrotum and the anus of a male.

**Pituitary Gland:** A small oval endocrine gland attached to the base of the vertebrate brain whose secretions control and influence *growth, metabolism, maturation* and *reproduction*. The pituitary is divided into several parts (lobes). It secretes six hormones, five of which have a direct effect on a particular organ in one or another part of the body. Three (3) of these which affect either the ovaries or the testes are also called gonadotropic hormones ("attracted to the gonads.") FSH from the pituitary gland causes small follicles inside the ovary to develop. One follicle begins to grow larger and secretes oestrogen, a female hormone. This dominant follicle produces a cell (an oocyte) that will become an ovum or egg.

**Placenta:** A vascular membranous organ that develops in females during pregnancy, lining the uterine wall and partially enveloping the foetus, to which it is attached by the umbilical cord. Following birth, the placenta is expelled.

**Progesterone:** An important female sex hormone produced in the ovaries (corpus luteum or the yellow part of the ovaries) whose function is to prepare the uterus for the reception and development of the fertilised ovum by transformation of the endometrium from the proliferative to the secretory stage and to maintain an optimal intrauterine environment for sustaining pregnancy.

**Urethra:** Not a part of the reproductive system, the urinary opening is located beneath the clitoris.

**Uterus:** Also known as the womb, it is the hollow muscular organ in females in which the fertilised ovum normally becomes embedded and in which the developing embryo and foetus grows and is nourished. It is shaped like an upside pear and consists of layers of muscle and tissue. It is about 3” long and 2” wide, consisting of a body, fundus, fallopian tubes and cervix. Its cavity opens into the vagina. It is supported by direct attachment to the vagina and by indirect attachment to various other nearby pelvic structures.
**Vagina:** An orifice approximately 3” to 5” long extending from the outer opening at the vulva to the cervix.

**Vaginal/Birth Canal:** The passage way for childbirth, menstruation, secretions and receives the penis.

**Vestibule:** The space between the labia minora into which the urethra and vagina open. (The term “vestibule” refers to a space or cavity at the entrance to a canal.)

**Vulva:** The external genital organs of the female including the labia majora, labia minora, mons pubis, bulb of the vestibule, vestibule of the vagina and the vagina orifice.

**Zygote:** The single cell formed by the union of a sperm and egg at the moment of fertilisation/conception.
Breastfeeding as a Family Planning Choice for Postpartum Women:

During breastfeeding, ovulation is inhibited by a series of physiological responses to nipple stimulation. More frequent or intense suckling sends nerve impulses to the mother’s hypothalamus in her brain, which in turn inhibits ovarian activity. When breastfeeding diminishes, the change in ovulation rises. Using breastfeeding for reliable contraception or lactational amenorrhea method (LAM) is more than 98 percent effective during the six months following delivery. However, research clearly shows that, if LAM is to work correctly, three criteria must be met:

- A woman must remain amenorrheic (no menstrual bleeding) since delivery (most critical)
- “Nearly fully” breastfeeding means about 90% of infant feeds are breastfeeds and no intervals between breastfeeds greater than four to six hours
- The woman must be within six months of delivery

Note: When any of these criteria change, the woman should begin immediately to use another family planning method if she wishes to prevent pregnancy.

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universally available</td>
<td>Depends on breastfeeding pattern</td>
</tr>
<tr>
<td>Very effective (98%)</td>
<td>Does not prevent STIs</td>
</tr>
<tr>
<td>Begins immediately postpartum</td>
<td>Duration of method limited</td>
</tr>
<tr>
<td>Health benefits for mother and infant</td>
<td>Only useful for breastfeeding postpartum women</td>
</tr>
</tbody>
</table>
Female Secondary Sex Characteristics

Family Life Education Programme
Reproductive Anatomy: Female

Vulva
Where a woman’s outside-the-body
sex organs are located.

Clitoris
Highly sensitive to touch.
Focus of sexual pleasure for women.

Labia
‘Lips’ that shield the vaginal opening.

Outlet for Urethra
Urine leaves the body here.

Hymen
Extra protective shield for vagina
in very young girls.

Entrance to Vagina

Ovary
Where egg cells are stored.
All eggs that will ever be
released in a woman’s lifetime
are already here at her birth.

Fallopian Tubes
Where fertilisation, meeting and joining
of egg and sperm, takes place.

Ovum (egg)
One egg (in one ovary or the other)
matures and is released in each cycle. It must
be fertilised by sperm for pregnancy to begin.

Follicle
The container for the egg. At time of
ovulation, it bursts open, releasing egg.

Endometrium
Lining of uterus. Gradually thickens
in course of each cycle, getting
ready to cushion and fertilise egg.

If the egg is not fertilised, extra
thickness dissolves and flows out of
the body. This is menstruation.

Uterus
Where the fertilised egg will
implant and in the course of
nine months grow into a baby.

Cervix
‘Neck of the uterus, with narrow opening.
Semen and sperm released by a man during
intercourse are delivered here, just at the opening.
Sperm start swimming up through the uterus to tubes,
traveling at the rate of 1/8 inch per minute.

Vagina
Warm, moist, highly elastic passageway
to uterus. Normally about three and a half
inches long, it expands to allow penis to enter
during intercourse and permits passage of
baby at birth.

Family Life Education Programme
The Journey of the Egg

(FRONT VIEW)

1. Fill in the boxes with the correct terms for the parts of the female reproductive system.

   uterus  ovary  oviduct  vagina  cervix  egg

2. Mark with a —— showing the route the menstrual blood takes when leaving the body.
3. Mark with an —— showing the route the egg travels from the ovary through the vagina.

(Adapted from In Between: A Family Education Curriculum For Early Adolescents, U.S. Department of Health and Human Services.)
The Journey of the Egg

(SIDE VIEW)

1. Fill in the boxes with the correct terms for the parts of the female reproductive system.
   - anus
   - bladder
   - cervix
   - clitoris
   - egg
   - labia
   - ovary
   - oviduct
   - urethra
   - uterus
   - vagina

2. Mark with a ● where the egg stops is fertilised.
3. Mark with an X where the egg is fertilised.

(Adapted from In Between: A Family Education Curriculum For Early Adolescents, U.S. Department of Health and Human Services.)

Family Life Education Programme
In a simple statement, please write the function for each part of the male reproductive system listed below.

Endometrium: _________________________________________________________
__________________________________________________________________

Myometrium: _______________________________________________________
__________________________________________________________________

Fallopian Tubes (Oviducts): __________________________________________
__________________________________________________________________

Fimbria: ___________________________________________________________
__________________________________________________________________

Ovaries: ___________________________________________________________
__________________________________________________________________

Cilia: ______________________________________________________________
__________________________________________________________________

Ovum:_____________________________________________________________
__________________________________________________________________

Menarche: _________________________________________________________
__________________________________________________________________

Vestibule:__________________________________________________________
__________________________________________________________________

Labia Majora: _______________________________________________________
__________________________________________________________________
FEMALE REPRODUCTIVE SYSTEM (cont’d)

Vagina: ___________________________________________________________
__________________________________________________________________

Bartholin Glands: ___________________________________________________
__________________________________________________________________

Perineum:__________________________________________________________
__________________________________________________________________

Os:_______________________________________________________________
__________________________________________________________________

Anus:_____________________________________________________________
__________________________________________________________________

Vaginal Canal (Birth Canal): _________________________________________
__________________________________________________________________

Cervix (Neck of the Womb): _________________________________________
__________________________________________________________________

Uterus:____________________________________________________________
__________________________________________________________________

Caesarean Section: _________________________________________________
__________________________________________________________________

Ovulation: _________________________________________________________
__________________________________________________________________

Oestrogen & Progesterone: __________________________________________
__________________________________________________________________

Ectopic Pregnancy: ________________________________________________
__________________________________________________________________
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Menstruation</td>
<td></td>
</tr>
<tr>
<td>Fertilisation (Impregnation)</td>
<td></td>
</tr>
<tr>
<td>Zygote</td>
<td></td>
</tr>
<tr>
<td>Blastocyst</td>
<td></td>
</tr>
<tr>
<td>Embryo</td>
<td></td>
</tr>
<tr>
<td>Foetus</td>
<td></td>
</tr>
<tr>
<td>Vulva</td>
<td></td>
</tr>
<tr>
<td>Mons Pubis</td>
<td></td>
</tr>
<tr>
<td>Labia Minora</td>
<td></td>
</tr>
<tr>
<td>Clitoris</td>
<td></td>
</tr>
<tr>
<td>Urethra</td>
<td></td>
</tr>
</tbody>
</table>
External Reproductive Organs

Family Life Education Programme
Internal Reproductive Organs

Endometrium
Myometrium
Fallopian Tubes (Oviducts)
Fimbria
Ovary
Ovum
Vaginal Canal/Birth Canal
Cervix
Uterus
## SEXUAL DEVELOPMENT IN YOUNG PEOPLE
### SOME KEY FACTS

Circle T (True) or F (False) by each statement.

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Almost immediately after conception, male and female differences can</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>be observed in the genital tissue that is developing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Infants have sexual feelings and responses from the time they are born</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>3. Males usually do not get erections until they are beginning puberty.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>4. The vagina of female infants is capable of lubrication.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>5. Early as four months old, infants are likely to discover and touch</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>their genitils for pleasure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. How the individual expresses affection as an adult is affected by the</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>physical contact experienced as an infant.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. The individual's image of his/her own body begins to form in infancy.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>8. Adult responses to the child's sexual behaviour will be important in</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>the child's feelings of the goodness and badness of sexual matters.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Most young children masturbate.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>10. Most children do not have a clear idea of what sex they are until</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>they are three.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Three and four-year-olds explore sexually through play with dolls</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>and peers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. By five years of age, most children understand that sexual</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>intercourse is a part of marriage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. When children do not have access to the facts about sexuality, they</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>are less likely to worry about it.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HUMAN SEXUAL RESPONSE CYCLE**

In 1966, two research scientists, Masters and Johnson, conducted an extensive study of the human body’s physiologic response to sexual stimulation. They discovered that regardless of what generates sexual excitement – fantasy, masturbation, “foreplay” (sometimes called “outercourse”) or intercourse – the human body goes through four phases or sequences of changes. These four phases are now referred to as the *human sexual response cycle*. Each phase is characterised by certain physiological changes or reactions that occur in both males and females. But the cycle is a continuum and some of the changes that take place in one stage only and in the next phase of the cycle.

**Phase 1: EXCITEMENT**
This phase is begun, for each person, by whatever that person finds sexually stimulating. If the stimulation fades, so does the response – the body returns to normal. If the stimulation keeps up, the excitement and sexual tension build and eventually reach the next stage.

<table>
<thead>
<tr>
<th>Male Response</th>
<th>Female Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>The penis gets harder, longer larger, stiffer.</td>
<td>Vaginal walls sweat, making lips of vagina wet.</td>
</tr>
<tr>
<td>About 30 percent of men notice their nipples become erect.</td>
<td>About 30 percent of women notice nipple erection.</td>
</tr>
</tbody>
</table>

**Phase 2: EXCITEMENT**
During plateau, sexual tension builds to its maximum. If something interrupts the process before orgasm, the pelvic area may feel congested for a while before it gets back to its normal unstimulated state. This is not harmful but can be uncomfortable.
<table>
<thead>
<tr>
<th>Male Response</th>
<th>Female Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing and heartbeat speed up, blood pressure rises slightly.</td>
<td>Breathing and heartbeat speed up, blood pressure rises slightly.</td>
</tr>
<tr>
<td>Increased blood flow to the pelvic area.</td>
<td>Increased blood flow to the pelvic area.</td>
</tr>
<tr>
<td>About 25 percent of men have a sexual flush.</td>
<td>About 75 percent of women have a sexual flush.</td>
</tr>
<tr>
<td>Muscles tighten, especially in pelvic area and buttocks.</td>
<td>Clitoris pulls in under hood skin attached to inner lips.</td>
</tr>
<tr>
<td>Testicles pull in closer to body.</td>
<td></td>
</tr>
</tbody>
</table>

**Phase 3: ORGASM**
If the stimulation keeps up, orgasm results; a sudden release of tension accompanied by a more or less intense sensation of pleasure.

<table>
<thead>
<tr>
<th>Male Response</th>
<th>Female Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden series of muscle contractions all along the penis.</td>
<td>Sudden muscle contractions throughout vagina and clitoris.</td>
</tr>
<tr>
<td>Faster breathing and pulse rates.</td>
<td>Faster breathing and pulse rates.</td>
</tr>
<tr>
<td>Ejaculation: discharge of semen in a few intense spurts.</td>
<td></td>
</tr>
</tbody>
</table>

**Phase 4: RESOLUTION**
The body relaxes and returns to normal. This may take half an hour, sometimes longer.

<table>
<thead>
<tr>
<th>Male Response</th>
<th>Female Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscles relax, penis becomes limp.</td>
<td>Muscles relax, congestion of blood in pelvic area is relieved.</td>
</tr>
<tr>
<td>Blood pressure, pulse rates and breathing drop to normal.</td>
<td>Blood pressure, pulse rates and breathing drop to normal.</td>
</tr>
</tbody>
</table>
**SEXUAL DYSFUNCTIONS**

**Sexual Dysfunctions,** also referred to as disorders or difficulties, are defined as recurring inhibition or lack of a natural healthy response at either the desire, excitement or orgasm stage of the human sexual response cycle and can be caused by biological, psychological or interpersonal factors as defined by the individual.

**Possible Causes of Sexual Dysfunction:**

<table>
<thead>
<tr>
<th>Biological Factors</th>
<th>Psychological Factors</th>
<th>Interpersonal Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aging</td>
<td>Lack or Negative Messages about Sex</td>
<td>Personal Risks</td>
</tr>
<tr>
<td>Physiological Malfunctions</td>
<td>Negative Sexual experience</td>
<td>Pregnancy, STIs</td>
</tr>
<tr>
<td>Drugs and Alcohol</td>
<td>Body Image</td>
<td>Conflicts or Tensions</td>
</tr>
<tr>
<td>Illness – spinal cord injuries, multiple sclerosis, stroke, heart and lung conditions, diabetes, cancer, cerebral palsy, etc.</td>
<td>Stress and Fatigue</td>
<td>Sexual Orientation Conflicts</td>
</tr>
<tr>
<td></td>
<td>Performance Anxiety</td>
<td>Lack of Privacy</td>
</tr>
<tr>
<td></td>
<td>Sexism, Double Standards</td>
<td>Sexual Abuse – i.e., Rape</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relationship Conflicts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of Communication</td>
</tr>
</tbody>
</table>
SECTION 5

Topic: Personal and Sexual Health

CONTENTS

Sexually Transmitted Diseases
Essential Facts about STIs
STI/STD Chart
Sexually Transmitted Infections – Quiz and Answer Key
HIV/AIDS
Nutrition and HIV Infection
Myths and Facts on HIV (including correct answers)
HIV/AIDS: Ice Breaker Exercise
Eight Steps To a Healthier and Safer Sex Life
Mother’s Milk
Breast-Feeding and AIDS
Guard against Breast Cancer: Have You Examined Your Breasts This Month?
How to Examine Your Breasts
Drug and Alcohol Abuse Outline
Six Steps to Prevent Drug and Alcohol Use
Domestic Violence Myth/Fact Sheet
Battering of Adult Women
Power and Control Cycle Chart
Controlling Behaviour Checklist
Effects of Family Violence
Why Women Stay
SEXUALLY TRANSMITTED DISEASES

STI stands for Sexually Transmitted Infection. VD stands for Venereal Disease which is the same thing. Under either name, these are diseases that are passed from person to person through sexual contact – genital, oral or anal. The germs cannot live outside the body so you can’t pick them up from toilet seats or door knobs.

The three kinds of sexually transmitted diseases that are the biggest threat to adults and teenagers today are gonorrhoea, syphilis and herpes II. You will find specific information on these three in the pages that follow, along with facts on a fourth disease, AIDS, in subsequent pages.

AIDS stands for Acquired Immune Deficiency Syndrome, which is a serious and usually fatal disease. AIDS is caused by infection with the Human Immunodeficiency Virus (HIV) which is most commonly transmitted through anal, oral or genital sex without a condom or by sharing hypodermic needles. There is as yet no cure for AIDS and it is spreading rapidly in all parts of the world. (See “HIV/AIDS” below, around page 393.)

Syphilis and gonorrhoea are curable if treated by a doctor at an early stage of the infection. Herpes II can be treated by a doctor but no cure for it has yet been found.

It is critically important to know that:

• no vaccine, no pill, no medical treatment can keep you from getting any STI or becoming HIV-infected if you’re exposed to it.
• HIV can remain invisible for years before it turns into AIDS but it is still infectious. The only way to know for sure if you’ve been infected is to be tested for the virus.
• if you have had an STI and been cured, you are not immune to that STI or any other – you can be infected again if you’re exposed again.
• gonorrhoea and syphilis can be cured if you get adequate treatment soon enough. But not all cases have clearly recognizable symptoms and sometimes there are no symptoms at all.

So don’t take chances. Know the facts. And protect yourself.

Protecting Yourself and Others
The best way to avoid STI or HIV infection is not to be exposed to it. You can avoid exposure by not having sex with anyone at all.

Or you can avoid exposure by having sex only in the context of a committed, exclusive relationship – one person, one partner, over the course of a lifetime. But if either partner has sex with even one other person who has had sex with someone else, that introduces risk and the risk goes up as the numbers do. People who have many sex partners are more likely to pick up and pass on some variety of STI and they are more likely to be exposed to HIV.

You can avoid exposure by making sure you’re protected during sex, whomever you’re with. This means using condoms. Contraceptive foam containing nonoxynol-9, when used with a condom, can give extra protection against STIs, HIV infection and pregnancy. (A man may get a little protection from some STIs if he urinates immediately after sex and washes his penis with soap and hot water, but infection is still possible.)
Getting Treatment

If anything makes you suspect you have an STI:
• Do not try to treat yourself. Only professional diagnosis and treatment will work.
• Go immediately to your local health centre or your doctor.
• If you test positive for an STI, don’t have any kind of sexual contact until you are cured.
• Don’t masturbate – it can spread the germs to other parts of the body.
• Don’t drink anything alcoholic. It may reduce the effectiveness of the medicine being used to treat you.
• Get in touch with all the people you’ve had sexual contact with so they can get treatment.

If anything makes you suspect you’ve been infected with HIV:
• Think seriously about getting tested. If you test positive, go to your local health centre or your doctor. The sooner you receive medical attention, the better.
• Tell the people you’ve had sexual contact or shared hypodermic needles with so they can get tested and receive medical care.
• Use a condom unfailingly, every time you have sex from now on.

BUBOS
Cause: Bubos are caused by bacteria.

Mode of Transmission:
It is transmitted mainly by penis-vagina, penis-anus, penis-mouth, vagina-vagina or vagina-mouth contact. People who have multiple sexual partners are at a greater risk of contracting the disease than those with only one sexual partner.

Signs and Symptoms:
Some signs of the disease include swellings around the groin area that look like boils. After a short period, pus is formed in the swellings. Painful blisters develop within five to twenty
days of having sexual intercourse with an infected person and they ripen after 10-15 days, followed by fever.

**Consequences:**
If the patient has other diseases, the blisters will take longer to heal and may result in deformity. The open sores provide an easy path for HIV infection; therefore, people with bubos should avoid sexual intercourse until treatment is concluded.

**Treatment:**
Since the disease can be mistaken for an ordinary boil, those infected often do not seek medical treatment until too late at which point the swellings cause terrible pain. It is therefore advisable to seek medical treatment when one observes a strange swelling around the groin. If the boil is already ripe, it has to be cut open in order to drain the pus.

**CHANCROID**

**Cause:** Chancroid is caused by an organism called Ducreyi Bacillus.

**Mode of Transmission:**
Chancroid is spread through sexual intercourse.

**Signs and Symptoms:**
Symptoms appear two to three days after contact with an infected person. Chancroid first manifests as small pustules on the external sex organs and then as painful ulcers accompanied by swollen glands in the groin area. In males the chancres appear on the edge of the prepuce, glans penis and shaft of the penis. In females, lesions may be found on the vulva perineum, clitoris, inside the walls of the vagina and on the cervix. The diagnosis of chancroid is easy to make if the patient has genital ulcers.

**Consequences:**
Untreated chancroid causes the inguinal glans to swell. The swelling is known as bubos which eventually rupture and discharge pus. The infection is very painful and destroys tissue around the inguinal glans.

**Treatment:**
Chancroid is treatable with antibiotics. The open sores caused by chancroid provide an easy path for HIV infection. It is extremely important to get the sores treated immediately and to avoid sexual intercourse until treatment is concluded.

**CHLAMYDIA**
Chlamydia trachomatis is a small bacterial microorganism that multiplies within cells. Within this genus are strains causing three distinct diseases, two of which are sexually transmitted. Chlamydia trachomatis attacks mucous membranes. The other, lymphogranuloma venereum, attacks the regional lymph nodes from a primary genital lesion. The most common type of chlamydia is chlamydia tracomatis.

**Chlamydia Trachomatis**
Facts: Chlamydia trachomatis is spread through sexual contact – penis-vagina (genital sex), penis-mouth (oral sex), penis-anus (anal sex) or from a pregnant mother to her unborn child. People can also spread the infection with their hands from one part of the body to another.

Untreated, chlamydia trachomatis is a serious health threat, especially for women. In women, the infection usually begins on the cervix and, if not caught in time, eventually spreads to the Fallopian tubes or ovaries, resulting in pelvic inflammatory disease (PID). PID can cause sterility by scarring and blocking the Fallopian tubes. If PID goes untreated, the infection can be life threatening.
Symptoms: Eighty percent of women infected with chlamydia trachomatis don’t know they have it until it has progressed to a more serious condition – PID. Some symptoms of PID are fever, abdominal pain, vomiting and tiredness. When women do have early symptoms, they include unusual discharge, pain during sex, abdominal pain or burning during urination.

Men are more likely to have early symptoms that include pus or watery or milky discharge from the penis and pain or burning feeling while urinating.

Because these symptoms are similar to the symptoms of gonorrhoea, the infection in men is called nongonococcal urethritis (NGU). Men often don’t take these symptoms seriously because they may only appear early in the day and can be very mild.

Chlamydia trachomatis can be treated with antibiotics. Both partners need to take the medication. The infection is cured in one or two weeks.

GONORRHoea
Facts: Virtually the only way you can get gonorrhoea is through sexual contact – penis-vagina (genital sex), penis-mouth (oral sex) or penis-anus (anal sex).

As oestrogen increases, the mucous becomes fertile, facilitating sperm travel through the cervical opening into the uterus and Fallopian tubes. Untreated gonorrhoea can cause:

- sterility in women
- arthritis
• heart disease  
• poor health generally  
• serious infection of internal organs  
• urinary problems in men, often lifelong

A pregnant woman who has gonorrhoea does not pass it on to the foetus. But when the baby is born, the gonorrhoea germs in the vagina – the birth canal – can attack the baby passing through and cause blindness.

Gonorrhoea can be treated and cured only by a health professional. The usual treatment is one or more high-dosage injections of penicillin.

A health professional will treat a person who thinks he or she may have been exposed to gonorrhoea even if the person has no symptoms (symptoms are not always present) and even if a test is negative (tests are still not 100% reliable).

Because more and more cases of gonorrhoea are without symptoms, all sexually active men and women – but especially women – should have a gonorrhoea test as part of a yearly medical check-up.

Symptoms: Three to six days after gonorrhoea germs enter a man’s body, he may get:
  • a dripping discharge from his penis  
  • a slight, cloudy discharge  
  • a discharge of pus  
  • a burning feeling when he urinates

But symptoms may not show up for a month after exposure.

Three to six days after gonorrhoea germs enter a woman’s body, she may get:
• a light vaginal discharge along with a burning feeling when she urinates
• inflammation of the cervix
• painful infection in the pelvic area
• anal irritation (resulting from anal sex)
• throat irritation (resulting from oral sex)

But in most cases, there are no signs at all. She may not know she has gonorrhoea for weeks, months, even years.

HERPES II

Facts: It’s commonly spread by sexual intercourse (oral sex as well as genital sex). But it can be transmitted through any contact with the blisters it produces and people may themselves spread it to other parts of their bodies.

Medical treatment can relieve the pain of herpes and make the eruption of blisters go away faster but there is no known cure. The disease will recur. The recurrences may be very frequent or very rare and they may or may not be triggered by special conditions such as stress.

A drug called acyclovir, in the form of an ointment, is particularly successful in treating initial herpes attacks and helps somewhat to reduce the frequency, severity and contagiousness of later attacks. Some doctors advise a special diet. Getting adequate rest and reducing stress may help.

A pregnant woman with herpes does not pass it on to the foetus but if the infection is in an active stage at the time of the baby’s birth, she will need a caesarean delivery; otherwise, the herpes germs in her vagina could infect or even kill the baby.
Women who contract herpes seem to run a greater risk of developing cervical cancer.

**Symptoms:** There is a tingling or burning sensation around the genitals or other site of infection. This warning signal is called a “prodome.” As soon as it occurs, the person is infectious. Then many tiny blisters appear on the genitals, thighs, buttocks, abdomen. Eventually the blisters burst, discharging pus, blood or watery fluid. The open sores may be mildly painful or agonizingly so. The person is infectious to others until the sores are completely healed. For the duration of the attack, the person has a general feeling of malaise. Many people have flu-like symptoms: body aches, fatigue, fever, headaches.

**HERPES XOSTER**

**Facts:** It’s commonly spread by sexual intercourse (oral sex as well as genital sex) but it can be transmitted through any contact with the blisters it produces and people may themselves spread it to other parts of their bodies.

Medical treatment can relieve the pain of herpes and make the eruption of blisters go away faster, but there is no known cure. The disease will recur. The recurrences may be very frequent or very rare and they may or may not be triggered by special conditions such as stress.

A drug called acyclovir, in the form of an ointment, is particularly successful in treating initial herpes attacks and helps somewhat to reduce the frequency, severity and contagiousness of later attacks. Some doctors advise a special diet.
Getting adequate rest and reducing stress may help.

A pregnant woman with herpes does not pass it on to the foetus but if the infection is in an active stage at the time of the baby’s birth, she will need a caesarean delivery; otherwise, the herpes germs in her vagina could infect or even kill the baby.

Women who contract herpes seem to run a greater risk of developing cervical cancer.

Symptoms: There is a tingling or burning sensation around the genitals or other site of the infection. This warning signal is called a “prodome.” As soon as it occurs, the person is infectious. Then many tiny blisters appear on the genitals, thighs, buttocks, abdomen. Eventually the blisters burst, discharging pus, blood or watery fluid. The open sores may be mildly painful or agonizingly so. The person is infectious to others until the sores are completely healed.

For the duration of the attack, the person has a general feeling of malaise. Many people have flu-like symptoms such as body aches, fatigue, fever, headaches.
LYMHPGRANULOMA VENERIUM
Facts: Lymphogranuloma venerium (LGV), also known as bubos, can be contracted from infected bedding or clothing as well as from sexual intercourse. LGV can be treated with antibiotics.

Symptoms: The incubation for LGV is from five to 21 days. The first symptom is a small painless blister or ulcer on the cervix, vagina or rectum. This heals in a few days. Then large dark lumps develop in the glandular areas of the groin. These open to drain pus, scar, then open again. There may also be fever, headaches and vomiting.

MONILIA
Facts: Monilia is caused by an overgrowth of yeast organisms naturally present in the mouths and intestines of most people, as well as in the vaginas of many healthy women. This kind of infection can be picked up through sexual contact or, if you’re a woman, it can suddenly show up when you’re not having sex at all. When the overgrowth occurs in the mouth or throat, it’s called “thrush.”

Monilia is more annoying than serious. It can be treated with vaginal suppositories or cream.

Symptoms: Vaginal itching and swelling and a white or cream-coloured vaginal discharge that smells similar to bread baking.
SYPHILIS
Facts: Virtually the only way you can get it is through oral or genital intercourse, though there have been cases of transmission by “French kissing.” If left untreated, syphilis can eventually cause:
• paralysis
• brain damage
• insanity
• heart disease
• skin disease

A pregnant woman with syphilis in any stage passes the infection on to the foetus.

Syphilis can be treated and cured only by a health professional. The usual treatment is one or more high-dosage injections of penicillin. The earlier the treatment, the better.

Several types of blood tests can detect syphilis but none is error free. Someone infected with syphilis for less than 90 days may have a negative test result.

Symptoms: Syphilis has three stages:

Phase I
Ten to 90 days after the germ enters the body, a chancre, or sore, appears. It looks like a pimple or a wart. It may or may not have pus in it. It shows up where sexual contact was made: on the penis, inside the vagina or in the rectum or the mouth.

This sore may go unnoticed since it usually does not hurt or itch. Meanwhile, any skin-to-chancre contact can spread syphilis. The germs can travel through the pores of the skin. After a few weeks, the chancre will go away. The disease will not.
Phase II

Two weeks to six months after the germ enters the body, other signs appear:
• rashes on palms of hands and soles of feet, sometimes over whole body
• moist looking welts around genital organs
• sores between toes or in armpits or mouth
• low fever
• headaches
• hair falling out in patches
• sore throat

Sometimes people interpret these as symptoms of an allergy or even a common cold. Eventually they go away, but the disease does not.

Phase III

Three to five years after the germ enters the body, the person is still infected but can no longer pass the disease on. During this stage, the person may feel perfectly healthy but in the next five to 20 years, the disease will probably reach the heart, brain and other organs. The result will be physical and mental crippling and possibly death.

TRICHOMONAS

Facts: A one-celled parasite that can cause an irritating, easy-to-transmit infection. Usually passed by sexual contact but can show up for no apparent reason. Condoms help prevent the infection (called trichomoniasis) from being passed back and forth. If left untreated, the infection can spread to the urinary tract and cause PID, a condition with serious health consequences.

Symptoms: Vaginal itching and swelling, white or cream-coloured discharge.
ESSENTIAL FACTS ABOUT SEXUALLY TRANSMITTED INFECTIONS

STI stands for Sexually Transmitted Infection: those infections that are transmitted by any type of genital, oral or anal intimate contact with an infected person. Twenty-one types of infections are currently known, each caused by a different micro-organism. The organisms rarely live outside the body but close contact spreads them easily. Knowledge of symptoms helps in detection but some people do not get any symptoms and occasionally some diseases are without symptoms. Exposure requires medical evaluation. Treatment is specific to the disease and should be followed carefully. The incidence of STI is highest in the age group 15-29.

Reasons for the spread of STI:
- decrease in use of condoms
- increase in oral-genital sex
- increase in sexual activity and number of sexual partners
- failure to recognize symptoms
- many a symptomatic cases (in gonorrhoea, an estimated 20 percent of men and 50-80 percent of women notice no symptoms)
- failure to comply with proper medical treatment

Sexually active people should:
- not have sex with a person who has a sore, discharge or any other sign of an STI
- use condoms if their partner(s) are sexually active with other people (condom use protects females as well as males)
- go to a doctor or clinic regularly for STI checkups
People with or exposed to an STI should always:
• go to the doctor or clinic immediately
• follow instructions given by doctor and/or clinic staff
• return for all appointments
• tell all of their sex partners to get tested and treated
• take precautions not to become infected or reinfected

Additional reminders:
• Anyone who has sex with a person who has an STI can become infected.
• A person can have sex just one time and become infected.
• Many people with STIs have no symptoms and are unaware that they are infected. Because these people do not receive treatment, they continue unknowingly to infect people with whom they have sex. This is a major reason for the current STI increase.
• If a woman with STI remains untreated, the infection can cause serious, irreversible complications such as pelvic inflammatory disease (PID).
• A person who receives treatment and does not inform his or her steady sex partner often becomes reinfected.
• Condoms effectively limit the spread of STI among men and women.
• Anyone who often has oral or anal sex needs to ask the doctor for special culture tests for the throat and the rectum.

(Adapted from The STI Teacher’s Guide, City of New York)
<table>
<thead>
<tr>
<th>If you have these signs</th>
<th>You might have these diseases</th>
<th>Diseases are passed</th>
<th>Signs usually show up in</th>
<th>If not treated, this could happen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burning and/or discharge (drip from sex organs)</td>
<td>Gonorrhoea (clap drip, dose)</td>
<td>Sexual contact with infected person</td>
<td>1-30 days</td>
<td>Arthritis, blindness, sterility, prostate problems in men, pelvic inflammatory disease in women, babies can be infected at birth and develop pneumonia and blindness.</td>
</tr>
<tr>
<td></td>
<td>Non-Gonococcal Urethritis</td>
<td>Sexual contact with infected person or articles such as towels and washcloths</td>
<td>1-3 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trichomonas (Trich)</td>
<td>Sexual contact with infected person or articles such as towels and washcloths</td>
<td>4-28 days</td>
<td>Gland infection or damage to women’s sex organs. Painful intercourse. Unknown in men.</td>
</tr>
<tr>
<td></td>
<td>Monilia (Yeast)</td>
<td>Overgrowth of yeast fungus normally present in women’s vaginas. Men get it by having sex with infected women.</td>
<td>Varies</td>
<td>Can be passed to newborn causing severe infection. Painful intercourse.</td>
</tr>
<tr>
<td></td>
<td>Gardnerella (Vaginitis)</td>
<td>Sexual contact with infected person or use of contaminated articles.</td>
<td>Varies</td>
<td>Rarely leads to any serious complications.</td>
</tr>
<tr>
<td></td>
<td>Severe lower stomach pain, nausea, fever</td>
<td>Pelvic Inflammatory Disease</td>
<td>(in women only) Sexual contact with male infected with Gonorrhoea or Non-Gonococcal Urethritis</td>
<td>2 weeks - 2 months</td>
</tr>
<tr>
<td>If you have these signs</td>
<td>You might have these diseases</td>
<td>Diseases are passed</td>
<td>Signs usually show up in</td>
<td>If not treated, this could happen</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------------</td>
<td>---------------------</td>
<td>-------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Severe itching and bumps on and around sex organs</td>
<td>Lice (crabs)</td>
<td>Sexual contact with infected person or use of contaminated articles such as towels, bed.</td>
<td>1-6 weeks</td>
<td>Other infections caused by the intense scratching of infected area.</td>
</tr>
<tr>
<td></td>
<td>Trich and Yeast</td>
<td>See above.</td>
<td>Varies</td>
<td>See above.</td>
</tr>
<tr>
<td>Painful sores or blisters on sex organs</td>
<td>Herpes</td>
<td>Sexual contact with infected person.</td>
<td>Varies</td>
<td>Can be passed to newborn and cause severe illness and death.</td>
</tr>
<tr>
<td></td>
<td>Chancroid</td>
<td></td>
<td>2-6 days</td>
<td>Can be passed to newborn and cause severe illness and death.</td>
</tr>
<tr>
<td>Painless sores on sex organs or rashes</td>
<td>Syphilis</td>
<td>Sexual contact with infected person. Pregnant woman can pass it to unborn child.</td>
<td>10-90 days</td>
<td>Blindness, insanity, nerve problems, heart diseases, stillbirth, death.</td>
</tr>
<tr>
<td>Nausea, vomiting, diarrhea, bloody stools</td>
<td>Giardiasis</td>
<td>Oral-rectal sexual contact (rimming) with infected person</td>
<td>Few days - few months</td>
<td>Recurring stomach cramps, prolonged diarrhea, dehydration</td>
</tr>
<tr>
<td></td>
<td>Amebiasis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shigellosis</td>
<td></td>
<td>1-7 days</td>
<td></td>
</tr>
<tr>
<td>Growth on sex organs</td>
<td>Venereal warts</td>
<td>Sexual contact with infected person.</td>
<td>1-3 months</td>
<td>Large growths can cause blockage of rectal and vaginal openings.</td>
</tr>
<tr>
<td>Yellow skin and eyes, dark urine</td>
<td>Hepatitis B</td>
<td>Sexual or other intimate contact with infected person.</td>
<td>1-4 months</td>
<td>Liver problems.</td>
</tr>
</tbody>
</table>
SEXUALLY TRANSMITTED INFECTIONS: QUIZ

Ask participants to answer True/False to the following quiz. (Note: add items to the quiz that reflect the situation in your own country including common myths about STIs)

1. T/F – Some STIs have no obvious symptoms in their early stages.
2. T/F – Only people who have had sex with many others are likely to get an STI.
3. T/F – STI prevalence is low among adolescents and youth.
4. T/F – Some STIs can affect the bones, heart and nervous system if they are not treated.
5. T/F – People who practice good personal hygiene are less likely to get an STI.
6. T/F – If a woman has sex with only one man she cannot get an STI.
7. T/F – Men with an STI are less likely to have symptoms than women with an STI.
8. T/F – STI symptoms can include burning or pain when urinating.
9. T/F – Some STIs can cause death.
10. T/F – Some insects such as mosquitoes and bedbugs can spread STIs.
11. T/F – Some STIs can lead to infertility.
12. T/F – STI symptoms can include an unusual discharge from the vagina or penis.
13. T/F – If an adolescent has a sore on or near parts of the body which have been involved in sexual contact, it could be an STI.
14. T/F – Itching, discomfort or swelling in or around the sex organs might indicate an STI.
15. T/F – Some STIs can lead to cancer.
16. T/F – STIs cannot affect newborn babies.
17. T/F – You can get an STI by stepping in infected urine.
18. T/F – Self-treatment of STIs is likely to cure them.
19. T/F – Condoms prevent STI infection.
20. T/F – STIs are decreasing in most societies.
21. T/F – Taking the pill protects against STIs.
ANSWER KEY PAD TO STI QUIZ

1. True
2. False You can get an STI after one sexual contact if either person is infected.
3. False STIs are most prevalent among the younger generation.
4. True Syphilis can affect the bones, nervous system and heart if untreated.
5. False You can get an STI regardless of personal cleanliness if you do not use a condom.
6. False Only uninfected couples who both have sex only with each other can be sure not to get an STI through unprotected sex.
7. False Men are more likely to have symptoms than women.
8. True
9. True HIV (Human Immunodeficiency Virus) is sexually transmitted. Infection leads to AIDS which is a fatal disease.
10. False STIs (including HIV) are not spread by insects; however, some conditions such as genital warts, Hepatitis B, HIV and Thrush are not always sexually transmitted.
11. True Untreated STIs can infect and block the Fallopian tubes in women and the urethra in men, causing infertility.
12. True
13. True
14. True Swelling at the top of the legs near the sex organs can also be a sign of STI.
15. True STIs caused by viruses have been associated with cancer of the reproductive tract.
16. False Gonococcal infection in the mother can cause eye infections and sometimes blindness in the newborn infant.
17. False This is a common belief in some countries.
18. False Self-treatment is likely to be inappropriate and it may be treating the wrong disease.
19. True However, condoms must be in good condition and must be put on and used properly to be effective.
20. False STIs are the most common group of communicable diseases reported in most countries and are on the increase in most societies.
21. False Only barrier methods protect against STIs. The most effective barrier method is the condom. A female condom has recently been developed and may be available in some places.
AIDS (Acquired Immune Deficiency Syndrome)
Facts: As its name indicates, AIDS attacks the body’s immune system, destroying the ability to fight off infections.

HIV (Human Immuno-Deficiency Virus)
Facts: The virus that causes AIDS is called HIV (Human Immuno-Deficiency Virus). HIV is fragile. It doesn’t survive well outside the body and it can be destroyed by heat, mild household bleach, even soap and water. But it is deadly if it gets into the body. And once it does, nothing can get it out of the body.

HIV can hide for years without producing signs of active infection. But whether or not an HIV-infected person has symptoms, he or she is infectious and able to transmit the virus to others under certain conditions.

The most common conditions necessary for infection are:
- sexual contact. This includes anal or vaginal sex and possibly oral sex, through exchange of semen, vaginal fluid or blood. (The risk is greater if there are sores or cuts, no matter how tiny, on penis, vagina or rectum.)
- shared hypodermic needles. The AIDS virus can be passed from person to person when drugs are injected with needles and syringes have been used by others.
- infection inside the womb. Pregnant women who have acquired HIV before or during pregnancy can pass it on to their unborn babies.

Possible but less common ways to pick up the virus are:
- transfusions of HIV-infected blood or blood products.
- contamination of an open wound or sore by HIV-infected blood.
- semen or vaginal secretions.
- organs transplanted from an HIV-infected donor.
- artificial insemination with sperm of an HIV man.
- being breast-fed by a woman who carries the virus.
Some population groups were once thought to be at higher risk than others for picking up the AIDS virus. Now we know that what matters is not who you are but what you do. It’s behaviour that puts people at risk.

Symptoms: Not everyone infected with HIV develops AIDS or even minor symptoms. But with time, many do develop AIDS-related conditions and have one or more of these persistent symptoms:
- Fever combined with “night sweats” or shaking chills
- Extreme fatigue
- Rapid weight loss of ten or more pounds
- Swollen lymph glands in the neck or underarm areas
- Diarrhoea
- White spots or blemishes in the mouth

After several months or years, a number of those infected with HIV will come down with AIDS. If that happens, deadly “opportunistic infections” develop against which the body has no defences. The most common are:
- Pneumocystis carinii pneumonia (PCP), a parasitic infection of the lungs
- Kaposi’s sarcoma (KS), a rare skin or mouth cancer. In its early stages, a KS tumour may look like a bruise – a flat, raised reddish brown or bluish spot

In more than 50% of AIDS cases, the virus also directly affects the brain and central nervous system
Treatment And Support Care Systems

Medical Treatment
There is no treatment for HIV/AIDS, but AIDS-related illnesses can be treated; therefore, persons with the following common AIDS-related illnesses should be referred to a hospital for treatment:

- Pneumocystis carinii pneumonia
- Tuberculosis
- Oral candidiasis
- Toxoplasmosis

Other AIDS-related illnesses are treatable with special drugs. These are:

- Herpes xoster
- Cryptococcus
- Herpes simplex

Those who test positive for HIV need to change their lifestyle immediately. Anytime they feel pain anywhere in the body they should seek medical attention. They also need to be open and inform their immediate family about their illness and always practice safe sex by using a condom.

Home-Based Care
One of the best places for a person with AIDS to receive care is at home where family members and friends can provide love. Home care can also help reduce the stress and cost of hospitalisation; however, health care providers should make sure that the person and his/her family:

- understand how to care for someone with AIDS.
- have the resources and ability to provide care.
- know what to do if the patient’s condition changes.

Home-based care involves family members, relatives and the community as a whole in the provision of care to people with HIV/AIDS. There are several areas to look at when caring for a person with HIV/AIDS at home. The most important areas of concern are the health, physical and psychological needs of the person who is ill.
What can be done at home for minor health problems?

- For fever and pain, give painkillers like Panadol and rub and massage sore, painful muscles.
- For sore mouth and throat, provide good nutrition and apply gentian violet to open ulcerations.
- For coughing and difficulty in breathing, give cough medication every four hours or as instructed. Provide lots of fluids and help them sit up when possible. They should cover their mouth when coughing and spit into a covered container. Throw away the sputum in a latrine or toilet or bury it. All soiled materials should be disposed of carefully.

Physical needs:

- Wash the person’s body regularly.
- Provide a balanced diet.
- Keep their clothes and bedding clean at all times.
- Change their resting position frequently and allow them to move about as often as possible.

Psychological needs:

Try to counsel the person in order to help him/her reduce depression, withdrawal, anxiety, etc.

Important: Providing home care can be a stressful and emotional experience. You may feel very frustrated watching a person become sicker despite your best efforts. To help cope with feelings of frustration, share your feelings with others including other caregivers, counsellors, the clergy or health workers. HIV/AIDS counselling is a professional activity. Persons requiring it should be referred to a qualified professional. However, religious leaders and other volunteers may be identified in the community or village to help those in need of counselling.

Some assistance with economic support and/or care in the home may be available from some of these sources:

- welfare groups
- religious organizations
- community-based AIDS organisations
- Red Cross volunteer programmes
- other non-governmental organisations
A Healthy Diet

HIV infection causes the immune system to work poorly and this makes it difficult to fight infection. Unplanned, severe weight loss can also break down the immune system, making it even more difficult to fight infection. When you lose a lot of weight, you not only lose fat, you also lose body protein. Protein has many important roles in the body; it’s part of the immune system and muscle is made from protein. We need muscles to keep our heart and lungs working and to keep ourselves strong and active.

This means that if you are HIV-infected, it is important to avoid losing weight. You can protect yourself by eating well. This will keep your immune system as healthy as possible and help you to feel strong.

It is also likely that if you are not eating enough to maintain your weight, you may not be getting enough vitamins and minerals. Deficiencies of certain vitamins and minerals can also make the immune system worse. So if you are not eating properly, you should take one or two multivitamin (with minerals) pills every day.

The Four Food Groups

Eating a well-balanced diet is the most important way to assure good nutrition. A well balanced diet will include a variety of foods. The minimum recommended servings for adults are listed below along with examples of different foods. Eating the suggested number of servings each day can help provide an adequate intake of protein, vitamins and minerals but may not provide all the calories you need.

<table>
<thead>
<tr>
<th>FOOD TYPE</th>
<th>SERVINGS PER DAY</th>
<th>RICH IN</th>
<th>SOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>MILK</td>
<td>2 OR MORE</td>
<td>PROTEIN, CALCIUM</td>
<td>MILK, CHEESE, PUDDING</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RIBOFLAVIN</td>
<td>ICE CREAM, YOGHURT</td>
</tr>
<tr>
<td>MEAT</td>
<td>2 OR MORE</td>
<td>PROTEIN, NIACIN, IRON</td>
<td>MEAT, PULTRY, FISH, EGGS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>THIAMIN</td>
<td>CHEESE, BEANS, PEANUT BUTTER</td>
</tr>
<tr>
<td>FRUITS AND VEGETABLES</td>
<td>4</td>
<td>VITAMINS A AND C</td>
<td>RAW, COOKED or JUICES, ESPECIALLY CITRUS AND BRIGHTLY COLOUR FRUITS AND DARK GREEN, LEAFY VEGETABLES</td>
</tr>
<tr>
<td>GRAIN (NSIMA)</td>
<td>4 OR MORE</td>
<td>CARBOHYDRATE, IRON</td>
<td>NSIMA, BREADS,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>THIAMIN, NIACIN</td>
<td>PASTA, RICE, POTATOES, CEREAL</td>
</tr>
</tbody>
</table>
Nutrition Problems
People who are HIV-infected must try to avoid losing too much weight. To gain weight, eat more from the meat, dairy and grain groups to add extra fats to your food (if you tolerate it). What follows are some ways to improve food intake:

• Poor appetite: eat smaller, more frequent meals. Choose calorie-dense foods.
• Nausea and vomiting: stick to light meals and beverages. Cold foods may be more acceptable.
• Diarrhoea: eat binding foods like bananas, rice and applesauce. Drink plenty of fluids.
• Difficult or painful swallowing: choose soft, high protein foods.
• Taste changes: add strong flavours to foods that taste bitter.
• Shortness of breath: eat slowly and frequently.
• Too tired to prepare meals: prepare extra food when you do have the energy. Check out the free food programmes in your area.

Food Poisoning
HIV infection makes you more susceptible to getting food poisoning and makes it harder to recover from it if you do get infected. To help decrease the risk of food-born infections, it is important to avoid the harmful germs in foods. The following steps can be taken to make food poisoning less likely:

• Wash all fruits and vegetables with warm water and mild soap. If possible, peel fruits and vegetables before eating.
• Do not eat rare meat. Medium or well-done meats have less risk of contamination.
• Avoid raw eggs, they can cause salmonella infection. Eggs cooked at least five minutes are best.
• Wash hands, counters and cutting boards well before starting food preparation and after contact with raw meats and poultry.
• Re-heat foods thoroughly before eating to kill any germs that may be in them.
• Don’t use the spoon you eat with as a serving spoon and don’t drink or eat directly from a storage container. Germs from your mouth can get into the food and make it spoil faster.
• If food seems even slightly spoiled, throw it out. Don’t take chances.
• Avoid raw/unpasteurised milk, cheese or other milk products. They can cause salmonella infections.
No Refrigerator or Stove

If you don’t have a refrigerator or stove, you can still eat at home. By planning carefully, you can save money and eat a well-balanced diet. Don’t let perishable items (foods that spoil quickly or go bad) sit around. Buy single serving sizes of canned and perishable goods.

- Keep food in a cool, dry place.
- Buy a hot plate to cook on.

(Adapted from materials developed by the Bellevue Hospital Centre Virology Nutrition Program, 1991, revised 10/92.)
MYTHS AND FACTS ON HIV

1. AIDS is a medical condition in which your body cannot fight off diseases.
2. AIDS is caused by a virus.
3. If you hug someone with AIDS you can get HIV.
4. Anyone can get AIDS.
5. AIDS can be cured.
6. Using someone’s personal belongings, like a comb or hairbrush, can spread HIV.
7. If a pregnant woman is HIV positive, there is a chance it may be passed on to her unborn baby.
8. Most people with AIDS die.
9. Having AIDS makes you more likely to get other diseases.
10. You can tell by looking whether someone is HIV positive.
11. Condoms are 100 percent effective against the transmission of HIV.
12. You increase your chance of getting HIV if you have sex with many people.
13. HIV is mainly in semen, blood, vaginal secretions and breast milk.
14. If you give blood, you are at risk for getting HIV.
15. You can catch HIV from a toilet seat.
16. Lesbians don’t have to worry about HIV infection.
17. An HIV-infected mother can infect her child through breast milk.
18. Birth control pills can prevent the transmission of HIV.
19. Loyalty to a partner is 100 percent effective.
20. If you kiss someone with HIV, you will get the disease.
21. Having unprotected sex with someone who is HIV positive is one way of getting it.
22. You can get HIV by sharing a needle with someone who is infected.
23. Having anal sex with a guy increases your chances of getting HIV.
Correct answers
1. Fact
2. Fact
3. Myth (no blood, semen or other infected bodily fluids)
4. Fact
5. Myth
6. Myth
7. Fact
8. Fact
9. Fact
10. Myth
11. Myth
12. Fact
13. Fact
14. Myth
15. Myth
16. Myth
17. Fact
18. Myth
19. Myth (only when partner is tested and is uninfected and sexual loyalty continues)
20. Myth
21. Fact
22. Fact
23. Fact

HIV/AIDS: ICE BREAKER EXERCISE

Distribute blue, red and yellow circles (you can get coloured paper and cut out circles to use for this exercise) to each participant. Do not indicate what the colour significance is. Instruct participants to spend two minutes walking around the room, meeting each other, and shaking hands with three other people in the room. When participants have met three other people, tell all participants to return to their seats.

Explain that each handshake, for the purpose of this exercise, was a sexual encounter. Everyone in the room, therefore, had sex with three others. Ask participants with red circles to stand. Explain that for the purposes of the exercise, they are HIV positive (some people may find this game too real; allow anyone who is uncomfortable the opportunity not to play along).

Ask participants to look around the room. If anyone shook hands with the red circle people, they should also stand. Explain that they have put themselves at risk for HIV infection. They have now been exposed to the HIV virus. Ask them to remain standing.

Now, ask participants to look around the room at those standing. If anyone shook hands with anyone standing, they should stand up as well. Explain that these people, too, have possible exposure to the HIV virus. They put themselves at risk by having sex with an HIV positive or HIV-exposed person.

Ask remaining seated participants to look to see if they shook hands with any standing person. If so, they should stand up. The majority of participants should be standing now. Explain how easily the HIV virus is passed along, as evidenced in this exercise.

Ask participants:
1. What did you think about this exercise?
2. Did the exercise illustrate how easily HIV is spread?
3. How did it feel knowing you were exposed to HIV?
4. For those participants seated at the end, did you feel happy not to be exposed?
5. Ask if there are other comments.
EIGHT STEPS TO A HEALTHIER AND SAFE SEX LIFE

1. Be selective when you choose a sex partner.
   • Have sex only with a partner who will increase your pleasure and comfort by making you feel secure about your health concerns.
   • Have sex only with a partner whose name and phone number you know.
   • Have sex only with a partner who has no genital bumps or sores or other apparent signs of infection.

2. Limit your number of sex partners.
   • It is safest to have sex with only one person who is having sex only with you.

3. Talk with your partner before sex.
   • Talk about your health concerns and your partner’s.
   • Find out about your partner’s health and sexual history.
   • Be direct. Talk about your sexual needs and expectations.
   • Be prepared to talk about your past experiences.
   • Be persistent. Don’t let your partner remain silent on these issues.
   • Make conversations about health a natural part of your sexual relationship.

4. If you have sex with more than one person or if your partner does, protect yourself while having sex.
   • Use condoms every time to give yourself a high degree of protection against STIs and infection from HIV (the virus that causes AIDS), even if you are using another family planning method.
   • Wash your genitals thoroughly with soap and water before and after sex acts. (This will help prevent transmission of STIs but not HIV.)
   • Urinate soon after sex. (This will help prevent transmission of STIs but not HIV.)
5. Keep medically fit.
   • Have a check-up for STIs at least once a year if you have sex with more than one person or if your partner does.
   • Have an annual physical exam. (Women should make sure it includes a breast and pelvic exam, plus a Pap smear. Don’t douche before a pelvic exam.)

6. If you think you have been exposed to an STI, be responsible.
   Go to your doctor, clinic or health department for testing and treatment. Tell your sex partner(s) as soon as you know you have been infected. Urge your partner(s) to get treatment, too.
   • Use all the medication that is prescribed. Even if symptoms disappear, you may still be infected.
   • Do not have sex until you and your partner have been cured.

7. If you think you have been exposed to HIV, don’t panic; there are things you can do.
   • You may want to get tested in order to take advantage of all medical treatment available to you. Although there is no way to eliminate HIV infection from your body once you’ve picked it up, doctors now believe that early medical care can help delay the onset of AIDS.
   • Get in touch with all the people you’ve had sexual contact or shared hypodermic needles with, so they can get tested and receive medical care.
   • If you do test positive for HIV, remember your partner’s life and health depend on your using a condom every time you have sex.
   • If you don’t test positive for HIV, make sure you stay uninfected; use condoms and avoid sharing hypodermic needles.

8. Stay in charge.
   • Good judgment and self-control are the basis of safer, healthier sex. Alcohol and drugs weaken them. Don’t let alcohol or drugs jeopardize your self-control.

(Adapted from a publication of the Planned Parenthood Federation of America, 1988)
Some Special Extras

Breast milk is made for your baby. It has all the nutrients in the proper amounts needed for growth and health. So it’s probably the best food you can feed your baby for at least the first four to six months of life.

Your breast milk is different from formula. Let’s look at several nutrients to see these differences.

**PROTEIN:**
Protein is an important nutrient because your baby needs it to grow. The type of protein in breast milk is different from the type in most cow milk-based formulas. Your baby can digest breast milk protein more easily. This is one reason why nursing babies have fewer intestinal problems than do bottle-fed babies.

Cow’s milk is made for cows and breast milk is made for babies. Your baby needs less protein because he or she is growing slower than a calf. Your breast milk has the proper amount of protein for growth and development.

**FAT:**
Your baby needs lots of energy to grow and move around. Some of this energy comes from fat. Your breast milk has more fat than does cow’s milk or formula. Also, your baby can use breast-milk fat more readily.

The fat in our diet makes us feel full at the end of a meal. The fat in your breast milk makes your baby feel full. This may prevent overeating. Babies who learn not to overeat when they are young are less likely to overeat later in life.

**IRON:**
As babies grow, they need more blood to reach all through their body. Iron is used to make this blood. Your breast milk contains less iron than formula does. Your baby can take the iron from your milk better than from cow’s milk or formula and then use it to make blood.
MILK SUGAR:
Lactose is the main sugar in your breast milk. Lactose gives your baby energy to grow and to move around. The high lactose in breast milk helps infants use iron better. Also, it may stop harmful bacteria from growing in the intestines and lessen the chance of having diarrhoea.

VITAMINS AND MINERALS:
Breast milk also contains other minerals and vitamins. When your baby is born, she or he may have problems with large amounts of minerals. Your milk contains smaller amounts of most minerals than does cow’s milk or formula. In breast milk, vitamins and minerals are found in the amounts your baby needs for growth and health.

Other Breast Feeding Benefits
When you nurse your baby, a hormone is released into your blood. It travels to your womb and makes it shrink to the size it was before you became pregnant. So you return faster to the shape you were before you became pregnant.

• Making breast milk and nursing take energy. You may find it easier than bottle-feeding mothers do to lose weight because some of this energy comes from the fat you stored during pregnancy.
• Usually, breast-feeding costs less than bottle-feeding. The only cost of breast-feeding is extra food for you.
• Travelling with your baby is easier. There is less to pack and bring along.
• When your baby is young and needs to eat in the middle of the night, bring your baby in bed with you. While he or she nurses, you can rest. No one has to get up to get the bottle ready.
• The milk you make during the first few days after your baby is born is called “colostrum.” Colostrum protects your baby from disease. Your breast milk also contains substances that help fight disease. So a breast-fed baby should get fewer infections and be sick less often than a bottle-fed baby.
• Breast-feeding babies may form a special closeness with their mothers.
The Risk of HIV Transmission

One of the few circumstances in which breast-feeding is potentially dangerous to your child is if you are infected with HIV (the virus that causes AIDS) or have AIDS or ARC (AIDS Related Complex).

Most mother-to-infant transmission of HIV occurs during pregnancy and delivery when mother and child exchange body fluids constantly. But it is also possible for you to pass the virus to your child through your breast milk, though not as likely. Your chances of passing the virus through breast milk are increased if you become infected with HIV when you are breast-feeding. You are less likely to infect your child through breast milk if you became infected before you gave birth.

(Adapted from Have You Decided? Bottle or Breast? and Mother’s Milk, by Diane C. Japlowitz and Christine M. Olson; published by Cooperative Extension, New York State College of Human Ecology and New York State College of Veterinary Medicine, at Cornell University and the U.S. Department of Agriculture.)
In view of the importance of breast milk and breast-feeding for the health of infants and young children, the increasing prevalence of human immunodeficiency virus (HIV) infection around the world and recent data concerning HIV transmission through breast milk, a Consultation on Breast-feeding was held by WHO (World Health Organization) and UNICEF (United Nations International Children’s Education Fund) from 30 April to 1 May, 1992. Its purpose was to review currently available information on the risk of HIV transmission through breast milk and to make recommendations on breast-feeding.

Based on the various studies conducted to date, roughly one-third of the babies born worldwide to HIV-infected women become infected themselves, with this rate varying widely in different populations. Much of this mother-to-infant transmission occurs during pregnancy and delivery and recent data confirms that some occurs through breast-feeding. However, the large majority of babies breast-fed by HIV-infected mothers do not become infected through breast milk. Recent evidence suggests that the risk of HIV transmission through breast-feeding (a) is substantial among women who become infected during the breast-feeding period and (b) is lower among women already infected at the time of delivery. However, further research is needed to quantify the risk of HIV transmission through breast-feeding and determine the associated risk factors in both of these circumstances.

Studies continue to show that breast-feeding saves lives. It provides impressive nutritional, immunological, psychosocial and child-spacing benefits. Breast-feeding helps protect children from dying of diarrhoeal diseases, pneumonia and other infections. For example, artificial or inappropriate feeding is a major contributing factor in the 1.5 million annual infant deaths from diarrhoeal diseases. Moreover, breast-feeding can prolong the interval between births and thus make a further contribution to child survival as well as enhancing maternal health.
It is therefore important that the baby’s risk of HIV infection through breast-feeding be weighed against its risk of dying of other causes if it is denied breast-feeding. In each country, specific guidelines should be developed to facilitate the assessment of the circumstances of the individual woman.

RECOMMENDATIONS

1. In all populations, irrespective of HIV infection rates, breast-feeding should continue to be protected, promoted and supported.

2. Where the primary causes of infant deaths are infectious diseases and malnutrition, infants who are not breast-fed run a particularly high risk of dying from these conditions. In these settings, breast-feeding should remain the standard advice to pregnant women including those who are known to be HIV-infected, because a baby’s risk of becoming infected through breast milk is likely to be lower than its risk of dying of other causes if deprived of breast-feeding. The higher a baby’s risk of dying during infancy, the more protective breast-feeding is and the more important it is that the mother be advised to breast-feed. Women living in these settings whose particular circumstances would make alternative feeding an appropriate option might wish to know their HIV status to help guide their decision about breast-feeding. In such case, voluntary and confidential HIV testing, accompanied in all cases by pre- and post-test counselling, could be made available where feasible and affordable.

3. In settings where infectious diseases are not the primary causes of death during infancy, pregnant women known to be infected with HIV should be advised not to breast-feed but to use a safe feeding alternative for their babies. Women whose infection status is unknown should be advised to breast-feed. In these settings, where feasible and affordable, voluntary and confidential HIV testing should be made available to women, along with pre- and post-test counselling and they should be advised to seek such testing before delivery.
4. When a baby is to be artificially fed, the choice of substitute feeding method and product should not be influenced by commercial pressures. Companies are called on to respect this principle in keeping with the International Code of Marketing of Breast Milk Substitutes and all relevant World Health Assembly resolutions. It is essential that all countries give effect to the principles and aim of the International Code. If donor milk is to be used, it must first be pasteurised and, where possible, donors should be tested for HIV. When wet nursing is the chosen alternative, care should be taken to select a wet-nurse who is at low risk of HIV infection and, where possible, known to be HIV negative.

5. HIV-infected women and men have broad concerns including maintaining their own health and well-being, managing their economic affairs and making future provision for their children and therefore require counselling and guidance on a number of important issues. Specific issues to be covered by counselling include infant feeding practices, the risk of HIV transmission to the offspring if the woman becomes pregnant and the transmission risk from or to others through sexual intercourse or blood. All HIV-infected adults who wish to avoid childbearing should have ready access to family planning information and services.

6. In all countries, the first and overriding priority in preventing HIV transmission from mother to infant is to prevent women of childbearing age from becoming infected with HIV in the first place. Priority activities are (a) educating both women and men about how to avoid HIV infection for their own sake and that of their future children; (b) ensuring their ready access to condoms; (c) providing prevention and appropriate care for sexually transmitted diseases which increase the risk of HIV transmission; and (d) otherwise supporting women in the efforts to remain uninfected.

Geneva, 4 May 1992
GUARD AGAINST BREAST CANCER: 
HAVE YOU EXAMINED YOUR BREASTS 
THIS MONTH?

When should I examine my breasts?
Every month, about a week after your menstrual period ends. (Waiting a week lets any breast swelling you may have around the time of your period go away). If you are past menopause and don’t have periods anymore, pick a date, like the first day of the month, and do your breast self-examination on that day each month.

When should a doctor examine my breasts?
Every time you have a routine check-up, which should be at least once a year. Between visits, if you find a lump or something that doesn’t feel right, make an appointment right away to see your doctor.

What’s mammography?
The process of making a mammogram that is an x-ray of the breast. A mammogram can find lumps when they are so small the hand cannot feel them; two or three years before your doctor may detect them.

When should I have a mammography?
Even if you have no signs, you should still be “screened” for it at certain ages. If you are between ages 35 and 40, you should have a “baseline” mammogram now. This will give your doctor something to compare later mammograms to, to see if any changes have taken place. Women between the age of 40 and 49 should have a “screening” once every year or two. Ask your doctor what would make sense for you. Each of your later mammograms will be compared to the “baseline” mammogram to compare for any changes.

What else can I do to prevent breast cancer?
Many physicians believe you can lower your risk of breast cancer by cutting down on fat to less than 30 percent of your daily diet, if possible. A diet that is low fat, low salt and low caffeine may also help you avoid non-cancerous lumps that masquerade as cancer.

Am I at higher risk for breast cancer than other women?
About one woman in ten develops breast cancer. The American Cancer Society says your risk is greater if:
• You are over 50
• You have a close relative with breast cancer
• You are childless or had your first child after 30

If any of these factors apply to you, be extra careful about getting yearly health checkups.
HOW TO EXAMINE YOUR BREASTS

1. First lie on your back with one arm behind your head, resting on a pillow. Then with your fingers flat, feel for lumps in your breasts, using one of the methods shown below. Choose whichever method you feel most comfortable with and use it consistently every month. That way, you will learn how your breasts ordinarily feel. And don’t forget the area between the breast and the armpit. When you finish with one breast, switch the pillow to your other shoulder and repeat the whole process on the other breast.

2. Method A: Start at the outer edge of your breast and press in small circles. Work slowly around the breast, gradually moving toward the nipple.

Method B: Start at the top outer edge of your breast and press in a straight line – down, then up, then down again, working toward the centre of your chest.

Method C: Start at the nipple and press in a straight line out to the edge of your breast. Keep doing this, moving slowly around the breast.

If you want to, you can do this part of the examination in the shower or the bath when your skin is wet. Some women find it easier to feel for lumps this way, when their soapy hands can glide more freely over their wet skin.

3. Now stand in front of a mirror with your arms at your sides. Look at your breasts. Then put your hands behind your head and look for any swelling or changes in the shape of your breasts. Squeeze each nipple gently to see if there is any discharge. Look for any change in the nipple’s colour, texture, shape, and position. When you are finished, switch hands and repeat on your other breast.

Information courtesy of the American Cancer Society, N.J. Div. Inc.
What are drugs?
Drugs are defined as substances (other than food) that affect the chemistry and function of the body and that sometimes cause addiction or habituation.

What kinds of drugs are there?
There are many drugs that affect the mind or behaviour and they are either legal or illegal. Legal drugs are those that have been approved for sale either by prescription or over the counter. Alcohol, which is legally available in beverages except to those under legal drinking age, is a drug. Illegal drugs are those whose manufacture, sale, purchase for sale or possession is prohibited by law. These include such drugs as marijuana, cocaine and heroin.

Prescription drugs are drugs that have been determined to be safe, effective and legal only when given under the direction of a licensed physician. Laws regulate both the manufacture and dispensing of prescription drugs. If used improperly, people can become physically dependent upon some prescription drugs; e.g., morphine and Valium.

It is against the law to buy or use illegal drugs. They may harm those who use them not only in terms of the direct physical and emotional damage they cause but also in terms of the criminal and financial consequences they bring.

How and why does drug use start?
How and why do some people start using alcohol and other drugs? There is no single answer to that question. Surely in the case of many youths, alcohol and other drug use starts in response to peer pressure. Young people naturally want to “fit in,” to be accepted by their classmates or friends. Whatever the reasons, first use can be dangerous. Research shows that once involvement with alcohol and other drugs begins, such involvement all too often follows a predictable sequence leading to problems due to the use of alcohol and other drugs.

Drug abuse often starts with the illicit use of legal drugs and with the use of alcohol (illegal for youth) and tobacco; users often progress from these substances to marijuana. Some users may eventually turn to other illegal drugs or combinations of drugs. For this reason, alcohol, tobacco and marijuana are frequently called “gateway” drugs.
What are the physical and psychological effects of alcohol and other drugs?

1. Alcohol
Alcohol, a natural substance formed by the fermentation that occurs when sugar reacts with yeast, is the major active ingredient in wine, beer and distilled spirits. Although there are many kinds of alcohol, the kind found in alcoholic beverages is ethyl alcohol. Whether one drinks a 341-milliliter beer, a shot (43-milliliters) of distilled spirits or a 142-milliliter glass of wine, the amount of pure alcohol per drink is about the same – 8 milliliters. Ethyl alcohol can produce feelings of well-being, sedation, intoxication or unconsciousness, depending on the amount and the manner in which it is consumed.

Alcohol is a “psychoactive” or mind-altering drug, as are heroin and tranquillisers. It can alter moods, cause changes in the body and become habit-forming. Alcohol is called a “downer” because it depresses the central nervous system. That’s why drinking too much causes slowed reactions, slurred speech and sometimes even unconsciousness (passing out). Alcohol works first on the part of the brain that controls inhibition.

A person does not have to be an alcoholic to have problems with alcohol. Every year, for example, many young people lose their lives in alcohol-related automobile crashes, drowning and suicides. Serious health problems can and do occur before drinkers reach the stage of addiction or chronic use. Some of the serious diseases associated with chronic alcohol use include alcoholism and cancer of the liver, stomach, colon, larynx, oesophagus and breast. Alcohol abuse also can lead to such serious physical problems as:

- damage to the brain, pancreas and kidneys.
- high blood pressure, heart attacks and strokes.
- alcoholic hepatitis and cirrhosis of the liver.
- stomach and duodenal ulcers, colitis, an irritable colon.
- impotence and infertility.
- birth defects and foetal alcohol syndrome whose effects include retardation, low birth weight, small head size and limb abnormalities.
- premature aging.
- a host of other disorders such as diminished immunity to disease, sleep disturbances, muscle cramps and oedema.

2. Marijuana (has many local names)
The marijuana plant is said to look like a marigold flower plant and it is the leaves that are dried and smoked. Contrary to many young people’s beliefs, marijuana is a harmful drug, especially since the potency of the marijuana now available has increased more than 275% over the last decade. There are more known cancer-causing agents in marijuana smoke than in cigarette smoke. In fact, because marijuana smokers try to hold the smoke in their lungs as long as possible, one marijuana cigarette can be as damaging to the lungs as four tobacco cigarettes.
Even small doses of marijuana can impair memory function, distort perception, hamper judgment and diminish motor skills. Health effects also include accelerated heartbeat and, in some persons, increased blood pressure. These changes pose health risks for anyone but particularly for people with abnormal heart and circulatory conditions such as high blood pressure and hardening of the arteries.

More importantly, there is increasing concern about how marijuana use by children and adolescents may affect both their short and long term development.

Mood changes occur with the first use. Observers in clinical settings have noted increased apathy, loss of ambition, loss of effectiveness, diminished ability to carry out long-term plans, difficulty in concentration and a decline in school performance. Driving under the influence of marijuana is especially dangerous. Marijuana impairs driving skills for at least four to six hours after smoking a single cigarette. When marijuana is used in combination with alcohol, driving skills become even more impaired.

3. Cocaine (has different local names)

Cocaine is one of the most powerfully addictive drugs and it can kill. No individual can predict whether he or she will become addicted or whether the next dose of cocaine will prove fatal. Cocaine can be snorted through the nose, smoked or injected. Injecting cocaine, or injecting any drug, carries the added risk of infection from the Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS) if the user shares a needle with a person already infected with the virus.

Cocaine is a very strong stimulant to the central nervous system, including the brain. The drug produces an accelerated heart rate while at the same time constricting the blood vessels, which are trying to handle the flow of blood. Pupils dilate and temperature and blood pressure rise. These physical changes may be accompanied by seizures, cardiac arrest, respiratory arrest or stroke.

Nasal problems, including congestion and a runny nose, may occur with the use of cocaine. With prolonged use, the mucous membranes of the nose may disintegrate. Heavy cocaine use can sufficiently damage the nasal septum so as to cause it to collapse. Research has shown that cocaine acts directly on what have been called the “pleasure centres” in the brain. These “pleasure centres” are brain structures that, when stimulated, produce an intense desire to experience the pleasurable effects again and again. This causes changes in brain activity and, by allowing a brain chemical called dopamine to remain active longer than normal, triggers an intense craving for more of the drug.

Users often report feelings of restlessness, irritability, anxiety and paranoia. Users also report being depressed when they are not using the drug and often resume use to alleviate further depression. In addition, cocaine users frequently find that they need more and more cocaine to generate the same level of stimulation. Therefore, any use can lead to addiction.
SIX STEPS TO PREVENT DRUG AND ALCOHOL USE

1. **Knowledge is a powerful weapon against drugs.** Talk to your child about alcohol and other drugs. Carefully explain the health consequences of alcohol and other drug use and the effect they can have on the child’s life in preparation for the future. Correct mistaken ideas perpetuated by peers and the media. Listen carefully to your child talk about alcohol and other drugs. Children are more likely to communicate when they receive positive verbal and nonverbal feedback from parents.

2. **Help your child develop a healthy self-image.** Self-regard is enhanced when parents praise efforts as well as accomplishments. In turn, when being critical, criticize the actions and not the person.

3. **Help your child develop a strong system of values.** A strong value system can give children the criteria and courage to make decisions based on facts rather than pressure from friends.

4. **Teach your child how to deal with peer pressure.** Explain that saying “no” can be an important statement about self-worth. Help your child practice saying “no.” Together, set up some situations for saying “no” and discuss why it is beneficial to avoid alcohol and other drugs.

5. **Make family policies that will help your child say “no.”** The strongest support your child can have in refusing to use alcohol and other drugs is to be found in the solid bond created within the family unit. Let your child know that drug and alcohol use is unacceptable within the family and is a violation of the family’s rules. The consequences and punishment for such a violation must be clearly spelled out.

6. **Encourage healthy activities that may help to prevent children from using alcohol and other drugs.** Help make your child’s life so full and active that there is no time or place for alcohol and other drugs.
DOMESTIC VIOLENCE MYTH/FACT SHEET

Respond to each statement by putting a ✓ under “True,” “False,” or “I don’t know.” Do not guess.

Domestic violence is the use or threat of physical violence against a partner in a primary relationship or a family member, resulting in fear and emotional and/or physical suffering.

<table>
<thead>
<tr>
<th>Myths/Facts</th>
<th>True</th>
<th>False</th>
<th>I don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Domestic violence is a private affair – it is no one else’s business.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Domestic violence is not a big problem.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Only lower-class men beat their wives.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. A woman can stop the abuse easily just by leaving.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Unemployment or job frustration is the only cause of domestic violence.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Domestic violence is a power issue – a physically stronger person or a person in a position of authority is abusing a weaker or more dependent person.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. A substantial number of homicides are committed against family members.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. The only person ultimately responsible for the battering is the person who made the choice to be violent.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. There is no one right decision for a battering victim.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Domestic violence does not occur 24 hours a day / 7 days a week. There may be peaceful periods between beatings.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Both domestic violence and alcoholism are found in families from all socio-economic, educational, religious, ethnic and racial backgrounds.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Both domestic violence and alcoholism are progressive, recurring and potentially fatal.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
BATTERING OF ADULT WOMEN

What are the forms of abuse women experience?

<table>
<thead>
<tr>
<th>PHYSICAL</th>
<th>EMOTIONAL</th>
<th>SEXUAL</th>
<th>ECONOMIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hitting</td>
<td>Name calling</td>
<td>Rape</td>
<td>Withholding money</td>
</tr>
<tr>
<td>Slapping</td>
<td>Constant harassment</td>
<td>Unwanted sexual practices</td>
<td>Lying about assets</td>
</tr>
<tr>
<td>Kicking</td>
<td>Refusing to speak</td>
<td>Forced sex with other men</td>
<td>Stealing money</td>
</tr>
<tr>
<td>Burning</td>
<td>Humiliating you with family and friends</td>
<td>Sexual abuse of your child</td>
<td></td>
</tr>
<tr>
<td>Mutilation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holding a knife to your throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Destroying a loved object or pet</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abuse is a Pattern of Coercive Control

What are the effects of abuse on the victim as reported by battered women?

<table>
<thead>
<tr>
<th>What are the effects of abuse on the victim as reported by battered women?</th>
</tr>
</thead>
<tbody>
<tr>
<td>It frightens me.</td>
</tr>
<tr>
<td>It controls my life.</td>
</tr>
<tr>
<td>I withdraw and get depressed.</td>
</tr>
<tr>
<td>I lose my self-confidence.</td>
</tr>
<tr>
<td>I’m nervous, get headaches and high blood pressure.</td>
</tr>
<tr>
<td>I lost my home.</td>
</tr>
</tbody>
</table>

What does the abuser gain? *The following quotations are from battered women.*

<table>
<thead>
<tr>
<th>What does the abuser gain?</th>
</tr>
</thead>
<tbody>
<tr>
<td>He got his way.</td>
</tr>
<tr>
<td>He got control.</td>
</tr>
<tr>
<td>He didn’t have to do anything at home.</td>
</tr>
<tr>
<td>He got taken care of.</td>
</tr>
</tbody>
</table>
POWER AND CONTROL CYCLE CHART

Battering Is an Abuse of Power

Family Life Education Programme
**CONTROLLING BEHAVIOUR CHECKLIST**

**Physical Controls**

- Hitting, grabbing, kicking, choking, pushing, rape, uninvited touching.
- Abusing pets, damaging furniture, walls, etc.
- Physical intimidation; e.g., standing in the doorway during arguments, angry gesturing, etc.
- Throwing things. Threatening violence (verbally or non-verbally).
- Uninvited visits or calls, following her around, checking up on her.
- Not leaving when asked to. Isolating her (preventing her from seeing or talking to friends, relatives, etc.).

**Psychological Controls**

- Criticism (name-calling, swearing, mocking, put downs, ridicule, accusations, blaming, etc.).
- Interrupting, changing topics, out-shouting, not listening, not responding, not respecting what she says.
- Pressuring her to take care of him emotionally when she doesn’t want to, rushing her by being impatient, guilt-tripping, sulking, making her feel sorry for him, making accusations.
- Using money to manipulate, controlling other resources such as the car.
- Sexual coercion.
- Claiming “the truth,” being the authority, defining her behaviour.
- Emotional withholding: not expressing feelings when appropriate, not giving praise, attention, information, support, concern, validation, not being vulnerable.
- Other forms of manipulation.
- Not taking care of himself, not making friends, finding support, etc.
EFFECTS OF FAMILY VIOLENCE

On Adults

- Emotional stress and deprivation.
- Disabling injuries.
- Perpetuation of social isolation or fear of violence being disclosed.
- Continuing violence that will escalate if alternative behaviours are not learned.
- Difficulty in obtaining, maintaining and adjusting to employment due to the tense and violent atmosphere.
- Depression. Victim may become immobilized due to constant fear and tension.
- Substance abuse.
- Break-up of family unit; relocation of victim and children.
- Expansion of violence into the community.
- Death by suicide.
- Death by homicide (of either perpetrator or victim).
- Recurrence of violent behaviour with new partner.

On Children

- Emotional injuries such as low self-esteem.
- Hyperactivity; poor control.
- Poor school adjustment.
- Aggressive behaviour toward others/delinquency.
- Depression.
- Runaway episodes.
- Alcohol and drug experimentation or use.
- Modelling behaviours learned: victim/aggressor roles.
- Early marriage.
- Continuation of violent behaviour in their adult relationships.
- Expansion of violence into the community.
- Death by suicide.
- Death by homicide.
WHY WOMEN STAY

Situational Factors

- Economic dependence.
- Fear of greater physical danger to themselves and their children if they attempt to leave.
- Fear of emotional damage to children.
- Fear of losing custody of children.
- Lack of alternative housing.
- Lack of job skills.
- Social isolation resulting in lack of support from family or friends and lack of information regarding alternatives.
- Fear of involvement in court processes.
- Cultural and religious constraints.
- Fear of retaliation.

Emotional Factors

- Fear of loneliness.
- Insecurity over potential independence and lack of emotional support.
- Guilt about failure of marriage.
- Fear that husband or partner is not able to survive alone.
- Belief that husband will change.
- Love for husband or partner.
- Ambivalence and fear over making formidable life changes.
- Learned helplessness.
- Dependency; co-dependent behaviour.
SECTION 6

Topic: Forms of Sexual Abuse (Rape, Child Molestation)

CONTENTS

Cultural Factors Contributing To Rape
Forms of Sexual Abuse: Rape and Sexual Abuse
Myths and Facts About Rape
Quiz On Facts About Rape
Reactions To Sexual Assault
Touch Continuum
Ori & Kori Help Adults & Children Learn
Preventing Sexual Abuse Of Children
Children Are Empowered When They…
Definitions of Sexual Abuse
Sexual Abuse Indicators
Child Sexual Abuse: Intervention And Prevention
CULTURAL FACTORS CONTRIBUTING TO RAPE

- Inequality of the sexes.
- Media that portray females as sex objects, property or weak creatures always needing protection.
- The double standard of sexual behaviour that says men must be sexually experienced but women must remain chaste.
- The idea that there are “good” girls and “bad” girls. These labels can suggest that it’s all right to force sex on “bad” girls.
- Cultural ideals that present rigid gender stereotypes – men as aggressive (attackers) and women as submissive (victims).
- In a study done by an anthropologist named Dr. Sanday, cultures that were high in levels of rape had a number of features in common. Cultures low in levels of rape also had shared characteristics.

<table>
<thead>
<tr>
<th>High-Rape Cultures</th>
<th>Low-Rape Cultures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low respect for women.</td>
<td>High respect for women.</td>
</tr>
<tr>
<td>Women seen as inherently inferior to men.</td>
<td>High value placed on fertility and other attributes of maternal behaviour.</td>
</tr>
<tr>
<td>Women viewed as property.</td>
<td>Complementary sex roles.</td>
</tr>
<tr>
<td>Much violence in culture.</td>
<td>Little violence in culture.</td>
</tr>
<tr>
<td>Low respect for women.</td>
<td>High respect for women.</td>
</tr>
</tbody>
</table>

Consequences of Rape for the Rapist

- Expelled from school.
- May contract STI or HIV that causes AIDS.
- Death.
- Imprisonment.
- Forced Marriage
- Fathering an unwanted child.
- Social outcast.
FORMS OF SEXUAL ABUSE:
RAPE AND SEXUAL ABUSE

• Rape is an act of violence. The weapon used is sex.

• Force can occur because of breakdowns in communication – someone’s seeming to say one thing and meaning another. Your body language may not match your words.

• Sex role stereotypes are dangerous in that they lead us to behave only in certain culturally “acceptable” ways and these ways can lead to sexual abuse. Stereotypes don’t give us a choice of how to act; they lock us into roles.

• Make and state your choices about sex. Know what your values and expectations are and verbalize them clearly.

• Take responsibility for your sexual choices. Say “yes” if you mean yes and “no” if you mean no.

• Don’t give in to peer pressure.

• Don’t buy into media messages that tell us we have to be sexy and have sex to be popular.

• Recognize that television also sends out confusing messages – for example, that girls should be sexy but “good” girls don’t have sex.

• Try to equalize your relationships by sharing responsibility, making decisions, etc.

• Reject stereotypes that encourage men to regard women as sex objects as less valuable than men or as property to be owned.

(Adapted from a publication of The Parent Education Programme of Planned Parenthood of New York City.)
MYTHS AND FACTS ABOUT RAPE

MYTH: Rape is sex.
FACT: For the victim of rape, it is an act of violence. It is a life-threatening experience. In a sample of 135 sexual assault victims interviewed by the Victim Treatment and Research Clinic (VTRC), 19 percent had had a sexual assault with two or more assailants, 33 percent had experienced an assault with a weapon, 32 percent had experienced an assault with “excessive force”; i.e. more force than is necessary to subdue the victim or enough to cause her serious injury.

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 given rapist will rape.

MYTH: Women secretly enjoy being raped.
FACT: No one – man, woman or child – enjoys being raped. It is a brutal intrusion on mind and body that causes lasting problems.

MYTH: Women “cry rape” to get men in trouble.
FACT: Reporting rape is a debilitating and humiliating experience that all too rarely results in a conviction. Of the sample of 135 women interviewed by the VTRC, only 15 percent of 321 sexual assaults suffered by the subjects were reported to the police.

A woman would gain nothing and would pay a heavy penalty for falsely reporting rape. We have yet to come across a genuine false report, though we are familiar with cases that have been incorrectly classified as such.
MYTH: If a woman didn’t fight back, she wasn’t really raped.
FACT: Any rape is a potential murder and this is abundantly 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: There is a “right” way to respond to a rape situation.
FACT: Since rape is life-threatening and each rapist has his own pattern, the best thing a victim can do is follow her instincts and observe any cues from the rapist. If the victim escapes alive, she has done the right thing.

MYTH: A victim who doesn’t report the 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: Rape trauma syndrome is a transient problem. Most healthy people will return to their normal state of functioning within a year.
FACT: Surviving a rape can lead a woman to a better understanding of her own strengths but rape is a life-changing experience. Out of a sample of 111 women (interviewed by VTRC) whose last assault had been three or more years ago, only one woman felt that her life had not been changed.

MYTH: A victim should be discouraged from dwelling on the rape. She should put it away and forget it.
FACT: This advice generally comes from people who are more concerned with their own feelings than with the victim’s. All victims should be offered the opportunity to talk about the assault with those personally close to them and with knowledgeable professionals. Victims who are not allowed to talk about the rape have a much more difficult time recovering from it. Enforced silence preserves the crisis in a state of suspended animation.
MYTH: A “recidivist” victim must be seeking rape.

FACT: No one – man, woman or child – enjoys being raped. It is a brutal intrusion on mind and body that causes lasting problems. Unfortunately, 50 percent of the sample of 135 women interviewed by the VTRC reported being assaulted more than once. This does not include rape situations that involve ongoing assault, as in marital rape or incest.

MYTH: Women never get pregnant as a result of being raped.

FACT: VTRC has so far found a 4 percent pregnancy rate. Rape counsellors have a clinical impression that pregnancy is most common from gang rapes and incest.

MYTH: Women raped by their husbands are masochists.

FACT: Wives are often imprisoned in the situation. Wives are often economically dependent on their husbands for themselves and their children. It is not easy, even for a woman with marketable skills, to escape from this situation. Most societal institutions support the notion that wives are the property of their husbands.

MYTH: Rapists never return to the same victim, so fears of retaliation after reporting a rape are irrational.

FACT: Many cases of rapists returning have been reported. In one case, a stranger rapist tracked down a victim who had moved after the first attack and raped her again five years later.

MYTH: Prostitutes can’t be raped.

FACT: Prostitutes, society’s official sexual scapegoats, are perfect targets for rape, especially very brutal ones. Assaults on prostitutes are unlikely to be reported unless they are homicides. One’s vulnerability to sexual assault increases inversely to one’s social prestige.

MYTH: Rapists are always non-white, lower class and/or “criminal types.”

FACT: Rapists that fit the myth are far more likely to be prosecuted but a rapist can be anyone – doctor, policeman, clergyman, social worker or corporation president.
MYTH: Incest isn’t necessarily harmful, because at least the child is learning about sex at home and is getting affection.

FACT: What a child learns about sex to meet an adult’s need isn’t necessarily helpful. Of a sample of 50 incest survivors interviewed by VTRC, 64 percent were suffering from sexual dysfunctions, 56 percent were experiencing difficulties with trust and forming relationships.

MYTH: Incest doesn’t happen in my community.

FACT: Incest happens in every community.

MYTH: Sexual assaults are rare deviations and affect few people. After all, no one I know has been raped.

FACT: Sexual assaults are very common. Someone close to you has been profoundly affected by a sexual assault. Not only are victims reluctant to discuss their assaults but also many succeed in totally blocking the assault from conscious memory. However, the trauma remains and may come to the surface at another crisis or when the opportunity to discuss it with a sympathetic person arises.

(Adapted from a publication of New York Women Against Rape)
## QUIZ ON FACTS ABOUT RAPE

Respond to each statement by putting a ✓ under “True,” “False,” or “I don’t know.” Do not guess.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rape is forced sexual relations against a person’s will.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Rape is committed in this country.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. A husband can rape his wife.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Over 50 percent of all rapes occur between people who have met before.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. The majority of rape victims are between 15 and 19 years of age.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. The majority of reported rapists are between 15 and 24 years of age.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Most rapes occur between people of the same race and similar social position.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Most rapes occur in urban areas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. An estimated 50 percent of all rapes are never reported to the police.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Rape takes place during daytime hours and often in the victim’s own home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Studies show that rapists plan ahead and choose women who seem likely victims.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Rapists interviewed say they have poor social relationships with women.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Sexual gratification is not the motivating factor in rape.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Rape is an expression of hostility, aggression and dominance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. All victims of rape, regardless of their previous sexual experience, report rape as a violent and dangerous attack upon them that deeply affects their lives.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Adapted from a publication of New York Women Against Rape)
## REACTIONS TO SEXUAL ASSAULT

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional Shock:</strong></td>
<td>I feel so numb. Why am I so calm? Why can’t I cry?</td>
</tr>
<tr>
<td><strong>Disbelief:</strong></td>
<td>Did it really happen? Why me?</td>
</tr>
<tr>
<td><strong>Embarrassment:</strong></td>
<td>What will people think? No, I can’t tell my family.</td>
</tr>
<tr>
<td><strong>Shame:</strong></td>
<td>I feel so dirty, like there is something wrong with me now. I want to wash my hands all day long.</td>
</tr>
<tr>
<td><strong>Guilt:</strong></td>
<td>I feel as if I did something to make this happen to me. If only I had…</td>
</tr>
<tr>
<td><strong>Depression:</strong></td>
<td>How am I going to go on? I feel so tired and hopeless.</td>
</tr>
<tr>
<td><strong>Powerlessness:</strong></td>
<td>Will I ever feel in control again?</td>
</tr>
<tr>
<td><strong>Disorientation:</strong></td>
<td>I can’t sit still. I’m having trouble getting through the day. I’m just overwhelmed.</td>
</tr>
<tr>
<td><strong>Re-Triggering:</strong></td>
<td>I keep having flashbacks. I wish they would stop.</td>
</tr>
<tr>
<td><strong>Denial:</strong></td>
<td>Wasn’t it “just” a rape?</td>
</tr>
<tr>
<td><strong>Fear:</strong></td>
<td>I’m afraid of so many things. Will I get pregnant or get VD? Am I safe? Can people tell what’s happened to me? Will I ever want to be intimate again? Will I ever get over this? I’m afraid I’m going crazy. I have nightmares that terrify me.</td>
</tr>
<tr>
<td><strong>Anxiety:</strong></td>
<td>I’m a nervous wreck! I have trouble breathing. (Anxiety is often expressed in physical symptoms, like difficulty breathing or muscle tension, sleep disturbances, change in eating habits, nausea, stomach problems, nightmares, bed-wetting.)</td>
</tr>
<tr>
<td><strong>Anger:</strong></td>
<td>I want to KILL him!</td>
</tr>
</tbody>
</table>
TOUCH CONTINUUM

<table>
<thead>
<tr>
<th>Lack of Touch (good)</th>
<th>Nurturing Touch</th>
<th>Confusing Touch</th>
<th>Exploitative Touch</th>
<th>Lack of Touch (bad)</th>
</tr>
</thead>
</table>

The Touch Continuum
Is the range of touch – from lack of touch, to nurturing touch, to confusing touch, to exploitative touch.

Lack of Touch
can be good or bad. If a person does not get any touching, yet needs and wants it, this lack of touch can be bad. If a person simply does not want to be touched, that is an individual right. In this case, lack of touch can be good.

Nurturing Touch
is positive and good touch. A touch that feels like something is being given or shared with you. Hugs, kisses and some games are examples of good touch.

Confusing Touch
is any touch that is not clearly good or bad. Either good or bad touch may become confusing. Therefore, confusing touches can’t be labeled. Any touch may become confusing when:

• we are not sure what the person means by it.
• the person is saying something that does not fit with the way he or she is touching us (we are getting a double message).
• we are not used to the touch or the touch doesn’t fit in with our values or we simply do not want to be touched.
• the touch gets equated with sex.

Exploitative Touch
is tricked or forced touch – a touch that feels painful or as if something were being taken away from you or as if you were being used. Kicks, hits, slaps and sexual abuse are types of exploitive touch. Even simple touches or games like wrestling or tickling may become bad or confusing touch if someone is hurt or forced.

(Adapted from The Child Sexual Abuse Prevention Project: An Educational Program for Children by Cordelia Kent, Minneapolis, Minnesota, 1979)
Touching is important. It can make you feel warm, loved and comfortable.

There are different kinds of touches: ok touches, not ok touches and confusing touches. You can tell what kind of touch a touch is by the way it makes you feel.

It’s ok to say “no” if someone wants to touch you in a way that makes you feel bad or confused. Your body belongs to you, so you get to decide who touches you and when.

We all have parts of our bodies that are private. Our swimming suits cover the private parts it’s not okay for just anybody to look at or touch.

Bigger people should always know better than to touch little people in a way that’s not ok.

If anyone touches you or makes you touch them in a way you don’t like, it’s ok to tell someone. If the first person you tell can’t help you, it’s ok to tell someone else.

It’s always ok to get your questions answered about touching.

For more information, to get your questions answered or to schedule an OK/Not OK Touches Workshop for your group or organization, call:

**Planned Parenthood of Mid Central Illinois**
Education Department
318 W. Washington Street
Bloomington, IL 61701
(309) 827-4368
What is sexual abuse?

Sexual abuse is forced, tricked or manipulated touch or sexual contact, although sexual abuse can occur without touch – obscene phone calls or exposing one’s sexual organs are examples. Sexual abuse can also include breaking down barriers to privacy; for instance, exposing children to information or activities that are inappropriate for their age or understanding level.

Myths about child sexual abuse abound. For instance, most children are warned not to talk to strangers but, in fact, 85 percent of all cases of child sexual abuse involve someone familiar to the child, usually a family member or someone the child knows well. Myths, obviously, do not give young people the information they need to protect them from sexual abuse.

<table>
<thead>
<tr>
<th>Myth</th>
<th>Fact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incest usually happens only once.</td>
<td>It usually occurs over and over. The average length of an incestuous relationship is two to three years.</td>
</tr>
<tr>
<td>Child sexual abuse happens “out of the blue.”</td>
<td>The relationship is used to gain special favours. Sexual abuse usually builds up over a period of time, progressing from fondling to other types of sexual contact. It may never include intercourse.</td>
</tr>
<tr>
<td>It’s rare.</td>
<td>One in four girls and one in eight boys, according to reported cases, will be sexually abused in some way before age 18.</td>
</tr>
<tr>
<td>Offenders are usually under the influence of alcohol.</td>
<td>Less than one-third of cases involve alcohol.</td>
</tr>
<tr>
<td>Child sexual abuse almost always involves violent attack.</td>
<td>Coercion, tricking and manipulation are most common, not extreme force.</td>
</tr>
<tr>
<td>Offenders are poor and uneducated.</td>
<td>Offenders can be anyone.</td>
</tr>
<tr>
<td>Victims are seductive and “ask for it.”</td>
<td>No one asks to be abused. No matter how seductive a child may have learned to act, it’s always the older person’s responsibility to see that there is no sexual contact.</td>
</tr>
</tbody>
</table>
What can be done to prevent sexual abuse?
Four ideas are useful when talking about sexual abuse with children: privacy, touching, asserting boundaries and support systems.

Privacy
• Your body is your own.
• You have a right to have things you don’t have to share.
• There are public and private body parts. Your private parts are the parts usually covered by underwear: penis, anus, vulva, breasts and buttocks or other places that feel sensitive or off limits to others.
• No one should look at or touch your private parts in a way that makes you uncomfortable.

Touching
• People touch each other in many ways. Touching is one way that people communicate and show they want to be close.
• You have the right to decide who touches your body and how.
• There are three kinds of touching: good, bad and confusing. Good touching is pleasant and warm, like a hug. Bad touching hurts or is a touch you don’t like. And some touching is confusing. Tickling or wrestling, for instance, might be confusing because it could start out OK but change so that you feel powerless.
• You can trust your feelings about touching and decide what is good for you. If you wonder whether a touch is OK or not, ask an adult you trust. If someone threatens you or wants you to keep a secret about touching – tell!

Asserting boundaries
• Assert your boundaries: say no to confusing or unwanted touch or to someone getting closer than is comfortable.
• Sometimes people with more power, knowledge and skill than you may try to trick you or trap you into doing something you don’t want to do.
• If someone touches you in a way you don’t like or that is confusing, tell that person firmly, “No.” Take action.
• Use protection skills: be aware of your environment, trust your feelings and assert your boundaries.

Support systems
• You have a support system made up of your family, friends and community members. They can help you if you have a problem.
• Sometimes you may need help caring for yourself. There are times you may need help, for instance, to wash your hair, to get dirt out of your eye, to help your sore throat get better or to see if you have cavities in your teeth. Some examples of helpers are your parents, your doctor, a babysitter, a relative or a friend.

If someone touches you in a way that makes you feel bad or confused, tell a trusted adult: your mom or dad, grandparents, a friend’s mother, the school nurse, your teacher, the police. Keep telling until someone believes you and helps you. It is not your fault if sexual abuse happens to you.

(Adapted from a publication of the Parent Education Program of Planned Parenthood of New York City)
CHILDREN ARE EMPOWERED WHEN THEY…

1. know the correct names of the body parts including the genitals.

2. understand what sexual abuse is:
   - an adult touching a sexual part of the body.
   - someone touching them in ways that make them feel uncomfortable
   - someone touching them and saying “This is secret.”

3. understand about GOOD – CONFUSING – BAD touch.

4. have a family secret word (for identifying a stranger sent by the parent).

5. trust their feelings including the “uh oh” feeling that signals something is wrong.

6. know they have the right to say NO, even to an adult.

7. practice decision-making:
   - Who would you tell?
   - What would you do if…?

Adults help empower children when they:

1. warn children about sexual abuse in the same manner they give other survival information; e.g., auto dangers.

2. answer children’s questions about sex simply and honestly; checking the meaning of the child’s question by asking “What do you think?”

3. teach the correct names for all body parts, including the sex organs.

4. explain exactly what they mean by abuse: “Don’t let anyone put their hands down your pants.”
   - Shared secret: secret place, time or activity.
   - Special friend.
   - Bribes: especially effective with children who need rewards and approval.
   - Threats: of loss of affection, money or reputation.
   - Use of force: relatively rare.

5. keep communication open, listen to the child, repeat prevention information, and encourage the child to report situations that are uncomfortable or difficult.

6. teach the difference between a “secret” that is never told and a “surprise” that is most fun when it is told!

7. develop the child’s self-esteem by listening to the child and by respecting the child’s feelings.
DEFINITIONS OF SEXUAL ABUSE

Sexual abuse defined at an adult level:
Forced, tricked or manipulated touch or sexual contact: rape, incest, molestation, fondling, sodomy. There is also sexual abuse without touch such as obscene phone calls, exposing, pornography and sexual harassment. Other forms of abuse are breaking down barriers of privacy (as when young people are permitted to watch intercourse or other adult sexual activities) and exposing a person to sexually stimulating information that is inappropriate for his or her age or level of understanding.

Sexual abuse defined at the elementary/middle school level:
Another person touching different parts of your body or having you touch different parts of theirs when you don’t want to. You are forced into it or tricked into it or your feelings about the touch are confused or mixed up.
- It may or may not mean you or the other person has your/his clothes off.
- It is different from stealing or robbing.
- The other person may be someone whom you don’t know at all, whom you know a little or whom you know very well.

Sexual abuse defined at the junior/senior high levels or above:
A person being forced into sexual intimacy (touching or non-touching) that she or he does not want to be involved in.
- It is not just rape. It includes a variety of sex acts: child molestation, incest, pressured or manipulated sex or date rape, sodomy, same sex assault.
- It includes flashing or exposing.
- It includes using power, knowledge and experience to manipulate or exploit another person for sexual gratification.

(Adapted from principles in Cordelia Kent’s Child Sexual Abuse Prevention Project: An Educational Program for Children, Minnesota, 1979.)
SEXUAL ABUSE INDICATORS

**Victim-behavioural:**
- Mood/behaviour often depressed
- Low self-esteem
- Secretiveness
- Lack of participation in school, outside activities
- Suspicious (especially of men), lack of trust
- Lonely, isolated, poor peer relationships
- Detailed and age-inappropriate understanding of sexual behaviour
- Sudden drop in school performance, inability to concentrate
- Seductive behaviour, promiscuity
- Flat affect – passive or overly compliant behaviour
- Psychosomatic complaints (stomach aches, headaches)
- Bedwetting, soiling
- Altered sleeping patterns
- Pseudo-mature behaviour
- Arriving early at school, leaving late
- Running away from home
- Substance abuse
- Suicide attempts
- Refusal to dress for physical education classes
- Acting-out behaviours (aggressive)

**Victim – physical:**
- Genital itching, vaginal infections, discharge
- VD
- Pregnancy
- Genital laceration, abrasion, bleeding
- Painful urination, defecation
- Sores, lesions in mouth, sore throats
- Bruises, fractures
Family dynamics – father /daughter incest:

- Blurring of generational lines
  - Father takes “child” position
  - Mother takes “child” position
  - Daughter takes role of “mother” and “wife,” excessive responsibility

- Father acts as suitor

- Father jealous of daughter’s interaction with peers, dating, overprotective

- Family socially isolated

- Father often alone with daughter

- Siblings jealous of “chosen” daughter, may act out

- Daughter hostile towards mother

- Family may be “blended” (step-parent, paramour, adopted)

- Family may severely overreact to child’s receiving any sex education information in school setting

- Family/father may be under stress (job dissatisfaction, laid off, poor relationship with wife, drinking, lack of money, illness, death, etc.)
Parents and educators are the people who spend the most time with children and can be a positive influence in their lives.

It is important for both parents and teachers to watch for signs of sexual abuse in children with whom they have contact. While no one thing can let you know for sure if a child is being abused, there are some things you can be alert to. Abused children are likely to have at least several of the following characteristics:

- Excessive need for affection. Attention seeking behaviour.
- Depression. The child’s mood is generally unhappy.
- Poor self-esteem. This may be exhibited by isolation and withdrawal or self-destructive behaviour in older children.
- Avoidance of home. Coming to school early or leaving late. Running away from home.
- Wariness of physical contact with adults.
- Excessive curiosity about sexual matters. Precocious sexual behaviour or compulsive masturbation.
- Physical problems such as: genital infections, soreness, venereal disease, abrasions, stomach aches, bleeding or discharge, painful urination.
- Regressive behaviour in small children: bedwetting, soiling, altered sleep patterns, nightmares and hyperactivity.

If sexual abuse is discovered, it may be very difficult for a parent to believe his or her child is being abused, especially if the offender is a family member. It is important that the child is believed. Children do not lie about sexual abuse. The child must receive support from family and medical treatment.

Although sensitive information is important, education is the best tool for prevention. Children need to know:

- how to talk about their bodies (teach them proper names for their private areas).
- they have a right to their own bodies.
- there are people who may try to touch them or encourage mutual touching.
- they have a right to say “no” or “stop.”
- they can talk to a trusted adult about the problem.

Adults must learn to be sensitive to children, believe children and respond if there is any indication of incest or sexual abuse. Abusers must be educated to recognize their problem and learn where to find help. The community needs to develop support systems to deal with the problem and encourage education and open discussion about child sexual abuse.
SECTION 7

Topic: Family Planning Issues

CONTENTS

Teaching about Family Planning
Traditional Methods of Fertility Control
Benefits of Family Planning
Men’s Role in Family Planning
Methods of Family Planning (Picture of Sterilization)
The Contraceptive Process
Consequences of Early Childbearing
Pregnancy, Childbirth and Parenting
The Importance of Medical Care During Pregnancy, Childbirth
Myth or Fact
Attitude Survey
Questions to Ask When Choosing a Method of Family Planning
Why People Use Family Planning Methods
TEACHING ABOUT FAMILY PLANNING

When presenting a session on family planning, it is important to bear in mind the fact that a session leader does not and cannot know which of those listening, if any, is sexually active.

Do not make assumptions about young people’s sexual activity and do not let yourself unconsciously imply that your listeners are or might soon be sexually active. Young people are already dealing with pressure of that kind from a variety of sources – media, peers, etc.

You may want to preface the session by explicitly saying that you don’t assume your listeners to be sexually active – you are simply providing information that everyone ought to have. They may not need this information now but at some point in the future they will.
TRADITIONAL METHODS OF FERTILITY CONTROL

Definition
The following are locally and culturally accepted medicinal plants, substances and practices used by communities to regulate fertility. They do not include modern methods of contraception.

Three Concepts of Traditional Methods of Family Planning
1. Traditional practices have been used throughout history and are still in use today, despite the availability of modern contraception. This suggests that historically, people have used many methods to control their fertility.

2. As a provider of community-based family planning services, one must be aware that clients may be using a traditional practice for fertility regulation. The use of these methods makes it evident that people believe in the ability to regulate their fertility and that they have seen a benefit in doing so for quite some time.

3. The rapid rate of modernization, urbanization and other social changes experienced in many countries makes it difficult to determine how common the use of traditional methods of fertility control is. Community-based family planning providers working in urban areas will probably see fewer individuals who actively use traditional methods. On the other hand, health workers in rural settings are more likely to be providing services to women who frequently use traditional means to regulate their fertility.
Two Categories of Traditional Methods of Family Planning

1. Use of local plants and substances.
   a. Oil from seeds; e.g., a plant known as Buchholzia macrophylla is said to have an oestrogen effect.
   b. Some plants are prepared as tea or rubbed on the breast such as pounded leaves of Hibiscus or Mpoz.

2. Behaviour patterns or practices that affect fertility.
   a. Post partum abstinence associated with lactation is one of the more important contraceptive practices used by many cultures. It is believed by many groups that exposure to semen during sexual intercourse will pollute a mother’s breast milk. Hence, breast-feeding has had a contraceptive effect primarily before the return of menses.
   b. Post partum abstinence until after the return of the first menses. In some cultures, abstinence is practiced until after the return of the first menses. If the menses is delayed, this acts as a form of contraception.
   c. In some cultures, when a child is born, the husband may go away to work or the wife may go home. By the time the husband or wife returns, the child is one year or older and the mother is ready for the next pregnancy.
   d. The woman wears a medicated rope around her waist that has beads or knots on it. The number of beads or knots signifies how many years she will wait before having another child.
   e. Infanticide: some cultures kill newborns as a means of fertility control.
   f. Many cultures equate readiness for intercourse with a specific age. When the child reaches the required age (age depends on the culture), the child is taken to the “mat” or bed where the act of intercourse will take place. Abstinence until this time acts as a contraceptive method.
g. Some cultures encourage families to practice coitus interruptus, coitus interpura (between the skin) and/or coitus interfemora (between the thighs) as a narrow method to reduce the likelihood of conception.

h. Polygamy has also been important as a traditional means of controlling fertility. Polygamy can reinforce the effects of post-partum abstinence by providing the husband with another sexual partner or outlet, thereby, decreasing the chances that abstinence will be violated and sexual relations resumed prematurely. Nevertheless, polygamy cannot be encouraged because of AIDS and rapid population growth.

i. In some areas, women are supposed to abstain indefinitely from intercourse as soon as they are grandmothers.

Three Advantages to Traditional Methods of Family Planning
1. No side effects related to oestrogen or progesterone
2. Cheap or inexpensive since no need for couple to be trained
3. Acceptable to people who do not believe in “artificial” contraception

Two Disadvantages to Traditional Methods of Family Planning
1. Not reliable (significantly less effective than modern methods)
2. May produce marital strains (couple denied sex when it is wanted)

Note: Facilitator should point out that although these methods are used by some communities, they should also point out that they are not always reliable.
The health and welfare of women and children represent a big invest-
ment in the health system of a country. Since these two groups represent
three-quarters of the total population of a developing country, we will be
focusing on them as we discuss the benefits of family planning.

Family planning improves the health of women by enabling them to have
children when they are between 20 to 29 years of age, the period of
minimal risks. It allows them to have children when they want, allows for
adequate spacing of children, and having the number of them that the
parents desire and feel they can afford. Family planning improves
children’s health, too, because they are born to mothers who have
planned a reasonable interval between children. When mothers have had
time to recover from the strain of the previous pregnancy, childbirth and
breast-feeding, children are better cared for and receive more attention.

Women’s Health and Family Planning
Complications of pregnancy and childbirth are still an important cause of
maternal mortality and morbidity in less developed countries. These
complications are most likely to occur when:

• women are younger than 18 or older than 35.
• women have more than four children.
• women have children too closely spaced.

Pregnancies among Adolescents
Although young girls who become pregnant and have children run
numerous risks, early childbearing is apparently on the increase
worldwide. In 1975, 25 % of those who became mothers (some 16
million) had not completed their own physical and emotional
development. Risks are still higher if a teenage mother has a second or
third birth.

Adolescent pregnancies are even more numerous than births, many
resulting in illegal abortions. In some developing countries, up to 60% of
gynaecological admissions in hospitals are related to incomplete and
septic abortions. In countries where abortions are legal, teenage
abortions tax the system heavily.
Why Are Very Young Women Becoming Pregnant?
In many societies, early marriage and childbearing give status to women. In some very poor societies; e.g., Bangladesh, very young girls are married to be protected against men.

Social norms are changing in various countries: some girls leave their families to go to school in the cities, others leave the rural areas to work in the cities and they may be sexually abused.

Ignorance about sex and its consequences still prevails and is sometimes a factor in accidental pregnancies among teenagers.

The Risks of Pregnancy among Adolescents Include:

Physical: related to abortions
related to lack of prenatal care (if pregnancy unwanted)
related to complications during labour and delivery (haemorrhage, premature birth, caesarean section, etc.)
related to short intervals between births

Educational: limitation of educational opportunities

Social: limitation of chances of adequate employment and means of support
risk of illegitimate pregnancies
risk of battered child

Pregnancies among Women 35 Years of Age and Older
Older women have higher risks of complications during pregnancy and delivery and of congenital malformations of the foetus. In less developed countries, the older a woman is, the more chance she has to be a grand multipara.

However, the absolute size of these risks is closely related to social and environmental factors and the access to professional health care. For example, a 42-year-old Swedish woman expecting her first child faces less risks than a 25-year-old woman expecting her fifth child in a rural area where there are no maternity care facilities and no qualified health personnel.
Pregnancies among Women Who Have More Than Three Children

Studies have demonstrated that multiparity (four or more children) carries increased risks of maternal mortality and obstetrical complications: placenta previa, abruptio placenta, malpresentation of the foetus, haemorrhage, anaemia, toxaemia, rupture of uterus, etc.

The range of risks includes:

Physical: related to unwanted pregnancies
related to obstetrical complications
related to nutritional deficiencies

Emotional: psychological exhaustion and depression
less emotional and psychological support for each child

Socio-economic: fewer opportunities for appropriate employment - economic poverty
dependence on others to be fed and cared for

Pregnancies among Women Who Have Children Closely Spaced

Pregnancy is a period of intense stress, depleting women’s physical and emotional resources. The interval between pregnancies is a period of adjustment and rebuilding of these resources.

The “birth interval” is the period between the birth of a child and the beginning of the next pregnancy. Intervals that are too short are believed to be health risks for the mother and children. A study conducted in the Punjab in India has shown that infants born less than two years after the previous child are 50% more likely to die than children born three to four years after the previous child. When the interval is less than 12 months, there is an even higher risk of stillbirth, prematurity, neonatal mortality and complications at delivery.

Food and the Foetus

Nutrition in pregnancy is most important, not only for foetal growth, but for the mother to develop reserves in preparation for the lactation process. Inadequate nutrition affects several of the important physiological processes of early pregnancy – the normal increases in maternal blood volume and uterine blood flow and the development of the placenta. Poor maternal nutrition may also affect the foetus. It is important to know that the development of deep fat sites within the
mother will take place even at the expense of foetal growth. Deep fat is essential for the mother to be able to lactate after the birth of her baby.

**Conclusion**
Effective family planning can favourably influence the healthy development and well being of families and their individual members in the following ways:

- Family planning makes possible the planning of family size, enabling couples to have the number of children best for them in terms of health, socio-economic position and life goals. There are several objectives for this:
  - to lower prenatal and infant mortality
  - to improve the physical, mental and intellectual development of the children in the family
  - to secure the health of the mother
  - to enhance family health and marital adjustment
- Family planning makes possible the planning of birth intervals in order to optimise maternal and child health and development.
- Family planning allows women to have children at the ages at which pregnancy carries the least risks and offers the best chances for a successful outcome.
- Family planning makes it possible for couples to avoid unwanted births and for women to avoid abortions.
- Family planning makes it possible for couples with hereditary diseases to receive genetic counselling.
- Family planning helps reduce childhood mortality, which will in turn enhance acceptance of family planning.
MEN’S ROLE IN FAMILY PLANNING

For family planning to be effective, there is a need for both men and women to be involved in the process. Family planning efforts often fail because of a lack of cooperation between spouses/partners.

As much as men realise the importance of family planning, most of them wrongly assume that family planning is solely a woman’s problem and that they don’t have a role. Responsible husbands/partners, however, should recognise the important role they can play in successful family planning.

Let us now examine these roles.

**Advisory Role** If a woman does not seem knowledgeable about family planning and its benefits, her husband/partner should take the initiative and bring the subject up. Men should be encouraged to take the lead when their partner does not and to become knowledgeable about the various methods of family planning.

**Supportive Role** Once the couple has agreed that they want to use family planning, they should both participate in deciding which method to use. The effectiveness of family planning is increased when both the man and the woman are involved in choosing a method that suits them both.

Women will sometimes experience side effects or other problems associated with certain methods of family planning. It is important for the man to continue to be supportive, encouraging her not to give up but to seek medical advice.

Certain family planning methods require following instructions carefully for them to be effective. Again, it is the duty of the husband/partner to help the woman follow through on all the instructions carefully and consistently.

**Decision Making Role** There are opportunities today for women to learn and discuss family planning with other women. Men should encourage their partners/wives to seek out these opportunities.

In most cases, a husband’s/partner’s consent is necessary for a woman to be sterilised. Therefore, men should be prepared to talk over this option with their wives/partners.

To sum it up, in order for family planning to be effective, men should be willing to play an active role.

TEMPORARY METHODS

FERTILITY AWARENESS
Also known as “rhythm” or “natural child spacing” or the “safe period,” a system by which a woman can monitor her own fertility, identifying the days in each cycle when an egg is likely to be around and time sex accordingly. It involves keeping records of the dates she menstruates, day-to-day changes in cervical mucous and/or body temperature, mid-cycle cramps if she gets them – whatever physical clues can help her pinpoint the time of egg release. It also requires training by expert teachers and a high level of motivation.

Advantages: No need to do anything about birth control at time of having sex. No supplies necessary after initial investment in instruction course, record keeping forms and special thermometer.

Disadvantages: Women have to keep records for several months before they can rely on the method for protection. There may be a variety of situations when calculations can be thrown off – the woman catches a cold that makes her run a fever or picks up a vaginal infection that affects her cervical mucous. Careful users may need to abstain from sex for as much as two weeks of every cycle.

Success Rate: Of 100 women using these methods for one year, about 24 will become pregnant.

WITHDRAWAL
Otherwise known as “being careful” and “getting out in time,” the man withdraws the penis from the vagina just before orgasm, so that the full ejaculate of semen and sperm is not delivered into the vagina or anywhere near it.

Advantages: No supplies or equipment necessary.

Disadvantages: Withdrawal at the right moment requires a cool head, perfect timing and self-control on the part of both partners. And some semen and sperm are released into the vagina even before ejaculation.

Success Rate: Of 100 women using withdrawal for a year, about 18 will become pregnant. (From *Contraceptive Technology 1988-89*, by Robert A. Hatcher, M.D., et al.)
CONDOM
A sheath of rubber or animal membrane that fits over the penis like a second skin. It catches and holds the semen released in ejaculation, so no sperm can get into the vagina (and from there to the uterus and Fallopian tubes). Most rubber condoms are coated with lubricants. Some brands add nonoxynol 9 to this coating, an ingredient that kills sperm (and many germs as well).

Advantages: One size fits all. Inexpensive and widely available. Protection against sexually transmitted diseases as well as pregnancy. (Condoms made of rubber also help protect against the HIV virus that causes AIDS.)

Disadvantages: Must be used every time a couple has sex. Some men feel it takes too much of the edge off their physical sensations during sex.

Success Rate: Of 100 women who use condoms, between 11 and 14 will become pregnant. Success rates are higher if vaginal contraceptive is used at the same time.

NON-PRESCRIPTION VAGINAL METHODS (foam, cream, gel, suppositories, sponge)
Assorted products containing a sperm-killing ingredient, usually nonoxynol 9. All need to be put into the vagina before a woman has sex. Positioned correctly, covering the opening to the uterus, they provide both a physical and chemical roadblock to sperm.

Advantages: Easy to use. Widely available. Products containing nonoxynol 9 seem to provide some protection against sexually transmitted diseases (including the AIDS virus) as well as pregnancy. Sponge can be inserted ahead of time and provides 24 hours of protection.

Disadvantages: Must be used every time. All types, except sponge, provide short, lasting protection (only about 30 minutes). Some users find them messy or irritating.

Success Rate: Of 100 women who use the sponge for a year, about 18 will become pregnant. Of 100 women who use other vaginal contraceptives for a year, about 20 will become pregnant. Success rates are higher if a condom is used at the same time.

DIAPHRAGM
A shallow cup of thin rubber stretched over a flexible ring, used with a sperm-killing cream or gel. Before sex (minutes or hours), it is inserted in the vagina where it fits exactly, blocking the entrance to the uterus. A doctor must prescribe the right size.

Advantages: Cannot be felt by either partner if inserted correctly. If it is put in ahead of time, using it need not interrupt lovemaking. May provide some protection against sexually transmitted diseases.
Disadvantages: Must be used every time a couple has sex. Women who feel uncomfortable about touching the sexual parts of their bodies may not like using it.

Success Rate: Of 100 women who use a diaphragm for one year, 18 will become pregnant.

**INTRAUTERINE DEVICE (IUD)**
A little piece of soft plastic, usually with a tiny nylon tail thread or threads attached to it. It is placed in a woman’s uterus by a physician or specially trained nurse and left there for as long as the woman wants protection against pregnancy. IUDs come in assorted shapes, sizes and types including some that have copper or hormones added. Most widely accepted explanation for IUD effectiveness is that it irritates the uterine lining slightly, so lining is unable to accept implantation of fertilised egg.

Advantages: Long-lasting continuous protection. Nothing to do at time of having sex. Very little to do at any other time, a woman just has to check regularly that the IUD is in place by feeling for the tail threads in her vagina.

Disadvantages: Not every uterus adjusts happily to an IUD; it may be expelled or cause more discomfort than a woman cares to live with. IUD users are also apt to get pelvic infections which, if overlooked and untreated, can cause permanent infertility or even death. And if a woman becomes pregnant accidentally, there’s a greater chance the pregnancy will be ectopic – outside the uterus, requiring emergency surgery and reducing future fertility.

Success Rate: Of 100 women who use a diaphragm for one year, about 4 will become pregnant.

**THE PILL**
A packaged series of pills containing manufactured oestrogen and progesterone, hormones normally produced by a woman’s own body. Taking one pill every 24 hours keeps the body’s hormone level steady which turns off ovulation. The ovaries do not release eggs as long as the woman sticks to her pill-taking schedule.

Advantages: Continuous protection. Easy to use. Lighter, less painful, more regular periods.

Disadvantages: Some women find the daily pill-taking schedule a nuisance. Some women notice side effects, though they’re usually mild and temporary. A very, very few woman run into serious trouble. The possible risks are high blood pressure, gall bladder problems, circulatory problems (blood clots, heart attack, stroke), liver tumours. Women most at risk are smokers and those over 35.

Success Rate: Of 100 women who use the pill for one year, fewer than 3 will become pregnant.
THE INJECTION (DEPO-PROVERA)
Every three months, a doctor or specially trained nurse injects a woman with a measured amount of a product containing a manufactured form of a single hormone, progesterone. Primarily, this works in the same way the pill does; the hormone slowly seeps into the blood stream from the site of the injection and turns off ovulation.

Advantages: Continuous protection. Mistake-proof and effort-free except for visits to the doctor or clinic every three months. Since it contains no oestrogen, it causes none of the oestrogen-related side effects produced by the pill.

Disadvantages: Periods are light and irregular; many woman stop menstruating altogether. This has no effect on physical health but can be psychologically troubling. Any side effects a woman may have cannot be reversed until the body has used up the injected amount of the hormone injection. Users may run a slightly higher risk of developing certain forms of cancer and some have had problems becoming pregnant when they wanted to after stopping the method.

Success Rate: Of 100 women using Depo-Provera for one year, fewer than 1 will become pregnant. (From Contraceptive Technology 1988-89, by Robert A. Hatcher, M.D. et al.)

THE IMPLANT
A set of tiny silicon rubber tubes, each containing a manufactured form of a single hormone, progesterone. They are implanted by a doctor or specially trained nurse just under the skin on the inside of a woman’s upper arm. The tubes, which are a little over an inch long, are invisible after insertion. A finger touching the area can detect them under the skin; except for that, the woman should be unaware of their presence. The progesterone, if left in place, is diffused into the bloodstream through the walls of the tubes at a very low rate over an effective period of five years. This small but steady seepage works in three ways. It stops ovulation in about half of all cycles and it keeps cervical mucous too thick for sperm to penetrate, even in cycles when an egg might be present.

Advantages: Long-lasting continuous protection. Mistake-proof and virtually attention free, yet easily reversible as implant just has to be removed.

Disadvantages: Irregular bleeding and spotting are common, especially in first three months after insertion. Evidence so far suggests that risk of serious trouble is very small but the method is still relatively new.

Success Rate: Of 100 women using implants for one year, fewer than 1 will become pregnant. (From Contraceptive Technology 1988-89, by Robert A. Hatcher, M.D. et al.)
PERMANENT METHODS

VASECTOMY
A minor operation for men usually done in a doctor’s office or clinic under a local anaesthetic. It involves cutting and tying off the tubes through which sperm must travel to enter the semen released during intercourse. Afterward, sperm cells are simply absorbed by the body, as other cells are, and since the operation does not affect hormone production, it has no effect on masculinity or sexual desire.

Advantages: It should mean no more worry about pregnancy again, ever.

Disadvantages: Once done, the operation can rarely be undone. A man must be sure that no matter what, he will never want to have children in the future.

Success Rate: Virtually 100%.

TUBAL LIGATION
An operation for women in which the Fallopian tubes are cut and tied off so no egg can reach the uterus or be reached by sperm. Some techniques for doing this require a woman to be hospitalised. With new methods – the simplest is called mini-laparotomy – the surgery can be done in a specially equipped clinic and the woman can go home in a few hours afterward. She will continue to ovulate but her body will simply absorb the egg cells; and since the operation does not affect hormone production, it has no effect on femininity or sexual desire.

Advantages: It should mean no more worry about pregnancy, ever.

Disadvantages: Once done, the operation can rarely be undone. A woman must be absolutely sure that no matter what, she will never want to have children in the future.

Success Rate: Virtually 100%.
Methods of Sterilisation

Vasectomy

Cut and Tied Fallopian tubes

Tubal Ligation
THE CONTRACEPTIVE PROCESS

Using contraception is not a natural process. It has to be learned and a number of psychological and behavioural events must take place before contraceptive vigilance is attained.

1. A person must decide to be sexually active (often not a conscious decision) and she or he must acknowledge to herself or himself that she or he is sexually active.

2. The person must recognise the possibility of pregnancy and the implications this would have for himself/herself and for others.

3. The person must think about, talk about and plan to use a method of preventing pregnancy.

4. The person must obtain a contraceptive method for personal use.

5. The person must use the method properly and regularly.

Many people, especially teenagers, have not reached the point where they can conceptualise all these tasks and implications and then carry them out.
CONSEQUENCES OF EARLY CHILDBEARING

Although adolescent fertility has received little attention from family planning professionals in most developing countries, the incidence of births to very young women – both married and unmarried – is growing and the trend appears to be universal. Each year, approximately 13 million children – one of every ten children – are born to females who themselves are little more than children. The percentage of live births to mothers under the age of 20 varies greatly among countries, ranging from 20 percent in some African and Caribbean countries, to 10 to 15 percent in much of Latin America, to 5 to 10 percent in Asia and 1 percent in Japan. The problem is as acute in many industrialised countries as in the developing world.

The reasons for increased out-of-wedlock adolescent pregnancy are diverse and complex. In much of the world, better childhood health and nutrition have resulted in earlier sexual maturity. Many of today’s youth are physically capable of reproduction at a younger age than their parents were. At the same time, the age of marriage is increasing. Unmarried young people now spend several years together in school and in the labour force, exposed to the risk of unwanted, premarital pregnancy for more years than previous generations.

In developing countries an additional factor, rapid urbanization, acts to diminish the traditional mechanisms which deter premarital sexual activity. Traditional family structures are weakened as individual family members attempt to adapt to the strains of continually accelerating urbanisation. Restrictive community and social controls are also rendered less effective as urban lifestyles permit teenagers ever-increasing mobility and personal freedom. Cultural restrictions such as chaperone and sexual segregation for young people, for example, may no longer be practical or even possible. But these newly emancipated young people are particularly vulnerable to urban dangers and disadvantages: high unemployment, housing shortages, overcrowding, drug and alcohol abuse, violence, etc. And their mobility and freedom, which give them increased opportunity for sexual contacts, also render them more vulnerable to sexual exploitation.

For young women, the possibility of pregnancy is an additional threat. Early childbirth, regardless of marital status, is especially dangerous for adolescents and their infants. Moreover, the consequences of adolescent childbearing are life-long and affect the entire community as well as the individuals involved.

The first concern for the pregnant adolescent is that of health. The risks of death and disease are far greater for pregnant women under the age of 20 than for those between 20 and 35 (the risk increases again after the age of 35). The younger the woman, the greater the risk of bleeding during the first and/or third trimester of pregnancy, toxaemia, haemorrhage, prolonged and difficult labour, severe anaemia, disability and death.
Lifelong Disadvantages

The young mother may suffer life-long social and economic problems as well. If she is ostracised for having borne a child out of wedlock, she may have little choice but to turn to prostitution to earn enough money to care for herself and her child and this may in turn lead to additional pregnancies. The large number of women in this situation ensures adverse social and financial consequences for the entire community. In many industrialised countries, the growing number of teenage births has resulted in serious public welfare problems.

If the young mother is fortunate enough to be cared for by her family or by the father of the child, her life will nonetheless reflect the disadvantages of her early pregnancy. Her education will have been interrupted, perhaps permanently, her career opportunities will be severely limited and, if the father of her child does not marry her, her opportunities for marriage will also be limited. Her future may be one of frequent unemployment, low social status, marital instability, a greater number of children than she can adequately take care of and a level of poverty worse than she might otherwise have experienced.

Her child will, of course, suffer these disadvantages with her. Like her, the infant’s most immediate problem will be that of health. Babies born to adolescent mothers experience a higher incidence of prematurity, low birth weight and nutritional deficiency than babies born to women in their twenties. The Pan American Health Organization has found in Latin America that low birth weight is the most important cause of neonatal and infant death. Low birth weight in children of very young mothers is also associated with birth injuries, serious childhood illnesses and mental and physical handicaps such as epilepsy, retardation, blindness and deafness.

Although out-of-wedlock births are common and socially acceptable in many areas, out-of-wedlock children in most countries face social and legal discrimination and economic hardship. In some areas, the extended family or community may care for out-of-wedlock children. However, in urban areas, adolescent mothers may resort to prostitution and child neglect and abandonment is common.

Early childbearing is also associated with a high number of pregnancies, large completed family size and short birth intervals. The subsequent children of young mothers suffer additionally from the hazards of close spacing, as the mother’s health and nutritional status does not have time to recover from the previous pregnancy. Foetal death rates increase dramatically after the mother’s second and third pregnancies. In England and Wales, where infant death rate has decreased, the rate still rises sharply among high birth order children. This holds true at all socio-economic levels.

Access to Family Planning Methods Limited

Those adolescents who are or could be, motivated to practice family planning are hindered by limited access to family planning information and services. In both developed and developing countries, social and cultural pressures and legal restrictions make it difficult for sexually active young people to avoid pregnancy.
In developing countries, family planning programmes are oriented toward older couples with children. They may make information or services available to young married couples but most exclude unmarried adolescents altogether. In addition to their emphasis on couples who have approached or completed their desired family size, many programmes operate under national laws or local customs that do not permit minors to give consent for their own medical care, regardless of their marital status. In this case, family planning methods may not be prescribed for young women or young women may be required to obtain their husband's or parents' consent.

In developed countries, the trend among family planning programmes has been to allow adolescents greater access to medical methods of family planning and to abortion services. French law, for example, eliminated parental consent requirements for family planning methods in 1974 and the United States did so two years later. Although there have been several initiatives in this direction in developing countries, law and custom remain restrictive.

Unwanted pregnancies resulting from failure to use family planning methods have led to increasing numbers of abortions among young women. In much of the world, despite the fact that young and/or unmarried women are often denied access to legal abortion services (or, as with family planning methods, are required to obtain their husbands' or parents' permission), both the number and proportion of abortions performed for young women has been increasing. Abortion is often more traumatic physically for adolescents than for older women since it usually takes them longer to recognise and admit the symptoms of pregnancy and then to seek help. Whether out of ignorance or fear, adolescents have a tendency to request abortion services later in pregnancy than older women, thus requiring more complicated and potentially more dangerous abortion procedures.

It is estimated that by the turn of the century there will be approximately one billion adolescents in the developing world – people who are physically old enough to reproduce themselves but far too young to be the responsible, healthy parents of healthy children. Since the effects of adolescent childbearing are felt by society as well as by the families directly affected, governments must become involved in the issues surrounding this complex and sensitive area. Both custom and law must change to reflect the needs of young people.

In addition, family planning programmes must expand their orientation to take into account young people who wish to postpone first births. This will require not only increased services and counselling but an education programme as well, so that adolescents can be made aware that family planning help is available to them. The savings in lives and health of both mothers and their children can be tremendous.

(From Consequences of Early Childbearing by Anameli Monroy de Velasco, Director, Centro de Orientacion para Adolescentes. Mexico, in Draper Fund Report, 11:26-27, December 1982)
Why people have children

Many factors contribute to the desire to have a child: unconscious needs, one’s personal beliefs and values, social customs, practical considerations. All these factors are constantly changing in force under the influence of social and cultural norms and values.

There is no proof that there is a universal instinct to produce children. (An instinct is an inborn trait that exists at birth. An example is the newborn infant’s instinct to suck.)

Some common motives for having children are:

• to experience the biological reproductive process: fertilisation, pregnancy, labour, delivery, nursing.
• to produce someone like oneself.
• to create a unique human being.
• to prove one’s masculinity or femininity.
• to live on in the future through one’s children.
• to create a family.

Some social and cultural reasons for having children are:

• pressure from family, friends and society to conform.
• to make one’s parents into grandparents.
• to feel more needed and important in the home.
• to have children to care for one in old age.
• to carry on religious traditions.

Some psychological motives for having children are:

• to overcome feelings of loneliness and alienation.
• to attain independence from one’s own family.
• to make the child an extension of oneself.
• to gain companionship, entertainment and stimulation from children.
• to make up for one’s own unhappy childhood by being a good parent to one’s child.
• to relive a happy childhood by providing a similar experience for one’s own child.
• to get back at parents by showing one can do a better job as parent than they did.
• to fulfil needs for interdependency, needing and being needed.
• to try to strengthen or enhance a marriage.
• to replace a loved one.
Demands of parenthood

Parenthood is a demanding full-time job that involves tremendous commitment and responsibility. Legally, parents are responsible for their children until the children reach the age of 18.

This responsibility involves economic as well as psychological demands.

The decision to have children is irrevocable and has a profound effect on the rest of the parents' lives.

The parent-child relationship is intensely intimate in a unique way. Some parents find this dependency too intense, even burdensome at times. Others find the closeness thrilling and growth enhancing. Babies need attention and care 24 hours a day. This can be overwhelming for new mothers and fathers, especially during the first year. New parents need nurturance and support for themselves to replenish the energy that goes into nurturing the baby. As the baby grows, the parent-child relationship becomes more reciprocal. But while physical demands lessen, the child's need for emotional support and unconditional love continues throughout life.

The parents' relationship automatically changes when a baby is born. Many new parents become so involved in meeting the baby's needs that they neglect giving each other much-needed support and nurturance. Fathers sometimes feel left out and jealous of the baby's demands on the mother's attention. Mothers may be so depleted themselves that they have no energy left for their partners. These problems can be eased by setting aside special times to be together and by constantly sharing new feelings and doubts with each other. Sharing the experience of producing and raising children can be enriching and growth-enhancing. Most often, parenthood brings a combination of difficulties and joys to a relationship.

Single parents encounter additional demands in raising children. The need for support and affirmation are equally strong for single parents. Single parents rely more on friends and family to fill these needs. Some single parents seek from their children the support and affirmation that is usually found in the marriage relationship. This is frustrating for the parent and dangerous for the child.

Some people find single parenting easier. If the parents' relationship is shaky, the conflicts around child raising can be severe. A single parent can raise a child according to her/his personal philosophy without having to compromise.

All in all, there are many factors to consider in deciding to have a child. Some people consciously decide and plan to have a baby. Some people conceive offspring accidentally. Some decide to continue the pregnancy.

Others feel that they are not ready or willing to make the lifelong commitment of parenthood and elect to terminate the pregnancy by abortion. Some choose to carry the pregnancy to term but to put the baby up for adoption. Still others find themselves unable to decide and resign themselves to fate. Sometimes this works out but too often it leads to resentment against the child.

(From a publication of the U.S. Department of Health and Human Services)
Many times when we talk about pregnancy and childbirth we also talk about the concept of risk. This is because during pregnancy and childbirth there can be unexpected occurrences that seriously affect either the mother or the child's health. There are many deaths associated with pregnancy and childbirth; a fact that men, women, boys and girls should understand.

RISK FACTORS ASSOCIATED WITH PREGNANCY AND CHILDBIRTH

A. Physical and psychological immaturity
The first pregnancy, especially if occurring before the age of 18, can be physically and psychologically traumatic for the body because it is a new and stressful process.

B. Caesarean section
Sometimes normal vaginal childbirth is not possible which makes it necessary for the baby to be removed from the mother's womb surgically.

C. Difficult delivery
Women born with a small pelvic girdle are more likely to have difficulties during childbirth. Malformation of the pelvic girdle may be hereditary, caused by poor nutrition or a hormonal imbalance.

D. Previous complications
There are many potential complications that affect childbirth: ectopic pregnancy, retained or delayed placenta, pelvic inflammatory disease, high blood pressure, anaemia, too little or too much weight gain or a sexually transmitted disease.

REASONS FOR ATTENDING AN ANTENATAL CLINIC

The most important reason for attending an antenatal clinic is to reduce the risk factors associated with pregnancy and childbirth. The initial visit to the clinic should be made within the first three months of pregnancy. The following are additional reasons for expectant mothers to visit the antenatal clinic:

- To have a trained health worker checking the progress of the pregnancy
- Check and monitor mother’s blood pressure
- Get malaria tablets and two injections for tetanus
- Get counselling about breast feeding and care of newborn
- Talk to a counsellor about family planning
- The health worker can reduce the risk of infections and recognize signs of potential complications
WHO SHOULD ATTEND ANTENATAL CLINICS?
There is a tendency to believe that it is only mothers-to-be who should go to the antenatal clinics. However, the services are for both mothers and fathers-to-be. A good example is if the expectant mother has been diagnosed with a sexually transmitted disease, the father should also receive treatment and counselling. Since men play an important role in procreation, the antenatal clinic would help them play an equally important role in pregnancy and childbirth. Men should also receive information about family planning methods, so they can learn how to delay the onset of the next pregnancy.

WARNING SIGNS DURING PREGNANCY, LABOUR AND AFTER DELIVERY
It is important that women and their families know the warning signs of potential complications so that they will not delay getting the proper care and treatment.

Warning signs during pregnancy:
• Bleeding with or without pain
• Convulsions
• Passing fluid that is not urine (amniotic fluid)
• Swollen hands, face and feet
• Failing to gain weight (6 kg during pregnancy)
• Paleness of inside eyelids (should be red or pink)
• Severe headaches (sign of high blood pressure), severe vomiting
• High fever

Warning signs during labour:
• Prolonged labour (12 – 18 hours)
• Too much bleeding
• Placenta does not discharge within 30 minutes of childbirth
• The bag of water (amniotic sac) breaks but labour does not start within 24 hours

Warning Signs After Delivery
• Excessive bleeding
• Convulsions (fits or fainting)
• Fever, chills and abnormal discharge

THE NEED FOR BLOOD DONORS IN AN EMERGENCY
We have seen that some of the warning signs during pregnancy and childbirth include anaemia and excessive blood loss. These conditions necessitate a blood transfusion in order to prevent further complications. Most hospitals maintain a blood bank but currently there is a shortage due to an increased demand. This problem has been compounded by the advent of AIDS and the fear of receiving donated blood.

THE BEST POSSIBLE SOLUTION
The best possible solution lies in educating all family members about the importance of having blood donors in case of an emergency during childbirth. Family members should be encouraged to accompany the expectant mother to the clinic or hospital so that when the need arises, they can donate blood. Family members are more likely to have a compatible blood type and will also find it easier to help a family member.
MYTH OR FACT

Would you believe….

…the longer a man’s middle finger, the longer his penis?
…if a woman douches right after sex, she can’t get pregnant?
…a girl can’t use tampons until she’s had sex?
…nice people don’t get sexually transmitted diseases?
…if a woman’s breast milk gets to her son’s penis, he will be sterile?
…during a woman’s period, she should stay in bed, avoid exercise and refrain from sex?
…an IUD can float through a woman’s body after it’s been inserted?
…if a woman uses a diaphragm, her partner will feel it?
…the amount of sexual satisfaction depends on the size of the penis?
…the pill can cause cancer?
…drinking a salt solution can prevent pregnancy?
…if you want a boy, you should have sex a lot?
…if you want twins, you should have sex sideways?
…an IUD will give a woman infections?
…a woman can’t get pregnant when she’s menstruating?
…if a woman does get pregnant when she’s menstruating, the baby will be an albino?
…if a woman has an IUD inserted, her sexual partner will feel the IUD strings?
…if a woman has sex while she’s pregnant, the baby will have a broken leg or arm or be otherwise deformed?
…if a woman has sex during her ninth month of pregnancy, she will give birth to an albino baby?
…if a pregnant woman has been unfaithful, she will have a difficult labour and delivery?
…a woman who is breast-feeding can’t get pregnant?
…menstruating women are unclean?
…the wider the woman’s mouth, the larger her vagina?
…if a pregnant woman sees anything frightening or ugly, she will give birth to a monster?
…you can contract STDs from dirty toilet seats or dirty towels?
Would you believe….

...if the umbilical cord of a baby is improperly disposed of, the baby will be sterile when he or she grows up?

...if a woman has sex standing up, she can't get pregnant?

...if a woman has sex in a river or stream, she can't get pregnant?

...a change in a woman's menstrual cycle is caused by infidelity?

...if a woman doesn't menstruate, she's ill?

...when a woman doesn't menstruate, bad blood accumulates in her womb?

...having sex cures period pains?

...having a baby cures period pains?

...if a girl washes her hair, goes bathing or sits on anything cold while she's menstruating, she will catch a cold?

...a girl can't conceive until after she starts menstruating?

...conception occurs when there is simultaneous orgasm?

...a baby is formed by the semen (starch) from a man's body?

...birthmarks are caused by a woman's drinking hot liquids when she's pregnant?

...breast milk inside a baby's ears can cause an ear discharge or deafness?

...the pill will rot a woman's internal organs?

...a condom can get lost inside and rot a woman's internal organs?

...syphilis is an advanced stage or complication of gonorrhoea?

...if you have gonorrhoea and are cured, you have a lifelong immunity?

...the colour of the line beneath the pregnant woman's navel determines the sex of the child?

...if an infant is buried in a dry place, the mother will not be able to have any more children?

...if a pregnant woman sits in a doorway during pregnancy, her delivery will be extremely difficult?

...if a pregnant woman's friends or relatives say good-bye when leaving, the baby will not come until those same relatives have returned?

...when a woman conceives and her husband leaves home, the baby will not develop properly without the continuing services (the ejaculate/semen) of the father?
# ATTITUDE SURVEY

Instructions: This is a survey of attitudes, not a test. There are no “right” answers. Please read each statement carefully and decide if you either strongly agree, agree, are neutral, have mixed feelings, disagree, or strongly disagree. Circle the appropriate number at the right of the statement.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Neutral</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
QUESTIONS TO ASK WHEN CHOOSING A METHOD OF FAMILY PLANNING

When you’re considering a method of family planning, ask yourself these questions. Every “yes” response is a sign of discomfort or uncertainty about the method that might make for problems in using it and lower its effectiveness.

- Am I afraid of using this method of family planning?
- Would I really rather not use this method?
- Will I have trouble remembering to use this method?
- Have I ever become pregnant while using this method?
- Are there reasons why I cannot use this method as prescribed?
- Do I still have unanswered questions about this method?
- Did someone close to me strongly urge me not to use this method?
- Will this method make my periods longer or more painful?
- Will prolonged use of this method cost more than I can afford?
- Is this method known to have serious complications?
- Am I opposed to this method because of religious beliefs?
- Have I already experienced complications from this method?
- Has a nurse or doctor already told me not to use this method?
- Is my partner opposed to using this method?
- Am I using this method without my partner’s knowledge?
- Will the use of this method embarrass me?
- Will the use of this method embarrass my partner?
- Will my partner or I enjoy sex less because of this method?
- Will this method interrupt lovemaking?

Most people will have several “yes” responses, indicating some chance of problems for people using almost any method of family planning. This is understandable since it isn’t easy to use cost methods and no method is without potential side effects or complications. But people can use methods effectively, in spite of negative factors, if their desire to avoid pregnancy is strong.

(Adapted from Contraceptive Technology 1984-1985 by Robert A. Hatcher, M.D., et al.)
WHY PEOPLE USE FAMILY PLANNING METHODS

Broadly, reasons for using family planning methods can be philosophical, social/cultural (on a personal or societal level), economic or educational.

Some specific reasons why people use family planning methods:
• To promote the quality of human life, theirs in particular.
• To improve their living conditions.
• To prevent unwanted pregnancies.
• To reduce the possibility of needing an abortion.
• To improve the health of women and children in particular.
• To be more responsible parents who are better able to provide food, clothing and education for their children.
• To conform to societal norms; for example, the woman is going to college.
• To wait until the woman is the “right age” to have children.
• To take advantage of improved family planning methods now available.
• To be free to go out without many children being along as well.
• To be able to know all your children, to have time to be with them.
• Older women may want to use birth control because they already have many children.
• Improved health education and communication make people aware of family planning.
• People are more knowledgeable about family planning methods.
• Men are interested in having fewer children so they have more money.
• Migration often means there is no extended family nearby to help raise a large family.
• People brought up in large families may not want their children to repeat that experience.
• There is less help to be found: girls go to school and are not available to work.
• Small apartments in the city do not allow for many children.

Some reasons why people do not use family planning methods:
• To have many children for help with farming.
• To have children to look after the parents when the parents get older.
• To have sons because they are important and prestigious. One keeps having children until sons are born.
• To win recognition by having children, especially among friends or wives of the same man.
• To ensure against being left childless. Because of the high levels of infant mortality, one cannot guarantee that all babies will live.
• To be “macho” – to prove that a man is virile.
• To show that a man is rich and can afford many children. To show that a woman is still young and fertile; her husband will leave her if she stops having children.
• It is “God’s will” to have many children.
• People are afraid of family planning.
• Negative attitudes toward family planning providers scare off or offend potential users.
• There are few or no family planning services in the area.
SECTION 8

Topic: Self-Esteem, Decision-Making, Values Clarification

CONTENTS

Positive Based Self-Esteem
Self-Esteem Exercise
My Declaration of Self-Esteem
Self-Esteem and Decision-Making Values List Questionnaire
What Should I Know about Making Up My Mind
Seven Value Indicators
Issues We Face in Real Life
Decision Making Model
Questions You May Ask Yourself about Dating
Sexual Decisions
The Perfect Mate
Hints for Better Communication about Sex (and other matters…)
How Well Do You Know Your Partner?
Differences between Love and Infatuation
The Different Kinds of Love
Values Clarification
Values Questionnaire
Values Clarification Exercise: Forced Choice
People Say…(Attitude Survey)
Values Clarification: Earthquake Exercise
Chief Executive Game
Values Clarification: A Moral Dilemma (Group Exercise)
Tips for Living (SCORE) Handout
SELF-ESTEEM MODEL

Self-Esteem Model

There is a theory that says that the following four conditions must be present for an individual to have high self-esteem:

1. Uniqueness – an individual must feel that he or she is special.
2. Connectedness – an individual must feel as though he belongs to some one or to some thing.
3. Power – an individual must feel empowered.
4. Model – an individual must have a role model to emulate.

It is important to note that just because a person has high self-esteem that does not automatically mean that he has positive based self-esteem. For example, a drug dealer, pimp or murderer can have high self-esteem but it is certainly not positively based.

Positive Based Self-Esteem edifies the physical, emotional and spiritual development of an individual and is evident in the behaviour and character of that individual.
SELF-ESTEEM EXERCISE

Write your name in the centre of the star and complete the statements.

A successful decision I have made lately...

Two things I've accomplished that I am proud of....

Two goals for the future...

Two qualities or traits I bring to a friendship...

Two people I admire...

Three positive words to describe myself...
MY DECLARATION OF SELF-ESTEEM

I am me.

In all the world, there is no one exactly like me. There are persons who have some parts like me but no one adds up exactly like me. Therefore, everything that comes out of me is authentically mine because I alone chose it.

I own everything about me – my body, including everything it does; my mind, including all its thoughts and ideas; my eyes, including all the images they behold; my feelings, whatever they may be – anger, joy, frustration, love, disappointment, excitement; my mouth and all of the words that come out of it, polite, sweet or rough, correct or incorrect; my voice, loud or soft; and all of my actions, whether they be to others or to myself.

I own my fantasies, my dreams, my hopes, my fears.

I own all of my triumphs and successes, all of my failures and mistakes.

Because I own all of me, I can become intimately acquainted with me. By doing so, I can love me and be friendly with me in all my parts. I can then make it possible for all of me to work in my best interests.

I know there are aspects about myself that puzzle me and other aspects that I do not know. But as long as I am friendly and loving to myself, I can courageously and hopefully look for the solutions to the puzzles and for ways to find out more about me.

However I look and sound, whatever I say or do, and whatever I think or feel at a given moment in time is me. This is authentic and represents where I am at that moment in time.

When I review later how I looked and sounded, what I said and did and how I thought and felt, some parts may turn out to be unfitting. I can discard that which is unfitting and keep that which proved fitting and invent something new for that which I discarded.

I can see, hear, feel, think, say and do. I have the tools to survive, to be close to others, to be productive and to make the most sense and order out of the world of people and things outside of me.

I own me and therefore I can engineer me.

I am me and I am okay.
# SELF-ESTEEM AND DECISION-MAKING: VALUES LIST QUESTIONNAIRE

Read the following statements. Put a check mark in one column or the other to show whether you feel the behaviour described in the statement is all right or not all right. When the statement contains two options (for example, daughter/son) circle the one for whom you feel the behaviour is all right and “X” out the one for whom it’s not.

<table>
<thead>
<tr>
<th>All right</th>
<th>Not all right</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Children playing doctor.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Mother kissing daughter/son on the lips.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Father kissing daughter/son on the lips.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Parent(s) hitting child for disciplinary purposes.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Show of affection between parents or caretakers in front of the children.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Husband hitting wife during a verbal fight.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Wife hitting husband during a verbal fight.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Family snuggling together to watch a video.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Teacher hugging student.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Teacher physically disciplining student.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Female friends hugging/kissing to show affection.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Male friends hugging/kissing to show affection.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Passionate kissing in public.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Fondling or petting on the first date.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Potentially damaging physical contact for athletic or competitive purposes.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Physical bullying among friends.</td>
<td></td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Massaging or rubbing another person for relaxation or pleasuring.</td>
<td></td>
</tr>
</tbody>
</table>

(Adapted from No Easy Answers, by Cordelia Kent)
**WHAT SHOULD I KNOW ABOUT MAKING UP MY MIND?**

Should I have sex or should I wait?

Some teens decide to go ahead. But remember, the results of this decision will fall on you. Ask yourself these questions before making up your mind:

- Can I take full responsibility for my actions?
- Am I willing to risk AIDS, sexually transmitted diseases, pregnancy, future infertility, or placing my child for adoption?
- Can I handle being a single parent? Am I ready and able to support a child on my own?
- Can I handle the guilt and conflict I may feel?
- Will my decision hurt others – my parents, my friends?

Decisions about sex may be the most important decisions you’ll ever make. So think before you act.

Here’s a checklist that may help you decide what is best:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is having sex in agreement with my own moral values?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Would my parents approve of my having sex now?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>If I have a child, am I responsible enough to provide for his/her emotional and financial support?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>If the relationship breaks up, will I be glad I had sex with this person?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Am I sure no one is pushing me into having sex?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Does my partner want to have sex now?</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

*If any of your answers is no, then you’d better wait.*

(Adapted from a publication of the U.S. Department of Health and Human Services, Office of Population Affairs.)
SEVEN VALUE INDICATORS

EXPRESSIONS, STATEMENTS OR ACTIONS THAT TELL SOMETHING ABOUT VALUES

ATTITUDES  (also beliefs, opinions, convictions, views)
Clue words:  The way I see it…    In my opinion…
             I believe…          Our choice is…
             I’m for…           I’m against…
             I’m convinced…

ASPIRATIONS  (long-range goals, dreams, remote yet realizable)
Clue words:  Someday I’d like…    In the future…
             In ten years I…    When I grow up…
             One of these days… When I retire…

PURPOSE  (short-range goals or objectives, achievable within a year)
Clue words:  This Christmas I…
             Next (specified time) I…
             By the end of (specified time) I’m going to…
             We’re thinking about doing…

INTEREST  (passing whims, things we spend spare time, money, energy on)
Clue words:  If I had (whatever) I would give…
             I really enjoy reading about…
             I’d like to know more about…
             Nothing makes me feel better than…
             My hobby, a…

ACTIVITIES  (how we spend our time; can be a part of other indicators)
Clue words:  I spend the most time on…    Another thing I do is…
             Most of my energy is expended on…

FEELING  (sense and emotions)
Clue words:  I get most excited when…
             I get angry when…
             The thing that makes me depressed is…
             Nothing makes me feel better than…
             What hurts me is…

PROBLEMS, OBSTACLES, WORRIES
Clue words:  The biggest obstacle facing me is…
             The problem I have with that is…
             What worries me about that is…
ISSUES WE FACE IN REAL LIFE

What are our attitudes towards them?

abortion                     alcohol abuse
anal sex                    artificial insemination
bisexuality                  celibacy
cross-dressing (transvestism) domestic violence/abuse
exhibitionism                family planning
group sex                    heterosexuality
homosexuality                incest
intercourse                  lesbianism
masturbation                 oral sex
pornography                  premarital sex
prostitution                 rape
sado-masochism               seduction
separation and divorce       sexual abuse of children
sexual fantasies and dreams  sexually transmitted diseases
                           and AIDS
single parents               sterilisation
teenage pregnancy            transsexualism
vibrators (sex toys)         violence against women
voyeurism

Margaret Sanger Center International, Copyright 2001
This decision-making model provides a process people can use in solving problems or making decisions. It is applicable to most situations in life, including sexual situations.

**The Steps In the Process:**

**Define the problem.**
State exactly what the problem is or the situation about which a decision needs to be made.

**Consider all alternatives.**
List all the possible ways to resolve the problem, all the possible decisions that could be made. You may need to gather more facts or consult with others to be sure you haven’t overlooked any options.

**Consider the consequences of each alternative.**
List all the possible outcomes – positive and negative – for each alternative or each course of action that could be taken. Make sure you have correct and full information by this point.

**Consider family and personal values.**
Values include beliefs about how we should act or behave and the personal and family rules we live by and believe are important; for example, beliefs about honesty, loyalty or whether it’s all right to smoke or drink. Most of our values come from the training we receive at home. Other values come from our friends and society. Consider whether each alternative is consistent with your personal and family values.

**Consider the impact on other people.**
Our decisions affect many people who are important to us: parents, siblings, friends, others. Think about the effect of each alternative on these people.

**Choose one alternative.**
After carefully weighing each alternative, choose the one that seems most appropriate based on your knowledge, values, morals, religious upbringing, present and future goals and the effect of the decision on the people who matter to you.

**Implement the decision.**
Do what is necessary for the decision to be carried out as you want it to be. You may have to develop a step-by-step programme with a timetable to make sure things get done.

(Adapted from Family Life Education Programme Development Project)
QUESTIONS YOU MAY ASK YOURSELF ABOUT DATING

• Do I feel ready to date?
• Do I want to date now?
• What would I like to get out of dating?
• Whom would I like to date?
• What qualities would I like my dating partner to have?
• What qualities would I not like my dating partner to have?
• How old should a person be to date?
• Who should do the “asking out” for a date?
• If you date someone, do you have to love that person?
• If you date someone, do you need to be physically intimate or have sex?
• Who sets the limits of physical intimacy on a date?
• What positive changes do you think dating would bring for you personally?
• Do you think that everyone should have to date?
• How would you perceive a person who decides that he or she doesn’t want to date?
• What influences your choice of the qualities you seek in your ideal partner?
• Is there really such a thing as a “perfect” mate?
• How do you know if you would like to date a person?
• Should a person discuss his or her dating expectations with a potential partner before making a date?
• Should a couple discuss their feelings toward each other?
• What should be discussed before accepting a date with someone?
• How can a person discuss personal “ground rules” with a partner?
• Why is communication important between dating partners?
• Should parents set down rules about dating behaviour?
• What responsibilities should young people have for themselves in regard to dating?
• Why do boys date?
• Why do girls date?
• Do the sexes have different reasons for dating?
SEXUAL DECISIONS

The following are some questions to ask yourself before you have intercourse.

1. How do I feel about sexual intercourse? When do I think it would be right for me?

2. How does the other person feel? How do these feelings fit with my own?

3. What makes me feel I want to have intercourse right now? Is there any chance that I am pressuring or exploiting the other person? Could they be pressuring me?

4. What do I expect sexual intercourse to be like? What if it’s bad and I do not enjoy it? How would I feel about myself, about my partner, about my future partners or a wife?

5. How would my partner and I feel if others found out about our relationship?

6. Do I really trust my partner completely?

7. What if this turns into a strictly sexual relationship and that’s all we ever do? How would I feel then?

8. What extra strains might there be on the relationship once we have had intercourse?

9. How will I feel if we break up?

10. What will I do to prevent pregnancy? To prevent sexually transmitted diseases?

11. What would I do if a pregnancy results from having intercourse? How would my partner and I feel?

12. What would I do if you get a disease?

13. How would my family feel if they found out about my sexual relationship? How would I feel about their knowing?

If you cannot answer the above questions with confidence, you may not be ready for sexual intercourse. You are the only one who can make the decision – Make It Wisely!
THE PERFECT MATE

(AN EXERCISE)

Adolescents are rarely given the opportunity to list what things they feel are ideal in an eventual partner. This exercise will allow them to brainstorm and focus in on what is important to them.

If the group is large, divide it into small ones. Give each small group paper and pen to record a group list. Where applicable, divide the group into boys and girls.

**Ask each group to make two lists.**

Ask the girls in the group to list:

- 10 qualities, in order of importance, that are important to them in choosing male partners and why.
- 10 qualities, in order of importance, that they think would be important for a girl or woman to have, when a boy or man is choosing a partner.

Ask the boys in the group to list:

- 10 qualities, in order of importance, that are important to them in choosing female partners and why.
- 10 qualities, in order of importance, that they think would be important for a boy or man to have, when a girl or woman is choosing a partner.

**After about 10 minutes, bring all participants back together and ask them all to give in their lists.**

- How similar were the lists?
- What kinds of qualities were similar on the lists?
- What were the differences between the sexes in the order in which they ranked certain qualities?
HINTS FOR BETTER COMMUNICATION ABOUT SEX

(AND OTHER MATTERS)

• Plan what you want to say. Sort out your feelings and fears before you begin. You may want to think about a good opening statement and open question to begin the conversation.

• Decide when you want to bring up the subject. It may be easier when you’re not romantic and ready to make love.

• It’s okay and natural to feel uncomfortable. If you say you’re nervous, it may help both of you to relax.

• Keep your sense of humour. Yes, these topics are serious, but being able to laugh and joke may help you both feel more comfortable.

• Give your partner time to think about what you’ve said. Pay attention to your partner’s response.

• Remember that getting started is the hardest part. After that the conversation should get easier. Your partner will probably be relieved you brought it up.
HOW WELL DO YOU KNOW YOUR PARTNER?

- Does your partner believe in love at first sight?
- How many boyfriends has your partner had?
- If your partner won the lottery, what would be the first thing she would buy?
- Does your partner attend religious services?
- Does your partner attend the local family planning clinic?
- What item of clothing has your partner bought recently?
- Where was your partner born?
- Does your partner enjoy dancing?
- How often does your partner like to have sex?
- What does your partner think of condoms?
- What is the name of your partner’s best friend?
- What’s your partner’s favourite singer?
- How many children does your partner want to have?
- How does your partner feel about pre-marital sex?
- What age does your partner think is the best age to get married?
## DIFFERENCES BETWEEN LOVE AND INFATUATION

<table>
<thead>
<tr>
<th>Love</th>
<th>Infatuation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Love usually comes gradually as a boy and girl share many experiences together. They “grow” into it after many experiences together.</td>
<td>Infatuation comes suddenly after a date or two. The pair “falls” into it almost as soon as they meet.</td>
</tr>
<tr>
<td>True love is based on knowledge. It knows the reasons for its love. It involves the entire personality. (Shakespeare: “Love looks not with the eyes but with the mind.”)</td>
<td>Infatuation is narrowly based on a few attractive traits, mostly physical. It cannot give intelligent reasons for its love. It argues that “you cannot explain love.”</td>
</tr>
<tr>
<td>True love kindles kindly feelings toward others. It makes the lover happy and improves his disposition. (‘All the world loves a lover and a lover loves the world.’)</td>
<td>Infatuation often makes one morose; it damages disposition. One becomes self-centered, indifferent and disagreeable toward others who “do not understand.”</td>
</tr>
<tr>
<td>True love inspires work and honest effort; brings new energy, ambition and increased interest in life.</td>
<td>Infatuation destroys interest and application to work. It causes general inertia and discontent.</td>
</tr>
<tr>
<td>True love causes one to be proud of the loved one and eager to “introduce” him or her to others; both to other young people and adults.</td>
<td>Infatuation is often embarrassed about the relationship and secretive with parents, teachers, the clergy, etc.</td>
</tr>
<tr>
<td>True love says, “We want forever!” We can afford to wait! Nothing can happen to our love for each other.</td>
<td>Infatuation or passion says, “We have only tonight. Let’s live it up.” or “Let’s get married. Now.”</td>
</tr>
<tr>
<td>True love becomes tender and even pure. It ennobles the lover and the beloved.</td>
<td>Infatuation seeks self in sensual delights and often even in sexual pleasures. It often demeans the character.</td>
</tr>
<tr>
<td>True love is accompanied by a willingness to face reality and solve problems realistically after mature decisions.</td>
<td>Infatuation causes one to disregard problems, obstacles and barriers. “If we love each other, nothing else matters” is the attitude.</td>
</tr>
<tr>
<td>True love thinks of the other person. It desires to protect the beloved and to do things to make the loved one happy.</td>
<td>Infatuation tends to exploit the other party for personal pleasure, security or other selfish satisfaction.</td>
</tr>
<tr>
<td>True love is trustful, sure, calm, secure, hopeful and self-confident.</td>
<td>Infatuation is distrustful, insecure, jealous, “nervous,” and fearful.</td>
</tr>
<tr>
<td>In true love, its physical expression has tender meaning and comes slowly, naturally, sincerely and “creatively.”</td>
<td>In infatuation, physical contacts – common and ordinary – tend to be the end. The meaning is lacking. It’s “for fun,” for the “thrill” of the experience, for personal gratification.</td>
</tr>
<tr>
<td>True love tends to occur in late teens or after.</td>
<td>Infatuation tends to be more frequent among young adolescents.</td>
</tr>
</tbody>
</table>

(From *Working Papers for Human Development in the Family*, Cincinnati Public Schools, Division of Curriculum and Instruction, 1973)
**THE DIFFERENT KINDS OF LOVE**

- **Agape:** Platonic love, love of one’s fellow man, unselfish love between two people, love between friends
- **Filia:** The love between family members, the close affiliation and feeling of connectedness between parent and child
- **Eros:** Romantic love which may include sexual desire
- **Patriotic:** Love of one’s own country or culture
- **Spiritual:** Love of God or higher spiritual being

In addition to these categories, there are many overlapping types of feelings.

The first three types of love are often part of marriage, with each type taking precedence over the others at different stages during the marriage.

Infatuation – an intense “crush” on or desire for another person – is often mistaken for love.

Infatuation usually happens impulsively. It is for the moment, not long-lasting. Love is stable, enduring and becomes stronger as the relationship develops.
VALUES CLARIFICATION

Values are beliefs, principles and standards that we assign importance to. They are things we prize and give a degree of significance to.

Attitudes are mental views, opinions, dispositions, postures or behaviours.

When are values and attitudes formed? During childhood.

Where do we get our values and attitudes? From parents, family, society, culture, traditions, gender scripts, religion, peers, media (TV, music, video magazines, advertisements), school, cinemas, climate, environment, technology, politics, experiences, friends, personal needs, economics, etc.

What are some of the cultural factors involved? Language, life style, race, ethnicity, family, heritage, gender, socio-economic status, religion, moral belief systems, education, country, role models, urban or rural environments, etc.

Values Clarification means sorting out one’s own “real” (intrinsic) values from the (extrinsic) values of the outside world – separating one’s personal beliefs from the beliefs of others.

It means saying what we really mean. Too often we say things we don’t really mean. For example, if a five-year-old child asks his mother or father how babies get inside of the mother’s tummy, the usual response is to make up a story that’s untrue in an attempt to avoid giving the child information that the parent is uncomfortable with. Unfortunately, in these cases, the parents’ real values are not being shared with the child. We often cover up our true values by making up answers that make us feel comfortable.
VALUES QUESTIONNAIRE

None of us is born with a values system. Values are things we develop. Since everything we do is based on our beliefs, attitudes and values, it is helpful to check out what we value. These values may change, even as we change and grow and you may wish to make extra copies of this questionnaire to fill out in the future or plan to review this one a few years from now.

<table>
<thead>
<tr>
<th>Okay</th>
<th>Not Okay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Adapted from a publication of the Parent Education Programme of Planned Parenthood of New York City.)

Margaret Sanger Center International, Copyright 2001
FORCED CHOICE:
A VALUES CLARIFICATION EXERCISE

Instructions: Take three large pieces of paper and write “Agree” on one, “Disagree” on the second, “Unsure” on the third. Tape them to the wall. Ask participants to listen carefully to the statements below and respond to each statement by standing under the appropriate paper that reflects their choice.

1. Men who rape should be castrated.
2. There should be a mandatory curfew for young people.
3. There should be a mandatory national service for young people.
4. Parents should be held responsible for their children’s behaviour.
5. Child molestation is a private family matter.
6. Drugs should be legalized.
7. Prostitution should be legalized.
8. Boys should not be expelled from school if they make a young girl pregnant.
9. Using alcohol is not as serious as using drugs.
10. It doesn’t matter how you get money as long as you have it.
11. Oral sex and anal sex within the context of marriage is okay.
12. There should be a mandatory HIV/AIDS test for everyone.
13. Homosexuals are a menace to society.
14. A 15-year-old boy/girl should be able to get condoms without any difficulty.
15. There should be some kind of law against a man who fathers a child but does not take care of that child.
16. Men and women are equal.
17. On the whole, men are more intelligent than women.
18. Women cannot be raped by their husbands.
19. Women take marriage far more seriously than men.
20. Women should understand that men/women need extramarital affairs.
21. Sex before marriage is always wrong.
22. A man’s sexual drive and needs are greater than a woman’s.
23. Two children are enough for anybody.
24. Women encourage men to rape them.
25. A 15-year-old girl who wants birth control should be able to get it without any difficulty.
26. A woman should have the right to choose whether to have an abortion.
27. Having a baby will hold a marriage together.
28. Sex education in the schools will help young people make better decisions about their fertility.
29. I think we should make some people have sterilization operations.
30. Men make better leaders than women.
31. A male child is more important than a female child.
32. A husband should always have the last say.
33. Both husband and wife should share household chores, especially if they both work.
34. Men are more jealous than women.
35. Couples should have sexual intercourse before marriage to see if they are sexually compatible.
**PEOPLE SAY…**

**Instructions:** This is a survey of attitudes, not a test. There are no “right” answers. Please read each statement carefully and decide whether you strongly agree, agree, are neutral, have mixed feelings, disagree, or strongly disagree. Circle the appropriate number at the right of the statement.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Women who get their tubes tied still feel feminine afterward.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. A baby holds a marriage together.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. If a girl fools around and gets pregnant, it’s her fault.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Sex education in the schools will help young people be more responsible.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I think we should make some people have sterilisation operations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Taking child spacing pills makes a young girl more apt to be promiscuous.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. If a girl or woman wants an abortion, she should be able to get one legally.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. If I were a patient, I’d be embarrassed at how frankly things like child spacing are discussed at the clinic.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. A woman should be able to get her tubes tied only if she’s had a certain number of children.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Condoms reduce sexual satisfaction.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
VALUES CLARIFICATION: EARTHQUAKE EXERCISE

This exercise is for both small groups of five or six people and larger groups of up to 30. There is a time limit for decision-making by the group and there are rules to follow. We expect to find many different values among the members of the group.

The problem:
In the next 30 minutes we have to decide which 6 of the 10 people listed below will be saved from an earthquake. The six we save may be the only six people left to start the human race over again. Which would you choose? Don’t let yourself be swayed by pressure (which doesn’t mean never give in). Try to make the best possible choices. If you don’t make a choice, you are choosing to let all 10 fight it out with the risk that more than four might perish.

The cast of characters:
Fisherman, 31 years old
His wife, six months pregnant
Schoolteacher, male
Farmer, 42 years old, male
Folk singer, female
Banker, male, 37 years old
Minister of church, 54 years old
Doctor, female, 29 years old
College student, female
Policeman with gun (gun cannot be separated from him)

The rules of the game:
• Only one member of the group talks at a time.
• Use first names.
• Don’t talk about anyone outside the cast of characters.
• Each member of the group is free to speak or not to speak.
• Don’t pressure anyone into saying what he doesn’t want to say.
• Don’t attack anyone’s opinion.
• Don’t ask “Why?”
• But do invite people to tell how they feel about their choices. Be open to simply listening, not to caring. Don’t give advice.
• Address each person in the singular: “You and I…” “I feel…”
• Talk to, not about, people in the group.
• Pledge to be honest.
This game is designed to help us look at how and why we make decisions.

You are the leader of the country, sitting at the head of the table. You are about to make an extremely important decision.

Who is in your cabinet, your circle of special advisors? The people you sit nearer to are the people you think will have more influence over your decisions than those sitting farther away. Try to fill in the entire table. Who will you choose?
VALUES CLARIFICATION:
A MORAL DILEMMA

Read the story below and rank the five people in it. Number one is the person you like best, number five is the one you like least. Give reasons for your choices.

This story is about a young man named Peter, a young woman named Lisa, another young man, Noah, Lisa’s friend Rosemary, and another young man called Bob.

Peter and Lisa are engaged to be married. Peter is away, working in Florida. Lisa is still in school.

Lisa shares a class with Noah. She and Noah become friends. They sleep together. Lisa decides she doesn’t feel right about having intercourse with Noah and tells him they’ll have to stop. They do.

Some time passes. Noah tells Lisa he is driving to Florida. Lisa asks Noah to take her along so she can see Peter. Noah says, “Okay, but only if you go to bed with me again.”

Lisa is uncertain what to do. She talks to Rosemary about it. She and Rosemary are close friends. Rosemary says, “Do what you think is best.” Lisa decides to go to bed with Noah.

Meanwhile Peter has been having a casual sexual relationship with a woman in Florida. When Lisa gets to Florida, she feels obligated to tell Peter about her relationship with Noah. Peter breaks off the engagement, saying he can’t trust Lisa.

Lisa returns home. She meets Bob. She is upset and tells him all. Bob asks her to live with him.

Rank in order the five people you like best and explain why.

1. _____________________________________________________________
2. _____________________________________________________________
3. _____________________________________________________________
4. _____________________________________________________________
5. _____________________________________________________________
The way you set goals has a lot to do with success. Here are a few important points that can help you achieve a successful life:

SPECIFIC Have specific goals so that you will have something to work towards.

CHALLENGING Choose something that you will stay interested in.

ORGANIZED Know which goal to work on first, second and so on.

REALISTIC Be realistic so that you can reach your goals.

EVOLVING Be prepared so that you can change your plans if you need to.

SCORE! Have a successful life.