GIRLS' POWER INITIATIVE
(GPI) NIGERIA
"towards an empowered womanhood"

GIRLS' POWER INITIATIVE
(GPI) Nigeria

TRAINING MANUAL

LEVEL 2

Adolescent Sexuality, Sexual And Reproductive Health And Rights

Second

Edited

BENE E

GIRLS' POWER INITIATIVE (GPI) NIGERIA

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Level 2

ADOLESCENT SEXUALITY, SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

GENDER-BASED APPROACH ON HUMAN SEXUALITY TOWARDS AN EMPOWERED WOMANHOOD

Edited by
BENE MADUNAGU

Second Edition
2003.

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In 1998, we produced our first volume of the GPI Training Manual in our enthusiasm to share our experiences in sexuality education for adolescent girls in southern Nigeria. Since then, we have again learned so much in our interaction and experience -sharing with adolescent girls that we have amassed so much information that we wish again to document and present our experiences which may help people engaged in assisting adolescents to develop their talents and experience their sexuality positively.

It is not always possible to thank everyone who has made contributions to an achievement even though no contribution is too small to be acknowledged. Yet to do so here would take a volume of its own. I would, therefore, be compelled to mention those with direct involvement in the production of this volume, if indeed that is even possible.

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Girls' Power Initiative runs a three-year programme for each set of in-take. This means that there are three levels of curriculum. The present manual was put together by a team of facilitators in GPI South -South zone, Calabar. These women worked tirelessly at their own time, individually, in groups, and plenary sessions to put this volume together. I commend their maturity, patience and commitment for having to write and re-write to include comments and to respond to constructive criticisms that often followed their presentation of chapters assigned to them. Those women who constituted the Training Manual Review Committee (TMRC) were initially Bene E. Madunagu, Chairperson, with Eka Bassey, Assumpta Ekpenyong, Imoh Bernard, Ofonasaha Ekpoudom, Ndodeye Bassey and Enobong James as members. Victoria Edet was later invited to join the committee. From November 2002 after Ofonasaha was involved in a motor accident. Helen Kanu

was invited to join the committee. I sincerely thank all of these women for their hard work. I need to single out Ndodeye Bassey for her sense of duty as the secretary of the committee. She produced the minutes of all the committee meetings to guide the proceedings of this documentation. She also typed more than 80% of the manuscript. My appreciation also goes to Inyene Regan Emah and Violet Nwaneri for assisting Ndodeye in completing the typing of the manuscript. Other staff of the GPI South-South, Calabar Centre willingly assisted in seeking for literature in the library, files of lesson plans, providing snacks at our meetings and in photocopying documents required by the committee members.

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BENE E. MADUNAGU
AUGUST 2003.

FOREWORD

What if girls were to keep their psychological strength, courage and voice? What would the world be like if women said what they knew and said it with authority?

- E. Debold, M. Wilson & I. Malave, ***Mother-Daughter Revolution***

In many cultures, the passage from girlhood to womanhood is often difficult. Girls are expected to conform to stereotypical images of womanhood - being dependent, soft-spoken and submissive. These limited expectations of girls and young women are often passed on from one generation to the next without questions. Research in gender bias and developmental psychology reveals inequalities in educational practices towards boys and girls, as well as harmful behaviours such as under-achievement, depression and early parenting among adolescent girls. Researchers have also learned that girls and women have different needs, learning styles and cultural experiences than boys and men.

Knowing the challenges facing girls and understanding that girls are fundamentally different from boys raises many questions. What are girls' most pressing needs and how can we address them? What do girls need for healthy development? How can we create learning environments that support girls' needs? What strategies are effective in working with girls?

While the challenges facing girls in USA, Nigeria and around the world are great, I have equally great hope that these challenges can and will be met. I believe this because I had the great pleasure to learn about Girls' Power Initiative (GPI) and meet its founders, Bene Madunagu and Grace Osakue. Through my study of the GPI Training Manual and the many hours we spent together, I can see that GPI is filling a great need and making an obvious impact on the daily lives of girls in Nigeria. The GPI programme actively addresses the deeper structural needs and services. I believe, as others do, that GPI is poised to have an impact on the lives of many girls through adaptation of the programme to new sites and developing similar types of programmes using GPI principles.

The GPI Training Manual volume 2 reflects the courage, energy, wisdom

and hope of the founders, staff, girls and community partners who have been involved in the development of the GPI programme over the past eight years. It reveals the passion, commitment and dream of building a culture that can respect and celebrate the strengths and contributions of girls and women. The designers of GPI have developed a programme that combines teaching human sexuality, sexual and reproductive rights and health with personal empowerment skills to create a balanced and powerful model for addressing gender inequalities. Pairing the educational lessons with character-building skills gives girls the necessary judgement and decision-making tools to transfer what they learned to their own lives.

GPI gives girls opportunity to learn about their most pressing needs and then put those lessons into practice immediately. With GPI supporting them, girls in Nigeria have a chance to change their own lives and change the world around them.

As a practitioner in the USA, I also work to address the challenges facing girls by designing and implementing new programmes for girls. Over the past ten years, I have worked to find and implement strategies that create supportive learning environments where girls are taken seriously and can speak about what they know and build their natural talents. I was inspired by an 11th century definition of the word courage - *to speak one's mind by telling all one's heart* - used by a colleague, Dr Annie Rogers of the Harvard Graduate School of Education. When I think of modern definitions of courage, what comes to mind is an image of physical bravery or daring. The 11th century definition of courage says more about the courage it takes to speak of personal truths. A key component in the work I do with girls and women is to help them develop their courage - the ability to take risk to speak about what they know, regardless of the consequences. Speaking about our personal truth has been a powerful tool in developing our individual and collective voices for change.

As a faculty member of the Harvard Graduate School of Education, I guide teachers in designing girl-friendly classrooms and programmes. To meet the needs of girls in a classroom or programme, we start by identifying

the psychologically healthy girl. She is purposeful, adventurous, independent, self-directed, has the ability to think critically and take initiative. She might ride a bike, play football, read a book, or go to school. Most cultures have examples of girls in stories, books or the media that have these qualities. Some examples from the United States' culture are: Laura Ingles Wilder, a pioneer girl who wrote about her life in the book, *Little House on the Prairie;* Annie, from the Broadway play, "Little Orphan Annie", a story about an orphan who is unafraid despite the hardship in her life; and Pippi Longstocking, a character from a book of the same name, is a girl who is awkward in her body but smart and able to solve difficult problems. What stories are passed down about strong women and girls in Nigerian culture? What qualities do psychologically healthy girls in Nigerian culture have? Once you know their traits then you can support those qualities in the girls you teach.

In the ten years I have worked with girls, the most important lesson I have learned is that girls are not the problem. The problem is the oppressive culture in which girls live. If we can remember this we can avoid blaming girls for the challenges they face, and we can better support each other in our pursuit of equality. I invite you to use this manual, support the vision of GPI, and work to change the lives of girls all over Nigeria.

Courageously Yours,

JOAN STEMMERMANN
Founder and Executive Director,
The Centre for Ventures in Girls' Education
Faculty Member, Harvard Graduate School of Education

PREFACE

The programme on sexuality education has been identified by the Nigerian government as being crucial for the healthy development of Nigerian children. In 1998 for instance, 60% of all reported cases of HIV/AIDS came from the age group 15-24 years, who constitute more than 50% of the national population. Hence, the concept of Sexuality Education (SE) was accepted as critical to helping young people with the acquisition of adequate knowledge, skills and responsible attitudes in order to prevent and reduce sexually transmitted infections (STIs), including HIV/AIDS. Consequently, at the 46th session of the National Council on Education (NCE) in March 1999, approval was given for the incorporation of SE into the national school curriculum. - (National Sexuality Education Curriculum for upper primary school, junior secondary school, senior secondary school and tertiary institutions in Nigeria.

- Nigerian Educational Research and Development Council (NERDC), 2001.

Girls' Power Initiative (GPI) NIGERIA

Girls' Power Initiative (GPI) is a Nigerian non-governmental, not-for-profit, and non-sectarian organisation. The organisation was founded in 1993 by Bene E. Madunagu and Grace Osakue, to address the rise of HIV/AIDS in Nigeria and to address the issue of the growing need for a programme on sexuality education. At the heart of GPI are regular weekly lessons for adolescent girls, which started in July 1994. Girls' Power Initiative has since inception been involved in educating girls, aged 10-18 years about human sexuality, sexual and reproductive health and rights and responsibilities. GPI also operates many other activities designed to inform, educate and provide support services for girls, parents and community partners.

GOALS OF GPI

1. Assist the girls to achieve personal empowerment and to reject gender inequality;
2. Educate the girls to take actions to overcome risks to their health arising from gender violence and discrimination;
3. Build their leadership skills to overcome subservient roles and take on active engagement on equal basis with their male peers;
4. Sensitise them to take social actions and educate their peers on risky behaviours that are harmful to their health;
5. To provide information in order to assist them to struggle against harmful traditional practices so that they can claim their rights as human beings;
6. To provide information through participatory learning approach in order to impart life management skills and help them overcome gender stereotypes.

BACKGROUND AND GUIDING CONCEPTS

GPI acknowledges that:

- Adolescent girls carry extra burden of risks and gender violence with very few opportunities due to gender discrimination and the traditional practice of son-preference in the patriarchal society we live in.
- All adolescent girls, irrespective of their age, educational status (in or out of school), married or unmarried, with different ethnic and social background and class (poor or rich) with or without a child (children), etc, are vulnerable to gender-based violence.
- Most adolescent girls lack basic information about their sexuality, sexual and reproductive health and rights.
- Many adolescent girls are sexually exploited, a situation compounded by ignorance, poverty and socialization of servitude.
- Adolescent girls' development goes beyond basic health problems of malaria, cough, alimentary canal infection or poor water and sanitation-based ailments, into needs arising from their anatomy and physiology, particularly those related to secondary sex characteristics of pubertal changes.
- Sexuality, sexual and reproductive health problems of adolescent girls have common roots and are inter-related.
- Socio-economic, environment and religious injunctions have strong influence on behaviour of adolescents, particularly girls.
- Gender prejudices, discrimination, gender roles and gender inequality are fundamental to the issues of female enjoyment of their sexuality, sexual and reproductive health and rights of adolescent girls.

GUIDING PRINCIPLES

Adolescent girls should:

- Be able to remain free of diseases, disability or death associated with sexuality or sexual and reproductive health and rights.
- Have the right of access to comprehensive education and correct age-specific information on reproductive health, rights and responsibilities. This must be gender-sensitive, free from stereotypes and presented in an objective, non-judgemental, constructively critical and pluralistic manner. It must be secular in character with no religious underpinnings.
- Have the right to sufficient education and information to ensure that any decision they make relating to their sexual and reproductive life career and future status, marriage and child-bearing are made with full, free and informed consent.
- Have the right to be provided with full information about STDs, including HIV/AIDS and Pelvic Inflammatory Diseases (PIDs).
- Have the right to information about all methods of birth control and contraceptives.
- Sexually active teenagers should be provided with non-judgmental information, services and counselling on contraceptives, reproductive tract infections and complications from unsafe abortion.
- Girls have the right to live their lives free from violence. Every adolescent girl, irrespective of ethnic origin or tribe, religion or class has a right to information and services offered by GPI. The organisation must therefore of necessity and ideologically, remain a secular institution that is non-religious. This is a factor that cannot be compromised.

However, we hasten to add that GPI respects the rights of individuals to their personal religious values. All adolescent girls have the right to protection from rape, sexual assault, sexual abuse and sexual harassment. All adolescent girls have the right to be fully involved in all aspects of the development of their lives and that of their communities as leaders and as equal participants. True freedom and the exercise of these rights can only be achieved in a popular democratic and just society with gender justice, equality and equity.

KEY STRATEGIES IN GPI PROGRAMMES

- **Personal empowerment** - to build self-esteem, assertiveness, self-identity, positive body image and self-assurance in girls.

- **Life management skills** - to assist girls to build risk reduction skills, economic empowerment skills through information and education to develop communication and negotiation skills to encourage career choices, values clarification and goal-setting and for positive development.

- **Healthy interpersonal development** - to inform and educate girls on friendship, love, caring, gift-giving/taking, dating, fantasies, infatuation, intimate relationships, marriage, divorce and parenting.

- **Leadership skills** - to develop leadership skills in girls through information and education and goal-setting and vision, chairing of meetings and rapporteuring skills, public speaking skills, reading and writing skills, creative thinking and problem-solving as well as decision-making skills and personal responsibilities.

- **Sexual/reproductive health promotion** - preventing related problems of sexuality, sexual and reproductive health and rights through information and education on pubertal changes, human anatomy and physiology, sexual health, including early, unprotected and unwanted sexual activity, contraception, abortion, sexually transmitted diseases, including HIV/AIDS, infertility and cancers.

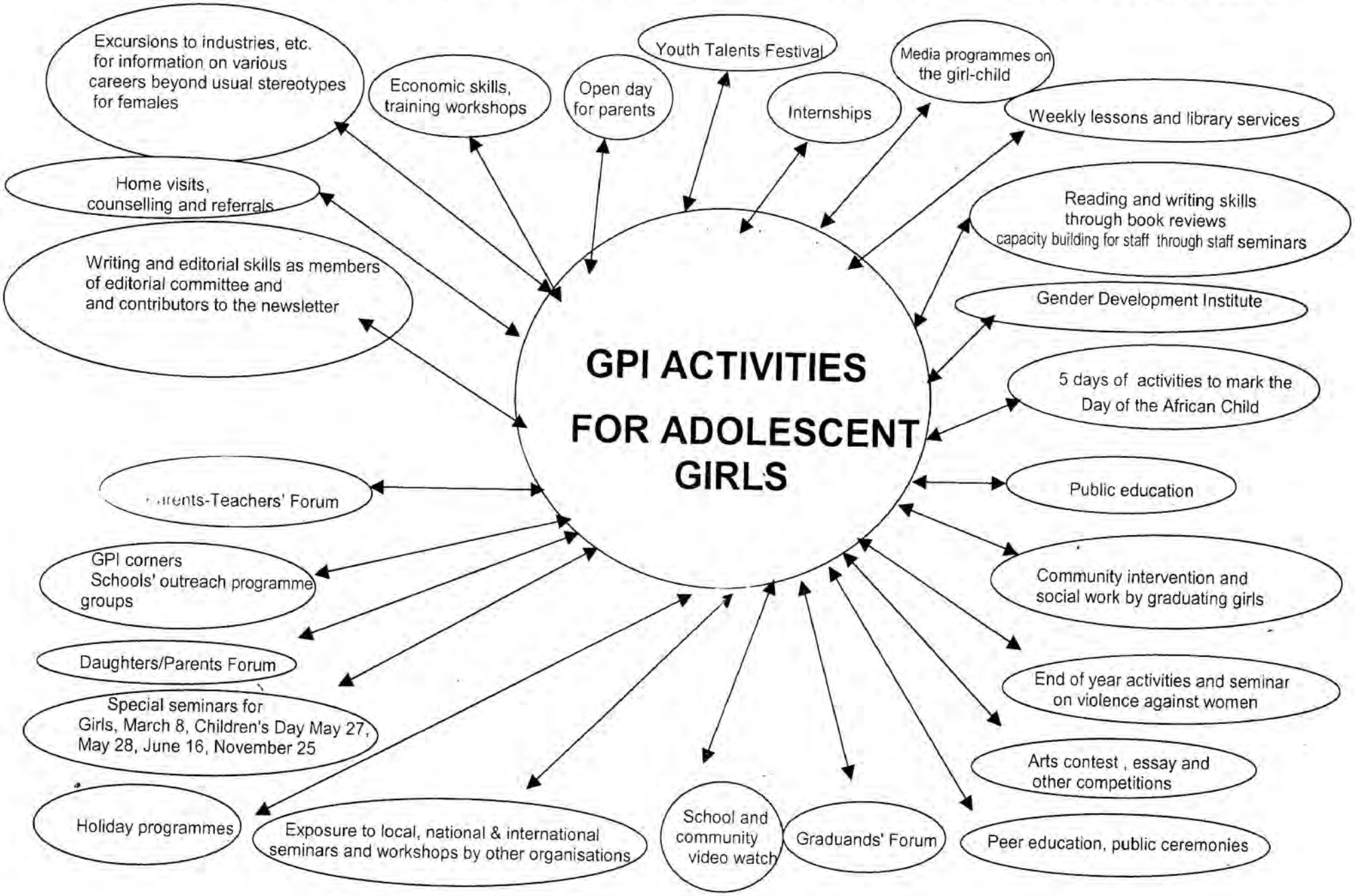
- **Support services** - assisting girls to solve personal health problems through counselling and referrals.

- **Sustainability, advocacy, networking** - responding to issues of sustainability through parents, teachers, health workers and service

providers and building political commitment through public education with the media and direct advocacy and interaction with policy makers and also networking and undertaking collaborative efforts with other youth- serving NGOs.

- **Safe space and supportive environment** - providing a safe space for recreation and learning through provision of video watch, educational games and library services for girls.

GPI INFORMATION, EDUCATION AND SERVICES FOR ADOLESCENT GIRLS



INTRODUCTION

Gender prejudices are embedded in language, expressions, culture, social values, songs and all aspects of life. Children are socialized into such sexist cultures. Therefore, GPI programmes are designed to break the sexist prejudices and assist girls to develop critical consciousness, overcome gender prejudices and to stand up for their rights.

GPI facilitators go through intensive training to acquire skills to be non-judgmental, good listeners, respectful. They learn to use non-sexist languages, e.g. humankind/people for mankind, spokesperson in place of spokesman, human resources in place of man power, etc.

They also learn to avoid such stereotypes which would see men as being superior to women. Examples are well chosen to avoid the culture of treating girls and women as dependent or subordinate beings by nature. Efforts are equally made to motivate and encourage girls' education and social participation. The girls are in turn, made to appreciate that there is no scientific basis for the differences in the daily tasks that males and females perform in the family and to appreciate how such gender discriminatory practices negatively affect activities like education, employment and hence social status of men and women, and how they place women as subjects to men.

GPI curriculum is thus, designed to empower girls to reclaim their courage to take actions to protect their rights through discussions about self-esteem, assertiveness, body-image and self-identity. Instead of telling adolescents only about the health risks and potential negative consequences associated with sex, adults need to provide young people with more balanced messages. Adolescents certainly need to receive clear, protective messages about sexual decision-making, because they need to hear affirming messages about healthy relationships and healthy sexuality. "Sexuality is more than sex. It

touches on many aspects of life, including biology; gender roles, body-image and interpersonal relationships; thought; beliefs, values, attitudes and feelings; and sexual behaviours". (National Sexuality Education Curriculum for upper primary school, junior secondary school, senior secondary school and tertiary institutions in Nigeria - **(Nigerian Educational Research and Development Council, 2001).**

In their relationships, girls should learn to demand respect and be firm in protecting their bodily integrity. For this reason, they are made to appreciate why they should assert their rights as equal partners in a relationship to break the chain of male power in relationship. Emphasis is placed on male responsibility for their sexual behaviour, and mutual respect between partners.

Each lesson begins with the exploration of social concepts to bring out myths, misconceptions and gender prejudices. Discussions and sharing of personal experiences help to debrief participants by providing accurate and technical information to add value to the lesson learned. They are given opportunity for public speaking to break the gender prejudice that a female should be seen and not heard. Lessons and practices in leadership roles assist girls to overcome subservient tendencies and shyness and embolden them to assert their rights. The slogan here is: "What anyone is taught to do, the person can do it."

In each lesson, questions are raised to identify gender biases and how to deal with them. With respect to sexual health, emphasis is placed on rights to enable participants to realize that they have choices to make to protect their health. Discussions on the male and female reproductive systems - structure and functions as well as pregnancy and childbirth are presented to assist participants to understand why it is important to make the right choice about one's sexuality issues.

We utilize age-specific curriculum for each of the 3 levels in GPI, representing the 3 years in the programme. Girls are encouraged to share experiences and to debate; questions and discussions that follow are framed from a gender perspective. Video watch is also used as a tool to

generate discussions and draw lessons from a gender perspective. Activities such as youths talents festival, excursions, boys/girls forum, etc, are built in to break the gender prejudices inherent in careers, jobs and capabilities of female and male in society. Issues of violence against women are treated at all levels to assist girls' struggle against such gender-based pressures.

ROLE OF FACILITATORS

Since classroom-type of teaching or lecturing would not achieve the goals of the education, sexuality education, therefore, has to be provided through participatory methodologies. Participants are encouraged to learn from each other. Sexuality educators, or facilitators, therefore, require a variety of strategies, methodologies and resources to assist participants to acquire accurate knowledge and skills on sexuality, gender, health (sexual and reproductive) rights. Whatever strategy adopted must be sensitive to cultural norms.

The sexuality educator/ facilitator must first be comfortable with her/his sexuality and be fairly well educated in sexuality issues. A facilitator must be aware that her/ his values and attitudes may not always be the same as those of the participants and therefore should not force his/her views on participants, but provide accurate information and listen to their own views.

Some facilitating tools for comprehensive sexuality education include books, video films, posters, pamphlets, photographs, flipcharts, worksheets, markers, cardboards and colour printing papers.

TIPS ON FACILITATING SKILLS

In order to utilize this manual effectively, facilitators require the understanding of the basics of facilitating as different from teaching and need to be knowledgeable and comfortable with topics of adolescent sexuality, sexual and reproductive health and rights. Facilitators need to be aware that learning takes place by seeing, doing, experiencing and active participation and not just by listening.

Active participation involves: The use of effective questioning

techniques; acknowledging that every participant is a valuable resource and enabling participants to learn from and share with each other.

Facilitators also need to be aware that a conducive environment for learning should include:

- fun, laughter
- encouraging participants in the learning process
- mutual respect
- questions and answers
- warm, inviting and open environment
- though facilitator is in control, she/he should be willing to learn from participants
- exercises and games
- group cohesion.

TEACHING VERSUS FACILITATING

Teaching implies:

- Making participants accept what you present as a fact or principle without questioning
- Passing judgmental comments in response to incorrect answers
- Showing people how to do things, believing that they do not know how to do them
- Giving information on a subject without getting any from participants
- Making others learn from you only
- Giving knowledge without receiving in return.

Facilitating implies:

- Setting goals and objectives for the topic and allowing participants to show what they expect to learn.
- Assisting participants individually and collectively in their own learning experiences rather than teaching, lecturing or dictating out information.
- Being knowledgeable and familiar with the local situation and using relevant resource materials to effect learning.
- Being responsible for ensuring that the objectives of the lesson or training are achieved.
- Creating a relaxed, warm and comfortable atmosphere with free-flowing discussions.
- Avoiding judgements or comments during discussions.
- Avoiding ready prescriptions of ideas that will make all other ideas "wrong".
- Encouraging participants to explore alternative solutions that suit their experiences.

- Having ready for each topic, relevant up-to-date information.
- Giving individual participants, opportunity to be involved.
- Being sensitive to feelings, values and attitudes of participants.
- Being able to present lessons in a logical fashion.
- Using open-ended questions to encourage participants to freely communicate.
- Being able to accept participants' ideas, opinions and feelings without putting off or making value judgement.
- Allowing participants to do the talking.
- Using "I" messages (personal experiences) to encourage participants to share theirs.
- Being aware of non-verbal messages.
- Making sure that your body language shows that you are listening.
- Using various methods and exercises to sustain the interests of participants.
- Measuring that learning has taken place - i.e. evaluation.

ASIC STEPS IN FACILITATING

Choose a topic, read about it. Prepare accurate/technical information from current scientific findings to add value to the lesson.

- Set simple, measurable, achievable, realistic and time-bound (SMART) objectives for the lesson.
- Know some social beliefs about the topic and get participants to supply other beliefs.
- Plan the activities to enable you to achieve the objectives.
- Use several techniques/methods to impart and obtain information on the topic.
- Engage the interest of the participants.
- Plan to finish within allocated time.
- Remember to check at the end if learning had taken place; i.e. evaluate the lesson.

NOTE:

Get the participants to set ground rules to create environment for learning, ensure mutual support and participation. Let the participants set their expectations before starting the lesson. In summary:

- Clear objectives

- Good planning
- Well presented with different techniques
- Well-timed and organised agenda
- Evaluation.

PROFILE OF A FACILITATOR

F - Flexible, Firm, Fascinating
A- Assertive, Alert, Accurate, Able
C- Confident, Communication skills, Clear thinking, Candid
I- Imaginative
L- Leader, Listener
I- Informed, Interested
T- Tactful, Talented
A- Active, Able to involve everyone
T- Thorough, Trusting
O- Organised, Objective, Observant, Open
R- Resourceful, Receptive, Respectful.

In addition, the facilitator has to be neutral, non-judgmental, knowledgeable, patient, sharp and professional.

METHODS

GPI methodologies for imparting sexuality education are varied. In the chapters that follow, methods are listed for each topic.

GPI facilitators use different methods to ensure students' participation, interest and learning.

- **Ice-breaker:** This is a warm-up exercise to establish group rapport. In GPI it starts with empowerment songs that girls have composed over the years. Ice-breakers or warm-up exercises, take different forms; from innovative and creative games to use of feeling-good cards with simple messages or questions that participant would read out, respond and comment on or react to.

Similar to ice-breaker is the use of "**Energizers.**" These are exercises used during lessons at any time when energy or attention is low.

Other activities include:

- **Role-play** to simulate situations and experiences familiar to the girls to generate discussions and draw lessons.
- **Use of cards** to check level of knowledge, review previous lessons and reinforce information.
- **Brainstorming** to generate ideas from the group.
- **Small group discussions** on

specific issues concerning the topic of the lesson. This is meant to create room for individual participation. The output would then enrich the lesson, build leadership and rapporteuring skills thereby raising the girls' self-esteem to see how much they know.

- **Visual aids:** Posters, diagrams and video watch are some of the visual aids used to assist the girls to think creatively and acquire analytical skills through discussions, based on what they perceive in the visual aids.
- **Assignment:** Different kinds of assignments are given for girls to learn to seek information and take responsibility of performing the task and reporting back.
- Individual work is given for each participant to write down her views on, and to demonstrate understanding of a subject so that the facilitator can assess the level of knowledge.
- **Matching exercise:** This could take different forms:
  - Two columns on a flipchart; one side contains explanations or definitions, the other contains words or phrases and participants are made to match the numbers that go together.
  - Two or three columns can be drawn on a flipchart and participants are given cards with words or phrases or sentences to read and stick under the column each fits.
- **Reading:** Volunteers read out sections from a text book to give technical information or the facilitator could ask for volunteers to read from the flipchart or a text may be presented with missing words for a volunteer to read and fill in.
- **Writing:** On-the-spot tests can be given for participants to provide answers and exchange their work with their peers to grade each other. Participants can also present answers to questions and pin them up (stick-up) on the flipchart. This acts as an energiser as well.
- **Story lines or case studies:** To simulate problems for

comments and discussions.

- **Variations:** Designing working groups of twos, threes, etc, to enable all participants to be actively involved in the lesson.
- **Fish bowl:** This involves the actor-volunteers to stage a role-play or a skit and the others to observe the "actors." This is followed by comments and discussions.
- **Fish bones:** Fish skeleton is drawn on a flipchart and bones put on one side. On top of the side with bones is written, "HINDERS" and on top of the other side is written "HELPERS". One group writes on the bones, the things that hinder the solution of a problem and the other group writes on the plain side, what helps as well as the strengths to address the weaknesses in an action plan.
- **Myths and facts:** Statements are given and participants identify which is a myth and which is a fact and give reasons for their choices. This can take the form of "True or False"; "Agree, Disagree, Not sure" and physical movement to where the captions are pasted to indicate their choice. Volunteers in each group then state reasons for their choices.
- **Evaluation:** Each lesson is evaluated using different techniques to assess if learning has occurred.

Others do not have to use these particular methods but should feel free to choose the ones that would work best for her/his audience and culture.

IMPLEMENTING THE PROGRAMME

GPI conducts 3-hour sessions once a week throughout the year; beginning in September and ending in June. Girls progress through a 3-year curriculum, including Level 1, Level 2 and Level 3. Training sessions do not hold on Easter and during the two-week Christmas and New Year holiday period. Ideally, thirty girls in a group is recommended to enable the facilitator to effectively engage all participants. This also makes it easier for all participants to be involved. From our experience, it is more useful to have girls of about the same age in a group. Thus, 10 and 11-year-olds can be in one group, 12 and 13 in another group

and yet, 14 and 15 in a separate group, while 17 -19 can also be in one group. It is difficult to get girls of 10 years and above 15 years in a group to benefit maximally, given the difference in experiences and needs.

It is more useful to use practical and comical methods as well as story-telling and role-plays in presenting lessons to the younger girls of 10-14; and better to use personal experiences for older girls and to give appropriate responses to problems aired by them to generate interest for girls above 15 years. Their interest and needs differ and so should the methods of training. For both groups - younger and older adolescents, the use of "small group work" to enable them to participate and think of the contents of each lesson together, not only reassures them of their resourcefulness, but helps to build group solidarity. It is also empowering for them to know that they can collectively find solutions to problems they face, thereby giving them a sense of independence; an important element in growing up, empowered. The younger girls of 10-13 years would also need a break of about 20 minutes for games and outdoor exercises of their choice, during the 3-hour per week sessions. This helps to sustain their interest and concentration.

For both groups, relevant songs and energizers would help to maintain their interest, enthusiasm and concentration. For example, after a lesson on body-image, the song that they find useful is ***"I feel just right in the skin I wear, there's no one like me anywhere."*** This would make them to visualise and reinforce the lesson that they are each unique; a notion that helps to make them accept who they are, while also encouraging them to take actions to defend their rights and raise their self-esteem. When time constraints require fewer lessons, we suggest the following adaptations: 1-year programme - use the Level I manual; 1-week programme-use lessons #2, #3, #4, #5 and #6 in the Level 1 manual.

TIPS ON USING THE MANUAL

It is important to understand that beneficiaries must first go through the lessons on Knowing About GPI, Human Sexuality, Self-Esteem, Vision and Goal-Setting,

Violence Against Girls and Women, Adolescence, Values Clarification, Friendship and Love, Knowing-Me-Knowing-You, Feelings, Gender and Leadership Roles, Rights and Responsibilities. This means that lessons in Level 1 need to be covered as a pre-requisite and basis for treating the topics in Levels 2 or 3.

The Level 1 lessons are for all beginners; whatever the age at registration. There should not be assumptions that girls above age 14 do already have information regarding the Level 1 topics. It would be more productive to use the manual from Levels 1 through 2 to 3 for effective and sustained outcome. Each volume is however valuable as reference in organizing workshops and training for facilitators. In such cases, the facilitators must first go through facilitating skill training sessions. The elements for facilitator's training are presented in the text.

It is also important for young people in the programme to be encouraged to use the GPI lessons in their daily lives wherever they are; at home, in the school and in the society at large. This will help them internalize the lessons and to bring about the intended behavioural changes. This is why there is also need to build in a forum to learn and get the support of parents and teachers for the programme.

In whatever situation users of this text may find themselves, there would always be an environment of adultism, intolerance for social changes, confusion and skepticism arising from people's culture, norms and even religious values. It is therefore, important to understand that what GPI is offering here is an attempt to create an environment that would present a fundamental shift from silence about sexuality to openness and honesty in assisting young people to learn about their growing-up. Young people need to learn from adults about their physical, emotional and anatomical development. They also need to know that they will face resistance and conflicts in their relationships with family members, friends, teachers and others in their lives. However, these things have to happen in the short-run to create the environment for lasting healthy development and mutual respect towards gender and social justice.

In the final year, participants are required to carry out social work project, designed and implemented by them. They are also given opportunity to plan and conduct lessons to build their skills to share and expand the knowledge they have gained from the programme. The creation of the Alumnae Association is similarly directed at sustaining GPI experience in the lives of girls after graduating from the programme.

CONDUCTING A GPI LESSON

Each lesson needs to be conducted in a room, spacious enough to accommodate thirty participants comfortably with space for participants to have about 5-6 small group work involving everyone equally. Participants are also encouraged to create and act short drama on each topic as this helps to strengthen lessons learnt.

- During the year, the evaluation of each participant is conducted and at the end of the year, there is assessment to enable the organisation to decide on who moves to the next level. Thus, participants get promoted yearly from Levels 1 to 2; 2 to 3, where they then graduate. For participants who do not meet the criterion for promotion, it is important not to lower their self-esteem. Thus, such participants are moved to the next group, but of the same level where they still repeat the lessons of that level to empower them to meet the requirements for promotion to the next level.

TYPICAL LESSON PLAN

Each lesson begins with empowering songs and energizers selected and conducted by the girls and led by a girl who would volunteer to chair the session. For each lesson, there is a volunteer chairperson and a volunteer rapporteur. The roles rotate at each lesson. The chairperson prepares the lesson plan and presents to the class for amendment and adoption. A typical lesson plan looks like this:

Date:
Group name:
Chairperson for the day:
Rapporteur for the day:
Facilitator(s):
Introductory session: Led by the chairperson for the day:

- Opening: songs
- Report of the last lesson: by previous rapporteur

- Corrections and comments on the report by participants
- Checking-in: This involves girls sharing experiences of how they applied previous lessons in their lives. This usually generates debates, discussions and comments.

Review of previous lesson (method depends on level and age of participants).

Lesson for the day by facilitator: Involving different methods, including energizers. The lesson plan consists of:

- **Goals** - This describes the intended learning that will occur during the specific lesson
- **Objectives** - This describes the specific skills to be gained through the lesson
- **Concepts/common beliefs** - They describe what the society holds to be true but which is not actually true. It may involve the facilitator asking participants to come up with what they have heard people say about a particular issue; which is believed or held to be true but which in actual fact is not true. Facilitator will also need to add to the output. This will serve as part of the wrong notions to be demystified during the session.
- **Methods** to be used for imparting the lesson - This describes the various activities to be used during the lesson
- **Opening** - This session is led by the chairperson of the day and it includes: opening songs; a report of the last lesson by the previous rapporteur; corrections and comments on the report by participants; checking-in: which involves girls recounting their experiences of how they used previous lessons. There will also be debates, discussions, lesson clues and goal-setting.
- **Announcements and assignments** - This time involves giving notice of activity to be held within the week, selecting group representatives for such activities or giving information on any pressing issue.

Lesson evaluation and self-reflections - This is when to give

either a take-home/action assignment or stem sentences to enable participants to say what they have gained from the lesson, and possibly comments on other areas not understood.

Self-reflection consists of getting individual girls to say one or two things that the lesson meant for them personally:

- What it is that each person learned that surprised her;
- Perhaps just saying or writing 5 words that would indicate what the lesson did for her.
- **Closing songs** - Here, participants sing empowering songs or songs relating to the session topic/issue, together with exercises, before closing for the session.

CRITERIA FOR PROMOTION

There are three levels. Level 1 consists of newly registered girls. Registration is once a year, in September, since the graduation for the 3rd level and hence final year, takes place between the end of July and the first week in August. On registration, questionnaires are administered to assess the level of information acquired, knowledge, attitudes, beliefs and other social tendencies of the girls. This provides the background data for measuring impact of the programme. Girls are assigned classes, based on their age, but all the classes in the first level use the same curriculum. Level of discourse and methods differ with age of participants.

Using the example of the South -South, Calabar centre, the three levels constituting the three years for the period of the programme for each set of girls, comprises altogether 8 classes. There are 3 classes in the first year (first level) namely: ***Shining Stars, Precious,*** and ***Silvers.*** There are 3 classes in the 2nd year, namely: ***Pearls, Alphas*** and ***Bosoms.*** There are two classes of the graduating level, in the programme - the ***Damsels*** and ***Seeders.***

Level 1 (First year) -Shining Stars
10-11 years - Precious
11-12 years - Silvers 15 and above

Level 2 (Second year) -Pearls
11 - 12 years - Alphas
13-14 years - Bosoms
15 and above

Level 3 (Third year) -Damsels

12-15 years -Seeders
16 and above

Shining Stars are promoted into **Pearls** in the second year, but if on evaluation at the end of the first year, some do not meet the criteria for promotion, in order not to lower their self-esteem, they would still be "promoted" into **Precious** where they continue with Level 1 curriculum for another year. **Precious** girls are promoted to **Alphas,** while **Silvers** are promoted to **Bosoms**. The 3rd year participants consist of those promoted from the 2nd level classes, who have met the promotion criteria. Those between 12-15 are in **Damsels,** while 16 years and above are in **Seeders.**

Promotion criteria

⇒ Regularity at lessons
⇒ Active participation
⇒ Demonstrating understanding of lessons taught
⇒ Changing attitudes and behaviour
⇒ Social intervention activities undertaken.

The class names: **Shining Stars, Precious, Silvers, Pearls, Alphas, Bosoms, Damsels and Seeders** represent what the girls chose for themselves for the philosophical underpinnings stated below. Hence, users of this manual are free to choose their class names as they deem fit.

1. **Shining Stars:** (Level 1) - These, as stated above, are mainly 10 and 11-year-old girls. They chose the name based on their conviction that they shine like stars in the midst of their peers. They stand out for their knowledge, assertiveness and boldness.

2. **Precious:** (Level 1)- These are the 11-12-year-old girls. Their name depicts the assertion that they are distinct and highly valuable gems that stand out at their age as assets in the struggle for gender equality.

3. **Damsels:** (Level 1) - These are girls aged 15 and above. The name literally means young unmarried, but distinguished young women because of their knowledge, skills, assertiveness and behaviour as different from

other girls of the same age who would lose their focus from lack of proper guidance.

4. **Silvers:** (Level 2) - These are 11-12-year-old girls. They see themselves as clear, level-headed, convinced and persuasive assets for women empowerment and gender equality.

5. **Pearls:** (Level 2) - Girls aged 13 and 14 years who see themselves as rare gems exhibiting clearly superior and diverse but quality knowledge and information and therefore of immense value for women empowerment.

6. **Alphas:** (Level 2) - Girls aged 15 and above literally the first among equals; the pivot of women empowerment; bold, assertive and knowledgeable about human sexuality, adolescent rights and responsibilities.

7. **Bosoms:** (Level 3) - Girls aged 12-15. They perceive themselves as distinct and cherished advocates and therefore the heart (bosoms) of gender equality.

8. **Seeders:** (Level 3) - Girls aged 16 and above. They see themselves as feminists in the making and therefore as the seeds for feminism and gender justice, activisim because they are already taking courageous actions to claim their rights.

CHAPTER ONE

KNOWING ABOUT GPI

GOAL:

Increase participants' knowledge on the organisational fundamentals to assist them to work together in order to achieve the organisational objectives.

OBJECTIVES:

- Develop a broader understanding of the term, GPI
- Understand and be able to discuss freely the aims and objectives of GPI with others in order to demystify the myths attached to GPI programme
- Get acquainted with GPI activities and goals of each activity

COMMON BELIEFS/CONCEPTS:

- GPI being a non-religious organisation means it will lead young girls to hell fire
- GPI activities make girls to be aggressive and disrespectful to elders
- Give participants a chance to say what they have heard about GPI and record responses.

MATERIALS:

Flipchart/board, felt pens (markers), stick (masking) tape, pieces of paper and resources on GPI as an organisation.

ACTIVITY/TIME:

- Brainstorming (20 minutes)
- Flow chart presentation (30 minutes)
- Write-and-stick exercise (10 minutes)
- Agree/disagree statements (20 minutes)
- Technical information (40 minutes)
- Evaluation (10 minutes)

PREPARATION:

Participants need to have information on the mission and vision of the organisation as well as the organisational structure and sources of funding, to enable them to pass on the information to others thereby helping to correct any wrong notions that may be associated with the organisation's activities.

LESSON SEQUENCE

Opening

Led by the chairperson of the day to oversee opening songs; a report of the last lesson by the previous rapporteur; corrections and comments on the report by participants; checking-in, that entails girls recounting their experiences of how they applied previous lessons in their lives; debates, discussions and lesson clues as well as announcements and goal-setting.

Energizers/Ice-Breakers

- Get participants to stand in a circle, each person takes turn to introduce herself and says why she **likes** or **dislikes** being a girl. Note down individual responses and put them down on flip chart.

Lesson topic

Activity 1:

Brainstorming

Get a participant or volunteer to say what she knows about the term, GPI. Put down responses on flipchart.

- Try to let volunteers explain their own understanding of the terms, GIRLS, POWER, INITIATIVE as contained in GPI.
- Probe participants on what they hear people say about GPI as an organisation.
- List responses on flipchart and then use it to demystify the wrong notions.

Activity 2:

Flow chart

Put up chart with the following labels:

- Non-governmental
- Non-religious
- Not-for-profit
- Female organisation
- Specific age = 10-18 years
- Use interrogative questions like, "Why", "How", to arrive at concrete answers. And add value where necessary.

For example;

* **Why is GPI for girls only?**

- discrimination
- ignorance
- poverty
- disease
- subjugation

* **How are girls discriminated against before birth?**
- Parents' preference for male children. Why?
- Because "sons carry on family lines"
- "Increases women's status"

* **Discrimination against females during childhood**
* **How?**
- Girls are used as mother's helper(s)
- Given less food than their brothers
- Have low resistance to disease
- Are not sent to school beyond primary level
- Will marry and leave the family.

* **Discrimination at adolescence:**
* **How?**
- Interrupted education
- Forced and pre-mature sexual activities, leading to diseases, early marriage, teenage pregnancies with attendant risks,
- Decisions made for, and by men
- Parents would not love to "water another man's farm."

* **At adulthood**
- Faced with unequal economic burden.
- No right to decide on number of children to have
- Little or no access to health care services and information.
- Faced with domestic and sexual violence
- Find it very difficult to attend leadership or political positions.

Now, ask participants to discuss on what they feel could be done to remedy the above problems faced by girls.

TIPS

Give adequate explanation on the following:
- Equal treatment/nurture
- Equal access to adequate education
- Equal access to healthcare services
- Special protection from sexual and economic exploitation and abuses.

- Access to sexuality education and information.

Activity 3:

Write and stick exercise.

Put up charts labelled,

- Right
- Education
- Health
- Skills

Ask participants to write on pieces of paper provided, those activities they think will be necessary under the terms above,

- Process their output and add value especially concerning the following:

⇒ **Weekly meetings**: Held every Sunday 3pm-6pm at GPI South-South Co-ordinating Centre - Number 44 Ekpo Abasi street, and GPI Benin Co-ordinating Centre, Benin City, Edo state.

⇒ **School outreach programme** for girls leaving far away from the resource centre, in various secondary schools.

⇒ **Excursions** aimed at exposing girls to various establishments to learn and have information about their prospectives careers.

⇒ **Skills training** to equip girls with life management skills

⇒ **Library services**

⇒ **Youth talent festivals**

⇒ **Essay competitions**

⇒ **Boys/girls forum**

⇒ **Counselling/referrals**

⇒ **Public enlightenment**

⇒ **Media programmes**

⇒ **Parents/teachers/healthcare providers forum**

⇒ **Seminars, workshops, symposia**

⇒ **Newsletters, manuals and books production.**

- **Direct services**
- Library, counselling and referrals

◊ **Community interventions**

◊ Social works

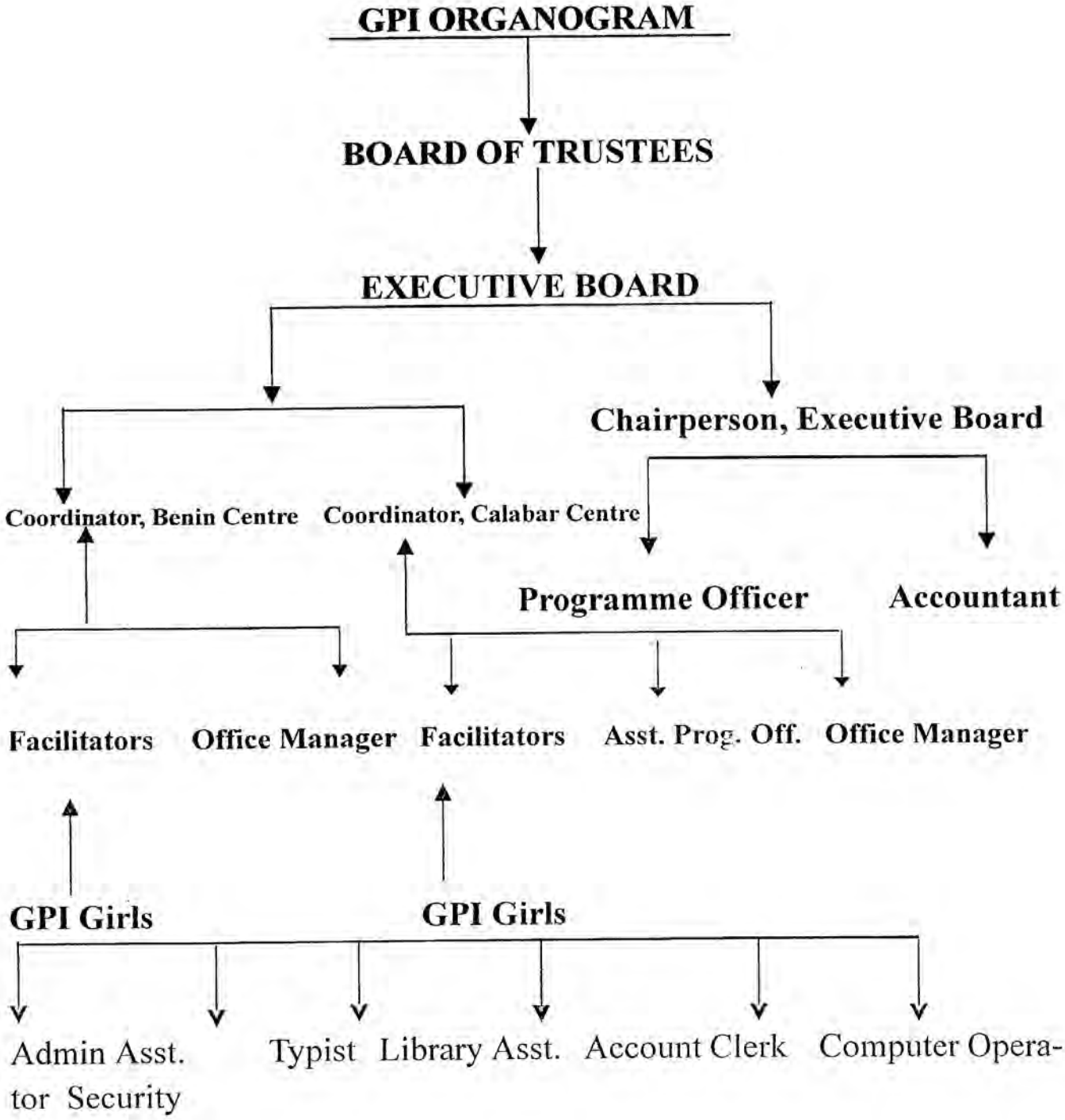
◊ Research and documentation

◊ Distribution of newsletters

◊ Networking and joint campaigns with other NGOs

◊ Advocacy

Give technical information on GPI's sources of funding and structure, bearing in mind its sources of both material and human resources.



Self-Reflection/Evaluation

Have girls to answer the following questions, either written or verbally:

1. What new lessons did you learn?
2. What aspect of the lessons was not clear?
3. Say in 3 short sentences how you understand the organisation.

NOTE: Refer to level one - Knowing About GPI

Closing

- Let participants sing some empowering songs like;
  Song: G—P—I—/ you're my only choice/for I can't stop singing a song for you (2 times)/ once in my live we were so passive/ we could not stand up for our rights.

Action assignment

- Participants to prepare to discuss in the next lesson, ways and personal experiences of how they have been able to intervene and demystify certain myths held by people about the organisation.

REFERENCES

1. GPI Training Manual
2. GPI at 5

CHAPTER TWO

HUMAN SEXUALITY

GOAL:

To assist the girls to develop comfort level about their bodies and to attain a healthy and satisfying future.

OBJECTIVES:

At the end of the lesson, participants will:

- Be able to say in simple terms what sexuality is
- Identify the differences between sex and sexuality
- Know the varying sources of sexual learning
- Know the components of human sexuality
- Identify sexuality throughout the life span.

CONCEPTS/COMMON BELIEFS:

- Sexuality is all about sexual intercourse
- Only adults should learn about sexuality
- A child or adolescent who is taught about sexuality will be corrupt.

MATERIALS:

Flipcharts, felt pens, stick tape, relevant resource for technical information, etc.

ACTIVITY/TIME:

- Brainstorming(20 minutes)
- Write, read and stick exercise (15 minutes)
- Small group work (30 minutes)
- Evaluation (15 minutes)

PREPARATION:

The society often treats any discussion about sexuality seem like a taboo. Therefore, young people grow up feeling very uncomfortable talking about sexuality issues.

LESSON SEQUENCE

Opening

This includes opening songs; a report of the last lesson by the previous rapporteur; corrections and comments on the report by participants as well as checking-in.

Energizers/Ice-Breakers

Ask for concepts beliefs from participants; i.e. what they hear people say about sexuality.

- Take down responses on a flipchart and then process the information to explain some false notions that might have been raised.

Lesson topic

Activity 1:

Write, read and stick exercise

- Ask participants to write down their understanding of the words, sex and sexuality.
- Process the information and add technical information on what sex means and what sexuality truly means.

Activity 2:

Brainstorming exercise on sources of sexual learning

- Ask participants to say where and when they first heard the word sex or sexuality and how they reacted.
- Write down responses.
- Process the information to find out the percentage of those who learnt about sexuality from parents, media, peers, magazine, school teachers, etc.

Activity 3:

Small group work

- Divide participants into groups of 5s to work and report back on the issue of sexuality throughout the life span, using a questions like: **What sort of activities are carried out by people (male or female) in the following age brackets**?

Group 1: Early childhood (0-3 years)

Group 2: Late child hood (4-8 years)

Group 3: Early adolescence (9-11 years)

Group 4: Adolescence (12-18 years)
Group 5: Young adulthood (19-30 years)
Group 6: Adulthood (31-45 years)
Group 7: Middle adulthood (46-64 years)
Group 8: Late adulthood (65-death)

- Acknowledge each group's contribution and process the information. Ask other groups to make input.
- Provide technical information on the components of human sexuality.

Evaluation/Self-Reflection

- Participants could be asked to state in one sentence what they have learnt after the session. Responses should be written down.
- Stem sentences could also be used such as:

- Sex means ——————
- Sexuality means ——————
- When a baby cries she/he is expressing his/her——————

Closing Close session with an alert exercise such as:

I'm alive, alert, awake, enthusiastic (2 times)
I'm alive and alert, I'm alive and awake, I'm alive and alert, awake enthusiastic.

Action assignment

Ask participants to write down 3 new things they have learnt about their sexuality and 3 new things they still will like to know about their sexuality.

TECHNICAL INFORMATION

Sex: Term used to describe what makes one either a male or female.

Sexuality: Total behaviour of a human being. Sexuality starts from the day we are born till the day we die and it is a normal, natural and an enjoyable part of being human. Sexuality is not limited to human biology, or sexual intercourse alone. There is much more to sexuality than this.

Components of human sexuality

Body-image: How we look, how we appear to others and how others see us.

Gender roles: The rules set by the society that differentiate between a girl and a boy and how they inter-

act or should interact with each other.

Relationship: Different ways we relate to, and interact with people (family, friends, loved ones, etc).

Intimacy: A special sharing of thought and feelings, not always physical.

Love/Affection: Love is different to everybody. Do you have to love somebody to show affection or are they the same?

Eroticism: What is sexy to you emotionally and physically. What excites you.

Social role: How do you contribute to the society, what do you believe in?

Genitals: Genitals define the sex of a person, male or female.

The way we walk, how we dress or act, who we are attracted to emotionally and physically, are all aspects of sexuality and how people express themselves as sexual human beings is all part of sexuality. Sexuality is a complicated mix of experiences, values, culture, biological changes, religion and preferences.

REFERENCES

1. *Peer Health Educators Manual,* by The Youth Action Project (YAP); Ijebu-Ode.
2. Tabifor, H. (2000) *The Dignity of Human Sexuality and the AIDS Challenge.*

CHAPTER THREE

COMMUNICATION SKILLS

GOAL:

Helping young people learn how to communicate effectively with others and to make wise decisions about all matters connected with their growing up.

OBJECTIVES:

By the end of the session, participants should be able to:

- Understand the meaning of the term, communication
- Learn about verbal and non-verbal forms of communication.
- Know how to communicate effectively
- Appreciate that good communication skills enhance good relationship among people.

CONCEPTS/COMMON BELIEFS:

- Only educated people can communicate
- Merely sending someone to deliver a message is communication.

MATERIALS:

Flipchart/board, felt pens (markers), stick (masking) tape, pieces of paper and the facilitator's resource.

ACTIVITY/TIME:

- Brainstorming (20 minutes)
- Group work (40 minutes)
- Role-play (20 minutes)
- Technical information (30 minutes)
- Self-Reflection/Evaluation (15 minutes)

LESSON SEQUENCE

Opening

The chairperson of the day will call for opening songs; a report of the last session and allows for corrections and comments on the report by participants. There will also be checking-in; debates, discussions and lesson clues; announcements and goal-setting, at this stage.

Energizers/Ice-Breakers

Energizers are quick activities that can be used to introduce the topic and to manage the energy and attention of the group and can also be used to have fun, among the participants.

Lesson topic

Activity 1:

Brainstorming exercise

- Participants to brainstorm individually on the meaning of communication [put answers on flipchart]
- Explain that many factors influence how well we can communicate and that when we communicate we are trying to accomplish some basic objectives such as:
  - Understanding: getting the message across so that the other person at the other end (receives) knows exactly what you mean.
  - Acceptance: getting others to agree with you or even where they have to disagree, give you a fair hearing.
  - Performance: getting others to act because they understand what you want them to do, why they should do it, and sometimes, how and when to do it.
  - To understand others: learning how others feel about you, a particular situation, or condition in general.
- Explain that in order to achieve the above, the following factors will influence how well we communicate: our own manner of speech, simplicity of message, self-confidence and attitude towards the listener(s)

Activity 2:

Role-play

- Ask a pair of volunteers to role-play (a speaker and a listener) different ways of communicating.
- Tell the listener that the speaker is going to say something to her and that she should respond in any way she thinks is appropriate.
- Now, discuss how the listener responded to the statement(s).
- Ask the listener to discuss how she felt about the statement(s).
- Repeat the procedure with different pairs of participants, using other forms of communication.

a. After each pair, discuss differences in communication style.

b. Which one was more effective and why?

- Record participants' responses on flipchart(s) and then provide technical information on what communication is.

Activity 3:

Brainstorming exercise

Ask participants to complete the following:

1. Verbal communication is.....
2. Non-verbal communication is....

Activity 4:

Role-play

- Let a volunteer demonstrate a verbal form of communicating.
- Let another pair of volunteers also demonstrate a non-verbal form of communicating.
- Ask participants to comment on which method they feel is most effective and why.
- List responses and then process and add value, using technical information.

Activity 5:

Read and stick exercise

- The facilitator will provide some short sentences or statements on pieces of paper
- Participants will read what they have written, then paste them on the appropriate column of the flipchart, labelled - Barriers and Bridges
- The statements/sentences will include statements like:

1. Very large group with lots of messages
2. Ignorance of personal views
3. Information overload
4. Simple, neat and clear messages
5. Fact inference conclusions:

jumping to conclusion

6. Willingness to listen and understand
7. Noise and other distractions
8. Poor timing and poor organisation of messages
9. Prejudices/bias
10. Lack of feedback
11. Use of wrong or ambiguous words
12. Interruption of speech
13. Changing topics
14. Attentiveness, understanding and thankfulness
15. Speed in speech
16. Relevant fact on the message to be passed
17. Reasonable control of emotions
18. Honesty and sincerity
19. Constructive criticism.

■ At the end, process output with participants and give technical information.

Reflection exercise

Communication check

Ask participants to complete the activity below for "communication check"

INSTRUCTION:

1. Rate each of the following skills using the key below:

* 1 = Never
* 2 = Sometimes
* 3 = Often
* 4 = Always

A. I do not interrupt in my group
B. My voice is appropriately pitched (not loud or too soft)
C. I do not dominate the conversation (giving others a chance to speak)
D. I look people in the face
E. I do not criticise (put down) others
F. I face the speaker and avoid crossing my arms or turning away from him/her
G. I respond to the speaker, showing interest
H. I ask questions to show interest in what the speaker is saying.

Total score

2. Add your scores for the items and identify where you stand on the summary score below:

Communication skills: Summary score

⇒ Lowest scores = Poor
⇒ Average = Fair
⇒ Highest = Excellent

Facilitator adds value after the exercise on ways to improve our communication skills.

Closing

Use relevant exercises of your choice or ask a volunteer to lead the group in closing exercise or sing relevant songs.

Song: She turned passive girls into assertive girls/She made us empowered/ we can't keep silent/ We must sing her wondrous song/o-o-oh

Action assignment

Ask participants to:

1. List your communication strengths

.....

.....

.....

.....

2. Discuss some of your communication strengths and weaknesses with a group member.
3. Discuss what each of you could do to help work on the weaker aspects of your communication ability.
4. List the aspects you need to work on

.....

.....

.....

.....

TECHNICAL INFORMATION

What is communication?

There are many definitions of what communication is, one of which, as defined by the *Lexicon Webster Dictionary,* Vol. 1, is as follows: "Communication means the act of communicating, transmitting, imparting or interchange of thoughts, opinions or information by speech; writing; or signs; that which is communicated between places."

For the purpose of our study, we can define communication as:

- The process of transferring information from the mind of one individual to the mind of one or more other individuals and getting feedback.

Who and who should be involved in communication?

◊ Communication is something that one person cannot do alone.

◊ There must be a sender and a receiver

◊ In between the sender and the

receiver, are the elements of message and

◊ The medium through which the sender communicates to the receiver.

NOTE: The sender may have a greater responsibility to see that communication is successful. A participant who learns to handle communication problems by asking question(s) is well on the way to creating rapport with one another.

To help avoid misunderstanding of the sender's idea(s), the following questions should be asked:

- What is the idea to be passed?
- Who is to receive the idea?
- How effectively can I pass the message to the other person?
- How could my message undergo changes along the way?
- How can I prevent distortion?
- How can I tell that the person has received the right message?

How we communicate: There are many ways of communicating:

- Thinking - non-verbal
- Action "
- Observation "
- Listening "
- Speaking - verbal

What is verbal communication?
Making known one's ideas or feelings to a person or persons through spoken words.

Non-verbal communication
Making one's idea(s) or feeling(s) known, without speaking e.g. facial expressions such as winking, nodding, smiling, frowning and movement of parts of the body e.g. gestures, postures, turning away, crossing arms, or legs, beckoning, coughing, shuffling, laughing, sighing.

The five Cs of communication
Your message must be:

1. **Clear** - use simple words and few ideas in each sentence
2. **Complete** - use all the words and thought necessary to convey the message
3. **Concise** - brevity is beautiful. Use the fewest words possible
4. **Concrete** - use specific words or terms rather than generalities
5. **Correct** - make sure your message is true accurate, properly researched and documented.

Security and safety can easily be hampered where communication is poor, for instance, if there is fire and messages have to be sent out, they must be sent accurately, to the right person, through the correct and quickest channels, if the right responses are to be received.

Benefits of good communication

a) Encourages good relationship with family, friends - males or females.
b) Enhances ability to impress the listener and helps in being understood.
c) Promotes respect for one another.

Communication check

Three skills we may need to improve our communication skills are listening attentively, giving feedback, and showing empathy (showing you understand how the other person feels or what her/his point of view is).

Ways to improve our communication skills

Listening well: To listen well so that you really hear and understand what another person is saying means that:

- You focus on the person with direct eye contact (looking into people's eyes)
- Do not interrupt
- *Do not cut in to describe your* experience
- Do not give your attention to outside disruptions (other people or events)
- You are comfortable with silence.

Giving feedback

To give feedback to another person means you comment on the person's statements, behaviour or performance. When you do this, you show the other person that you are listening and care about what he/she has said or done.

Dos and don'ts in communication

Dos

- Ask questions to show you are interested in the person
- Be sincere, caring and understanding
- Use verbal encouragement such as "what happened then?"
- Use non-verbal encourage-

ment such as nodding your head

- Ask questions to make the situation clearer (if necessary)
- Summarise the person's point and feelings.

Don'ts

- Do not judge the person
- Do not comment on the things that cannot be changed
- Do not interrupt too early to give feedback.

REFERENCES

School Health Education to Prevent AIDS and STDs - A Hand book for Curriculum Planners, by UNAIDS

CHAPTER FOUR

PEER PRESSURE

GOAL:

Prepare participants for some tough choices they will have to make now and in the future.

OBJECTIVES:

A t the end of the session, participants will be able to:

- Understand what peer pressure means
- Explore and distinguish between negative and positive peer pressures as well as their effects
- Come up with tips on what to do when faced with negative peer pressure.

COMMON BELIEF/CONCEPT:

- Everyone is doing it so it's okay to join.

MATERIALS:

Flipchart/board, felt pens (markers), stick (masking) tape, pieces of paper and facilitator's resource.

ACTIVITY/TIME:

- Writing exercise (15 minutes)
- Role- play (20 minutes)
- Case study/group work (20 minutes)
- Technical information (20 minutes)

PREPARATION:

Young people are often faced with situations they are expected to make decisions that might influence their lives in future. Some of such decisions become very difficult to make if one were not well prepared. Absence of correct information means that one may be forced into taking actions that are

points, start with a 'but why' exercise to make sure the participants get the full import of the story; e.g. But why did Sarah sneak out of school?

But why was Henry drunk?, etc.

Discussion points

(1) Henry and Sarah were victims of .....

(2) What could Henry and Sarah have done when their friends asked them to sneak out of the school?

(3) What other possible things could have happened to Sarah or Henry as a result of being drunk?

(4) How can the above incident be prevented?

(5) What would you do if you were faced with a similar situation?

Allow each group to make its presentation after 20 minutes. Facilitator processes the information and adds value on effects of negative peer pressure as well as how it can be detected.

Activity 3:

Role-play/group work on positive peer pressure

Participants to role-play about a student who encourages her friend to study hard, even though her friend complains of not being comfortable with mathematics. The result was that her friend scaled through scoring the highest grade in the class.

Discussion points

(a) What type of peer pressure was that?

(b)What lessons did you draw from the role-play

(c)Comparing this and the role-play which of these is desirable?

(d) Why?

Reinforce information and add technical information on tips on how to avoid negative peer pressure.

Self-Reflection/Evaluation

Ask participants to say one new thing they have learnt from the lesson. List down responses.

Closing

Close session with an "Alert exercise."

I'm Alive, Alert, Awake, Enthusiastic (2x)

I'm Alive, I'm Alert (3x) Awake Enthusiastic.

TECHNICAL INFORMATION

Peer: Person of same rank or ability.

Pressure: When someone verbally encourages us to think, as she/he thinks, act as she/he acts or do as she/he does.

Peer pressure: When someone of same rank or ability encourages us to think, act or do as she/he does.

Negative peer pressure

Negative peer pressure may sound like some of these "famous lines:"

- mummy's baby
- common it'll be fun. We won't get caught
- It's no big deal. Everbody is doing it
- I thought you were my friend , if you were you'd do this with me
- Trust me, no one will find out
- Don't act like a fool
- I dare you to do this
- If you don't come along you will not be my friend again
- Grow-up
- What a goody-goody you are
- You are chicken-hearted.

We have at one time or the other heard these lines being said to us. Not knowing how to handle this properly and quickly can get us into trouble.

The three steps of peer pressure reversal (PPR)

These steps contain plenty of good common sense, they involve learning how to assess situations quickly, think logically and decide what is best for oneself and how to follow up one's decision with appropriate action to protect one self.

(a) Check out the scene
(b) Make a good decision
(c) Act to avoid trouble

Check out the scene: This involves your being alert, with eyes, ears and mind open to what is going on around, you. Look and listen and be more aware of the environment and watch out if there is any unusual signs about your friends, groups, behaviours, whisperings, etc.

Make a good decision: This involves thinking logically, weighing both sides of the decision you are

about to make. Either you decide to stop, or go.

Act to avoid trouble: The first two steps are to prepare you for this step. Now, you need to follow through on your decision and avoid being controlled. These actions to avoid trouble can be diplomatic, dramatic, smooth, friendly, strong, nice, aloof or whatever you want or need them to be in order to handle the situation. It's up to you to decide which ones to use and how to use them. They will help you get out of trouble. Use them to help you reverse the peer pressure and keep your friends at the same time.

The ten peer pressure reversal responses

- Simply say "No"
- Leave the scene
- Ignore the peers
- Make an excuse
- Change the subject
- Make a joke
- Act shocked
- Use flattery
- Suggest a better idea
- Return the challenge

REFERENCE

How to Say No and Keep Your Friends: Peer Pressure Reversal for Teens and Pre-teens, by Sharon Scot

CHAPTER FIVE

RAPE

GOAL:

Towards the prevention of rape among adolescent girls as well as women.

OBJECTIVES:

By the end of session participants would have been able to:

- Explain what constitutes rape
- Identify the different types of rape
- Explore the consequences of rape
- Learn some tips on how to reduce the incidence of rape
- Identify where to seek redress when raped.

COMMON BELIEFS/CONCEPTS:

- Girls mean 'YES' when they say 'NO'
- Girls wearing short dresses call for rape.

MATERIALS:

Flipcharts, papers, markers, blackboard, felt pens, stick tape, technical information, etc.

ACTIVITY/TIME:

- Participants' expectations (5 minutes)
- Stem sentence/brainstorming (5 minutes)
- Case studies/group work (1 hour)
- Discussion (30 minutes)
- Technical information (1 hour)

PREPARATION:

Our patriarchy society makes people believe that males should be aggressive and in control while females should be meek, passive, submissive and yield-

ing to advances by any male. This type of prejudice and stereotype can lead to dangerous misinterpretation of certain situations and abuse of females by males. This is why males believe that when a female says no, she means yes. And also that strength does not depend on the sex organs but on the physical development, good health and other factors that build strength.

This prerogative of power and domination ascribed to males has often led to wider acceptance of violence as means of settling any misunderstanding or conflict. Many males feel that they can use rape as a weapon against a female that refuses their advances.

LESSON SEQUENCE

Opening

The chairperson of the day will start with opening songs and the report of the last lesson, corrections and comments on the report by participants made, as well as checking-in and debates, discussions and lesson clues.

Energisers/Ice-Breakers

Energisers are used to introduce the topic, and get participants in the mood for the lesson.

Lesson topic

Activity 1:

Brainstorming

- ❑ Using a stem sentence to explore from participants, their understanding of the term, rape.
  Rape is.....?

- ❑ Take down participants' responses and add value using technical information.

Activity 2:

Presentation of case studies

- ❑ Participants are to work on the case studies, using discussion points
- ❑ Divide participants into 4 groups and give each group 2 case studies to work on.

***Case study 1*:**

Nkoyo was 14 years old when it all happened. She went with her friends for a church crusade held somewhere in town. At about 9pm, she was feeling feverish and decided to go back home since it was not far off. On her way home, she was accosted by a group of hefty boys, who dragged her into a nearby uncompleted building and had sexual intercourse with her.

Due to the rough handling and struggling, she sustained inju-

ries and had cuts in her vaginal opening. Nkoyo could not walk, but managed to crawl out of the building after the boys had left. She tried to shout for help but was too weak to do so. However, a passer-by saw her and assisted her home.

Case study 2:

Arit is 11 years old. She was sent by her mother at about 7p.m to collect a debt owed her by a customer. On her way, a man stopped her and pretended to ask her the way to a church near by. While she was trying to explain, the man forcefully carried her to an isolated path. She was thoroughly beaten up to a state of unconsciousness and sexually assaulted. She was later found by a security night patrol team when she regained consciousness, several hours after the incident. She had lost much blood and was rushed to the theatre for surgery.

Case study 3.

A 9-year-old girl by name, Ndifreke lives with her elder sister who is a petty trader. Their house is situated in a large compound with other tenants living around. Ndifreke stays at home, while her sister goes to sell. Whenever Ndifreke's sister is away, their neighbour, Mr. Udo who is 56 years old and lives alone, invites Ndifreke to assist him to carry out some domestic errands. One day, Mr. Udo called Ndifreke and asked her to help buy something for him, Ndifreke did. When she came to return what she had bought Mr. Udo was sitting in his parlour, he quickly grabbed Ndifreke, covering his hand over her mouth and took her to the bedroom where she was raped. He gave her #10 and promised to buy her shoes and dresses and asked her never to tell anyone what had happened.

Case study 4:

Mr. Nsa has a wife by name, Iquo. They have been married for 11 years with 6 children. Iquo was a farmer and a petty trader while Nsa had become a drunk since he was retrenched from work. Iquo worked so hard to make ends meet by going to the farm and coming back to sell her produce. On one particular day, Iquo was so tired after the day's work and was down with headache. Though she still tried to prepare the evening meal, her husband came back very late from the local beer parlour where he had

gone to drink and insisted on having sexual intercourse with her. She explained to her husband that she was ill and tired, but her husband will hear nothing of such, saying that "satisfying him whenever he wants is her major and primary duty as his wife." He threatened to end the marriage if she does not accept. Iquo reluctantly gave in to save her marriage.

Case study 5:

Uduak is 16 years old and in college. She wanted to register for her final exams but her parents could not afford the money. An uncle of hers promised giving the money to her, and asked her to come to his office to collect it. When she went to the office to see her uncle, he started fondling her. She resisted but her uncle told her that it is either she gives in to his sexual demands or she will not get the money. She pleaded but her uncle grabbed her and she was forced to have sexual intercourse with him.

Case study 6.

Mmayen had a school mate called Akpan. One day Akpan, invited Mmayen for a Saturday outing. The aim was for them to have fun and get to know each other better. Mmayen never knew that Akpan had something else up his sleeves. She took Akpan for a nice guy, and so, was very comfortable. Akpan however, drugged Mmayen's drink and she became unconscious after taking the drink. Akpan took advantage of the situation and had sexual intercourse with Mmayen.

Case study 7:

Otu was attractive, tall and good looking. He was celebrating his birthday and so, invited Eno to the party. At the party, Otu kept passing over drinks to Eno. Eno never thought that Otu was plotting something. Eno kept telling herself that something was going wrong but ignored it. After Otu's friends had left, Eno and Otu were sitting on the couch and Otu leaned over and kissed her. Eno thought Otu was just being a nice guy; so, no problem. When Eno stood up to go, Otu grabbed her from behind. He had his hands over her eyes and she did not know where he was taking her to. He laid her down on the floor and started taking off her clothes. Eno shouted, "wait, time out, this is not what I want," he grabbed her rather tight and she started yelling

and thrashing around, but he held on saying, "I know you like this because a lot of women like this kind of thing." Eno struggled until she was tired. Otu had sexual intercourse with her and finally rolled over, saying, "don't tell me you didn't enjoy every bit of it." Eno could not say anything but just cried and walked out.

Discussion points

1. What types of rape are depicted in the case studies?
2. What are the possible effects on the victims?
3. Were the victims raped because of what they were wearing?
4. Between boys and girls, who are those mostly affected by these types of rape?
5. What can be done to prevent them?
6. What should be done when faced with threats of rape?

- Ask rapporteurs for each group to make their presentations.
- Commend each group and ask for input and suggestions from other groups
- Process output at the end of each presentation
- Add value to the presentations using technical information

Activity 3:

Understanding consent

❑ This activity should be used when treating this topic with participants from 18 years and above and not minors.

■ Ask participants to think of what people do (physical expressions) or say (verbal expressions) that could depict consent to sexual activity.

■ Take down responses and add on the following if not given:

⇒ Saying, I love you
⇒ Pulling off his/her clothes
⇒ There will be no yelling, screaming for help, etc.
⇒ Initiating romance
⇒ Wanting to see a partner again
⇒ Being ready with things to practise safe sex, e.g. condom.
⇒ Be happy afterwards.

Self-Reflection/Evaluation

Have participants complete the following sentences:

■ One new thing I have learnt about rape is.....
■ When I hear people say dress-

ing causes rape I will.....

- One thing I am still not sure about rape is.....

Closing

Close session with appropriate songs, like;

Everybody is talking about GPI - Wombo, lombo

Where can I find her, no one answer-Wombo, lombo

I heard it is at 44 Ekpo Abasi - Wombo, lombo

In this place, they teach us how to be empowered- Wombo, lombo

Have you ever seen these girls being raped- Wombo, lombo

Do you think anyone else can try them - Wombo, lombo

Really these girls are empowered - Wombo, lombo

No one, no one outside can try them -Wombo-lombo

TECHNICAL INFORMATION

What is rape?

Rape is any forced or manipulated sexual activity with or without penetration, i.e. sexual intercourse. It may occur through verbal threats, physical restraint, intimidation or violent acts. Rape is a criminal act and a violation of the rights of the victim. 50% of rape victims are less than 16 years.

Types of rape

- **Gang rape**: When more than one person force a victim to have sexual activity with them.
- **Stranger rape**: Forced or manipulated sexual activity with a stranger without consent. It is the most traumatising and most likely to be associated with injuries, use of weapons or threat to life. It is most highly associated with grave medical and psychological consequences.
- **Statutory rape:** Sexual activity between an adult and a minor under the age of 18, regardless of consent.
- **Marital rape**: When a man or woman forces/coerces/manipulates the partner to engage in any sexual activity.
- **Incestuous rape**: Forced sexual activity between persons who have blood relationship.
- **Date rape**: Forced or manipulated sexual activity between people who decided to just go out together to have fun and know each other better.
- **Acquaintance rape**: Forced sexual activity by someone that

the victim has met before. It may be that the two persons were romantically involved or they may have just met each other. This type of rape may be extremely confusing to the victim though less likely to be associated with serious physical injury but with a great deal of self-blame and guilt. 75% of this type of rape occur in our immediate environments.

- **Genocidal rape:** This occurs during war situations and civil strifes

Possible effects of rape

- Rape is a terrifying experience for the victim with the threat of injury or death often present. The aftermath of being raped is, for instance, that a victim might act in an inappropriate manner such as being withdrawn, aggressive, or:
- Shock and depression in behaviour
- Phobia, fear
- Psychological or emotional problems
- Contracting of sexually transmitted infections, including HIV/AIDS
- Pregnancy/teenage pregnancy and its attendant consequences
- Unsafe abortion

Note: Girls and women are mostly affected as noted above. They suffer unsafe abortion, unwanted pregnancies and all the health implications.

Tips on how to reduce the risk of rape

- Avoid keeping late nights
- Avoid taking bush paths or short cuts
- Always be firm when saying **No** and your body language should indicate that you are saying **No**
- Do not receive gifts unnecessarily because givers will want something in return
- Avoid accepting lifts. Be sensitive to your environment, always obey your instinct
- Avoid getting tipsy i.e. being under the influence of alcohol.

What to do if you are a victim

- Never blame yourself
- Immediately go to a safe place
- Talk with someone you trust, like a close friend
- Get immediate care at the hospital, or see a doctor
- Keep all physical evidence, in-

cluding clothings. Don't shower or bathe after the attack until you have reported, to show evidence.

What has dressing got to do with rape?

People or rapists often try to justify their action by arguing that the way girls dress is often the reson for rape. Such dressing is always described as "irresponsible and provocative."

Researches have shown that over 50% of rape victims are between the ages of 9-12 years. The question then is, what kind of dressing by this age bracket could be termed irresponsible and provocative? On the other hand, even in areas where women and girls veil themselves from head to toe, leaving only their eyes, they still get raped. There is no justification for rape. If someone forces another into any sexual activity against the person's will, it is rape and a crime.

What is consent before sexual activity?

This is an un-induced, un-manipulated agreement by partners towards any sexual act. Unfortunately, most people assume consent and would never actually communicate their needs to each other. In order to get consent, both partners must say **yes** A person can say "**no**" at any time and once a partner says, no, she/he has no longer consented.

Also a person cannot give consent when she/he is a minor, drunk, asleep, drugged, emotionally or mentally challenged.

REFERENCES

1. *CMA Manual for Discussion Leaders and Counsellors* (2002), Calabar, Nigeria: Clear Lines Publications
2. Robin Warshaw (1994) *I Never Called it Rape.*

CHAPTER SIX

ANATOMY AND PHYSIOLOGY OF FEMALE REPRODUCTIVE SYSTEM

GOAL:

To assist participants to be familiar with the parts and functions of the female reproductive system.

OBJECTIVES:

By the end of lesson, participants would have been able to:

- Identify the various parts of the female reproductive system (Internal and External)
- Learn the functions of each part
- Develop comfort levels to talk about the female reproductive parts, using their correct names
- Increase their knowledge on personal hygiene practices to keep the reproductive organs healthy.

COMMON BELIEFS/CONCEPTS:

Ask participants what they hear people say about the female vulva. Take down responses on flipchart and add on the following if not already given:

- The female vulva is considered dirty, ugly, smelly and watery
- Thinking, touching and discussing the female reproductive and sexual organs is sinful
- Calling these parts by their proper names is considered a taboo.

MATERIALS:

Flipcharts, papers, markers, felt pens, enlarged diagrams of female reproductive systems (labelled and unlabelled), technical information.

ACTIVITY/TIME:

- Brainstorming (15 minutes)
- Write, read and stick exercise (20 minutes)
- Identification exercise (30 minutes)
- Group work (40 minutes)

LESSON SEQUENCE

Opening

The chairperson of the day will call for opening songs; a report of the last lesson. Debates, discussions and lesson clues; making of announcements and goal-setting, will also be generated at this stage.

Energisers/Ice-Breakers

Ask participants if they think studying this topic was necessary and why. Write down their reasons and add on information on the need for participants to know about their reproductive organs. Such as:

- To be able to know when something is wrong
- To be comfortable to talk about them, etc.
- To take care of them and avert possible future health complications

Activity 1:

Brainstorming exercise

This activity is to explore reasons why people don't take care of their bodies.

- Write down responses on flipchart and process information. Add value by discussing possible reasons for developing comfort levels in talking freely about their body.

Activity 2:

Write, read and stick exercise

Ask participants to write down on pieces of paper:

- Parts of their body they see
- Parts of their body they do not see
- Parts used for sexual intercourse and reproduction.

Process the information and add on value using technical information on female anatomy and physiology.

Activity 3:

Brainstorming exercise

Ask participants to brainstorm on slang names given to the vulva, vagina, clitoris, etc.

- List down responses from participants on flipchart

- Explain that the purpose of this exercise is to let participants know the current words people use to call such parts
- Ask participants to compare the slang names to those given to the male parts. This is to point out how sexist they are and also to get them to feel comfortable talking about the reproductive and sexual parts using the right names.

Activity 4:

Ask participants to draw and label the external parts of the female reproductive organ (the vulva)

- After 15 minutes, place a labelled diagram of the female reproductive organ and ask participants to compare with what they have drawn
- Ask volunteers to explain the functions of the part
- Add value using technical information on the parts of the female external reproductive organ.

Activity 5:

Display an enlarged unlabelled diagram of the female internal reproductive organs

- Ask participants to identify and write down the names and description of the various parts on the diagram as well as their functions (15 minutes)
- After the writing exercise, place a well-labelled diagram of the internal reproductive organs. Ask them to compare with what they have. Use the diagram to point out each part and explain what it is and how it functions.
- Provide technical information

Activity 6:

Group work

Divide participants into 2 groups to discuss the following:

(a) How do you take care of the body, especially during menstruation?

(b) How to perform vaginal self - examination

Let the groups present what they have come up with then process the information and add on value, using technical information.

Activity 7:

Review exercise/evaluation exercise (matching exercise)

- On blank pieces of paper, write down parts (one part in

each piece of paper) of the female reproductive organ. On flipcharts, write down description of the parts and allow participants to match each part on the paper to the description on the flipchart; e.g.

Words on paper	Descriptions on flipchart
1. Vulva	Female organ in which egg cells and sex hormones are produced
2. Mons pubis	Pear-shaped female organ in which the foetus grows and develops until birth
3. Labia majora	Neck-like, narrow end of uterus which opens into vagina, it stretches to allow a baby to be born
4. Labia minora	Either of two tubes through which egg released from an ovary every month travels to the uterus
5. Clitoris	The passage that extends from the outer sexual organs to the uterus and is the organ for sexual intercourse
6. Urethra	The external reproductive organ
7. Vagina	The passageway of urine from the bladder
8. Hymen	Fatty cushion at the upper part of the vulva situated at the pubic area where the pubic hair grows

9. Cervix	The lining of the uterus which nourishes the foetus
10. Endometrium	Outer lips of the vulva
11. Fallopian tubes	Hormone which is carried to the uterus to stimulate the growth of the lining of the uterine wall called endometrium
12. Ovary	Hormone which maintains the uterine lining
13. Egg cell	Inner lips of the vulva
14. Uterus	Web of skin which partly covers the opening of the vagina
15. Progesterone	Considered as counterpart of the penis of the man, it is a small cylindrical body located in the soft folds in the upper part of the vulva
16. Oestrogen	Female reproductive cell which if fertilised produces a baby.

Closing

Close session with appropriate empowering songs and exercises of your choice.

TECHNICAL INFORMATION

Anatomy: (Parts of the body they see) This refers to the study of the structure of the body.

Physiology: (Parts of the body they do not see) This refers to the functions of the body.

Reproductive system: Parts used for sexual intercourse and childbirth.

Anatomy and physiology of the female reproductive system refers to

the study of the structure and functions of those organs responsible for sexual intercourse and childbirth.

External parts of the female reproductive organ (the vulva)

Vulva: The female external reproductive organ or genitalia is called the vulva.

Mons pubis: The upper part, which is the fatty cushion, situated at the pubic area where the pubic hair grows.

Labia majora or outer lips: Below the mons pubis are two rounded folds of skin parallel to each other, these are called labia majora.

Labia minora or inner lips: These are situated under the labia majora. The labia cover and protect the vaginal opening.

Clitoris: This is a small cylindrical body located in the soft folds of the upper part of the vulva. The clitoris is the counterpart of the penis of the man. This is because the clitoris comes from the same tissue that develops into the head of the penis in the male, it has the same nerve endings as the glands and because it is so much smaller, it is very sensitive.

Urethra: This is situated below the clitoris and is the passageway for urine from the bladder to the outside of a woman's body.

Hymen: This is a web of skin, which often times, but not always, partly covers the opening of the vagina.

Vaginal opening: Just below the urethral opening is the entrance to the vagina.

Internal parts of the female reproductive organ

Vagina: This is the elastic muscular passage extending from the woman's outer sexual organs (the vulva) to the uterus. It is about four inches long and is the organ for sexual intercourse. It receives the penis during sexual intercourse. Besides serving as organ for sexual intercourse, it also serves as the birth canal, the passage through which a baby is born. The vagina

is not a hollow tube, the walls are collapsed when it is empty, however, it can stretch to various sizes during childbirth, sexual intercourse or menstruation. The vagina is self-cleansing as it periodically sheds mucus and dead cells.

Cervix: At the upper end of the vagina and the opening of the uterus is a button-like structure called cervix. It 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.

Uterus or womb: It is a pear-shaped muscular organ in which the fertilised egg grows and develops into a foetus. Normally, the uterus is about 3 inches long and 2 inches wide. During pregnancy, it stretches and grows with the foetus. In pregnant women the lining of the uterus, called the endometrium nourishes the foetus. In non-pregnant women, the lining is shed about once a month if an egg is not fertilised. This shedding is what is called menstruation.

Fallopian tubes: The fallopian tubes are 4 to 6 inches long in a mature female. They curve around the ovaries and extend to the uterus. These tubes are the passageways through which the egg travels from the ovary to the uterus. Each fallopian tube links one ovary with the uterus.

Ovaries: Connected by ligaments to the uterus are two ovaries; one on each side of the uterus. These are the organs which store the egg cells. They also produce some of the female sex hormones, which regulate the menstrual cycle and are responsible for the development of female secondary sex characteristics. 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 ovaries produce a hormone called oestrogen, which is carried in the blood stream to the uterus where it stimulates the growth of the lining of the uterine wall called endometrium.

Eggs or ova: Eggs or ova (which are about the size of a dot made

from a sharp pencil) are some of the largest cells in the human body. When the egg is expelled from the ovary, it travels to the uterus in one of the fallopian tubes. This takes three to five days. The egg cell dies if not fertilized within 12-24 hours after ovulation. Fertilization occurs in the outer 1/3 of the fallopian tube. If fertilization does not occur, the egg cell will dissolve and become absorbed by the body. After ovulation, the ovary secretes progesterone and also more oestrogen. The progesterone maintains the uterine lining. If fertilization does not occur, the ovary will stop producing oestrogen and progesterone after about two weeks. This decline in hormones signals the uterus to shed its lining (menstruation). If fertilization occurs, 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.

Menstruation

This comes once a month for most women. It 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. Periods or menstruation lasts between three to seven days in most women but this also varies. At the onset, a woman's periods may be irregular -every three, four, five or six weeks. Then gradually the body develops its own pattern of regularity. Some women feel uncomfortable on the first or second day of their periods, but for most women menstruation does not interfere with their normal activity.

How to take care of the body, especially the vulva during menstruation

- Take your bath daily and at least twice during menstruation
- Clean the vulva from front to back after urinating or during bowel movement
- During sex play, do not allow fingers used in the anus to be put inside the vagina without washing. Wash the vulva with mild soap and water before and after sexual relations
- Never use powders, deodorants, perfumes, medicated soap while bathing the vulva area, they may

cause irritation

- Use white toilet paper to avoid irritation
- Do not douche. This may spread infections higher up the organs
- During menstruation, change sanitary pads tampons or menstrual cloth regularly to avoid stale odour and spread of infections from the anus to the vulva.
- Never use toilet paper to absorb menstrual flow as it may cause irritation and lead to infections.
- Leave out wearing pants at night to allow air to circulate within the vulva
- Examine your vulva at least once a month (between your monthly periods) to check for signs of irritation
- Report to a gynaecologist all pains, abnormal discharge, redness, itching, bumps, warts, unusual bleeding, swellings, sores and ulcers except for minor injuries with a known cause.

How to perform vaginal self-examination

⇒ Find a comfortable place such a s a bed or carpet with good lighting.

⇒ Hold a mirror in one hand, then use the other hand to separate and expose the parts of the vulva around the vaginal opening. Once you have a good viewing position, examine the main part of the vulva as follows:

◊ Check the mons pubis. Look for any bump, warts or ulcers, any changes in skin colour, then use your fingers to check any visible changes and to feel for any bump just below the surface. You may feel something, which you may not see.

◊ Check the clitoris and the areas around it (just above the vaginal opening) by looking and touching

◊ Examine the labia majora. Examine both right and left just as you did with the labia minora

◊ Move down to the perineum and check carefully

◊ Finally examine the areas around the anal opening by looking and touching.

Note: Vulva diseases can be treated more easily and safely when signs are noticed early. Report a new growth or changes

to your health care provider as soon as possible.

dose

REFERENCES

1. GPI Training Manual
2. *Where Women Have No Doctor-A: Health Guide for Women,* by August Burns, Ronnie Lovich, Jane Maxwell and Katherine Shapiro (1997)
3. Step-by-Step Flipchart on Reproductive and Sexual Health Education for Reproductive Health Educators and Promoters (1998).

CHAPTER SEVEN

ANATOMY AND PHYSIOLOGY OF THE MALE REPRODUCTIVE SYSTEM

GOAL:

To assist participants to be familiar with the parts and functions of the male reproductive system.

OBJECTIVES:

At the end of the session, participants would have been able to:

- Identify the parts of the male reproductive system
- Explore the functions of each part
- Explore and demystify sexist stereotypes about male superiority.

CONCEPTS/COMMON BELIEFS:

- It is believed that it is possible to kill sperms inside the testicles by taking certain drugs.
- It is believed that during erection, a bone extends into the penis
- The size of a man's penis reflects his ability to satisfy a partner
- It is not proper for girls to discuss the male reproductive system in public.

MATERIALS:

Flipcharts, papers, markers, felt pens, enlarged diagrams of the male reproductive system (labelled and unlabelled), resource for technical information.

ACTIVITY/TIME:

- Brainstorming (15 minutes)
- Write, read and stick exercise (20 minutes)

- Identification exercise (30 minutes)
- Group work (40 minutes)

LESSON SEQUENCE

Opening

The chairperson of the day will begin with the opening songs and calls for a report of the last lesson by the previous rapporteur followed by announcements, if any.

Energisers/Ice-Breakers

Ask participants why the need to study the male reproductive system.

List down responses and add value as follows:

- To know how it functions
- To detect any abnormality
- To treat infections on time to avoid infertility problems
- To identify certain myths and misconceptions and to deal with them
- To overcome deceit from boys
- To correct misinformation where possible.

Lesson topic

Activity 1:

Brainstorming exercise

Ask participants to brainstorm on slang words they often hear people use to describe the male reproductive organs

- List responses on flipchart and tell participants to compare them with those given to the female.
- Stress the fact that the slang words for the male connotes power and are not used as a language of abuse unlike those of the females.

Activity 2:

Display an unlabelled diagram of the male reproductive system and ask volunteers to identify and describe the parts

- Ask another set of volunteers to name the functions of these parts as given in the diagram
- Place a labelled diagram of the male reproductive parts and use it to explain the parts. Describe them and their functions to add value to what participants have given as well as correct wrong names and descriptions.

Activity 3:

Group work

Divide participants into 2 groups

and ask them to work on the following:

- Ask participants to name the types of problem they have read or heard people talk which males have with their organs.
- How can these problems be remedied or taken care of?

After the group presentations, process the information and add value on some problems of the male reproductive organs.

Activity 4:

Matching exercise

On blank sheets provided, write the letter corresponding to the definition of each of the organs of the male reproductive system.

Male reproductive organs	Definition
1. Testicles/Testes	(A) Duct through which urine and semen are discharged
2. Penis	(B) Either of two ducts that allow sperms pass from the testicle
3. Scrotum	(C) A path which connects the vas deferens and the urethra
4. Urethra	(D) A filling station that provides the sperms with sugar energy
5. Vas deferens	(E) The gland in the male that produces sperms
6. Seminal vesicles	(F) The external pouch that contains the testicles
7. Semen	(G) The male sex organ, also the male urinary organ

8. Sperm	(H) A small tube-like resting station on top of each testes where the sperm matures
9. Testosterone	(I) A gland in the brain that sends a message to the testicles to make sperms
10. Androgens	(J) A storage container for milky water which helps the sperms swim more easily
11. Epididymis	(K) A milky, sugary liquid containing the sperms which leaves the male body through the urethra in the penis
12. Prostate gland	(L) The male reproductive cell made in the testicles
13. Cowper's gland	(M) The male sex hormone which prompts the production of sperms
14. Ejaculatory duct	(N) Gland that squirts out a cleansing fluid to clear the urethra
15. Pituitary gland	(O) Hormone which is responsible for physical development in males.

Evaluation/Self-Reflection questions

1. What new lessons have you learnt?
2. What do you need more information about?

Closing

Close session with appropriate songs and exercises

Action assignment

Give an action assignment for par-

ticipants to discuss with close friends the parts and functions of the male reproductive organs.

TECHNICAL INFORMATION

Parts of the male reproductive system

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

Testicles: These are two sex glands located in a wrinkled-looking pouch or sac called the scrotum, which hangs behind the penis. An adult male has 2 testicles which are about the size and shape of plums. The testicles contain hundreds of thousands of chambers where sperms develop. The testicles correspond to the ovaries in a woman because both ovaries and testicles produce reproductive cells. The scrotum controls the temperature of the testicles. Its temperature is about six degrees below body temperature. This is ideal for producing sperms.

Testosterone, androgens and sperm cells: One vital function of the testicles is hormone-production. The male hormones are called androgens. Androgens are responsible for the physical development in males. Moreover, they help activate male sexual behaviour. The chief androgen produced in the testicles is testosterone. Messages from the pituitary gland signal the development of testosterone, the male sex hormone which prompts the production of sperms. As sperms are produced, they pass into a tubular structure called the **epididymis.** While the sperms are resting in the epididymis, they mature until they are ready to be used. Then from the epididymis they pass through the **vas deferens** on their way to the seminal vesicles. The **seminal vesicles** are small, sac-like structures, which open to the ejaculatory duct. At the time of ejaculation, secretions from the two primary glands, the seminal vesicles and the prostate are mixed with

sperm cells. The seminal vesicles empty some sugar into the vas deferens to provide energy for the sperms. The prostate gland empties some milky fluid called semen into the ejaculatory duct to enable the sperms swim easily. Two pea-sized bulbo-uretheral glands or cowpers' glands also produce some fluid to cleanse the urethra of any urine residue which may prove harmful to the sperms.

Semen or seminal fluid is the whitish fluid that carries the sperms and is ejaculated during intercourse. Each ejaculation contains 100 million sperms in about a teaspoon of fluid. From the ejaculatory duct, the sperms move through a long tube called the urethra through the penis. Both urine and sperms are released from the body through the urethra. When the sperms are released, a valve closes off the flow of urine.

Sperms are microscopic male reproductive cells, which make up less than 2% of the total ejaculate. They are much smaller than the egg (the female reproductive cell). They have a head and tail, resembling the tadpole. When ejaculated during sexual intercourse, they swim through the vagina, into the uterus through the cervix and come up into the fallopian tubes. Sperms can live for six to eight hours in the vagina but once they get into the tubes and uterus they can live for three to five days. They usually reach the tubes within one hour to one hour thirty minutes after ejaculation. Upon 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 towards the uterus. Of several hundred million sperms ejaculated only about 2,000 reach the tubes. Even though the egg must be totally surrounded by sperms in order to be fertilised, only one sperm is able to penetrate it. The rest are absorbed by the body. Sperm cells only retain the ability to fertilize an egg in a period of 48 to 72 hours.

Some problems of the male reproductive organs

Problem signs:

* An open sore or persistent sore spot around the penis

* A burning feeling when one urinates
* An un-descended testicles
* Discharge of pus or whitish fluid coming from the end of the penis
* A pain in the testicle that does not go away
* A lump that was not there before.

The above signs may be signs of sexually transmitted infections (STIs). If one experiences any of these problems, it is better and necessary to see a health service provider for proper diagnosis and treatment.

Care of the male reproductive organs

- Always wash your genitals with mild soap and clean water at least once or twice a day
- Clean away any semen that may collect, especially if you are not circumcised
- Check for testicular lumps by examining your testicles at least once a month.

How to examine the testicles

- The best time to examine the testicles is right after a hot bath or shower. The scrotal sac is most relaxed at this time and the contents can be felt easily.
- Each testicle should be examined with the fingers of both hands. Place your index and middle fingers on the underside of the testicle and your thumb on the top.
- Gently roll your testicles between your thumb and fingers feeling for a small lump about the size of a pear. Repeat this procedure for both testicles.
- You should learn what the collecting structures at the back of the testicle feel like so that you don't confuse it with an abnormal lump. It is called the epididymis and it collects the sperms from the testicles so that they can travel up the vas deferens to the prostate. If you find anything abnormal, most often it will be a firm area on the front or side of the testicle.
- Testicular cancer contains less than one percent of all cancers but is one of the common cancers in men, aged 20-35 years. It is forty times more likely to occur among men whose testes never descended to the scrotum

or descend after the age of six.

- Men themselves would first discover most testicular cancers. Since testicular cancers found early and treated promptly have excellent chances for cure, learning how to examine your testes properly can save life. It really does not take much effort to feel for those small lumps and you have to do it once a month. Use the simple testicular self-examination (TSE) procedure as explained.

REFERENCES

1. *Internal Organs in the Human Body: Body Literacy*, by Talthapi (Women and Health Resource Development, India, 2001)
2. GPI Training Manual, Vol.1

CHAPTER EIGHT

PREGNANCY AND CHILDBIRTH

Safe Motherhood

COMMITMENTS TO ACTION

Governments, with the increased participation of the UN system, civil society, including NGOs, donors and the international community, should recognise the linkage between high levels of maternal mortality and poverty and promote the reduction of maternal mortality and morbidity as a public health priority and reproductive rights concern; (and) ensure that... women have ready access to essential obstetric care, well-equipped and adequately staffed maternal healthcare services, skilled attendance at delivery, emergency obstetric care, effective referral and transport to higher levels of care when necessary...

(Key Actions for The Further Implementation of the ICPD Programme of Action, 62 (A,B).

GOAL:

Assist the girls to be familiar with the processes and changes that occur during pregnancy as well as how one can stay healthy during pregnancy.

OBJECTIVES:

By the end of the session, the participants would have been able to:

- Say in simple terms, the meaning of the term, pregnancy.
- State some of the processes involved for pregnancy to occur and the different stages of pregnancy
- Explore some myths and facts about pregnancy
- Identify the three trimester periods.

CONCEPTS/COMMON BELIEFS:

- Pregnant women are very lazy
- Having sexual intercourse during menstruation produces albino babies
- Pregnancy is a disease
- If you have sex in the day time you can't be pregnant.

MATERIALS: Universal childbirth picture book, labelled diagram of fertilisation pathway, labelled and unlabelled diagrams of male and female reproductive systems.

ACTIVITY/TIME:

- Brainstorming (15 minutes)
- Discussion (1 hour)
- Identification exercise (15 minutes)
- Group work (40 minutes)
- Write, read and stick exercise (15 minutes)

Note: The topic is broad and should be taken in at least, three sessions.

Session 1:

Goal of the session: Group to come to terms with the fertilisation process and how pregnancy occurs.

Objectives of the session: Participants to be able to:

1. Say in simple terms what pregnancy means
2. Be able to explain the process of fertilization.

Opening

The chairperson of the day opens with songs; a report of the last lesson by the previous rapporteur; corrections and comments by participants; checking-in and debates, discussions and lesson clues; making of announcements and goal-setting.

Energizers/Ice-Breakers

- Begin session with a warm-up exercise; e.g. breast and vulva exercise.

Lesson topic

Activity 1:

Review

- Review the human reproductive systems using unlabelled and labelled diagrams.
- Ask participants to read out the topic as written on a flipchart. Introduce the topic by noting that the term, pregnancy is often used by the society, and that though we see women and

young girls who are pregnant, we give no serious thought about the processes involved for pregnancy to occur, thus leading to many misconceptions and misinformation surrounding the issue of pregnancy.

Activity 2:

Identification exercise

- Display unlabelled diagrams of the male and female reproductive systems and ask participants to volunteer to identify the parts and functions of the male and female reproductive systems.
- Facilitator to correct misinformation from participants and add on value to strengthen participants' knowledge.

- Facilitator to ask from participants what they hear people say about pregnancy and pregnant women. Add on societal concepts of pregnancy and pregnant women as given above and generate discussion to bring out the myths and facts.

Activity 3:

- Brainstorming exercise on what participants understand by the term, pregnancy
- Take down responses and process information, and then add value on what pregnancy is, using the technical information.

What is pregnancy?

- Pregnancy is the period between the implantation of a developed embryo on the walls of the uterus and to childbirth.

Activity 4:

Hang a diagram of the fertilization pathway. Ask volunteers to explain what they have seen on the diagram, pointing out the various processes involved at the different stages. Add value at the end by providing information on the various processes such as:

Ejaculation: The ejection (expulsion) of the male sperm cells, contained in a liquid called, semen, from the penis

Ovulation: The release of a ripe (matured) egg cell from the ovary (about once a month)

Menstruation: The monthly elimination of the blood-filled lining of the uterus (womb), which takes about 3-5 days

Fertilization (Impregnation): The fusion of the male and female sex cells to form a zygote

Implantation: The attachment of a fertilized egg cell to the lining of the uterus

Conception: The process of becoming pregnant involving fertilization or implantation or both.

Activity 5:

Explaining the issue of sex determination

- Facilitator to explain the issue of chromosomes found in the bodies of males and females - Males (23 pairs) **XY** chromosomes, females (23 pairs) **XX** chromosomes.
- The **X**-chromosomes represent females, while the **Y**-chromosomes represent males.
- Facilitator to use this to debunk the concept that women are to blame if they give birth to female children when their partners wish for male children.
- Also explain the process of cell division (meiosis and mitosis), as well as the formation of identical and un-identical twins.

Session 2

Signs of pregnancy and discomforts

Objectives

- Identify early signs of pregnancy
- Explore for first trimester discomforts and remedies
- Be familiar with what ante-natal is and what is involved.

Activity 1:

Group work

- Break participants into 3 small groups. Let each group pick a rapporteur to make presentation on behalf of the group.
- Give the following tasks to the groups:

Group 1

⇒ What are the early signs that they have either seen or heard which pregnant women usually experience?

Group 2.

⇒ What do they understand by the term, ante-natal and what is done during ante-natal?

Group 3.

⇒ What are some of the discomforts (common problems) that pregnant women face during the early stage of pregnancy and how can these be handled or remedied?

Report back

- Ask the group representatives to report back what each group has discussed
- Acknowledge participants' contributions and ask others to make input.

Process the output and add value on the early signs of pregnancy, using the following, if not already given; such as:

Some early signs of pregnancy

- Missed period
- Nausea
- Tiredness and vomiting
- Frequent urination
- Abdominal cramps
- Breasts feeling sore and growing bigger
- Distaste for certain foods

Note: Some of these signs could also be signs of other ailments.

What is ante-natal?

- This is a medical examination or check up carried out on a pregnant woman in a clinic; healthcare centre or hospital. This is necessary to check if the foetus and the woman are healthy as well as make recommendations for proper healthcare and nutrition and to determine Expected Date of Delivery (EDD).

What is done during ante-natal

When a pregnant woman visits a healthcare provider, the following will be carried out:

1. A detailed health and family history (twins, hypertensive, diabetic) of the woman will be taken

2. The Expected Date of Delivery (EDD) will be determined
3. Blood samples will be taken to determine blood group, presence of STDs, anaemia, etc.
4. A uri-analysis will be carried out to check glucose content, protein, white blood cells level, bacteria, etc
5. Weight and height will be measured
6. A pelvic examination will be carried out
7. Check presence of edema and varicose veins
8. Nutrition prescription, e.g. vitamins
9. Date will be given for follow up which could be:

1-7 months	- once a month
8 months	- twice a month
9 months	- weekly

First trimester discomforts and how to manage them

(a) **Morning sickness:** This is as a result of:

- accumulation of acidic enzymes:
- higher level of hormonal secretion
- Rapid expansion of the uterus, inducing vomiting and digestive discomforts

Remedies:

⇒ Guard against an empty stomach

⇒ Keep crackers/toasted bread handy

⇒ Give yourself time to wake up gradually

⇒ Avoid fatty foods at breakfast and spicy foods throughout the day

⇒ Avoid sweet processed foods and coffee

⇒ Do not take fruits with high acidic content

⇒ Take five small meals, instead of 3 heavy ones

⇒ Take a lot of fluids, e.g. ginger ale

⇒ Consult healthcare provider.

(b) **Fatigue:** Pregnant women are often regarded as lazy. This is not true as it is nature's way of helping them conserve energy.

Side effects of fatigue

- Impatience
- Irritability
- Lack of concentration
- Loss of sexual interest

Remedies

⇒ Find time to take a nap

⇒ Go to bed early

⇒ Sleep and eat good nutritious food.

Evaluate the session using question and answers.

Session 3:

Childbirth and miscarriage

Objectives:

- Participants to be able to say in simple terms what labour is
- To identify labour signs
- Come up with some effects of teenage pregnancy
- Identify materials needed during childbirth.
- Explore myths and facts about childbirth
- Identify danger signs during labour.

Activity 1:

Write and stick exercise on what labour is

- Participants to write down in their own words, what they understand by the term, labour.
- Process output and add value on the meaning of labour.

What is labour?

Labour is the act of giving birth. The regular contractions (cramps) of the uterus, to expel the baby. The involuntary contraction of the uterus to push out the baby is called labour. The contractions, which one cannot control, start when the baby is ready to be born.

Activity 2:

Group Work

Break participants into 4 groups and give the following:

Group 1.

- To explore the labour signs they have heard or seen

Group 2.

- Identify materials needed during labour

Group 3.

- Name some danger signs during labour

Group 4.

- To identify effects of teenage pregnancy

Report back

- Each group representative would make the group's presentation.
- Facilitator processes the information after each presentation and then adds value, using tech-

nical information on the various issues raised.

TECHNICAL INFORMATION

Things to have ready before childbirth

Some of the things a pregnant woman should have ready by the seventh month of pregnancy are:

- Soap
- Methylated spirit
- Clean string
- New razor blades
- Clean clothes
- Bowels
- Towels
- Eye ointment

Signs that labour is near

These 3 signs show that labour is starting or will start soon. They may not all happen, and they can happen in any order:

1. **Clear or pink colour mucus comes out of the vagina**- During pregnancy, the opening to the womb (cervix) is plugged with thick mucus. This protects the baby and womb from infection. When the cervix starts to open, it releases this plug of mucus and also a little blood.
2. **Clear water comes out of the vagina** - The bag of water can break just before labour begins, or at any time during labour.
3. **Pains (contractions) begin** - At first, contractions may come 10-20 minutes apart or more. Real labour does not begin until contractions become regular (have about the same amount of time between each one).

When any one of these signs occurs, it is time to get ready for the birth.

- Facilitator to use this period to clarify some myths concerning pregnancy and childbirth such as: when the head of a baby touches the clitoris the baby dies.

Danger signs during labour

There are some signs, which signify that there is danger during labour. Such signs could be:

1. **Water breaks but labour does not start** - Most women will start labour within 24 hours after their water breaks. If labour has not started after 1 day and 1 night, the woman and her baby could get serious infection.

2. **Baby lying sideways**
3. **Bleeding before the baby is born**
4. **Too long labour** (more than 1 day and 1 night)
5. **Green or brown water**
6. **Fever**
7. **Fits or convulsion**

Effects of teenage pregnancy

- Prolonged labour
- Damage to the pelvic region
- Bleeding
- Damage to reproductive organs
- Death

Miscarriages (spontaneous abortion)

Causes

- Genetic or uterine abnormality
- Infection
- Uterine tumours
- Environmental factors (smoking, excessive drinking, etc.)
- Ectopic pregnancies (tubal pregnancies)
- Toxic substances
- Incompetent cervix

Signs of miscarriage

- Abdominal cramps
- Vaginal bleeding
- Passing of blood clots and tissues

Evaluation

- Participants to say one new thing they have learnt
- Close session with an exercise or songs.

Closing

Close session with suitable exercise such as "breast and vulva knees and toes."

REFERENCES

1. *Universal Childbirth Picture Book* by Fran P. Hosken (1995).
2. *Where Women Have No Doctor: A Health Guide for Women,* by August Burns, Ronnie Lovich, Jane Maxwell and Katherine Shapiro (1997).

CHAPTER NINE

PREGNANCY BY CHOICE

COMMITMENT TO ACTION

Unsafe abortions threaten the lives of a large number of women, -representing a grave public health problem. Most of these deaths, health problems and injuries are preventable through improved access to adequate healthcare services, including safe and effective planning methods and emergency obstetric care... (Fourth World Conference on Women (FWCW) Platform for Action, 97).

GOAL:

To understand that unsafe abortion is a major public health problem and one of the leading causes of adolescent deaths.

OBJECTIVES:

By the end of the lesson, participants will be able to:

- Appreciate and know what pregnancy by choice is all about
- Explore reasons why women need to choose to carry pregnancy to term
- Appreciate the need to reduce the risk of unsafe abortion
- Explore some myth and misconceptions surrounding why women choose to have abortion
- Discuss safe and unsafe abortions.

COMMON BELIEFS/CONCEPTS:

- Abortion is murder
- Abortion is chosen by women who are promiscuous
- Only prostitutes procure abortion
- Abortion decreases the ova in a woman's ovaries

ACTIVITY/TIME:

- Brainstorming
- Individual writing exercises
- Read and stick exercise
- Case study
- Technical information.

MATERIALS:

Flipcharts, felt pens, stick tapes, facilitator's resource, etc.

PREPARATION:

Young people and the society in general see any open discussion of abortion issue as a taboo. Young people are therefore inhibited, made uncomfortable and embarrassed to talk about this, leading to grievous consequences that should have been prevented.

LESSON SEQUENCE

Opening

- The facilitator starts the session with a warm-up exercise of her choice or asks a volunteer to lead in one.
- Facilitator then asks the girls to brainstorm on some of the health problems that young people, especially girls face in our society.
- Take note of their responses
- Probe further, if abortion is not mentioned
- Commend them and pick on abortion as a topic.

Energizers/Ice-Breakers

Energizers are quick activities that can be used to introduce the topic and manage the energy and attention of the group and equally used to have fun.

Lesson topic

Introduce the topic as follows:
Unintended pregnancy is a major public health problem across the globe. It is one of the five leading causes of maternal mortality and morbidity, contributing to nearly 50,000 deaths and hundreds of thousands of disabilities each year. At least 3% of maternal mortality around the world is traceable to unsafe abortion, arising from unintended pregnancies. A significant number of the deaths occur in developing countries like Nigeria.

The World Health Organisation estimates that as many as 20 million unsafe abortions take place each year and that the ensuing complications cause nearly 80,000

deaths - 13% maternal deaths annually.

Activity 1:

- Ask participants to explain in their own words what they understand by abortion.

a) List participants' responses on flipchart or blackboard and add value using, technical information.

Activity 2:

Written exercise

Here, participants will be required to write down what they hear as reasons why some women prefer to have an abortion.

- At the end of the exercise, ask participants to individually read out what they have written.
- Record their output on flipchart and commend them, then add value, using technical information on reasons why some women terminate pregnancies.

Activity 3:

Write and stick exercise

- This exercise depicts what constitutes an unsafe abortion.
- The facilitator will distribute blank pieces of paper for participants to record the various things people use to terminate pregnancies and possible effects of such methods.
- Put up flipchart for the girls to stick what they have written on.
- Process their output and give technical information on safe and unsafe abortions, including what constitutes them.

Activity 4:

Group work

- Participants will be divided into 3 or more groups, depending on their number.
- Let each group discuss and brainstorm on what they consider preventive measures to reducing an unintended pregnancy and the possible conditions under which abortion can be necessary.
- Process each group presentation and commend them for their contributions.
- Give technical information on preventive measures.

Self-Reflection/Evaluation

Have participants discuss:

- Their experiences with health service providers
- How such experiences can affect young people
- What should be done to help

correct such negative experiences.

Closing

End the session with the song-

We have a vision, of a world of good health

World without AIDS and STDs free

Let's stop gender discrimination.

Female circumcision unsafe abortion

So we can live in harmony.

TECHNICAL INFORMATION

What is abortion?

Abortion is a procedure that removes the foetus from the uterus before it develops into a baby that could live outside the mother. In most manuals this period extends roughly over the first two-thirds of the pregnancy (24-28 weeks), when the foetus reaches a point where it can survive outside the mother for at least a short while, under intensive medical care.

Some reasons why women choose to terminate pregnancy

◊ Sexual coercion or rape
◊ Mental or physical problem that may endanger the life or health of the woman or her foetus
◊ Contraceptive failure
◊ Abandonment or an unstable relationship
◊ Financial constraints
◊ Young age
◊ Desire to continue schooling
◊ Single marital status
◊ Too many children
◊ Not wanting to have a child.

Note: Research has shown that no woman ever wants to become pregnant in order to terminate it. That abortion is always traumatic, but sometimes women are forced by economic necessity or psychological desperation to have it.

Deciding whether to have a baby or an abortion is always a serious choice. One has to decide what one believes is responsible, moral and best for oneself depending on one's needs, resources, commitments and hopes.

Safe and unsafe abortion

Safe abortion - Abortion is considered safe when it is done:

■ By a trained and experienced medical practitioner (a gynaecologist)
■ With proper instruments
■ Under clean conditions, making

sure that anything that goes into the vagina and womb must be sterilized and made free from germs

- Up to two months after the last monthly bleeding

Unsafe abortion is when it is done:

- By someone who has not been trained to do it
- With the wrong instruments or medicine
- Under unclean conditions
- After three months (12 weeks) of pregnancy, unless it is done in a hospital that has special instruments or equipment.

Dangerous methods and procedures used by some women, girls and untrained providers to terminate pregnancy include:

* Inserting foreign objects such as stick, wires and knitting needles into the uterus. Use of plant stalk is also common. This practice can puncture the uterus or cause other injury and infection.
* Drinking concoctions made of poisonous herbs or other harmful substances. Mixture of herbs believed to be abortifacients are very common as are chemical drinks, including ingredients such as bleach, hair dye and vinegar.
* Taking dangerous over dose of certain over-the-counter medications, laxatives, cola, anti-malarial medications and pro stalgladins intended as treatment for gastric ulcers are among the drugs that women report using to induce abortion.
* Douching with herbs or caustic substances, such as chlorine and bleach is another method. In some countries, abortifacient pastes are sold in pharmacies without a prescription. These can cause burns in the vagina and cervix.
* Intentionally undergoing physical abuse such as strenuous exercise, jumping from heights, falling down stairs and blows to the belly, intended to provoke miscarriage. Rough uterine massage is the procedure of choice among traditional practitioners in many places. This can result in haemorrhage.

The impact on personal health and well-being

The World Health Organisation estimates that between 10 and 50 percent of women who undergo unsafe

abortion need medical care. Some of the most frequent complications are:

- Incomplete abortion: The retention of some or all products of conception in the uterus, which can lead to infection and sepsis. Other complications include:
- Haemorrhage, vaginal and cervical trauma;
- Infections resulting from unsanitary conditions and;
- Intra-abdominal injury such as uterine punctures and tears.

These complications can lead to serious long-term health problems and permanent disability.

Long-term health problems attributed to unsafe abortion include:

• Chronic pelvic inflammation

• Permanent or recurrent pain and secondary infertility.

Other health consequences of unsafe abortion are:

- Ectopic pregnancy
- Increased risk of spontaneous abortion and premature delivery in subsequent pregnancies

Note: Treatment for these complications can also have a long-term impact on women's lives and fertility. For example, uterine perforation and trauma can necessitate hysterectomy.

Social and economic impact of unsafe abortion

Long -term abortion and related health problems can interfere with women's domestic work, limit their productivity outside the home, constrain their ability to care for their children and affect their sexual relations.

Impact of unsafe abortion on adolescent girls

Young girls suffer disproportionately from abortion complications:

- Adolescents frequently have poor access to information and services that could help them avoid unwanted pregnancy, and they are less likely than older women to have the social contacts and financial means necessary to obtain a safe abortion.
- Adolescent girls may have incentive to seek abortion, since an unplanned pregnancy can prevent them from concluding their education and jeopardize their social, marital and financial future. However, because of ignorance, shame or for other reasons, adolescents may delay

seeking the procedure until the pregnancy is relatively advanced, which then increases the risk of serious complications. If the complications are not treated, they can render a young woman infertile.

Reducing incidence of unintended pregnancy and the need for abortion

- One way to reduce the incidence of abortion-both safe and unsafe - is to help couples avoid unwanted pregnancy. Research has shown that the rate of abortion declines with increased use of effective contraceptive methods.
- Despite the potential impact that increased contraceptive use could have in reducing abortion rates, approximately millions of women world-wide, lack information about contraceptives and access to the full range of family planning methods, information and services.

Role of family planning providers

- Family planning providers have an important role to play in reducing the need for abortion by ensuring that their services are accessible, affordable and responsive to needs and preferences of their clients.
- Providers should be trained and encouraged to help their clients when contraceptive failure occurs, by counselling them and referring them to whatever health and social services are available to them.
- Providers can also help prevent repeated abortions by ensuring that women treated for abortion-related complications or provided with induced abortion services are offered compassionate counselling and introduced to a range of contraceptive methods available.
- Encourage the use of condom, each time a woman has sexual intercourse. This could be backed up by the use of emergency contraceptive pills (ECPs) which are the most common forms of emergency contraception. They work by interrupting a woman's reproductive cycle.

REFERENCES

1. *Where Women Have No Doctor: A Health Guide for Women,* by August Burns etal (1997)
2. A Guide for Action (Preventive and Management of Unsafe Abortion -Family Care International.

CHAPTER TEN

CONTRACEPTION

COMMITMENTS TO ACTION

The United Nations system and donors should request and support governments in:

(1) Mobilising and providing sufficient resources to meet the growing demands for access to information, counselling services and follow-up on the widest possible range of safe, effective, affordable and acceptable family planning and contraceptive methods, including new options and under-utilised methods.

Key Actions for the Further Implementation of the ICPD Programme of Action, 57.

GOAL:

To assist young people to avoid unhealthy practices that are detrimental to them and those around them.

OBJECTIVES:

At the end of the session, participants will be able to:

- Explain the meaning of contraception
- Become familiar with the different methods of contraception
- Feel comfortable handling contraceptive devices and know how to use them when and if they have to
- Identify personal consideration that should influence contraceptive decision-making for an individual
- Know how to include contraceptive decision-making as part of language of romance.

COMMON BELIEFS/CONCEPTS:

Ask participants to say things they have heard about contraceptives. Add the following if not given:

- That contraception causes infertility and sterility
- Can cause deformity and, or kill children in the womb
- Encourages promiscuity and causes infertility in women
- Interferes with sexual pleasure, e.g. condom
- Pregnancy can be prevented through the use of local herbs, minerals mixed with laxative, hot drinks, etc.
- Contraception should not be practised because children are gifts from God
- Intra-Uterine Device (IUD) will hurt the man during sexual intercourse.

MATERIALS:

- Flipcharts, markers, facilitator's resource, samples of contraceptives.

ACTIVITIES/TIME:

- Brainstorming (15 minutes)
- Group work (30 minutes)
- Individual work (15 minutes)
- Written exercise (15 minutes)
- Technical information (1 hour)

Opening

Energisers/Ice-Breakers

Start session with a warm-up exercise: e.g. participants to label and discuss functions of the male and female reproductive systems.

Lesson topic

Activity 1:

Brainstorming exercises

1. Ask participants to brainstorm and say in one or two words, what they understand by contraception.
   - List responses on flipchart,
   - Commend participants for their efforts.

- Clarify by giving the definition of the term as follows:
   - It is a deliberate attempt by a sexually active person to avoid pregnancy
   - The various procedures employed to interfere at one stage or the other with the normal sequence of events in the process of reproduction leading to failure of conception.

Since pre-historic times, people have tried to control their fertility: how many children they would have.

2. *Is contraception necessary? Why?*

Get participants to brainstorm, then add value as follows:

It is necessary to curtail the terrific rise in the world population, so that food and medical facilities would be available for everyone. In 1976 - about 20 years ago, world population was only 1 billion, 1985- ½ billion was added. Will unborn generations have a chance to survive on the available food and medical resources?

Today, effective methods of birth control enable people to choose when they will have children in ways never possible before. People, particularly, women can now determine how they will live their lives.

Why contraception is necessary

The impact at national level is the same as global level, only that it is more localized.

At individual level contraception is necessary to:

- Space and limit family size and be able to cater adequately for children born
- Make sexual intercourse more satisfactory without the added problem of pregnancy.

3. Ask participants to name some local contraceptive devices they have heard or known that people use. Add the following if not given:

⇒ Herbs, padlock, broom, pepper, salt, boiled sand from the river, ground bottles, charms/talisman tied round the waist, rings, hot drinks (ogogoro), etc.

- Process the information, bringing out the effect of such contraceptive measures which could lead to the following:
  - failure to achieve the aim
  - damage to internal body organs
  - infertility
  - bleeding
  - infections and even death

(a) How does pregnancy occur? List responses.

TECHNICAL INFORMATION

- Pregnancy occurs when a woman or a mature girl has unprotected sexual intercourse during her ovulation period or shortly before and after ovulation.
- A woman's fertility (menstrual cycle) runs in cycles unlike a man's fertility, which is for the most part, constant
- In each female cycle, hormones

(the body's chemical messengers) stimulate the changes in the body. These changes continue gradually to build a peak in which a mature egg ripens for fertilisation.

- The key event that determines if pregnancy will occur revolves around ovulation.
- Each of the two ovaries contains 300,000 - 400,000 follicles. Follicles are balls of cells with immature eggs at the centre.
- In one monthly cycle, about 10-20 egg follicles will mature fully and others will degenerate (die off).
- As the follicle matures, it secretes oestrogen and progesterone, which would cause the lining of the uterus (endometrium) to become a rich, nutritious bed in anticipation of potential pregnancy by thickening the uterine lining with tissues and extra vessels.
- When the egg matures within the developing follicle, it moves to the surface of the ovary until it can float away into the fallopian tube.
- The release of an egg is called ovulation.
- Some women may experience a cramping or a bloody discharge during ovulation.
- Many women will notice that the cervical mucus coming from their vagina increases and becomes slippery and more stretchable.
- It takes 6 ½ days for the egg to go through the fallopian tube.
- Within a day after ovulation, the egg can be fertilised by sperm.
- If the egg is not fertilised, then the hormones gradually stop preparing the body for pregnancy. The blood vessels die off and without support the nutritious lining of the womb sheds and the cycle begins again.
- The cells that line the now empty follicle rearrange themselves into a collection of cells called the corpus luteum.
- If pregnancy occurs, the corpus luteum now continue to release progesterone until the developing placenta begins to secrete its own hormone to continue the support of the uterine lining.
- Understanding the menstrual cycle can help in preventing a pregnancy or planning for one as well as understanding and di-

agnosing many medical problems.

4. Ask participants what sporadic sexual activity with multiple partners may lead to.

Sexual activities of Nigerian teenagers

- Studies of urban teenagers in Nigeria show the average age of first sexual activity to be 16 years.
- By age 20, 80% of teenage girls have had sexual intercourse.
- Research also shows that sexual activities are usually unplanned and the young people tended to have multiple sexual partners.
- Sporadic sexual activity with multiple partners often put male and female teenagers at risk of unwanted pregnancy and sexually transmitted diseases.

5. Ask participants to list on paper strategies for reducing the high rates of unplanned pregnancy among adolescents.

- Take down suggestions on flipchart then add value, using technical information.

Strategies for reducing unplanned pregnancies

- Sexuality education in schools and tertiary institutions.
- Making contraceptives easily available through school-based clinics.
- Encouraging parents to communicate with their children about sexual matter, including contraception.
- Advertising of contraceptives in media.
- Improving teens' hopes and expectations for their future.

6. Ask participants to say which methods are popular with young people today, and why? Then add technical information.

Contraceptive methods that are popular with young people

- Many young people in Nigeria rely on the traditional such as abstinence, rhythm and withdrawal methods.
- Research shows that this attitude is as a result of:

➢ lack of access to modern contraception for teenagers
➢ attitudes of health service providers

- fear of being seen by adults and relatives
- only counselling, no drugs
- high cost of procuring such methods.

Activity 2:

Group work

Form 3-4 groups and list on flipcharts the following for participants to brainstorm on:

- Which modern methods of birth control are they aware or familiar with?
- Where can they get them?
- How do they work?
- What are the advantages?
- Are there any side effects?

- Report back presentations. Commend participants for efforts, then process information and add value using technical information as follows:

TECHNICAL INFORMATION

It is currently believed that sperm cells remain fertile for 4-5 days after introduction into the genital tract and that the ovum can survive for 2 days following ovulation. Conception is likely to occur if sexual intercourse takes place anytime in the 4 days before or 2 days after.

Modern birth control methods

These methods will be discussed under the following headings:

- Continuous abstinence method
- Barrier method
- Hormonal method
- Permanent method
- Periodic abstinence and fertility awareness
- Withdrawal method.

Continuous abstinence: Not having sexual intercourse.

How it works

- Pregnancy cannot happen if sperm is kept out of the vagina.

Effectiveness

- It is 100% effective in preventing pregnancy.
- There is also a reduced chance of contracting sexually transmitted infections.

Advantages

- No birth control devices necessary
- No medical or hormonal side effects
- Many religious groups endorse abstinence among unmarried people
- Helps prevent STIs.

Who can use it?

- Any woman or man can abstain from sexual intercourse
- Many do so at various times in their lives - while in school, ill health, etc.

- Some people choose to express their sexual feelings in other ways.

Possible problems

- It is difficult for most people to abstain for long periods of time
- Men and women often end their abstinence without being prepared to protect themselves against pregnancy or STIs.

Activity 3:

Brainstorming - **(Could be used as closing exercise for first session)**

Participants to brainstorm and come up with:

- Other ways that sexual feelings can be expressed without vaginal intercourse. List responses.
- Give technical information to strengthen them. Ask each participant to read aloud.

TECHNICAL INFORMATION

BARRIER METHODS

These could be divided into two groups: Mechanical and Chemical types.

Mechanical types include:

- Condom
- Diaphragms
- Cervical caps.

Diaphragms and cervical caps: Both are **reversible** barrier methods made from flexible rubber that are intended to fit securely over the cervix.

DIAPHRAGM is a shallow dome-shaped cup with flexible rim that fits securely in the vagina to cover the cervix. It is used with creams or jellies that kill sperm cells before they enter the uterus.

This device was invented in the 19th century by a German physician who under the pseudonym, Wilhlm Mensigna, described the device in an 1880 article.

CERVICAL CAP is latex cap, smaller than the diaphragm and fits smugly over the cervix itself. The cervical cap was invented by a Berlin gynaecologist, Friedrich Wilde, who made wax impressions of his patients' cervixes and then moulded rubber caps from the impressions.

How they work

- The diaphragm and cervical cap must be coated with spermicidal jelly or cream and inserted into the vagina before intercourse. This blocks the en-

trance to the uterus and the jelly or cream kills the sperms.

- The diaphragm can be inserted up to six hours before intercourse and must be left in place for 6-8 hours after intercourse to be effective.
- It can be worn continuously for 24 hours.
- Each time sex is repeated more jelly or cream must be inserted in the vagina (without removing the diaphragm) with an applicator.
- If worn over 48 hours, an unpleasant odour may develop.
- They are effective for multiple acts of intercourse. Using additional spermicides with the cap is optional.

Who can use diaphragms and cervical caps?

Diaphragms:

- Can be worn by most women when they are not menstruating.
- Not recommended for women who have poor muscle bone of the vagina or a sagging uterus.

Cervical caps:

- Can be worn by most women when they are not menstruating.
- Can be used by women whose pelvic muscles are too relaxed to hold a diaphragm in place.
- Some women cannot be fitted with existing sizes.
- Compared to the diaphragm, the cervical cap may be more difficult and time-consuming, for a professional to fit and for a woman to learn to fit and remove.
- Women who are not comfortable touching their genitals probably will not like the diaphragm or cervical caps.

Effectiveness

- Typical use - failure rates for women, not consistent or always correct
- Perfect use - is consistent and always correct
- Of 100 women who use diaphragm or cervical caps, 18 will become pregnant during the first year of typical use, only 6 will become pregnant with perfect use.
- You may increase protection by checking if the cervix is covered every time you have intercourse.
- May provide some protection against certain sexually transmitted infections.

Advantages

- Very few side effects
- Spermicidal jelly or cream used also acts as a lubricant
- No medical supervision necessary after fitting - once learned, insertion is easy, not felt by either partner- if properly placed, the devices not generally felt by either partner during sexual intercourse.
- They are re-useable
- The insertion can be part of sexual activity
- Can be shared by both partners during sex play.

How they are used

Proper use of diaphragms and cervical caps involves the following:

- Inserted deep into the vagina before intercourse and positioned to cover the cervix, so that interruption does not occur.
- The right size must be prescribed for proper fitting
- Knowledge of how to insert and remove and store - practise insertions before actual use
- Always use contraceptive cream or jelly when inserting
- Must be in place every time because it may become dislodged
- Leave in place for hours after the last sexual intercourse
- Do not douche while a diaphragm or cervical cap is in place - showers and baths are acceptable
- Not to be used during menstrual period or any vaginal bleeding
- Proper (right size) fit should be checked by a health provider if any of the following occurs:
    1. Significant weight gain or loss (10 pounds or more than 5 kilograms or more).
    2. A full term pregnancy
    3. An abortion or miscarriage beyond the 1st three mouth of pregnancy
    4. Pelvic surgery
    5. Pain or discomfort during use
    6. Suspicion that the size may be wrong for any reason
    7. Sign of toxic shock syndrome develops
    8. Fever, diarrhoea, vomiting, muscle ache or rash (to avoid this, should not be in place for more than 24 hours)

- Should be checked from time to time for weak spots or pinholes by holding device up to light.

Disadvantages

- Requires planning
- Sizes must be checked after significant weight gain or loss or after pregnancy
- Proper positioning in vagina and cervix is necessary, women with short fingers may need to use inserter for the diaphragm and may not be able to use the cervical cap
- Mild irritation or allergic reaction to rubber, cream or jelly occurs occasionally
- Some women are prone to develop bladder infections with the diaphragm.

How accessible - Where to get it

- Must be fitted by a health provider
- Family planning clinic e.g. Planned Parenthood Federation of Nigeria (PPFN), university teaching hospitals - may cost less (price subsidised), private hospitals, gynaecologists.

CONDOM

History: Mechanical barriers covering the penis have been used for centuries for protection against pregnancy and infection. As early as 1350 BC Egyptian men wore decorative covers for the penis. The condom became popular in the 18th century as a means of preventing diseases and pregnancy. Casanova (1725-1798) was one of the first people who made the condom popular as a contraceptive.

Definition: Condoms are made from thin rubber or animal tissue (young lamb intestines). They are available dry or lubricated, it is the only temporary means of birth control a man can use.

How condoms work

Condom collects semen before, during and after ejaculation and keeps sperms from entering the vagina.

Of 100 women whose partners use condoms, about 12 will become pregnant during the first year of typical use and only two will become pregnant with perfect use.

More protection is possible if at the same time, a woman uses a vaginal contraceptive such as foam, cream, jelly or suppositories. They can immobilise sperms if the condom breaks.

Advantages

- Protects against some sexually transmitted infections; when used in every instance of vaginal-penis contact; also prevents re-infection during treatment period.
- Allows men to take responsibility for birth control and STIs prevention - in long-term relationship.
- Easy to get - available without prescription
- Reliable back-up or two-method approach
- Inexpensive
- Can help relieve problems of premature ejaculation because it decreases stimulation and helps delay ejaculation.
- No side effects - except for those who are allergic to rubber or spermicides
- Shared responsibility; e.g. short-term relationship.
- Catches semen so that the woman does not feel too wet immediately after intercourse
- Light weight and disposable.

Who can use condoms?

- Any man can use condom, people who are sensitive to rubber may use animal tissue condoms, but they lack protection against sexually transmitted viruses as latex condoms.
- Can be purchased by men and women from chemists and drug shops without prescription.

How to use the condom

- The condom should be put on the penis before it has any contact with the opening of the vagina.
- Place the rolled condom on the tip of the erect penis.
- Roll the rim of the condom all the way to the base of the penis, leaving about ½ inch of empty space - at the top, or buy condom with nipples to hold the semen.
- After intercourse, hold the condom as you withdraw the penis to avoid spilling semen anywhere near the opening of your partner's vagina.
- The penis should be withdrawn soon after ejaculation to avoid

losing erection and causing the condom to slip off.

- You may lubricate the outside of the condom to help the penis enter the vagina - do not use petroleum jelly or vegetable oil-based lubricants as it may cause the rubber to break.
- Contraceptive foam, KY jelly, saliva may be used but this increases one's chances of development of yeast infections, or other water-based lubricants may be used, especially if one has a tendency to tear condom during intercourse.
- Apply the lubricant after the condom is on the penis.
- Do not carry condoms near any heat source as heat can damage the rubber.
- Do not carry condoms in back pockets, wallets, purses, car glove compartments - if a you do, use the type with sealed foil.
- In case of accidents, if condom breaks withdraw the penis immediately and replace it. Women should insert contraceptive cream, jelly or foam in the vagina- no douching.
- Use a fresh latex condom only once, a fresh one must be used every time.
- Condoms have a shelf life of 5 years if kept away from heat.
- To increase effectiveness of condoms, use contraceptive foam at the same time.

Disadvantages

- Some men may not have the patience to slip it on during sexual excitement - women should slip it on during foreplay.
- Condom use requires high motivation and a strong sense of responsibility.
- Occasional allergic reaction by users.
- A small percentage of people are allergic to rubber condoms, they should use skin condoms instead.
- Can interfere with sexual feelings or sensitivity - some men are unable to enjoy intercourse or maintain the erection while wearing condoms.
- To increase sensitivity, natural skin condom or lubricated latex condoms may be used.
- Condoms may break when not put on correctly.
- Ruins spontaneity of sex - you have to put the condom right at

the time of intercourse. Can, though be part of sex play if the woman is putting it on the man.

- Eliminates one source of lubrication for intercourse (one, are the drops of fluid that leak from the penis during erection). The resultant friction can cause irritation for the woman, use a lubricant.
- Because it is mass-produced, one condom in a thousand may be faulty and therefore ineffective.

Reasons for failure

- Rough usage
- When expired condom is used
- Condom exposed to heat.

Where to get condoms

- Available in chemists, drug stores, pharmacy shops, supermarkets, family planning clinics.

Non-contraceptive benefits

In addition to protection against pregnancy other benefits of the condoms are:

1. Sex therapists occasionally recommend the use of condoms in the treatment of premature ejaculation as they reduce sensitivity of the skin during intercourse.
2. Some women and men do not wish to have the penis in direct contact with the vagina, the condom is therefore, an effective barrier that may make intercourse more pleasurable if this concern exists.
3. Occasionally, older men or those who have lower abdominal operations are unable to maintain erection during intercourse, the rim of the condom may have a slight tourniquet effect helping to maintain an erection.
4. Lubricated condoms can reduce mechanical friction and irritation of the penis and vagina.
5. Some women are allergic to their partners' sperms or semen. Condom prevents such allergies.
6. By reducing the risk of STIs, condom may reduce the likelihood of infertility and cervical cancer in some women. Plastic or tissue condoms are not recommended for protection against STIs, no sufficient test done on plastic condom. Some viruses such as hepatitis B and

HIV may be small enough to pass through the pores of animal tissue.

Putting on a condom

- For pleasure, ease and effectiveness both partners should know how to put on and use a condom.
- Remember, practice makes perfect, to learn without feeling pressured or embarrassed, practise on your penis, or banana, cucumber or penis-shaped objects like ketchup bottle. Put on condom before the penis touches the vulva. Men leak fluids from the penis before and after ejaculation, pre-ejaculation can carry enough sperms to cause pregnancy or STIs.
- Condoms come foiled in ring shapes. They are individually sealed in aluminium foil or plastic.
- Be careful, do not tear while unwrapping it
- If condom is brittle, stiff or sticky, throw away and use another
- Put a drop or two of lubricant inside the condom
- Place the rolled condom over the tip of the hard penis
- Allow a half-inch space at the tip to collect semen, pinch the air out of the tip. (friction against air bubble causes most condoms to break).
- Unroll the condom over the penis all the way down to the base of the penis.

Taking off a condom

- Pull out before the penis softens
- Do not spill the semen by holding the condom against the base of the penis while you pull out
- Throw the condom away then wash the penis with soap and water.

If condom breaks

- During intercourse, - pull out immediately and replace it
- Men should be able to tell if a condom breaks during intercourse, to learn what it feels like when it breaks, the man can break condom on purpose while masturbating.
- If semen leaks into the vagina during a woman's fertile period, ask at a family planning clinic for information about emergency contraception.

Choosing and buying a condom

- All condoms are tested for defects but like rubber bands, condoms deteriorate with age.
- If properly stored, condoms can be used 5 years after date of manufacture or until expiration date printed on the wrapper.
- Size is not usually marked on the package but condoms come in different widths and height and thickness.
- Try different brands and styles to find out which fits best.

Female condom (vaginal pouch)- The newest barrier method for women.

Definition

Female condoms are made of soft loose fitting polyurethane plastic that is stronger than male latex condom. It is closed at one end (this is the part that covers the cervix).

How it works

It covers the cervix, the vagina and a portion of the female perineum as well as the base of the penis and so lines the vaginal wall creating a covered passageway for the penis. Since it covers the cervix, sperm cells cannot pass through.

Effectiveness

The pouch does not require pressure placement over the cervix. It is as effective as the cervical cap or diaphragm in preventing pregnancy. It offers more protection against STDs and HIV infection than the cap or diaphragm. This is because it reduces the potential transfer of infectious organisms.

- During intercourse, movement of the pouch from side to side is normal
- Remove, add extra lubricant to the opening of pouch and reinsert.

How to use it

- Like the male condom, it is intended for one time use
- Lubricate the close end
- Squeeze the inner ring and insert the pouch into the vagina just past the pubic bone so that the ring covers the cervix - outer ring hangs just about an inch outside the vagina.
- Check with the finger to make sure it is not twisted so that it will be easy for the penis to enter the vagina.

Advantages

- Helps women to protect themselves against both pregnancy and STDs, particularly for women whose partners are unwilling to use condoms.
- Since it is inserted before intercourse, it does not break the flow of love-making in the way that male condom can.
- Good for men who are willing to use the condom but find it difficult to keep an erection while putting on a condom.
- An erection is not necessary for the removal of the vaginal pouch.
- The polyurethane lining in the vaginal pouch is stronger than the latex used for the membrane in male condoms.
- It is thin and soft and more resistant to oils
- In countries where they are sold, they can be bought from the drug store and supermarkets without prescription.

Disadvantages

- May slip during intercourse
- Some people say feeling is reduced
- Some women find a female condom a little cumbersome
- Sometimes the outside ring is too noticeable making it to appear ugly - inner ring can irritate penis, and may also irritate the vulva
- It requires one to be comfortable - women who are uncomfortable touching their genitals cannot use it
- Women with short fingers would have difficulty inserting and removing it.

Barrier methods - chemical types
-(Contraceptive foam, tablets, suppositories)

Description

Foam is a white aerated cream that has the consistency of a shaving cream and contains effective sperm -killing chemicals. It comes in a plastic application as tablets or suppositories.

Contraceptive and suppository capsules are solids that melt after they have been inserted.

How they work

Deposited just outside the entrance to the cervix at the top of the vagina to block the entrance to the

uterus with bubbles. Foam keeps the sperms from entering the cervix and kills them as well.
Contraceptive jellies, suppositories, tablets, creams melt into a thick liquid through the vagina. They block the entrance to the uterus and contain spermicides.

Effectiveness

Of 100 women who use them, 21 might become pregnant during the first year of typical use and only 3 with perfect use. Using a condom increases effectiveness, it is effective as a back-up for the pills and IUD.

How to use

Detailed instructions for correct use written on containers, and packages. Be sure to read and understand them before using the products.

- Foam: Inserted 10-30 minutes before vagina-penis contact. This method does not remain effective for more than one hour after insertion.
- If foam is in a can - shake very well up to 20 times. The more the bubble the foam has the better it blocks the sperms. Also, spermicides tend to settle in the bottom of the can.
- The problems with effectiveness arise from using too little foam; failure to shake the foam correctly, or inserting the foam correctly, or inserting after penis-vagina contact has begun.
- Put in more foam every time you have intercourse, or penis-vagina contact.
- Leave the foam in for 6-8 hours and do not douche.
- If the foam is dripping wet use a sanitary pad or panty liner in your underpants
- Keep extra container or packet handy, some brands do indicate when they are running out others would come out of the can more slowly.
- Use with condom for maximum effect.

Advantages

- Spermicides offer some protection against certain STDs like gonorrhoea, chlamydia, trichomoniasis
- They are easy to buy in drug stores and supermarkets
- No prescription
- Once learned, insertion is easy

and can be done by your partner as part of sex play
- When used with a condom, it is a highly effective method of birth control.

Who can use them?

Can be used by any woman and it must not be used during any vaginal bleeding, including menstruation.

Non-contraceptive benefits

- Foam provides vaginal lubrication
- In general, it must dissolve in 10-30 minutes but this is not the case in some cases. In some instances, they do dissolve completely causing increased friction, irritation, and decreased effectiveness.

Problems

- Spermicides in contraceptive foams, creams, jellies, films, suppositories may irritate penis or vagina
- Switching brands may solve the problem of pain, sensation of heat or itching
- If not used exactly as directed, product may not form a good barrier over the cervix
- Some women complain of messiness or leakage
- Alone, it may be ineffective
- Using it can be an interruption if not treated as part of sex play
- Some brands use aerosol which environmentalists are against.

Where to get them

- Family planning clinics, pharmacies, etc.

Periodic abstinence and fertility awareness methods (FAMs)

Natural family planning refers to monitoring natural and physiological signs to determine the fertile period. They are ways one can prevent pregnancy using one's fertility pattern. This helps in predicting ovulation- the day the egg is likely to be released. The information can be used to also help one become pregnant.

How periodic abstinence and FAMs work

There are several ways to predict when to abstain or use birth control. Currently, 3 main methods are used: Basal body temperature method, cervical mucus method and calendar or rhythm method.

Basal body temperature method

- Take your temperature every morning before getting out of bed
- A woman's temperature rises between 0.4°F - 0.8°F on the day of ovulation and remains at that level until the next period
- Fertile days are the first 3 full days after ovulation.

Cervical mucus method

- Developed 30 years ago by an Australian couple - Evelyn and John Billings who sought to develop a method that will be active in preventing pregnancy and also acceptable to the catholic philosophy about sexuality, marriage and women.
- It is a method based on the woman's observation of a sequence of changes in the quality of her cervical mucus as a result of hormonal changes in the body. Through careful daily observation, the woman can read to predict and detect the time of ovulation and the fertile period.
- She must observe the change in cervical mucus, and has to do so all through the first part of the menstrual circle until sure of ovulation
- Normally, cloudy mucus will become clear and slippery in the few days before ovulation and stretch through the finger and when this happens, you are in your most fertile period. Use a barrier contraceptive or abstain from vaginal intercourse.
- This is sometimes called ovulation method.

Calendar or rhythm method

- Discovered in the 1930s by Drs. Ogino and Khams - independently published findings that ovulation occurs 2 weeks before menses.
- Designed to predict the fertile period based on the duration of previous cycles.
- The method requires the knowledge of the past 6-12 cycles.
- Calculation of the fertile period is based on the following:
    - That on the average, ovulation occurs 14 days (plus or minus 2 days) before the onset of the next menses.
    - Sperms retain their fertilisation capacity for about 2-3 days (but sometimes up to 5-8 days).

- The ovum retains its ability to be fertilised for no more than 24 hours following ovulation.

- The method involves counting the menstrual cycle on a calendar. It is possible to predict ovulation if periods are the same every month.
- It will be more difficult to predict the ovulation day if the cycle length varies from month to month.
- It is best to combine all the above methods; this is called sympothermal method.

Post-ovulation period

- Abstain or use a barrier method from the beginning of your period until the morning of the 4th day after your predicted ovulation.

How well do periodic abstinence and FAMs work?

- Of 100 women, 20 might be pregnant after first year of typical use, while 9 women may get pregnant after 1 year of perfect use. Pregnancy rates generally higher for single women.

Advantages

- Makes one more aware of one's body cycle and this knowledge can be useful in making other health care decisions.
- During fertile days, it can lead to exploration of other ways to give and receive pleasure such as mutual masturbation (avoid all vagina-penis sex).
- No medical or hormonal side effects.
- Calendars, thermometers and charts are easy to get.
- Method acceptable to most religious groups and people who do not believe in artificial contraception.

Who can use periodic abstinence and FAMs?

- Women with good health who have had careful instructions
- Women whose only sex partner is equally committed to the method
- Women should not rely on this method if they have irregular periods
- Women with irregular body temperature patterns should not use
- Uncooperative partners - the co-

operation necessary for this method can bring understanding and closeness between partners.

How to use them

- Expert and professional guidance is essential for women to learn how to use these methods successfully.

Disadvantages

- Relatively long instructions.
- Care is needed in keeping records and interpreting signs because the major disadvantage is the risk of pregnancy if one is not committed to use the method correctly - requires daily monitoring and charting.
- They do not protect one against STIs, including HIV infections.
- They require commitment and co-operation from both partners to be effective.
- Illness or even lack of sleep can *cause false temperature signs.*
- Vaginal infections or use of vaginal products or medication may alter the state of cervical mucus.
- You or your partner may be tempted to take risks during fertile period.
- May take at least 2-3 trials to learn to use confidently.
- It may be impractical if you are not in a committed co-operative relationship with your sexual partner.
- If you choose not to use a barrier method, abstain from intercourse and vagina-penis contact when fertile. It can be sexually frustrating unless you enjoy other forms of sex. This may cause marital difficulties.

Where to learn about periodic abstinence and FAMs

- Family planning clinics.

Self-Reflection/Evaluation

CONDOM exercise - Strategic responses:

1. "Why should I use it, after all we are getting married".
    - Condoms should be used by all men at all times, when they want to prevent undesirable pregnancy with their spouse. Men should also use condom during love-making with their wives.

2 "This is too tight it is not my size."

- The condom can fit all sizes of penis, because it can stretch and expand. In fact, it can be blown to the size of a football without breaking.

3 "I don't want to use it, it might get lost inside your body."

- If the edge of the condom is held firmly against the penis soon after ejaculation, and should it mistakenly slip into the vagina, it can easily be removed by the woman with her fingers.

4 "I guess it means you do not really love me."

- I do but I'm not risking my future or life to prove it.

5 "Let's face it, making love with a condom is like taking shower with a raincoat on."

- Let's face it, doing it without a condom is not making love but gambling with our lives.

6 "Don't you trust me?"

- Trust is not the point, people carry STIs without knowing it."

7 "Just this once without it."

- It only takes once to get pregnant and it also can only take once to get an STI.

8 "It does not feel good with the rubber on."

- I feel more relaxed if you use it, I can make it feel better for you.

9 "I don't stay hard when I put on a condom."

- I can do something about it.

10 "I'll pull out in time."

- A woman can get pregnant from pre-cum you can get STI from pre-cum too.

TECHNICAL INFORMATION

HORMONAL CONTRACEPTIVES

These include the pills, depo-provera (contraceptive injection), Intra-uterine devices (IUD) and norplant.

Hormonal contraceptives consist of synthetic compounds made to resemble actual hormones in a woman's body. Oestrogen and progesterone are essential for the functioning of the menstrual cycle and hence for ovulation which is required for fertilisation to occur. The synthetic compounds interrupt

the menstrual cycle and prevent ovulation and implantation.

INTRA-UTERINE DEVICES (IUD)

Description

These are small devices made of plastic that contain copper or natural hormone. They are made in different sizes and can be left in place for 8 years while others can be replaced every year.

How it works

Usually works by preventing fertilisation, affecting the way the egg or sperm moves as well as the lining of the uterus and thus, prevents implantation. It acts as foreign bodies in the uterus thus preventing pregnancy.

Effectiveness - 76-98%

Advantages

1. Allows spontaneity - a woman does not need to think about birth control method every-day or, every time she has sex, does not change the hormone level in the body.
2. Inexpensive
3. String can easily be checked
4. No preparation before intercourse
5. Highly effective.

How to use

- Insertion often done during menses by a trained health care provider; it may be slightly painful but eases with medication and rest
- Antibiotics can be given to reduce infection during insertion
- The string must be checked regularly to make sure it is in place, especially after menses
- Annual check-ups necessary
- Check-up necessary 3 months after insertion.

Who can use?

- If you have sex with only one partner who also has sex only with you
- You have had a baby.

Those who should not use

- Unexplained abnormal vaginal bleeding
- A recent history of pelvic infection
- History of tubal pregnancy
- An abnormal pap test recently
- Any disease that decreases your inability to fight infection e.g. leukaemia, HIV/AIDS

- An artificial valve in your heart
- Allergic to copper; (copper IUD)
- If you are having heat treatment (diathermy)
- If there is a chance that you may be pregnant.

Disadvantages

- Medical supervision required
- Bleeding may occur between periods
- Bleeding may be heavier and last longer
- Uterus might expel the IUD
- Increased chance of pelvic infections/STDs
- Possibility of tubal pregnancy and perforation of the uterus
- Can cause cramp, heavier and longer menses and allergic reactions.

Reason for failure

If it's not checked to make sure IUD is in place it may lead to partial expulsion and incorrect insertion.

Where to get them: Family planning clinics, private gynaecologists.

ORAL CONTRACEPTIVE - THE PILL

Description

Made of synthetic compounds similar to those naturally produced by the women's body to regulate the monthly cycle - monthly series of pills are taken once a day. There are two types thus:

Combined: Oral contraceptive contains both oestrogen and progesterone.

Mini: Pills contain progesterone only.

How it works

The hormones in the pill prevent ovaries in releasing eggs and thicken the cervical mucus and this then prevents sperms from joining the egg. Mini pills may also prevent implantation.

Effectiveness: 90-96%

Advantages

1. More regular period; less menstrual flow
2. Less menstrual cramps
3. Less iron deficiency (anaemia)
4. Fewer tubal pregnancies, less pelvic inflammatory diseases
5. Less ache, less pre-menstrual tension
6. Less rheumatoid arthritis

7. No preparation before intercourse
8. Allows spontaneity with round the clock protection
9. Highly effective.

How to use

- Must be taken as directed - you will be protected as long as you take them on time and regularly, pregnancy can happen anytime you stop taking the pills.
- To plan for pregnancy, stop and use another method, normal periods usually return in a few months.
- After baby, get medical advice before starting again, especially if you are breast-feeding.
- Annual check-ups necessary.
- Tell your new doctor that you are on the pill.

Who can use?

Most women can use it safely.

Those who should not use

- If you are over 35
- If you smoke more than 15 cigarettes daily
- Have unexplained vaginal bleeding
- Have blood clots in the veins
- Have cancer of the breast or uterus
- Have skin cancer - malignant melanoma
- Have certain medical conditions - diabetes, high blood pressure, liver disease, high cholesterol levels.

Disadvantages

- Skin spots
- Some women experience severe headaches, nausea, weight gain or loss, missed period, breast tenderness, depression.
- Users have a slightly greater chance of developing serious medical problems that can lead to heart attack, blood clots in the vein and tumours; all these increase with age and heavy smoking.

Reasons for failure: Not taking the pill according to instructions, inconsistent usage and unreliable means of re-supplies.

Where to get: Family planning clinic, gynaecologists or drugs stores.

INJECTABLE CONTRACEPTIVE - DEPO-PROVERA

Description

Made of synthetic hormones that act like natural female hormones - progesterone to regulate the menstrual cycle.

How it works

The hormone keeps the ovaries from releasing egg and thickening the cervical mucus to keep away the sperms from fertilising egg.

Effectiveness: 96-99%

Advantages

1. Prevents pregnancy for 12 weeks (3 months)
2. Can be used during breast-feeding without affecting milk supply of the mother
3. It is free of any of the risks associated with the use of oestrogen.
4. In place before vaginal intercourse.

How to use

- After taking medical history and giving physical examinations, health care provider will inject Depo-Provera into your buttocks or arm.
- Protection against pregnancy is immediate if injected during the first 5 days of your period. Follow up injection after 12 weeks.

Who can use?

Most women can use it safely.

Those who should not use

- If you are pregnant
- Unexplained vaginal bleeding
- Ever had cancer recently or blood clots in the legs, lungs
- Have serious liver disease like growth in the liver
- Cannot put with irregular bleeding, migraine headaches, diabetes, high blood pressure, heart disease, and depression.

Disadvantage

- Some women experience menstrual irregularities
- Irregular bleeding in intervals between periods
- Spotting between periods
- No bleeding for months at times.

Other side effects

- Change in appetite, weight gain, sore breasts, abdominal discomforts, nervousness, dizziness, depression, skin rashes or spotty darkening of skin, hair loss, increased hair on face or body; increased or decreased sex drive,

tubal pregnancy, delayed return to fertility after months of discontinuation (10-12 months).

Reasons for failure: Missing injections; failure to take it 2-3 months as directed.

Where to get: Family planning clinics, gynaecologists.

NORPLANT

Description

This consists of six soft capsules, each about the size of a matchstick inserted under the skin in the upper arm. Each stick contains synthetic hormone like the one produced by the body to regulate the menstrual cycle.

How it works

A small amount is released constantly, the hormone keeps the ovaries from releasing eggs and thickens the cervical mucus thereby preventing fertilisation and this also prevents implantation.

Effectiveness

- Most effective reversible method of birth control
- Protects against pregnancy for 5 years.

Advantages

- Ensures continuous long lasting birth control
- Does not need to be taken daily or taken before vaginal intercourse
- Does not contain oestrogen
- Can be used while breast-feeding (6 weeks after delivery)

How to use Norplant

- After taking medical history and physical examination, health care provider will anaesthesised small area of your arm with pain-killers and make a small cut.
- The 6 capsules will be inserted under the skin of the arm you use least. Insertion takes 10 minutes.
- Protection against pregnancy begins within 24 hours.
- Follow-up visits after 5 and 12 months.
- Be sure to tell any new health care provider that you are using norplant.

Who can use?

Most women can use it safely.

Those who should not use

- Those who are pregnant
- Unexplained vaginal bleeding
- Breast-feeding in the first 6 weeks after delivery
- Have blood clots or inflammation of the veins
- Serious liver disease, breast cancer, diabetes, migraine headaches
- Heart disease, serious depression, cannot put up with irregular bleeding
- Bleeding between periods.

Disadvantages - other side effects

- Change in appetite
- Weight gain or loss
- Increased hair on the face or body
- Discolored skin over the implant spot
- Enlarged ovaries, ectopic pregnancy.

Where to get: Family planning clinic, gynaecologists.

Activity 4:

Review exercise

➢ Ask participants to describe the following:

Female condom, diaphragm, and cervical cap - What are these?

➢ Take down responses and add value which might be as follows:

1. It is closed at one end and made of soft loose fitting plastic, which is stronger than male condom.
2. It helps to reduce the transfer of infectious organisms.
3. During intercourse, it can move from side to side.
4. It does not require precise placement over the cervix.
5. It is for one time use, since it is inserted before intercourse. It does not break the flow of love-making.
6. It requires one to be comfortable with one's genitals.
7. It helps women protect themselves against pregnancy and STIs, it is soft and thin and more resistant to oils.
8. It comes in a can with the consistency of a shaving cream and contains sperm-killing chemicals.
9. They melt into thick liquids through the vagina.
10. It blocks the entrance of the uterus with bubbles.
11. It does not remain effective

for more than one hour.

12. Must be inserted 10-30 minutes before vaginal intercourse.

- They are individually sealed in aluminum foil or plastic
- Not recommended for protection against STIs
- Must be kept away from heat
- Protects against some sexually transmitted infections
- Made from rubber (latex) or animal tissue
- Oil-based lubricant may cause them to break
- It must always be used with contraceptive foam, cream or jelly
- It makes some women prone to bladder infections
- It requires planning
- They can not be used after significant weight gain or loss
- It requires proper positioning in the vagina
- Must be left in place 8 hours after intercourse, and are reusable
- Knowledge of how to insert, remove and store, essential
- Additional spermicides is optional for multiple acts of intercourse
- It can be worn continuously for 24 hours
- It can be left in place for up to 48 hours
- Must be fitted by a health care provider.

COITUS INTERRUPTUS - WITHDRAWAL METHOD

This involves waiting until ejaculation is about to occur at which point the man withdraws his penis from the vagina.

How it works

- Ejaculation occurs completely away from the vagina thereby preventing the possibility of conception.

Effectiveness: About 77%.

Who can use? Not recommended for young people.

Advantages

- It requires no devices or chemicals
- It is available at no cost.

Disadvantages

- High failure rate
- Preliminary ejaculation often occurs
- Requires a lot of self-control, experience and trust

- Lack of ejaculating control
- Does not protect against STIs and HIV/AIDS.

PERMANENT METHODS - STERILIZATION (vasectomy and tubal ligation)

Methods: They are surgical birth control and are permanent for both men and women.

How they work

Vasectomy - Is a surgical operation for men. It involves cutting or blocking the vas deferens- the tube that carries sperms from the testicle to the penis. Once the tubes are blocked, sperms are prevented from entering the semen. Pregnancy cannot occur when sperms cannot reach the egg.

Tubal ligation - Is a surgical operation for women and it involves blocking the fallopian tubes - where eggs are fertilised by sperms - thereby preventing the female egg from travelling to meet the sperm. This is done surgically using bands, clips or cutting and tying.

- Both methods are simple operation, under local anaesthesia.

Effectiveness: 99.9%

Activity 5:

Practical session

- Show samples of various contraceptive devices, making sure that each participant touches and feels it. Explain how they are used to reinforce information.
- Carry out a condom demonstration exercise (using an artificial sample of a penis) and allow participants to practise doing same. This is to make them feel comfortable handling some contraceptive devices.

TECHNICAL INFORMATION

Provide current research information on contraceptive usage by women.

The 2000 World Population Data Sheet gives the percentages of women using contraception as follows:

⇒ More Developed World: women using all methods (modern and traditional) of contraception are 60%, while those using only modern methods are 52%.

⇒ Less Developed World: women

using both traditional and modern methods are 74%, while those using only modern methods are 60%.

⇒ Africa: women using both traditional and modern methods are 25%, while those using only modern methods are 18%.

⇒ Nigeria: women using both traditional and modern methods are 15%, while those using only modern methods are 7%.

⇒ The 1999 Nigerian Demographic Health Summary Data base on Reproductive Health Statistics in Nigeria reports that, the percentage of women, 15-49 using any method of contraception is 15.7%.

⇒ Implicit in the above is the population explosion that Nigeria is experiencing. Nigeria's population projection is the highest in West Africa, standing at 204.5 million, with current data

Evaluation/Sèlf-Reflection

- Ask participants to say one thing that they have gained from the lesson.
- Let participants say how they felt before and after the lesson. How has their attitude towards contraception changed?
- List responses on flipchart.

Closing

End session with a song.

REFERENCES

- Health Workers Manual on Family Planning Options.
- 2000 World Population Data Sheet, Population Reference Bureau (PRB).
- Nigerian Demographic Health Survey Database on Reproductive Health Statistics in Nigeria.
- *The Whole Truth About Contraception- A Guide to Safe and Effective Choices* - by Beverly Winkoff and Seizanne Wymelenberg (1997).

CHAPTER ELEVEN

HARMFUL TRADITIONAL PRACTICES (HTPs)

GOAL:

To learn and understand that harmful traditional practices are a wide spread violation of women's human rights and to understand and appreciate why HTPs should be abolished.

OBJECTIVES:

By the end of the session, participants should be able to

- Understand what constitutes traditional practices in our communities
- Identify which of such practices are harmful to women
- Be able to appreciate the need for action, to undertake advocacy and dissemination of relevant information to stop HTPs.

CONCEPTS/COMMON BELIEFS:

- Females are often times used as sacrificial animals because they are seen to be responsible for the woes of the womenfolk.

MATERIALS:

Flipchart, paper, markers, blackboard and chalk, technical information on harmful traditional practices.

ACTIVITY/TIME:

- Brainstorming (30 minutes)
- Writing exercise (30 minutes)
- Small group work (40 minutes)
- Experience-sharing (15 minutes)

PREPARATION:

Traditional practices evolve from people and value system, defining their

culture and identity and as such they are a source of pride, irrespective of the inherent harm that may result thereby.

In Nigeria, harmful traditional practices are legion, cutting across linguistic groups, geographical boundaries, educational, social strata, age and generations. However, females fall victims of harmful traditional practices more than males. In other words, females (from girl-child to women) are more prone to the harmful consequences of these practices than are boys and men.

The long-term harmful effects are often expressed in the adolescent and adult years.

HTPs could be physical or psychological or a combination of both. Top on the list of these are Female Genital Mutilation (FGM) and early marriage. Following closely are sexual abuse, wife inheritance, bride price, widowhood rites, etc. These practices have hazardous consequences on a woman's life. The practices, as earlier noted, cut across social classes. For example, there are cases of women with university education who believe they had no choice but to comply with the cultural dictates, although sometimes this could be for some reasons other than acceding to the cultural values inherent.

On the contrary however, it is instructive that there are almost no corresponding rites for widowers (husbands) to carry out in case of the death of their wives and even where they exist, they are not nearly as severe.

- Display the following stem sentence either on flipchart or board:
- Traditional practices that are common in my area are.....
- Ask participants to select from the list of traditional practices which they consider healthy or harmful and give reasons for their choice. For example:

  (a) The traditional practices that I consider healthy in my area include....., because of.....

  (b) Those traditional practices which are not considered harmful in my area are....., because .....

- Review their contributions and note if FGM, widowhood rite, bride price and early marriage are mentioned as harmful traditional practices. Explain that HTPs is a broad topic.

Sub-topic: **FEMALE GENITAL MUTILATION (FGM)**

LESSON SEQUENCE

Opening

Start the session with some songs. Let participants set individual goals for the day.

Energizers/Ice-Breakers

These can be used to introduce the topic and manage the energy level and attention of the group as well.

Lesson topic

Activity 1:

Brainstorming exercise

Ask participants to read out the topic as presented on the flipchart or blackboard. For instance, put up the letters HTPs and ask participants to say what they stand for. Introduce the topic by giving a background information on traditional practices with focus on the harmful ones.

OBJECTIVES: By the end of the session participants will be able to:

- Explore the meaning of FGM
- Identify the different types of FGM
- Appreciate and be convinced about the harmful effects of FGM on females and why the practice must be stopped.

ACTIVITY/TIME:

- Brainstorming (20 minutes)
- Write and stick (20 minutes)
- Myths and facts (20 minutes)
- Agree/disagree (15 minutes)
- Discussion (40 minutes)
- Individual work (20 minutes)

Evaluation (15 minutes)

Concept: Ask the participants to discuss the following questions:

- What are the societal views towards FGM?
- Why is it practised in some societies?

Activity 2:

Write and stick exercise

Participants to discuss the various forms of practice that are considered harmful and why they are considered harmful

Activity 3:

Review exercise

1. Review the female outer reproductive organs with unlabelled diagrams, asking participants to identify and label the different parts along with their functions. Explain that the review is necessary as the practice of FGM is directly linked to these organs.

2. Ask participants for the meaning of Female Genital Mutilation (female circumcision). Note down responses.

3. Find out how many of them have been circumcised. If facilitator has been circumcised, share your experience with participants to encourage them do same.

4. Give technical information on what FGM is and describe the types.

Activity 4:

Small group work/discussion

Divide participants into small groups of between 5-10 persons (depending on the number of the girls) to discuss on:

Group 1

- Why FGM is carried out in their locality?
- How is FGM done in their locality?
- Instruments used (names in local languages could be used)
- Who are those involved in the operation?
- How do the victims feel after the operation?

Let the various groups present their output. Process the information and add value where necessary to strengthen information.

Activity 5:

Discussion on effects of FGM

- Ask participants if they have ever heard of any problems arising during or after circumcision of girls or women
- Write down responses
- Add value on effects of FGM, using technical information

Activity 6:

Myths and facts **(clarification of concepts)**

Participants are to either agree or disagree with the following statements:

(a) The female genitalia is unhygienic and needs to be cleaned by FGM

(b) Female clitoris is very ugly and will grow and become too long if not cut

(c) FGM is fashionable because it makes girls to become real women

(d) The uncircumcised female cannot be married

(e) FGM makes vaginal intercourse more desirable than clitoral stimulation

(f) God sanctifies FGM

(g) FGM improves fertility and prevents maternal and infant mortality.

Explain that none of the underlying messages used to justify FGM is unique in our society. Such messages reflect a universal language used to perpetrate women's second class status and are reminiscent of similar reasons given for slavery, colonialism and racism. Some women in effort to defend themselves from self-guilt would deny that FGM damages their bodies or their sexuality.

The fear of losing the psychological and material benefits of "belonging" is one of the greatest motivations for conformity. But this is not the reality. FGM is increasingly being regarded not only as an assault on the physical integrity of the female body, but also an abusive practice and as such a human rights abuse.

Activity 7:

Group work

Divide participants into groups for them to discuss

- How they feel the problem of FGM could be eradicated in the society with focus on:
  - (a) The community leaders
  - (b) Parents
  - (c) Religious leaders
  - (d) Media
  - (e)Non-governmental organisations (NGOs)
  - (f) Policy makers

Process the information after each group presentation and add value, using technical information on public policy positions towards elimination of HTPs.

Self-Reflection/Evaluation

- One initial view I held about FGM was.....
- I now see FGM as.....
- Some questions I still have about FGM are.....
- What I will do personally to stop FGM is.....

Closing

This provides time to engage in group reflection and to make some announcements, and give assignment.

Action assignment

Ask participants to discuss with their close friends something they have learnt about FGM and to discuss their reaction with the group at the next meeting.

TECHNICAL INFORMATION

What is Female Genital Mutilation?

Female Genital Mutilation is the partial or total removal of part(s) of the female external genitalia (sexual organ). Mutilation is the cutting off or permanently destroying an essential part of the body. By these definitions, the act is a violation of the right of the victim(s) and their bodily integrity. FGM is indeed an infringement on the physical and psychosexual integrity of women and girls. It is particularly a form of violence against the victim.

There are four types of FGM commonly practised depending on the community. These are:

(1)**Clitoridectomy**: Which involves partial or complete removal of the clitoris

(2)**Excision**: Removal of the clitoris and partial or complete removal of the labia minora

(3)**Infibulation**: Partial or complete removal of any external genitalia, followed by stitching or narrowing of the vaginal opening. At times the opening left after stitching is as small as the head of a matchstick.

(4)**Unclassified**: These are various forms of scarification, piercing, massaging of the vulva, etc.

Explain to participants that these acts pose grave danger to the health and lives of girls and women. FGM is a human right problem because 99% of the victims are forced into the operation with no prior knowledge of its consequences.

Effects of FGM

Researches have documented various consequences of FGM to include:

1. **Immediate effects**

- **Intense pain,** since the act is performed without anesthesia;
- **Haemorrhage,** life-threatening blood loss from the operation and from rupturing of infected scar;
- **Shock,** from intense pain, fear of even the sight of blood.

2. **Intermediate effects**

- **Infection** from un-sterilised equipment leading to tetanus and HIV infection. The infected wound can increase the risk of reproductive tract and pelvic infections, leading to infertility;
- **Improper healing** in some victims may lead to excessive scar tissue and formation of keloids;
- **Injury** from the struggling of the victim in pains and the use of imprecise tools can lead to injury to other organs and glands

3. **Long-term effects**

- **Chronic infections:** The scar from FGM may need to be recut before intercourse and at delivery and this increases the victim's vulnerability to infections;
- **Infertility** resulting from chronic reproductive tract infections;
- **Labour complications**, FGM scar can make vaginal examination and the monitoring of the progression of labour through cervical dilation difficult. Women also enter into prolonged labour as a result of FGM complications, thus threatening the survival of both the mother and child.

Painful intercourse: The husband of a circumcised woman may be unable to penetrate the vaginal opening and can injure or tear the genital tissue in his attempts.

Public policy positions towards elimination of HTPs

Though the law and responses to issues of violence against women reflect exaggerated notions of sexual differences and double standards of immorality, this often adds to the victim's sense of victimisation. It is of note that much of these practices remain unnamed,

unreported, unchallenged and unchanged. An understanding of this problem, needs an inquiry into the prevailing relationship between sexual identity and social subordination, for it is founded on the unequal treatment of men and women. It also crosses the barriers of class, income, race, culture and religion.

In Cross River State for instance, in recognition of the immediate and traumatic effects on the victimised women and long-term effects in the future of the women, children, families and on the community at large, Bills have been passed against perpetrators of forced/child marriage, FGM, etc.

REFERENCES

1. *Women's Right as Human Rights: The Nigerian Experience* (LRRDC)
2. Articles by Bene Madunagu and Ndodeye Bassey on *Tribune* newspaper of Thursday 8 November 2001.
3. The Cross River State Bill on FGM and Child Marriage, 2001.

CHAPTER TWELVE

HUMAN SEXUAL RESPONSE CYCLE (HSRC)

GOAL:

To enable participants to understand the biological basis of certain feelings and what happens in the body during sexual activity.

OBJECTIVES:

By the end of the session the, participants

- Will be able to discuss the issues about human sexual response cycle
- Will be able to describe the processes of vaginal lubrication and clitoral enlargement
- Understand the nature of body reactions involved during the HSRC.

COMMON BELIEFS/CONCEPTS:

- It is dirty, vulgar and 'immoral' for young girls to discuss issues of sexual activity
- Any girl who discusses issues of sexual activity is assumed to be sexually active.

MATERIALS:

Flipcharts, markers, masking tape, diagram of human sexual response cycle, diagram of male and female anatomy, facilitator's resource, etc.

ACTIVITY/TIME:

- Review exercise of female and male reproductive systems (30 minutes)
- Introduction (5 minutes)
- Brainstorming/discussions (25 minutes)
- Group work and report back (30 minutes)
- Role-play/discussion (60 minutes)
- Self-reflection (5 minutes)
- Closing (5 minutes)

PREPARATION:

In 1966, two scientists, Masters and Johnson, conducted an extensive study of the human body's physiological 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 "human sexual response cycle."

During puberty, the female genitals grow and become increasingly more sensitive due to hormonal changes. As girls mature, they notice these changes and would begin to be curious about them. A discussion of the female reproductive system, therefore, might include information about vaginal lubrication, clitoral enlargement and orgasm, as well as the menstrual cycle.

Information about sexual responses often come mainly from unreliable or incomplete sources, such as peers and the media. This lesson serves to offer them more reliable sources of accurate information.

Accurate information tends to satisfy curiosity rather than encourage it. Children who learn about sexual response from reliable sources are much better prepared to understand their own bodies and make thoughtful decisions about their sexual behaviour.

LESSON SEQUENCE

Opening

Led by the chairperson of the day to open with songs; a report of the last lesson, debates, discussions and lesson clues; making of announcements and goal-setting.

Energisers/Ice-Breakers

Energisers can be used to introduce the topic.

Lesson topic

Activity 1:

- Explain to the participants the need to review the anatomy and physiology of the female and male reproductive systems. This is to aid a better understanding of the topic (refer to chapter on male and female reproductive systems).

Activity 2:

Brainstorming

Identify the different phases of the human sexual response cycle.

- Put responses on flipchart
- Add value and clarify new terms, using technical information e.g. vaginal lubrication, orgasm.

Activity 3:

Group work/report back

Having identified the phases of the HSRC, break participants into four groups thus;

Group one - Phase 1 (Excitement)
Group two - Phase 2 (Plateau)
Group three - Phase 3 (Orgasm)
Group four - Phase 4 (Resolution)

- Ask each group to identify the body reaction that occurs during each phase
- Reconvene and commend the groups
- Report back/comment by each group
- Add value telling participants that;

Each phase of the HSRC 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 intensify in the next phase of the cycle.

Activity 4:

Review exercise (role-play)

Adding fun to the HSRC

Instructions: Distribute copies of the telephone conversation to participants. Then ask for 2 volunteers to role-play the conversation.

Two girls from the same class had an interesting telephone conversation one night. It went thus:

"Hi. I couldn't wait to talk to you tonight. Wait a second I want to close the door. I don't want anyone to hear this."

"You always keep me in suspense. What happened?"

"I had this talk with my parents at dinner time about sex."

"Your parents?"

"Yeah. It's not the first time we've talked, but this time was really in-

teresting! Remember that book they gave me a while ago about sex?"

"You mean the one I read that night when I stayed over?"

"That's the one. Well, at dinner, they asked me if I read it and if I had any questions."

"You didn't say anything, did you?"

"Not at first. But my Mom asked me if I understood the parts about girls."

"You mean periods and stuff?"

"Not that part, the part where it talks about when a girl gets sexually excited, you know...horny!"

"You got to be kidding. Your parents talked about that!"

"They really surprised me. They both said they were embarrassed to talk about this because their parents hadn't told them when they were my age. Dad said he and Mom thought it was important to talk about."

"They were embarrassed and they still wanted to talk? What did they say?"

"Mom told me that when a woman gets sexually excited, certain things happen to her body. One of the things that happen is that the clitoris becomes more sensitive to touch."

"Wait a minute! What's a clitoris?"

"The clitoris is a sensitive spot in the upper part of the labia. It's down there. Just above where the urine comes out."

"Well, what else did they say?"

"My father explained that another thing that happens when a woman is sexually aroused is that the vagina gets wet. He called it vaginal lubrication. It's not like urination, but something entirely different."

"Where does the wet stuff come from?"

"From the walls of the vagina. It happens to girls all throughout life, even to babies."

"Did you ask them if any of this stuff hurts?"

My mother said it doesn't hurt. She said it feels nice. Then I asked how a girl gets sexually excited in the first place."

"You really asked them that? I don't believe you!"

"I really did. Mom said it could happen from dreams or thoughts, from masturbation, or for no obvious reason at all. Dad said that it happens more often once a girl goes through puberty. It's nothing to worry about since it is normal and all girls have vaginal lubrication."

"Was all this stuff in that book? When can I borrow it?"

"I'll lend it to you as soon as my brothers finished reading it. See you tomorrow. Bye."

"Bye."

(Adapted from *New Methods for Puberty Education,* Cooperman and Rhoades, 1983).

Reflection questions

1. Have you ever had an opportunity to discuss the human sexual response cycle?
2. How did you feel when you listened to the telephone conversation?
3. Why are these issues not discussed generally at home or in class?
4. What would you do with this information when you grow up to become a parent?

Self -Reflection/Evaluation

Have girls complete the following open-ended questions:

1. I felt..... during the session because.....
2. One new thing I have learnt during the session on HSRC is.....
3. One thing I did not like about the session was.....
4. One thing I still want to know about HSRC is .....

Closing

End the session with songs/exercises of your choice

TECHNICAL INFORMATION

Vaginal lubrication and orgasm

Vaginal lubrication: The lining of the vagina contains many blood vessels and between the vessels is clear fluid. During sexual arousal in the female, the heart pumps

faster and extra blood rushes into the blood vessels in the vagina. This causes the blood vessels to enlarge and when this happens, the surrounding fluid is displaced. The fluid goes through microscopic pores or holes in the vaginal wall and seeps into the vagina itself.

Orgasm: This involves the build-up and release of tension in muscles and nerves. A simple way to demonstrate build-up and release is to slip one end of a rubber band around a pencil. Holding the other end of the rubber band tightly, twist the pencil round and round so that the rubber band becomes very taut. Release the pencil, allowing participants to observe the unwinding process. Note how the materials return to their original state. Compare this to the build-up and release of sexual tension.

PHASES OF HUMAN SEXUAL RESPONSE 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 stimulus keeps up, the excitement and sexual tension builds and eventually reaches the next stage.

Male response: The penis gets hard-longer, larger, stiffer. About 30% of men notice that their nipples would become erect.

Female response: Vaginal walls begin to sweat, making lips of the vagina wet. About 30% of women can notice nipple erection.

PHASE 2: PLATEAU

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.

Male response: Breathing and heartbeat speed up, blood pressure rises slightly. Increased blood flow to the pelvic area. About 26% of men have sexual flush. Muscles tighten, especially in pelvic area and buttocks. Testicles pull in closer to body.

Female response: Breathing and heartbeat speed up, blood pressure rises slightly. Increased blood flow to the pelvic area. About 75% of women have a sexual flush. Clitoris pulls in under hood of skin attached to inner lips.

PHASE 3: ORGASM

If the stimulation keeps up, orgasm results - a sudden release of tension accompanied by more or less intense sensation of pleasure.

Male response: Sudden series of muscles contractions all along the penis. Faster breathing and pulse rate. Ejaculation-discharge of semen in a few intense spurts.

Female response: Sudden muscles contractions through vagina and clitoris. Faster breathing and pulse rate.

PHASE 4: RESOLUTION

The body relaxes and returns to normal. This may take half an hour. Sometimes longer.

Male response: Muscles relax, penis becomes limp. Blood pressure, pulse and breathing rates drop to normal.

Female response: Muscles relax congestion of blood in pelvic area is relieved. Blood pressure, pulse and breathing rates drop to normal.

Some women are capable of having several orgasms before they move on to the stage of resolution. Virtually all men require at least a short time in the resolution phase after orgasm before the response cycle can begin again. This period between orgasm and re-excitement is called the **refractory period.** While it lasts, which can be anything from a few minutes to a few hours,

sexual response is impossible and/or un-pleasurable. Many factors seem to influence the varying length of the refractory period in different men-among them are age, level of stimulation, and genetic predisposition.

Summary of human sexual response cycle

The following review of the HSRC could be the basis of a lecture and/or handout for trainees to keep.

A general body reactions

Excitement phase

Male	**Female**
Nipple erection (30%)	Nipple erection
	Sex-tension flush (25%)

Plateau phase

Sex-tension flush (25%)	Sex tension flush (75%)
Carpopedal spasm	Carpoperdal spasm
Generalised skeletal muscle tension	Generalised skeletal muscle tension
Hyperventilation ↑	Hyperventilation ↑
Tachycardia (100-160/min)	Tachycardia (100-160/min)

Orgasmic phase

Specific skeletal muscle contractions ↑	Specific skeletal muscle contractions
Hyperventilation ↓	Hyperventilation ↑ ↓
Tachycardia (110-180/min)	Tachycardia (110=180/min)

Resolution Phase

Sweating reaction (30-40%)
Hyperventilation ↓
Tachycardia (150-180/min)

Sweating reaction (30-40%)
Hyperventilation ↓
Tachycardia (150-180/min)

REFERENCES

1. SIECUS Fact Sheets (1996) at a Sexuality Education Training, Ogere, Nigeria.
2. GPI Lesson Output

CHAPTER THIRTEEN

SEXUAL DYSFUNCTION

GOAL:

To assist participants to be familiar with the common sexual dysfunctions and to understand their causes and remedies. This is to help them to live healthy life devoid of ignorance.

OBJECTIVES:

By the end of the lesson participants would have been able to:

- Explain what sexual dysfunction means
- Identify some types of sexual dysfunction in males and females
- Identify where to get treatment or referrals for such dysfunctions.

COMMON BELIEF/CONCEPT:

- When a young man or woman gets to a certain age without having sexual intercourse, he/she will have sexual dysfunctions.

MATERIALS:

Flipcharts, papers, markers, felt pens, enlarged diagrams of the male reproductive system (labelled and unlabelled) and technical information resource.

ACTIVITY/TIME:

- Brainstorming (15 minutes)
- Write, read and stick exercise (20 minutes)
- Group work (40 minutes)

LESSON SEQUENCE

Opening

The chairperson of the day will commence proceedings with opening songs and a report of the last lesson by the previous rapporteur; corrections and comments on the report by participants are made, followed by checking-in: debates, discussions, etc.

Energizers/Ice-Breakers

Appropriate energizers can be used to introduce the topic.

Lesson topic

Activity 1:

Brainstorming exercise

Begin the session by asking the participants if they have ever heard about the words, **sexual dysfunction**. Pick a story from a health column on a magazine, depicting a case of sexual dysfunction and give a participant to read.

Activity 2:

Write and stick exercise

- Ask participants to write down their understanding of the term, sexual dysfunction.
- Process the information and add technical information.

Activity 3:

Small group work

Divide participants into 2 groups and give the following tasks:

Group 1

(a) Let them name the different sexual dysfunctions they know or have heard of in males

(b) The perceived causes of such dysfunctions

(c) The possible treatment for them.

Group 2

(a) Different sexual dysfunctions in females

(b) Causes of such dysfunctions

(c) The possible treatment for them.

Participants to make presentations and the facilitator adds technical information.

Self-Reflection/Evaluation

- Participants to say one new thing they have learnt during the lesson

Closing

End session with an exercise.

TECHNICAL INFORMATION

What is sexual dysfunction?

This refers to conditions in which the normal physical response of the sexual functions is impaired. It could also mean the problems or difficulties and disorders that may prevent a person from having or enjoying sexual activities.

Dysfunctions in males

These can be divided into 3:

1. Erectile dysfunctions
2. Ejaculation disorders
3. Problems with sexual desire

(a) *Erectile disorders*

Impotence: This is the inability of the man to attain or maintain an erection that is sufficient for intercourse (not firm enough).

Causes

- Isolated problems with erection common in most men can be physical or psychological and even emotional in nature.

Physical causes

- Nerve damage due to diabetes
- Prostate cancer
- Spinal cord injuries, back injuries
- Hormone disorders, (low level of testosterone)
- Cardiovascular disorders
- Drug abuse
- Alcoholism
- Nicotine (cigarettes, kola)

Emotional causes

- Stress (work related)
- Relationship problem - anger, negative feelings, disagreement
- Lack of privacy
- New partner
- Fatigue
- Anxiety

(b) *Ejaculation disorders*

Premature ejaculation: (Rapid ejaculation) This has to do with inability to control the timing of the ejaculation. It commonly happens after the penis has entered the vagina, but in some cases, mere kissing, touching, holding hands can trigger off an ejaculation. It generally affects younger men and tends to improve with age.

Ejaculatory incompetence: Inability to ejaculate despite a firm erection and being aroused.

Retarded ejaculation: Although intra-vaginal ejaculation does occur, it takes a very long time. Adolescents and young men starting a new relationship are prone to this.

Retrograde ejaculation: This refers to a condition where little or no semen emerges during intercourse. Here, semen does not exit through the end of the penis, but instead enters the bladder. This dys-

function poses no physical threat because semen is expelled in the urine, but may prevent a man from fathering a child, except through other methods e.g. artificial insemination.

Desire problems: This refers to lack of sex appetite, differences in sexual preferences, dissatisfaction with partner relationship, drugs, medical conditions, depression, stress and fatigue, sexual fears.

Treatment for some of the dysfunctions in males

Premature ejaculation

Squeeze technique

- The man's partner squeezes the end of the penis (point were the gland joins the shaft) when he indicates he is about to ejaculate
- After the penis is squeezed, couple wait for about 30 seconds and then return to foreplay
- Squeezing causes the penis to shrink but soon regains its firmness with adequate stimulation
- After a few sessions, many men can stop having premature ejaculation.

Retrograde ejaculation

Treatment for this depends on the causes. If drug related, doctor may recommend drug to be eliminated or dosage adjusted.

Sexual dysfunctions in females

1. Painful intercourse (dyspareunia causes)

- Lack of lubrication (penetration difficulty) This is common in post-menopausal and breast-feeding women. These groups of women are prone to dryness because of hormonal change, as oestrogen production is low.
- Allergic reactions to laundry detergents, deodorants and condoms.
- Women with bladder infections, endometriosis, fibroid, ovarian mass.
- Physical abnormality - Child birth, bladder infections, ectopic pregnancy, genital warts/herpes.
- Vaginismus - Involuntary spasm of the muscles around the vagina (vagina closes up)
- Negative feelings towards partner due to anger, disagreement, etc.
- Sexually abused children
- Anxiety about pregnancy
- Female Genital Mutilation (FGM)
- Hyper religiosity - equating sex

with sin, negative family attitudes about sex.

Treatment

Counselling by health professionals

Use of vaginal dilators - different sizes of penis specimen

Sensate focus techniques such as genital massages, non-genital massages, body stimulation.

2. Anorgasmia i.e. inability to experience orgasm.

Causes

- Depression (dysperunia)
- Relationship problems
- Anger, stress, fear
- Shame and guilt

Treatment

- Develop good communication with partner to find out what turns you on
- Engage in different types of foreplay
- Self-knowledge
- Explore other positions

3. Lack of sexual desire

Aversion to sex is severe or persistent.

Causes

- Age- sexual desire may diminish with age
- Marital discord
- Demands from work, family responsibility
- No longer sexually appealing
- Tubal ligation
- Medication
- Painful intercourse due to dryness of vagina
- Hormonal changes - menopause, pregnancy
- Stress, alcoholism, drug abuse, etc.

Treatment

- Counselling

4. Sensation disorder

- Person experiences desire but the body does not "cooperate"
- Despite stimulation, the person can't get excited
- Vagina does not lubricate, leading to painful intercourse.

Causes

- unavailability of partners
- Negative feelings about partner

Treatment

- Sex therapy
- Counselling
- Open communication

REFERENCE

Book of Women's Health: Your Comprehensive Guide to Health and Well-Being, (1999)

CHAPTER FOURTEEN

SEXUAL BEHAVIOUR

GOAL:

To assist young persons to understand that sexual behaviour is a part of a person's total development into a mature individual.

OBJECTIVES:

By the end of the lesson participants should be able to:

- Understand what sexual behaviour is all about
- Understand the different ways human beings satisfy their sexual desires
- Discuss the standard and non-standard sexual behaviours identified by society
- Explore and appreciate that some forms of sexual behaviours are risky.

COMMON BELIEF/CONCEPT:

- Sexual satisfaction can only be derived from heterosexuality.

ACTIVITY/TIME:

- Brainstorming (30 minutes)
- Card game (20 minutes)
- Discussion (40 minutes)
- Group work (30 minutes)

MATERIALS:

Flipcharts, markers, masking tape, technical information on sexual behaviours etc.

LESSON SEQUENCE

Opening

The chairperson of the day begins by inviting songs from participants and calling for a report of the last lesson, checking-in process which involves the girls recounting their experiences of how they utilised previous lessons in their lives and discussions and lesson clues; an-

nouncements and goal-setting, then follow.

Energizers/Ice-Breakers

Appropriate energizers can be used to introduce the topic.

Lesson topic

Activity 1:

Brainstorming exercise

- Ask participants what they understand by the term, sexual behaviour
- Take down responses on flipchart and add value on what sexual behaviour is.

Activity 2:

Write and stick exercise

- Ask participants to write down as many activities/feelings as possible that involve intercourse and outercourse.
- Process information and add value using technical information on some existing sexual behaviours.

Activity 3:

Card game

Certain sexual behaviours are considered normal and healthy in our society.

- Ask participants to pick from the list below the sexual behaviours they consider normal and standard and also which of them are considered abnormal or non-standard and why. Tabulate answers under normal and abnormal behaviours.

⇒ Abstinence- Deciding not to have sex for a period of time
⇒ Celibacy - Abstaining from sex
⇒ Fellatio - using mouth on penis
⇒ Cunnilingus- using mouth on the vulva
⇒ Analingus - Licking the anus with mouth
⇒ Incest - Sexual intercourse with blood relation
⇒ Transuetism- Getting aroused by someone's dressing
⇒ Paedophilia - Sexual satisfaction from love of small children
⇒ Voyeurism - Sexual satisfaction by watching people's nudity
⇒ Pederasty - Love of young boys
⇒ Nymphomania - Insatiable sexual urge by a female
⇒ Sadism - Love receiving cruelty
⇒ Bestiality - Sexual intercourse with an animal
⇒ Gerontosexual - Turned on by old people

Activity 4:

Individual work:

Ask participants to identify risky behaviours from those sexual behaviours discussed and why they would consider them risky under the following headings:

Safer	Risky	Riskiest	Why

- Process their output and reinforce information where necessary.

Self -Reflection

- Have participants complete the following open-ended questions:

1. One thing I have learnt about sexual behaviour is.....
2. One thing I did not like was.....
3. One thing I still want to know about sexual behaviour is.....

Closing: Sing relevant songs of your choice or ask a volunteer to lead in songs and exercises.

Action assignment

- Ask participants to write down 5 things they like about the topic, and discuss with their close friends what they have learnt from the lesson.

TECHNICAL INFORMATION

What is sexual behaviour?

Sexual behaviours have to do with various ways people derive their sexual pleasure and satisfaction. Some of these ways are safe and normal and some are normal but risky.

Sexual behaviours can be exciting, satisfying and rewarding, if planned ahead and delayed until one is quite ready for it. If we know what we are doing and staying in-charge, we can have happier, healthier and more successful life. But we have to constantly remind ourselves of the risks involved in any type of sexual behaviour. No matter how turned on we may be,

and no matter what our partner might say, we have to be in-charge and play safe.

Types of sexual behaviours

⇒ Fellatio - using mouth on penis
⇒ Cunnilingus - Using mouth on the vulva
⇒ Analingus - Licking the anus with mouth
⇒ Incest - Sexual intercourse with blood relation
⇒ Transuetism- Getting aroused by someone's dressing
⇒ Paedophilia - Sexual satisfaction from love of small children
⇒ Voyeurism - sexual satisfaction by watching people's nudity
⇒ Pederasty - Love of young boys
⇒ Nymphomania - Insatiable sexual urge by a female
⇒ Sadism - Love receiving cruelty
⇒ Bestiality - Sexual intercourse with an animal
⇒ Gerontosexual - Turned on by old people

Safe and unsafe sex

Protected or safe sex refers to any activity that prevents the exchange of blood, semen and vaginal secretions. Such activities include masturbation, body massages, hugging, touching the genitals or using a condom correctly and consistently. Unprotected or unsafe sex includes any sexual activity that involves the exchange of body fluid- blood, semen, vaginal secretions and any act that causes bleeding.

No risk sexual behaviours refer to acts that do not involve the exchange of blood semen, vaginal secretions e.g. masturbation, lip kissing.

Risky sexual behaviours bring about

- Accidental pregnancy
- HIV/AIDS and other STDs
- Serious damages to genitals, etc.
- Events that can frustrate our future
- It can damage our health for the rest of our life and can even lead to sterility.

There is therefore need for us to choose to practise safer sex, be it outercourse or intercourse. There is no 100% safe sexual behaviour, except abstinence. If you cannot abstain, use protection and barrier methods like condoms.

REFERENCES

1. School Health Education to Prevent AIDS/STDs - UNAIDS, WHO, UNESCO
2. Conveying Concerns:Media Coverage of Women and HIV/AIDS
3. Adolescence Education, Sex Roles, Module Three - UNESCO Principal Regional Office for Asia and the Pacific.

CHAPTER FIFTEEN

ADOLESCENCE

GOAL:

To assist participants to be familiar with the changes that occur during adolescence and to avoid unhealthy practices thus promoting good health and well-being.

OBJECTIVES:

By the end of this session, participants would have been able to:

- Define the term, adolescence and who an adolescent is;
- Explore the developmental stages of adolescents;
- Know that the orientation of adolescents is strongly determined by the broader socio-cultural context
- Explain some myths and misconceptions associated with adolescence.

COMMON BELIEFS/CONCEPTS:

- Adolescents generally are difficult, aggressive and insulting
- Adolescents are expected to have control over their lives.

MATERIALS:

Flipchart/board, felt pens (markers), stick (masking) tape, sheets of paper and technical information resource.

ACTIVITY/TIME:

- Individual work (15 minutes)
- Visualisation exercise (20 minutes)
- Brainstorming (10 minutes)
- Small group work (30 minutes)
- Technical information (30 minutes)
- Evaluation (10 minutes)

PREPARATION:

Why the study of adolescence?

- Adolescents are over 1 billion, world-wide and constitute about 75% of the total population.
- Adolescents' attitudes, behaviours and use or non-use of health care system and services are linked directly to their health and well-being as adults.
- Adolescents need correct information about their sexual health, rights and responsibilities in the society.

Young people are often not used to the changes that occur in their bodies as well as the developmental stages in life. Thus, they are often confused and withdrawn when these changes occur.

LESSON SEQUENCE

Opening

- Participants to stand in a circle and pick a partner among themselves
- Tell your partner what you like about her after introducing yourself and your age
- Each partner then reports back what her partner has said, to the group.

Energizers/Ice-Breakers

- The facilitator starts with a song or asks a volunteer to suggest one like "I'm alive, alert, awake, enthusiastic" and a simple exercise follows to get people ready for the session.

Lesson topic

Activity 1:

Brainstorming

Each participant will be required to read out what she has written about adolescence. These will be recorded on the flipcharts at the end of which the facilitator will process their responses and add value, using technical information.

Activity 2:

Visualization exercise (showing transitional process)

- The facilitator at this point will lead the activity by asking every participant to close eyes and try to recall her own developmental process from childhood. The facilitator will be asking the

following questions to participants:

- Think about yourself as a child of 6-7 years old
- Remember your first day in nursery or primary school
- Think of a photograph of yours at age 6 or 7
- What or how did you look like?
- How tall were you?
- With whom did you used to spend your time with and why?
- Who were you close to?
- What things were important to you then?

These questions will be repeated for the period of 10-13, 14-16 and 17-19 years.

- Participants will then be encouraged to discuss their feelings as they go through the above process.

Activity 3:

Small group work

- Divide participants into three or four groups depending on the number of participants
- Ask participants to look at different adolescent groups and record their thought or experiences and the tasks of development.
- Process responses after presentations and add value at the end, using technical information.

Activity 4:

Discussion

Reflection questions

Have participants discuss their responses to the following questions:

1. What are the concerns of adolescents aged 10-14 years?
2. What shapes the lives of adolescents of ages 15-17 years?
3. What are the concerns of adolescents of ages 18 and above?

Self-Reflection/Evaluation

Have participants complete the following open-ended questions:

1. One new lesson I have learnt today is.....
2. One aspect of the lesson I still need to know.....
3. One thing I still want to know about this topic is.....

Closing

Go back to the set objectives, process participants' expectations, and end the session.

TECHNICAL INFORMATION

What is adolescence?

Adolescence is a relatively new term that has been used widely only during the past 50 years or so. It refers to the period when children are in the process of becoming adults. Simply put, adolescence is the period between childhood and adulthood. The World Health Organisation puts this period at 10-19 years, while the Nigerian Policy on Adolescents Reproductive Health puts adolescents as those between 10-24 years.

Who is an adolescent?

Adolescent refers to any young person of ages 10-18 or 10-24 years. There are currently more than one billion adolescents in the world and 85% of them live in the developing countries. This period of life can be viewed as one of both opportunity and risk.

Different categories of adolescents

* Married Adolescents
* Adolescents as parents
* Adolescents with physical and mental disability
* Children living on the street
* Refugee adolescents
* Adolescents in rural communities
* Adolescents in urban centres
* Sexually active and those not.

Each of these categories faces different challenges and different health risks.

Younger adolescents - 10-13
Middle - 14-16
Older - 17 above

Note: The period of 8-12 years is regarded as pre-adolescence. This is when young people begin to change physically and their social development is likely to be rapid. Adolescence thus begins at puberty with the onset of menstruation for girls and production of sperms for boys. During puberty, the boys and girls' bodies grow faster, their reproductive organs start to function and they mature sexually. Boys begin puberty at about 12.5 to 13 years. The process takes about 5 years. Girls begin at 11.5 to 12 years of age and the process takes about 6 years.

Phases and tasks of adolescence

Adolescence can be conceptualised by dividing the process into three

psychological developmental processes

- **Early adolescence** - Approximate age 10 -13 or middle school years
- **Middle adolescence** - Approximate age of 14 -19 or high school age
- **Late adolescence** - Approximate age 17 -20 years.

These stages overlap among different adolescents. The transition from childhood to adulthood does not always occur by a continuous uniform synchronous process.
By the end of adolescence most individuals have been emancipated from parents and other adults and have attained a psychosexual identity and with sufficient resources from education, family and community to begin to support themselves in an emotionally, socially, and financially satisfying way.

What shapes the lives of adolescents in general?

Adolescence is a period of extreme instability. Some parents feel that this is a natural stage of development and not a matter of concern, but some others don't just know what to do. Regardless of their circumstances, what shapes their lives is the impact of social expectations and gender roles and discrimination -society defining what is proper and typical for females and males.
The messages are transmitted by families, schools, religion, laws and the media, advertising, entertainment, etc. Persons in the age group of adolescence are very impressionistic and malleable. The transition to adulthood often involves periods of stress, innovation, experimentation and disorganization. This is a period of rapid social changes and accompanying social confusion. Adolescents are often confronted with conflicting and often times contradictory social expectations.

Development tasks

- *Independence*: Adolescents need to become less dependent on parents. They begin to shift from parents to peers or to belief systems in order to achieve independence. This shift is strong and may involve rebellion, leading to mood changes.
- *Identity:* Adolescents struggle to define themselves and what they want to accomplish. They are answering the questions: Who

am I? What can I be? This process involves experimenting. Adolescents need to develop gender role identity, a positive body-image and sense of esteem and competence and need guidance, counselling and understanding, which they rarely get.

- *Intimacy*: Adolescence is a time of preparation for relationships. Adolescents at this stage learn to express and manage emotions. They develop the capacity to love and be loved and to be intimate in relationships, but receive little or no information to guide them in making such decisions.
- *Integrity*: Adolescents must develop a foundation for sorting out values. Parents have to provide a base for this. However, there is always a tremendous amount of other input at this time - peers, media, school, etc. Adolescents would then decide on what to believe in and how to behave.
- *Intellect*: Adolescents' intellectual capacity increases and changes from concrete thinking to include abstract thinking. Many adolescents become capable of conceptual thinking and of understanding logic and deductive reasoning. This increased ability may heighten self-esteem. Some adolescents tend to overvalue their intellectual theories and see things from an idealistic point of view.

Factors that influence adolescents' developmental task

Experiences are vital events as we grow into adults. Adolescence is a critical period in every person's life. It is a time when young people discover themselves as individuals and establish life-long patterns of adult behaviour and relationships. Various factors play important part in the development of the individual. These include:

- Environmental
- Nutritional
- Social
- Religious
- Family situation

Why adolescents don't confide in adults

- Privacy and confidentiality not guaranteed
- Judgmental attitudes of adults
- Lack of respect for their opinions

- Not being given accurate information
- Not being told the truth.

REFERENCES

Things Will Be Different for My Daughter, By Mindy Bingham and Sandy Stryker.

Changing Bodies, Changing Lives. - By Ruthbell et al

Adolescence Education: Sex Roles Module 3, By UNESCO

CHAPTER SIXTEEN

CANCERS AND SELF-EXAMINATION

GOAL:

Assist participants to know and develop the habit of self-examination in order to detect early signs of abnormalities in their bodies, if any.

OBJECTIVES:

At the end of the session, participants will be able to:

- Say in simple terms what cancer means
- Identify some possible factors responsible for the development of cancers
- Recognise some signs and symptoms of cancers
- Explore the importance of self-examination in the early detection of some cancers.
- Clarify some myths about cancers.

CONCEPTS/COMMON BELIEFS:

- Women are at greater risk of cancer than men
- Putting coins or other materials inside the bra would lead to cancer of the breast
- Use of contraceptives causes cancer
- Cancer is punishment for smokers
- Only medical personnel should examine one's body.

MATERIALS:

Flipcharts, papers, markers, felt pens, enlarged diagram of breast self-examination, plastic specimen of a breast, technical information resource.

ACTIVITY/TIME:

- Agree/disagree exercise (15 minutes)
- Brainstorming (15 minutes)
- Write, read and stick exercise (20 minutes)

- Group work (40 minutes)
- Practical session on breast examination (30 minutes)
- Evaluation (15 minutes)

PREPARATION:

Cancer touches most people in some way. It directly or indirectly affects one in four families and the incidence of women's cancers especially breast and lung and uterine cancer, is on the rise. To change this, women must feel empowered to make a difference in their personal healthcare. Early detection and prevention can work if women consistently use resources like self-care methods such as breast self-examination, swoop tests and regular check-ups.

LESSON SEQUENCE

Opening

The chairperson of the day would follow the usual sequence of activities to get participants set for the day.

Energizers/Ice-Breakers

Appropriate ones are chosen to begin the lesson.

Lesson topic

Activity 1:

Brainstorming exercise

- Ask participants for things they have heard people say about cancers and self-examination.

Activity 2:

Discussion

Facilitator to discuss the above concepts to demystify popular myths.

Activity 3:

Brainstorming exercise

- Ask participants to give local names people call cancers.
- List them down on a flipchart, this is to enable participants to be familiar with the names.

Activity 4:

Individual writing exercise

- Participants to write down their understanding of the term, cancer.
- Process the information and link incorrect definition(s) to the general belief discussed in the concepts.
- Provide technical information on what cancer is.

Activity 5:

Brainstorming exercise

Participants to brainstorm on the common types of cancer and those who are prone to such cancers.

- List participants' responses on the flipchart and discuss.
- Add technical information on the common types of cancer, those at risk.

Activity 6:

Statements on cards (agree/disagree exercise)

- Facilitator distributes statements on cards on various views on the causes of cancers. Participants will read them out and indicate whether they agree or disagree with the statements. Participants are to give reasons to explain their position.

Some of such statements can be:

- Putting of coins (materials inside bra causes cancer of the breast)
- Use of contraceptive devices causes cancer of the cervix
- All smokers are liable to cancer of the lungs
- Excessive exposure to radiation causes cancer of the lungs and breast
- Cancers can be hereditary
- Age is the single most important risk factor for cancer
- Inhaling chemical substances emitted from industries are known to cause cancer
- Excessive exposure to sun can cause cancer of the skin.

Facilitator provides or reinforces each correct response with appropriate technical information on some factors responsible for cancer.

Activity 7:

Small group work

- Divide participants into 2 small groups
- Give them the names of two of the cancers identified in activity 5; cancer of the cervix and cancer of the breast
- Let them use the following discussion points to work on them:
  - (a) To name signs and symptoms of such cancers
  - (b) What should be done to detect such cancers early enough
  - (c) What can be done when such cancers are eminent
  - (d) How to reduce the risk of such cancers.
- ❑ Participants should present their

output and discuss. Process information and add value, using technical information.

Activity 8:

Practical session (performing the breast self-examination).

- With the aid of a model breast and a poster of breast self-examination, facilitator will demonstrate to the participants how to perform the **Breast self-examination** (BSE).
- Ask volunteers to try doing same
- Reinforce information on the need for participants to be comfortable with their bodies and the need for regular examination to detect abnormality.

Self-Reflection/Evaluation

- Ask participants to say one new information they have acquired during the session.

Closing

- End session with a closing activity such as alert exercise.

TECHNICAL INFORMATION

What is cancer?

Cancer is a malignant growth or tumour, which is caused by excessive multiplication of cells. People who are exposed to cancer causing agents commonly called cacinogens stand the risk of developing cancers.

For an abnormal growth to be considered as cancer, the cells must:

(a) Look different from normal cells

(b) Divide rapidly enough to upset the body's status quo

(c)Have the potential both to invade adjoining cells and tissue and to spread to other parts of the body.

Common types of cancer

1. Cancer of the lungs,
2. Cancer of the breast
3. Prostate cancer
4. Cancer of the cervix
5. Cancer of the skin

Men have more cancers than women. This is because of their behaviours, nature of work, intake of alcohol, smoking, etc, working in industries, in the x-ray rooms. It is not advisable for one to work in the x-ray room if one has not got children yet.

People of African descent are believed to have more cancers than

the caucasians because of the fact that the whites have better hygienic environment than the blacks as well as better diet combinations than the blacks. The whites also go for yearly check-ups in order to be able to detect any cancer in an early stage and as such, treat it early.

Factors that cause cancer

This could be divided into 2 basic groups: those that are under a person's control and those that are not.

Major risk factors are

(a) Environmental: Non-occupational habits: smoking, alcohol consumption, sun bathing, and diet
- Customs
- Air and water pollution

(b) Chemicals e.g. asbestos
- Physical e.g. radiation

(c) Sex differences
- Hormonal
- Anatomical

(d) Virus

(e) Race

(f) Habitat-rural versus urban

(g) Genetics

(h) Marital status

(i) Psychological
- Personality
- Stressful life events

(j) Socio-economic class

(k) Medical therapy -related cancers.

Geographical cancers

Gynaecology - Greek words: Gyne and Gynaikas, meaning "woman" logia meaning, "study."

Gynaecology - Disorders of a person's reproductive system.

Gynaecological cancers: Cancers that affect organs of a person's reproductive system. It can affect any of the reproductive organs;
- breast
- uterus
- ovaries
- cervix

Detecting cancers

Cancer of the cervix

Cancer of the cervix is the most common in the less developed world. The main cause is a virus-human papiloma virus, or HPV, which is the same virus that causes genital warts. This cancer grows slowly for about 19 years and if it is treated early it can be completely cured. But many women die every

year from cancer of the cervix because they never knew they had it.

Those at risk of cervical cancer

- Older women of 35 years and above
- Women who started sexual activity at a very young age - within only a few years of starting monthly period.
- Women who have many sex partners or have partners with many sex partners
- Women who had frequent STDs, especially genital warts
- Women who have HIV/AIDS
- Women who smoke tobacco.

Some warning signs of cancer of the cervix

There are usually no outward signs of cancer of the cervix until it has spread and become more difficult to treat. There are often early signs on the cervix, which can be seen during a pelvic examination. Abnormal bleeding from the vagina, including bleeding after sex or an abnormal discharge or bad smell from the vagina can all be signs of a serious problems including advanced cancer of the cervix. If you have any of those signs, try to get a pelvic examination and a pap test.

Finding and treating cancers early

Finding and detecting cancers early can often save a woman's life, because she can get early treatment, before the cancer spreads. Some cancers have warning signs that show that something may be wrong. But usually, to find out if one has cancer, one must have a test that takes a few cells from the part of the body where the cancer may be. Then the cells must be examined by someone who is trained to recognise cancer.

Cancers that do not have early signs can often be found with screening tests, routine tests given to people to see if everything is normal. A pap test for cancer of the cervix is one kind of screening tests.

Reducing the risk of cancer

Women can reduce the risk of cancers when they do the following:

⇒ Avoid frequent x-ray exposures, especially at earlier ages

⇒ Do not smoke and avoid smoke-filled environments

⇒ Avoid oestrogen replacement therapy at menopause and any other medication with oestrogen such as the morning after pill. The relationship between oral contraceptives and breast cancer is very controversial. Studies show that a person who begins using birth control pills at an early age and continues for a long period has a higher risk of breast cancer. Also, pills tend to lower a person's chances of developing ovarian and uterine cancers.

- To be on the safe side; one may avoid oral contraceptives

⇒ Minimize intake of smoked, salted or pickled foods, e.g. bacon

⇒ Avoid additives, preservatives and refined flour

⇒ Keep fat consumption low

Research shows that people who are over-weight easily get cancer and die more frequently from cancer-related ailments.

⇒ Maintain frequent and regular bowel movement

⇒ Exercise

⇒ Eat diet high in fruits, vegetables, whole grains, etc.

⇒ Eat foods high in beta-carotene, carrots, yellow and green leafy vegetables, yellow fruits

⇒ Eat foods containing yeast, garlic, onions, liver, mushroom, shrimps, kidney, whole grains, etc.

⇒ Carry out regular self-examination, examine all parts of your body.

How to perform the cervical self-examination

1. Find a comfortable sitting and get into a relaxed position, on the floor or couch. You may prefer sitting on the floor with a pillow at the back for support.
2. Familiarize yourself with the speculum and then lie back with your knee bent and your feet wide apart. You may want to lubricate the speculum.
3. Hold the speculum in a close position with the handle pointing upwards. You may prefer to place the speculum into the vagina sideways and then turn it upwards. Experiment until you discover the most comfortable variation for yourself.
4. Once you have fully inserted the speculum, grasp the handle and firmly pull its shorter section towards your vagina. This opens

the speculum inside your vagina. Now, hold the speculum steady and push downwards on the outside section until you hear a click, this means that the speculum is locked into place.

- For some women, placing the speculum and finding the cervix may take some effort, breathe deeply and manipulate the speculum gently while looking into the mirror or light on the mirror to help see better. (A friend can help you with this).

5. With speculum locked, both hands are free to hold a mirror and a flash light, focused on the mirror with the speculum in the correct position, you will be able to see the walls of the vagina and the cervix. When the cervix is visible, you can see a round flattened knob - like structure with a hole or slit in it, called the Os.

Your cervix might be pink and smooth or it might have a few reddish blemishes. It can also be uneven, rough or spotty in any case, the only time to worry is when abnormal cells are found in a pap smear.

How to perform vaginal self-examination

⇒ Find a comfortable place such as a bed or carpet with good lighting.

⇒ Hold a mirror in one hand, then use the other hand to separate and expose the parts of the vulva around the vaginal opening. Once you have a good viewing position, examine the main parts of the vulva as follows:

◊ Check the mons pubis. Look for any bump, warts or ulcers, any changes in skin colour, then use your fingers to check any visible changes and to sense any bump just below the surface. You may feel something, which you may not see.

◊ Check the clitoris and the areas around it (just above the vaginal opening) by looking and touching.

◊ Examine the labia majora. Examine both right and left, just as you did with the labia minora

◊ Move down to the perineum and check carefully

◊ **Finally examine the areas**

around the anal opening by looking and touching.

Note: Vulva diseases can be treated most easily and safely when signs are noticed early. Report a new growth or changes to your health care provider as soon as possible.

Breast cancer

Breast cancer usually grows slowly, if it's found early, it can sometimes be cured. It is hard to tell who will get breast cancer. The risk might be greater for a woman whose mother or sisters have had breast cancer, or for a woman who has had cancer of the womb. Breast cancer is more common in women over age 50.

Signs of breast cancer

- A hard painless lump with a jagged shape, that is only on one breast and does not move under the skin
- Redness or sore on the breast that does not heal
- Skin around the breast that is pulled in or looks rough and pitted like orange or lemon
- A nipple that is pulled inward
- Abnormal discharge from nipple
- Sometimes a painful swelling under the arm
- Occasional pain in the breast

Breast lumps and other breast infections

Breast lumps are very common in most women, especially soft, fluid-filled ones (called cysts). These usually change during a woman's monthly cycle and sometimes feel sore or painful when pressed. Few breast lumps are cancerous, but since breast cancer is always a possibility, a woman should try to examine her breasts for lumps once a month. If a woman is breast-feeding a baby and gets a hot red sore area on the breast, she probably has mastitis or an abscess. This is not cancer and is easily cured. If she is not breast-feeding, it may be sign of cancer.

Discharge from the nipple

Milky or clear discharge from one or both nipple is usually normal if a woman has breast-fed a baby in the last one year. Brown, green or bloody discharge - especially from only one nipple - could be a sign of

cancer. Get checked by a health worker who can examine your breasts.

Finding and treating breast cancer

If you examine your breasts regularly, you are likely to notice if there are any changes or if a new lump develops. A special x-ray called a mammogram can find a breast lump when it is very small and less dangerous. But mammograms are not available in many places and they are very expensive and cannot even tell for sure, if a lump is cancerous.

The only way to know for sure that a woman has breast cancer is with a biopsy. For this, a surgeon removes all or part of the lump with a needle or a knife and has it tested for cancer in a laboratory.

Treatment depends on how advanced the cancer is and what is available where you live. If a lump is small and found early, just removing the lump may be effective. But for some cases, an operation may be needed to remove the whole breasts. Sometimes doctors also use medicines and radiation therapy.

No one knows yet how to prevent breast cancer. But we do know that finding and treating breast cancer early makes a cure more likely. For some women it never comes back, in others the cancer may come back years later. It may come back in the other breast or less often in other parts of the body.

Performing breast self-examination

What to look for when there are breast changes:

- Any breast changes that last over a month in a pre-menopausal female
- In a post-menopausal female, any breast change must be checked immediately
- Persistent pain

How to perform breast self-examination (BSE)

- To examine visually, stand with arms relaxed at your sides in front of a large mirror, look carefully at your breasts, their asymmetry shape, colour. This can help disclose any changes in breast contour.
- Turn slowly, bringing your breast forward and examine, then the other, so that light and shadow can help disclose any

changes in breast contour.

- Raise your arms above with elbows back or clasp your hand behind your head.
- Tighten chest muscles
- Accentuate any breast swellings or puckings
- Elevate the breasts and tighten the skin
- Bend forward at the hips and check the symmetry of breasts as they hang down
- If breasts are large or pendulous, lift each one with opposite hand to inspect the underside.

Feeling the breast

- Lie down in the best position to feel your breasts effectively. You can feel lump or changes more easily if you lie on a bed or other flat surface with folded towel or small pillow under your shoulder
- With your hands tucked behind your head, if you apply powder, oil or lotion to the breasts, it is easier for the fingers to glide over them and feel any changes.
- Place the flat area of three or four of your fingers, (not thumb) on the tissue to be examined
- Use the hand opposite the breast to be examined and place the fingers flat and parallel to the chest wall.
- Move your fingers in small circles all over the breast tissue.
- Also, check for nipple discharges
- Try to express a drop or two of fluid from each breast
- Perform breast self-examination in small circles around the alveoli, with fingers positioned on both sides of the nipples, press alveoli.
- Pink, red or black are abnormal, your discharge should be investigated by a doctor.
- If you find something, check the same area on the opposite breast- if there's something abnormal, anything new should be reported immediately.

REFERENCES

1. *Women's Cancers: How to Prevent Them, Treat Them and How to Beat Them*, by Kerry A. McGinn and Pamela J. Haylock (1993).
2. *Dr. Susan Love's Breast Book* (2nd edition. 1995).
3. GPI Training Manual, Vol. 1.

CHAPTER SEVENTEEN

HIV/AIDS

GOAL:

To promote behaviours that prevent the transmission of HIV/AIDS.

OBJECTIVES:

By the end of the session, participants will be able to appreciate:

- Basic information on the prevalence of HIV/AIDS
- Differentiate between HIV and AIDS
- Identify ways in which HIV is not transmitted
- Identify ways of transmission of HIV and prevention
- Know the progression of HIV/AIDS with signs and symptoms.

CONCEPT/COMMON BELIEF:

- We can only protect ourselves from AIDS if we understand what AIDS is and talk about it with our families and friends.

ACTIVITY/TIME:

- Brainstorming (20 minutes)
- Pre-test (10 minutes)
- Agree/disagree (15 minutes)
- Case study (30 minutes)
- Technical information (30 minutes)
- Evaluation (15 minutes).

MATERIALS:

Flipchart, paper, markers, blackboard and chalk, technical information on HIV/AIDS.

PREPARATION:

Basic information about HIV/AIDS is essential to help participants understand other concepts of the topic. Thus, the facilitator starts the session with the information below.

The AIDS epidemic inflicts a heavy toll on young people. About 50% of all new HIV infections around the world occur among people of ages 15-24 years, the age range within which most people begin their sexual lives. When children under the age of 14 are added, the total increases to 60% of new infections. The vast majority of these young people live in less developed countries where AIDS cases are concentrated.

Approximately 90% of the 1 million children under 15 years living with HIV/AIDS around the world acquired the virus from their mothers. In Ghana, children between 0-4 years constitute 2% of known AIDS cases in 2998.
World-wide, more than 13 million children under the age of 15 have lost either a mother or both parents to AIDS and an estimated 92% of these children live in sub-Saharan Africa, including Nigeria.

LESSON SEQUENCE

Opening

Led by the chairperson of the day the opening includes songs; a report of the last lesson by the previous rapporteur; corrections and comments and checking-in.

Energisers/Ice-Breakers

Energisers are used to introduce the topic and to manage the energy and attention of the group.

Lesson topic

Activity 1:

Pre-test

This is to determine participants' knowledge on the topic.

- It should be a participatory session
- The facilitator to design true/false test questions with a category rating scale at the end. Sample of the pre-test could be as follows:

  ⇒ HIV may be passed by sharing clothes with an infected person
  ⇒ Married people don't become infected with HIV/AIDS
  ⇒ If you only have sex with people who look healthy you will not become infected
  ⇒ If you stick to one uninfected partner you will not become infected with HIV
  ⇒ People infected with HIV are usually very thin and

sickly

⇒ You may get HIV from a mosquito bite

⇒ It is dangerous to hug a person with AIDS

⇒ You cannot get HIV if you only have sex once or twice without a condom

⇒ A condom can be safely reused

⇒ There is no way to protect yourself from HIV/AIDS.

These and other statements may be formulated at the end of which participants' contributions will be processed and technical information provided by the facilitator on how HIV/AIDS can or cannot be transmitted.

Activity 3:

Brainstorming exercise

What is HIV/AIDS?

Facilitator to compile series of definitions into a "grab bag."

- Participants pick definitions from the "grab bag" and place them on the correct boxes provided on flipchart.

- Sample:

H - Human
I - Immuno
V - Virus

A - Acquired
I - Immune
D - Deficiency
V - Virus

Antibody - A special protein that is created by our body's immune system and used to fight specific agents that cause infections. In the case of HIV infection however, the infecting virus cannot be destroyed by the antibody.

Asymptomatic - This means that a person has the infection but shows no sign or symptoms. It is possible to infect others even if one is asymptomatic.

Immune system - Protects the body from infections. In this case, specialised cells and proteins in the blood and other bodily fluids work together to eliminate disease - producing agents and other toxic foreign substances.

Opportunistic infections take the opportunity to attack people whose immune system is no longer active.

T-Cell or CD_4 - A type of white

blood cell (lymphocyte) that is vital to the proper functioning of the immune system. They are the targets of HIV.

The exercise at the end must be followed by a proper illustration by the facilitator who adds value, using technical information after processing participants' responses.

Activity 4:

Agree/disagree exercise

The facilitator uses agree/disagree statements to describe various ways HIV can be acquired as shown below:

1. One cannot get AIDS if one has sex just once without a condom
2. A young person can inject drugs bought from any chemist shop without getting infected with HIV as long as she or he uses barrier during intercourse.
3. It is difficult for women to get HIV/AIDS.

These and other statements may be formulated at the end of which participants' contributions will be processed and technical information provided by the facilitator on how HIV/AIDS can or cannot be transmitted.

Activity 5:

Case study/discussion

Aniefiok and Atim are close friends but live in different towns. They often visit each other and on one visit Atim asks Aniefiok how AIDS is prevented. Aniefiok has had a few lessons about AIDS in his club, but cannot remember everything. However, he did tell Atim what he knows about prevention. Some of what he says is not true. Mark "D" for statements that you disagree and "A" for statements you agree.

Statements

- It is easy to tell who has HIV and who hasn't.
- HIV is only present in certain body fluids, mainly male semen, vaginal secretions and the blood.
- Be careful of mosquitoes and other insects that bite because that is one way HIV is spread.
- The only really safe way to protect yourself is to delay sex until you are ready to take the responsibility.
- A blood test for HIV is the only way to tell if you have been infected with HIV.

Facilitator to process the information and then add value to strengthen knowledge.

Activity 6:

Condom demonstration (refer to topic on contraception)

- Carry out a condom demonstration exercise (using an artificial sample of a penis) and allow participants to practise doing same. This is to make them feel comfortable handling some contraceptive devices.
- Facilitator to ask participants to come up with some reasons why people don't want to use condoms.

Self-Reflection/Evaluation

- Do you think you can now protect yourself from HIV/AIDS?
- How?
- What about in the future?
- Would you be able to talk about HIV/AIDS with your friends - boys or girls?
- Is there any aspect of the preventive measures that you feel would be difficult? Why?

Closing

Song

We have a vision, of a world of good health
World without AIDS and STDs free
Let's stop gender discrimination,
Female circumcision and abortion
So we all can live in harmony.

TECHNICAL INFORMATION

AIDS - stands for Acquired Immune Deficiency Syndrome. AIDS is a viral syndrome (a group of diseases that weaken the immune system). A person has AIDS when the immune system gets so weak that it can no longer fight off common infections and illnesses.

HIV- the abbreviation for Human Immuno Virus. It is a very small germ called a virus, that one cannot see. The HIV is a slow acting virus that is believed to be the main cause of AIDS. When a person becomes infected with HIV the virus attacks the immune system, the part of your body that fights off infections. The HIV slowly kills the cells of the immune system until the body cannot defend itself against germs anymore.

How is AIDS transmitted?

HIV lives in the human body fluids such as blood, semen and vagi-

nal fluids of people infected with the virus. The virus is spread when these fluids get into the body of another person. This means that HIV/AIDS can be spread through:

- Unsafe sexual intercourse with someone who has the virus
- Using un-sterilised needles and syringes or any sharp skin piercing objects.
- Blood transfusion, if the blood has not been tested or screened to be sure it is HIV-free.
- Infected mother to her baby through pregnancy, birth or breast feeding.
- Deep kissing or oral sex when the lining of the mouth has cuts.

How HIV/AIDS is not spread

HIV does not live outside of the human body for more than a few minutes. It cannot live on its own in the air or in water. This means one cannot contract or spread HIV in the following ways:

- ◊ Touching, pecking or hugging an infected person
- ◊ Sharing food or bed with an infected person
- ◊ By sharing or washing clothes, towels, bed covers with an infected person
- ◊ Sharing of spoons, cups or drinking glasses.

Information about how HIV/AIDS is not transmitted will reduce irrational fears about the disease. The facilitator may illustrate the information using pictures of how HIV is not transmitted where necessary along with the technical information.

Who is at risk?

Facilitator to design 10 questions for participants to classify as "no risk", "low risk" or "high risk." They will also assess their own vulnerability on scale of 1 to 10.

	No risk	Low risk	High risk
If your boyfriend wants you to have sex, it is better to agree rather than lose him.			
It would be all right with me to be in the same class with somebody who has AIDS.			
It is all right not to have sex while you are a teenager.			
Condom offers complete protection against HIV.			

Methods of protection against HIV/AIDS

- Not having sexual intercourse
- Delay sex
- Use condom properly
- Do not use un-sterilised injection needles or syringes
- Get infections only in the hospitals or health centres
- Have only one sexual partner who is not infected with HIV/AIDS or STDs
- Do not touch someone else's blood or wound without protection
- Practise safer sex.

What happens with HIV infection (The window period)

Window period is the period when a person is infected until when antibodies are produced. This is usually 2-12 weeks. It is important because when one is

tested during this period, the test will be negative since the test looks for antibodies against HIV, which cannot be formed yet. However, the person can infect others.

How people look and feel when they are infected with HIV to when they die from AIDS

- They look healthy and feel fine for a long time after they get infected. They may start having swollen glands, fever, night sweats, fatigue, and cough.
- Then serious disease may occur e.g. tuberculosis, cancer, lung disease, brain illnesses and fungal infections. These result eventually in death.

The HIV tests

Tests that detect the presence of antibodies directed against HIV include:

1. **ELISA or Enzyme-linked immunosorbent assay** - This tests blood and other body fluids with indicator solutions that detect the presence of antibodies, directed against HIV. The entire test requires tiny volumes of solutions and is automated to yield highly accurate results with a minimal opportunity for human or other types of error. The careful performance of the test and appropriate use confirmatory procedures make the ELISA test accurate in over 99.5% of cases. The two possible outcomes from an ELISA test indicate either that antibodies against HIV are present or absent.
2. Further testing is by using **Western blot technique** - done as a confirmatory test. A negative western blot rules out infection with HIV and a positive blot confirms infection with HIV.
3. **Oral HIV-1 antibody test** was approved in 1996 called **oral mucosal transudate** that is obtained from the inside of the cheek rather than saliva.

Reasons why people should be tested

- Not to infect others
- Not to pass HIV onto their babies
- To get treatment which may help to prevent opportunistic infections such as pneumonia.
- Not to donate infected blood.

Why people would not use condom

◊ No money or no place to get them
◊ Didn't have one at the time
◊ Used alcohol or drugs, therefore unable to make wise decisions
◊ "Nothing can happen to me " - takes risks
◊ Embarrassed to buy or use condoms
◊ Sex is not enjoyable with it.

Things you should look for in a good condom

♦ Lubricated
♦ Expiry date or date of manufacture
♦ Package easy to open
♦ Made of latex
♦ Diagrams on how to use
♦ Instructions on packet
♦ Spermicide added

Why young persons are vulnerable to HIV/AIDS

Young people are especially vulnerable to HIV exposure because of physical, psychological and social factors. For one thing, while youth is a time of exploring and discovering feelings and behaviours, young people often lack the social skills, services and information necessary to avoid the risks associated with such activities as unprotected sex and illicit drug use.

The context within which young people live influences their exposure to HIV. Among the most vulnerable groups are those who live on the edges of society, including orphans, refugees and street children, those who face isolation because of their sexual orientation.

* The young people often have limited access to education, health information and health services.
* Some may increase their risk by selling sex to survive; others may be abducted and sold into the sex trade.
* Many take up injecting drug and expose themselves to high HIV risks by sharing needles.

REFERENCES

1. *School Health Education to Prevent AIDS and STDs: Handbook for Curriculum Planners*, by UNAIDS, WHO, UNESCO.
2. *Where Women Have No Doctor*; by August Burns.
3. *Conveying Concerns: Media Coverage of Women and HIV/AIDS*.
   Population Reference Bureau.

CHAPTER EIGHTEEN

SEXUALLY TRANSMITTED INFECTIONS (STIs)

GOAL:

To assist the girls to develop preventive behaviours to avoid infections.

OBJECTIVES:

By the end of the session, participants will be able to:

- Understand what STI stands for and why it is so called
- Know sexual activities that can lead to contracting STIs
- Know the common types of STI and their causative agents
- Understand why STIs are considered serious problems and who is likely at risk
- Reasons for the spread of STIs among young people and how to prevent the spread
- Be familiar with signs and symptoms of some STIs.

CONCEPTS/COMMON BELIEFS:

- Nice girls don't get STIs
- It is a disease for prostitutes and dirty females.

MATERIALS:

Flipchart, paper, markers, blackboard and chalk, technical information on HIV/AIDS.

ACTIVITY/TIME:

- Brainstorming (20 minutes)
- Individual work (10 minutes)
- Role-play (15 minutes)
- Case study (30 minutes)

- Technical information (30 minutes)
- Evaluation (15 minutes).

PREPARATION:

Many people are sometimes surprised to learn that STIs are one of the most common kinds of infection around today. Every year more people, especially young people contract STIs, passed primarily through sexual contact. Until recently, such infections were called venera
l diseases or VD, a term many people associate with gonorrhoea and syphilis.

Actually, there have been more than 20 STIs identified, many are at epidemic levels, while others range from mild to life-threatening and some with chances of complications for girls and women that can impair their fertility. Young people (girls) are more vulnerable to contracting STIs than males.

LESSON SEQUENCE

Opening

The chairperson of the day starts with songs and calls for a report of the last lesson.

Energizers/Ice-Breakers

Energizers used to introduce the topic and to create fun.

Lesson topic

Activity 1:

Brainstorming exercise

- What does the term, STI mean?
- Why is it so called?

List responses on flipchart and:

- Let them write down all what they have heard people say about STIs.
- Read out before pasting them on the board
- The participants' contributions will form part of the common notions about STIs
- Facilitator to process the information and add value on what STI means, using technical information.

Activity 2:

Individual work

- Participants or volunteers will be asked to mention the types of STI known to them and what causes them
- At the end, process their information and give technical infor-

mation on the types and causes.

Activity 3:

Small group work

- Participants are divided into small groups to discuss and make presentations on why STIs are serious problems and who can likely be infected with reasons.
- Process the information and add value, using technical information.

Activity 4:

Case study

Akpan and Mmayen have decided to have sexual intercourse. Both using condom but are confident that none of their previous partners had a disease. Mark "T" for any statement that is True/Correct and "F" for any that is not true or false.

True or false statements from case study

(a) If they have sex, Akpan should wear condom every time they have sexual contact

(b) They would know if their previous partners had STIs

(c) They would be safe if they had oral or anal sex without a condom

(d) They w
delayed se
properly test

Activity 5:

Role-play discussion

- Here, volunteers to act male and female. The male threatens to end his relationship with the girl if she refuses to have sexual intercourse with him each time he needs it. The girl being uninformed and passive has no choice than to comply.
- Facilitator to lead group in a discussion on possible effect of such situation.

Activity 6:

Small group discussion

- This discussion is focused on signs and symptoms that show presence of STI and what to do.
- After report back by the various groups, facilitator processes the information and adds technical Information.

Self-Reflection/Evaluation

1. What new lesson did you learn?
2. What was least interesting in the lesson?
3. What was striking during the

- Tec' lesson?
- 4. Has your attitude changed in any way after the lesson?

Closing

Close session by asking volunteers to lead in exercises or songs.

TECHNICAL INFORMATION

What are STIs?

STIs simply means sexually transmitted infections. They are infections acquired primarily through sexual contact. These infections can be caused by bacteria, viruses, tiny insects or parasites. The most common types of STIs include the following:

Names of some STIs	Causative agents
1. Gonorrhoea	Bacteria
2. Chlamydia (cervicitis)	Bacteria
3. Syphilis	Bacteria
4. Herpes	Virus
5. Hepatitis B	Virus
6. Non-gonococal urethratis (NGU)	Bacteria
7. Scabies	Mites
8. Chancroid	Bacteria
9. Pubic lice	Protozoa/lice
10. Genital warts	Bacteria
11. Trichomoniasis	Bacteria
12. Bacterial vaginosis (hemophilus)	Bacteria
13. AIDS	Virus

Why STIs are serious problems

STIs are serious problems because if left untreated, they can cause infertility, chronic pain, cancer, mental problems, premature births, blindness in both babies as well as adults and death in severe cases, e.g. AIDS.

People who can contract STIs

Girls are more at risk or more vulnerable to contracting STIs because of the nature of their reproductive organs and because majority of young girls engage in unprotected sexual activity. Females get in-

fected so easily because during sexual activity, a man's penis goes into some parts of a woman's body -such as her vagina, mouth or anus. And also because most STIs are inside a woman's body, the signs are harder to see than in a man. So, it is often hard to tell if a woman has an infection in her genitals -much less what kind of infection she has.

Why so many women contract STIs

It can be hard for females to protect themselves from STIs. Often she may not know if her partner has had sex with other partners, or if he is infected with an STI. A woman or girl sometimes may not be able to persuade her partner to use condom.

How can you know if you have an STI?

Sometimes people do not know they have an STI because some of them can remain for a long time without any sign or symptom. And some symptoms of STIs are often hard to spot especially in females. Example is gonorrhoea, where 80% of the females and 20-30% males do not notice early symptoms.

A person with an STI perience the following

- Feel sickly
- May have sores or rashes or strange blotches or spots on his/her genitals or body
- There may be burning sensation during urination or severe stomach cramps or a bad cough.
- May have abnormal discharge with foul smell or yellowish discharge
- Pain in the lower abdomen
- Pain or bleeding during sex
- Sore throat, fever, swollen joints
- Yellow eyes and/or skin.

Reasons why STIs spread so much among young people

- Peer pressure
- Mixed messages -verbal, body languages different from the real message.
- Equating sex with love
- Morbidity -parties , outings, no use of condom
- Experimentation and exploration
- No education about sexual issues
- Lack of proper lubrication lead-

ing to "tear"
- Rape and anal sex leading to bruises and abrasions
- Scarifications, FGM, etc.

How to know if you are at risk of an STI

Even if you do not have any signs, you may be at risk if:

- Your partner has signs of an STI. He/she has probably passed it to you, even if you have no signs.
- You have more than one partner -the more partners, the greater the chances that one of them has passed on an STI to you.
- You have had a new partner in the last 3 months. He or she may have had others just before you.
- Your partner lives away from home, or you believe your partner has other partners. This means he/she is more likely to become infected with an STI.

What to do if you have an STI

- If you already have an STI or think you are at risk to get one:
- Get treatment early
- Go for a test
- Do not wait until you are very ill
- Help your partner to get treated at the same time you do
- Make sure you take all the medicine, even if your signs start to go away. Do not buy only part of the medicine you will not be cured until all the required medicine is taken.
- Practise safer sex because you can always get STI if you do not protect yourself.
- Try to get tested for syphilis because if you have one STI, you could be infected with another. Also consider being tested for HIV.

How can STIs be prevented?

- Education
- Abstinence
- Safer sex practices
- Behavioural change
- Select partner
- Limit sexual contact only to one person (faithful partner)
- Talk to your partner about STIs
- Abstain from drugs and alcohol because these can impair your judgement
- Beware and always check your partner's genitals
- Go for regular medical examination.

REFERENCES

1. *School Health Education to Prevent AIDS and STDs: Handbook for Curriculum Planners*, by UNAIDS, WHO, UNESCO.
2. *Where Women Have No Doctor*, by August Burns.