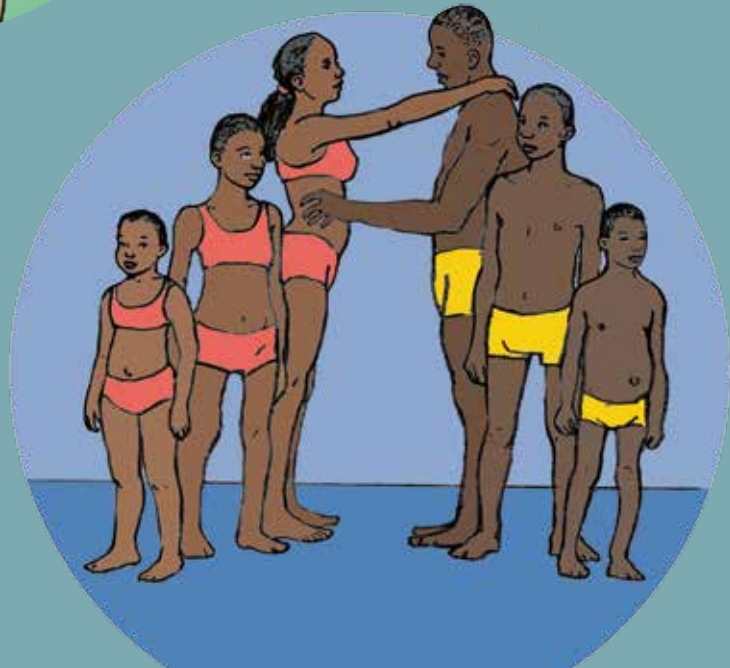


Religious Leaders'
Handbook on
**Adolescent Sexual &
Reproductive
Health and
Rights**





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CONTENTS

1	Chapter 1: Setting the Scene	6
1.1	Introduction	7
1.2	Religious Leaders, Adolescents and Sexual Activity	7
1.3	Religious Leaders and other Stakeholders	8
1.4	Young Children, Adolescents and Young Adults	8
1.5	Parents, Guardians and Governments	8
1.6	Qualities of people who interact with young people on ASRHR	8
2	Chapter 2: Sex, Gender and Religion	9
2.1	Introduction	10
2.2	What is Sex?	10
2.3	What physical features make up the female or the male?	10
2.4	What is Gender?	10
2.5	Religion on Sex and Gender	12
3	Chapter 3: Reproductive Anatomy, Physiology and Religion	14
3.1	Introduction	14
3.2	Background Information	14
3.3	Female Reproductive Organs	14
3.4	The Male Reproductive Organs	17
3.5	Myths and Facts related to sex	18
4	Chapter 4: Adolescent Sexual and Reproductive Health	19
4.1	Introduction	20
4.2	Adolescence	20
4.3	Sexuality	20
4.4	Reproductive maturation	20
4.5	Adolescent Reproductive Health	21
4.6	Children's Rights	22
5	Chapter 5: Puberty	23
5.1	Introduction	23
5.2	Puberty in Girls	23
5.3	Puberty in Boys	27
6	Chapter 6: Menstrual Health Management	30
6.1	Introduction	31
6.2	Background	31
6.3	Beliefs and Taboos Related to Menstruation	31
6.4	Key Issues in Menstrual Health Management	31
7	Chapter 7: Positive Sexual Behaviour for Adolescents	32
7.1	Introduction	33
7.2	What are Life Skills?	33

8	Chapter 8: Sexually Transmitted Infections and their Prevention	37
8.1	Introduction	38
8.2	What are STIs?	38
8.3	The Relationship between STIs and HIV and AIDS	39
8.4	How to avoid STIs	39
8.5	Religious Teaching on Sexually Transmitted Infections	40
8.6	Some common questions related to STIs	40
8.7	Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)	41
8.8	HIV Testing Services	41
9	Chapter 9: Teen Pregnancy	43
9.1	Introduction	44
9.2	Causes of Teen Pregnancy	44
9.3	Health Challenges of Teen Pregnancy	45
9.4	Other Challenges faced due to Teen Pregnancy	46
9.5	Religious Leaders for the Prevention of Teen Pregnancy	47
10	Chapter 10: Child Marriage	49
10.1	Introduction	50
10.2	What is child marriage?	50
10.3	What are the Causes of Child Marriages?	50
10.4	Problems Associated with Child Marriages on the Girl Child and Boy Child	51
10.5	Child Marriage Among Boys	51
11	Chapter 11: Gender-Based Violence Against Adolescents and Young People	52
11.1	Introduction	53
11.2	Gender and Gender Norms	53
11.3	Gender - Based Violence	53
11.4	Effects of GBV on Adolescents and Society in General	54
11.5	Religious Leaders Against Gender-Based Violence	54
12	Chapter 12: Drugs and Drug Abuse	57
12.1	Introduction	58
12.2	Alcohol and Substance abuse	58
12.3	Staying off Drugs	58
13	Chapter 13: Counselling	60
13.1	Introduction	61
13.2	What is Counselling?	61
13.3	Who Provides Counselling Services?	61
13.4	Procedures of Counselling Sessions	62
14	Glossary	64
15	Major Sources Consulted	70

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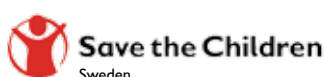
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THE PURPOSE OF THE HANDBOOK

This handbook is a tool for religious leaders to understand and address sexual and reproductive health and rights issues among children and adolescents aged 5-18 and youth aged 19-24 years. The handbook was piloted in Lusaka, Zambia in November 2017 at a regional workshop with Christian and Muslim leaders. These leaders subsequently recommended its broader use.

The main aim of developing the handbook is to assist religious leaders and parents to provide effective sexual and reproductive health guidance to children and adolescents. Religious leaders are strategically placed to support adolescents because they are unanimously regarded as authority figures. Scriptures from both the Bible and the Quran were used to clarify the major themes discussed in this handbook. This handbook has two purposes:

- To provide information to religious leaders about adolescent sexual and reproductive health and rights, sexually-transmitted infections, and HIV and AIDS.
- To help religious leaders to communicate with adolescents about these issues within the context of shared faith.



Always, religious leaders must be aware and attuned to adolescents with disabilities.



What Makes this Handbook Different?

Although there are numerous resources on adolescent sexual and reproductive health and rights (ASRHR), this handbook is different in two important respects:

- The focus is on religious leaders, who are in turn encouraged to work alongside parents, teachers and other service providers. Most of the available resources do not fully acknowledge religious leaders as a strategic constituency.

It seeks to promote active interaction among religious leaders, parents and young people. Through engaging with parents, religious leaders may discover the benefits of embracing a participatory approach.





CHAPTER 1

SETTING THE SCENE

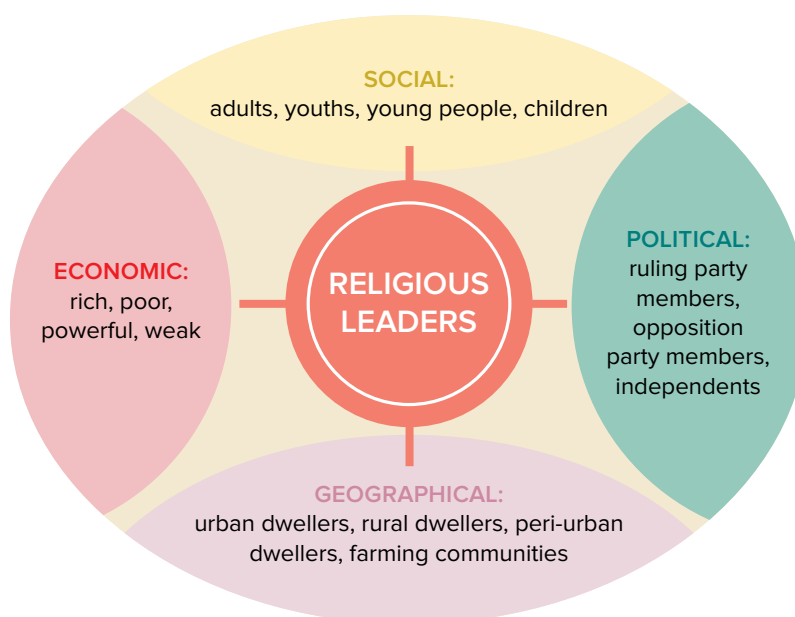
CHAPTER 1: SETTING THE SCENE

“...who conduct their affairs by mutual consideration”
Quran 42:33

“Come now, let us reason together...” Isaiah 1: 18

Introduction

Religious leaders usually have access to all people: those across the social, economic and political divide, children, adolescents, young adults, the middle aged, and the elderly.



Religious leaders, should they use their power effectively, can lead societies towards sustainable transformation on many issues.

1.1 Religious Leaders, Adolescents and Sexual Activity

Religious leaders, faith communities and religions in general tend to hold the following beliefs about sex:

- Sexual activity is only for those who are married.
- Abstinence is the only option for those that are not married, no matter their age or stage of relationship with their partner. Those who fail to abstain must be excluded from social activities because they may influence those who are abstaining.
- Sexual activity should not be discussed with those not ready for marriage because it will encourage them have sex.
- Comprehensive sexuality education¹ (CSE), which is broad and covers relationships, values,

attitudes, life skills, culture, society, human rights, human development, sexual development and sexual and reproductive health, falls under the category 'sexual activity' in faith communities.

- The major function of sex is procreation. Sex for pleasure (restricted only for those who are married) is a contested issue.

However, religious leaders, despite the observations about their views on sex, are important players in addressing adolescent sexual and reproductive health and rights (ASRHR). In other words, adolescents may currently look to them for advice.

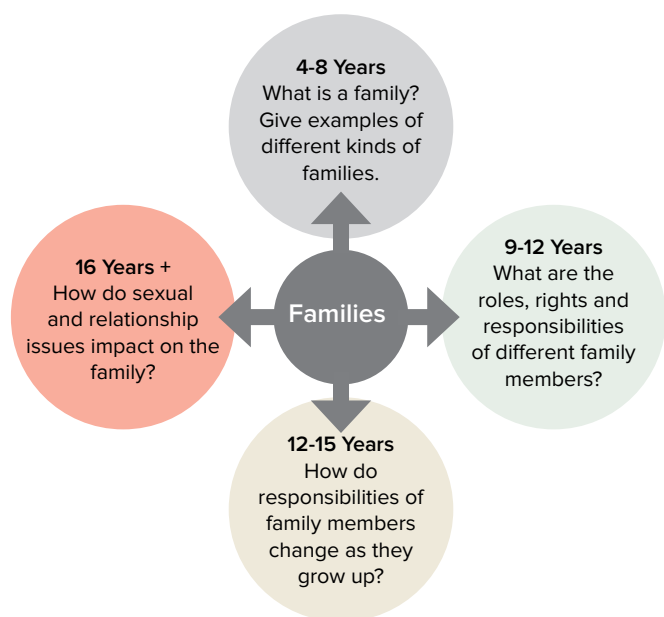
1. Sexuality Education is defined as an age-appropriate, culturally-relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. Sexuality Education provides opportunities to explore one's own values and attitudes on sexuality and to develop decision making, communication and risk-reduction skills. UNESCO, *International Technical Guide on Sexuality Education*, Volume II, Paris: UNESCO, 2009.

1.2 Religious Leaders and other Stakeholders

Even though religious leaders have been largely on the margins of SRHR for adolescents, they can use their strategic position to be coordinators and champions of CSE in partnership with various stakeholders.

1.3 Young Children, Adolescents and Young Adults

Whereas, in the past, many religious leaders were only prepared to discuss sexuality education with young adults in preparation for marriage, it is now important to introduce CSE to children from as early as four years old, in an age-appropriate manner. For example, on the topic “Families” in CSE, age-appropriate questions could be as follows:



1.4 Parents, Guardians and Governments

Religious leaders need to discuss SRHR with the parents of the target groups to enable replication and reinforcement of the religious leaders' teachings by the parents at home. Parents need to be equipped with the appropriate information on SRHR for them to collaborate with religious leaders in disseminating appropriate CSE to young persons.

Religious leaders must be prepared to engage with government officials from various ministries offering services that affect the target group. The ministries of education, health, and gender can be key allies in the dissemination of SRHR, such as in schools and hospitals.

1.5 Qualities of People Who Interact with Young People on ASRHR

An effective person who interacts with young people needs to have the following attributes:

- Alertness
- Widely accommodating
- Knowledgeable of ASRHR issues
- Accepting of criticism
- Easily fosters connections
- Participatory (not dictatorial)
- Communicative
- Being a good listener
- Non-judgmental
- Creativity
- Knowledgeable of ASRHR tools



SETTING THE SCENE: RELIGIOUS LEADERS TO ATTAIN KNOWLEDGE (AND ACT ON) ON HOW TO DO THE FOLLOWING:

- Influence social and moral values/ traditions of the public.
- Collaborate with parents to promote awareness of the Sexual and Reproductive Health Rights (SRHR) and other issues for adolescents.
- Discuss different family models, such as child-headed families.
- Increase and influence public knowledge and opinion.
- Influence and support political attitudes, opinions, policy and laws.
- Reapportion existing charitable resources for spiritual and social care and raise new financial resources for care and support.
- Pave the way for public awareness and promote action from grassroots up to national level.
- End the silence that exists about HIV and AIDS in many areas and convince people to discuss related issues and problems.
- Empower people living with HIV to live longer, more meaningfully and with dignity as opposed to stigmatizing them as sinners or criminals. This approach may help to change society's attitudes towards people living with HIV and AIDS, while simultaneously offering a ray of hope to people living with HIV that they can live normally (adapted material).



CHAPTER | 2

SEX, GENDER AND RELIGION

CHAPTER 2: SEX, GENDER AND RELIGION

“O mankind, indeed We have created you from male and female and made you peoples and tribes that you may know one another. Indeed, the most noble of you in the sight of Allah is the most righteous of you.”

Quran 49: 13

“So God created mankind in his own image, in the image of God he created them; male and female he created them.”

Genesis 1:27

2.1 Introduction

This chapter will first provide definitions of sex, gender and religion. Generally, communities face challenges in reconciling how the subjects of sex and gender interact with religion. In this chapter, issues related to the understanding that boys and girls, young men and young women have of sex, gender and religion will be highlighted.

2.2 What is Sex?

Sex refers to one of three categories into which human beings are divided based on their reproductive functions – male, female, and intersex (born with several variations in sex characteristics). This can be determined through scans before birth or at birth.

In this regard, sex is used to distinguish human beings in terms of their reproductive functions. We talk about sex (anatomy) when discussing biological roles. It is also important to highlight that there are other biological variations such as intersex. (There is a fundamental difference between biological roles and gender roles. Gender roles are not rigid, are socially constructed and can thus be changed or defined differently.) The box below highlights the main differences between the male and female sexes:

- Sex is biological and natural; we all have it at birth.
- We therefore can ascertain that sex is given to us by God (for a religious explanation).

- Sex is neither chosen by the one being born nor by the parents of the unborn child; it is willed to every individual by God (for a religious explanation). If a baby is born intersex, the individual, at a later stage, can choose which sex they identify with.

After birth, both males and females undergo natural biological development. As children grow older, their bodies change to allow for procreation. However, not everyone will be able to fall pregnant or to impregnate.

2.3 What is Gender?

There is a common misconception that sex and gender are the same thing. Sex describes the anatomy and the physical functions of the male and female, whereas gender refers to the societal norms and expectations of what makes a male a ‘man’ and a female a ‘woman’.

Therefore, gender is a social construct that affects an individual’s identity from birth (pink is associated with girls and blue is associated with boys for example) and continues to inform their expected development and identity through all stages of life.

Crucially, sex does not necessarily determine gender: a male can identify more as woman than a man and vice versa. Therefore, there are more than two forms of gender identity. People can be masculine, feminine, transgender, bi-gender, gender-fluid, agender or any blend of these.

Attribute	Female	Male
Reproductive organ	Vagina	Penis
Voice	Typically has a higher pitch	Typically has a lower pitch
Pregnancy	Can get pregnant	Can impregnate
Menstruation	Menstruates	Does not menstruate
Other physical attributes	<ul style="list-style-type: none"> • Has breasts and is therefore capable of breastfeeding • Does not have testicles 	<ul style="list-style-type: none"> • Does not have mammary glands for breastfeeding. • Has testicles

2.4 Gender Identity

Gender identity refers to a person's internal sense of being male, female or something else. Gender expression refers to the way a person communicates

gender identity to others through behavior, clothing, hairstyles, voice or body characteristics. Below are characteristics of different gender identities:

Gender identity	Attributes
Masculinity:	<ul style="list-style-type: none"> • Masculinity refers to a set of characteristics, roles, behaviors and attitudes that define or identify one as a man. • A society that is organized on men having power over women and children is defined as a patriarchal society. • Hegemonic masculinity is the dominant form of masculinity. Hegemonic masculinity refers to the dominant form of masculinity that subjugates femininities and other forms of masculinities to their standards. • Masculinity is prescribed for all men, but not all men will meet the expected standard. • Men who meet the expected standard are called gender conforming or "real men." Such men are often honored and celebrated. • Men who fail to meet the expected standard are called gender-non-conforming or "men in the absence of real men"; otherwise, they are "women." "Women" designates weakness and inferiority. Such men are often shamed and stigmatized. • Hyper masculinity refers to the extreme behaviors of stereotypical masculinity. This can refer to display of strength through aggression, sexual activeness, social dominance and lack of sensitivity and emotion.
Femininity:	<ul style="list-style-type: none"> • Femininity refers to a set of characteristics, roles, behaviors and attitudes that define or identify one as a woman. • Hegemonic femininity is the dominant and "ideal" form of femininity, with other forms called alternative femininities. Hegemonic femininity refers to the dominant qualities a female subscribes to and subjugates other forms of femininities. Hegemonic femininity does not however challenge dominant forms of masculinity and is more often a response to hegemonic masculinity. • Femininity is prescribed for females by most societies, meaning that if a child is born female, society will train and expect them to be feminine. • The woman who conforms to the expected feminine traits will be celebrated in most societies as the "ideal woman." This woman is celebrated and honored, while gender non-conforming women are often shamed and frowned upon. • Since most societies are patriarchal, this celebrated woman is raised to be a woman who does not challenge the patriarchal structure of society, perpetuating the power men have over women and children.
Transgender:	<ul style="list-style-type: none"> • Transgender is an umbrella term for persons whose gender identity, gender expression or behavior does not conform to that typically associated with the sex to which they were assigned at birth. • Transgender people are sometimes called transsexual if they desire medical assistance to transition from one sex to another.
Bi-gender:	<ul style="list-style-type: none"> • Someone who closely identifies with both masculine and feminine.
Gender-fluid:	<ul style="list-style-type: none"> • Someone whose gender shifts between masculine, feminine and everything in between.
Agender:	<ul style="list-style-type: none"> • Someone who does not have a gender identity, is neither masculine, feminine, transgender nor bi-gender.
Gender norm	<ul style="list-style-type: none"> • Gender norms refer to what is socially accepted as masculine or feminine, and may differ from society to society. Some norms include a man earning more than a woman, and women as child-bearers and primary caregivers. Therefore, gender norms begin to cast individuals who do not adhere to expectations as 'different' or 'abnormal'. Gender norms also privilege men over women in certain arenas such as business, politics and religion.

2.5 Religion on Sex and Gender

Since the subject of this handbook is ASRHR for religious leaders, how religion interacts with sex and gender in most African communities is worthy of discussion.

Even though religions and religious communities believe that gender comes from God, religion, as part of broader society, contributes to constructing gender identity.

Through religious teachings, young females and males are socialized to become women and men who are accepted in the religious community. Selected passages in sacred texts illustrate how Christianity and Islam present gender:

RELIGION	SACRED TEXTS
Christian Bible and the Construction of Gender	<p>Genesis 2-3 are central to the construction of gender in Christianity. These chapters are interpreted by some to mean that man was made superior to women by God after the fall in the Garden of Eden. However, others interpret these chapters as promoting gender justice.</p> <p>Texts such as Genesis 1:26-27 are central to the construction of gender equality in some Christian communities because the emphasis is in the creation of all human beings at the same time, making them equal in the eyes of God. Biological differences are, therefore, not an excuse for gender imbalances.</p>
Islamic Qur'an and the Construction of Gender	<p>Qur'an 4:34 says that men are the protectors of women. This has often been used to suggest that, therefore, women occupy a position that is lower than that occupied by men.</p> <p>Qur'an 49:13: "O people, we created you from the same male and female, and rendered you distinct peoples and tribes, that you may recognize one another. The best among you in the sight of GOD is the most righteous. GOD is Omniscient, Cognizant." This text can help in re-thinking gender equality in Muslim communities.</p> <p>Quran 42:49, says that, "To Allah belongs the kingdom of the heaven and the earth. He creates what He wills. He bestows female (off-springs) upon who He wills and bestows male (off-springs) upon who He wills."</p> <p>Quran 42:50: "Or He bestows both males and females and He renders barren whom he wills. Verily He is the All-knower and is able to do all things." This text can help to address violence against women on the basis of giving birth to girls only.</p>

If religion plays an important role in the construction of gender, religion can help formulate new gender roles.



Whereas discourses of secrecy, shame and silence have tended to characterize approaches to sex and sexuality in Africa (mainly due to the impact of missionary religions and modernity), CSE seeks to mobilize religious leaders to equip children with knowledge and skills and a positive view of sexuality and sex.

Young people's lack of access to adequate and appropriate information on sex and gender, and the threats made to those who don't conform, means religion and religious leaders are required to revisit traditional teachings.

The following are some of the major issues affecting adolescent boys and girls:

- The absence of adequate and appropriate education and information regarding normal sexual development, sex and sexuality.
- The availability of alternative sources of sexuality education and information not driven by the values of religious communities.
- The problem of inter-generational relationships between older men ('sugar daddies' or 'blessers') and young girls in schools and colleges. Gender constructions have led to adolescent girls and youth facing the following challenges

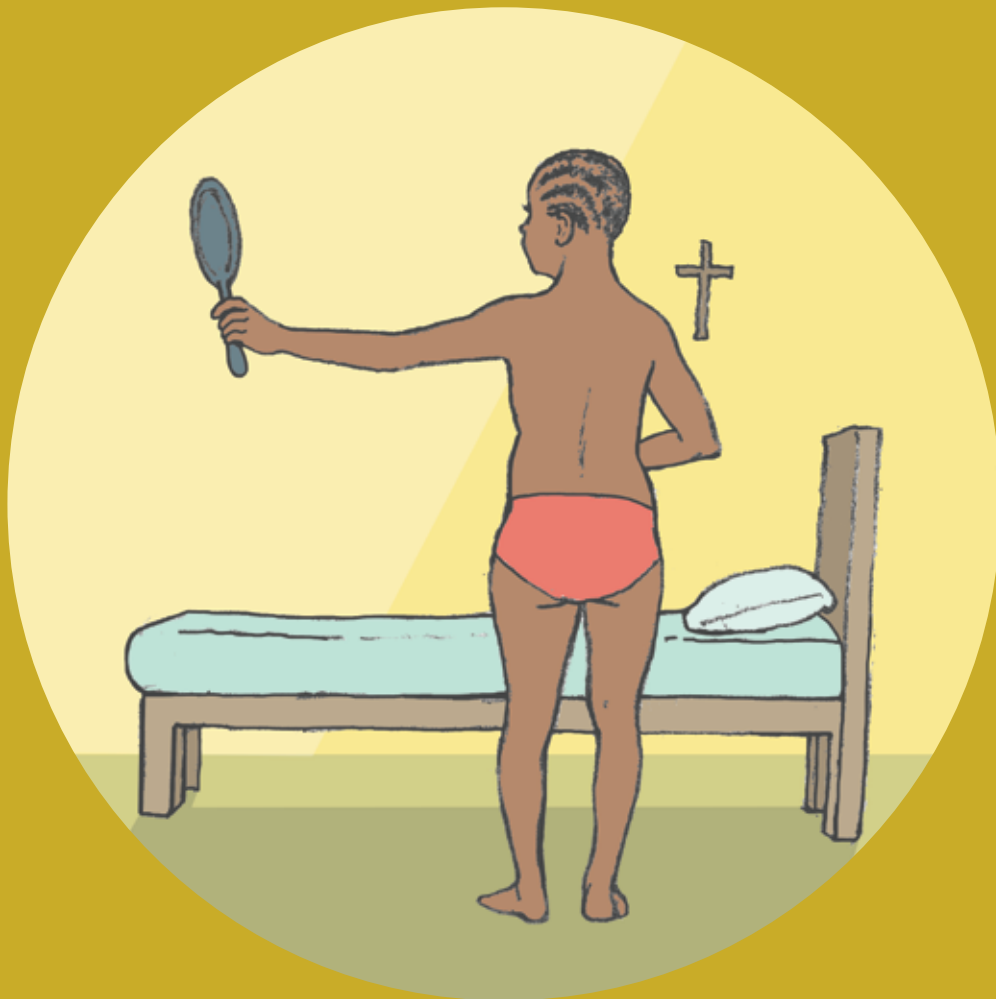
(please note that boys may be affected too):

- Frequent cases of gender-based violence and risks of sexually-transmitted infections (STIs) and HIV infections, especially because of gendered expectations, and the consequences of inter-generational relationships.
- Mismatch between sexual maturity and social and physical maturity.
- Being excluded or stigmatized for engaging in pre-marital sex.
- Hegemonic femininity perpetuates the cycle of violence of men against women (women should remain silent and stoic for the sake of peace, for example).



SEX, GENDER AND RELIGION: KEY ADVOCACY POINTS FOR RELIGIOUS LEADERS

- Mobilize caregivers, churches, non-governmental organizations, government institutions and other stakeholders to ensure that only positive gender norms and values are upheld.
- Support equity between boys and girls in families and in society by promoting equal access to education.
- Interpret sacred texts in non-sexist ways.
- Address issues of sex and sexuality, such as the biological changes adolescents go through, in a realistic and informed manner.
- Respond to questions on sex and sexuality in an honest, accurate and age-appropriate manner.



CHAPTER 13

REPRODUCTIVE ANATOMY, PHYSIOLOGY & RELIGION

CHAPTER 3: REPRODUCTIVE ANATOMY, PHYSIOLOGY & RELIGION

“I praise you, for I am fearfully and wonderfully made. Wonderful are your works.”

Psalms 139:14

“Then we made the nutfa into a clot then we made the clot into a brought it forth as another creation, so blessed is Allah the best of creators.”

Quran 23:14

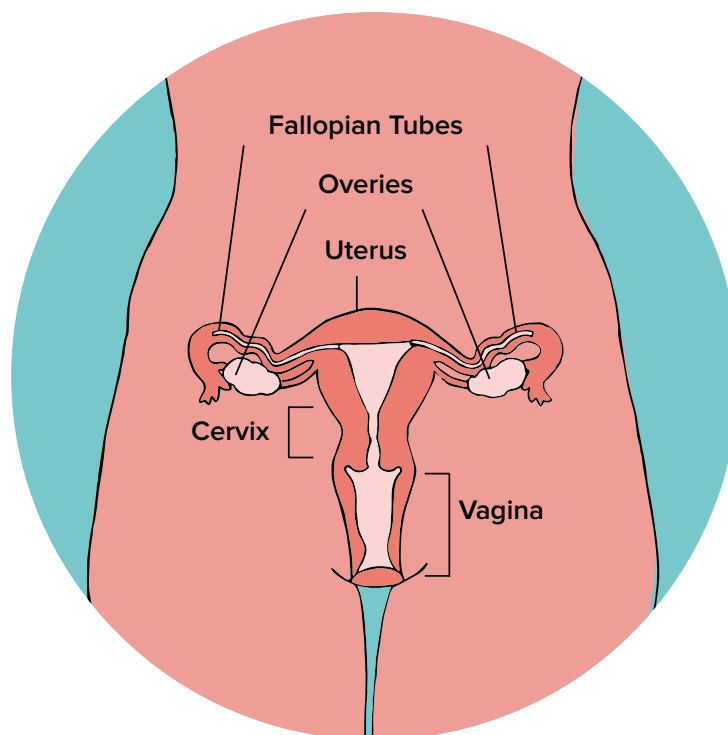
3.1 Introduction

This chapter is divided into three sections. Section 1 examines female anatomy and physiology; Section 2 focuses on male anatomy and physiology; Section 3 details advocacy points that religious leaders can follow. Although African culture and religious traditions often discourage open discussions of sex among people of different age groups and gender, it is important for religious leaders to be open minded about sex when engaging with adolescents.

3.2 Background Information

- A human being undergoes physical and emotional changes through life. These stages may be identified in a simplified way as childhood, adolescence, adulthood and old age. The changes are gradual and occur at different ages and rates in different people.
- In spite of their different appearances, the sexual organs of men and women arise from the same structures and fulfil similar functions.
- Hormonal changes in the body during puberty, alongside powerful cultural and personal factors, all shape the expressions of one's sexuality.

3.3 Female Reproductive Organs



The female reproductive organs are those parts of the body that are directly involved in sexual activity, pregnancy, and childbearing. They comprise external parts, internal parts and the breasts.

3.3.1 External reproductive organs

The vulva is the area surrounding the opening of the vagina, which can be seen from the outside (see above figure). It consists of the clitoris, vaginal opening, labia majora and labia minora. The outer folds of skin, called the labia majora, are thick and covered with hair.

How to Keep External Female Reproductive Organs Clean

- Use soap and water to wash the external genitalia, especially during menstruation. Most soaps have a high pH level (alkaline), which can cause irritation to the external genitalia, which has a relatively low pH (acidic). If irritation occurs, washing with plain water is good enough.
- Use either a disposable pad made of cotton, which has a nylon base, or a clean piece of cotton cloth to absorb blood during menstruation. There are also the newer reusable menstrual cups that can really be useful when pads are not affordable. These should be changed frequently.
- Properly dispose of the pad after each use in a dustbin. If a reusable cloth is used as a menstrual pad, it must be handwashed in cold water regularly.
- Wash only the external genitalia. Do not try to clean the inside part of the vagina.
- Do not wash from the anus to the vagina. The latter will allow germs to enter the inner genitalia easily and cause infection.
- Be aware of abnormal fluids from your vagina. Do not confuse this with normal vaginal fluids. An infection is usually signalled by green, yellow or grey discharge. A fluid consistency that changes from smooth to lumpy may also indicate an infection.
- If you see any changes in the vaginal fluid – a change in color or odor, a clinic visit is necessary.

3.3.2 Internal Reproductive Organs

- These are organs of the female body that are located inside the lower part of the abdomen, called the pelvis, and are protected by bones and muscles. They consist of the vagina, the uterus (womb), two ovaries, and two fallopian tubes.
- The vagina, covered at the opening by a thin membrane called the hymen, is the largest of the three openings in the genital area. It is made up of soft folds of skin and is about 7cm deep and 3–4cm wide. The other two openings are the anus (below the vagina) and the urethra (above the vagina).

- The walls of the vagina produce a fluid or discharge that serves to keep the region clean.
- At different times of each month the amount of discharge increases - particularly at times of sexual excitement - this is completely normal. However, if that discharge changes its normal color, causes itching or takes on a bad smell, it may indicate an infection. It is important to note that infections are not always related to sexual activity and can be due to bacterial or pH imbalances in the vagina or bladder. Discharge may change over the course of the menstrual cycle, which is normal.
- The ovaries are two small egg-shaped organs on either side of the uterus that store eggs and release one mature egg each month during a girl/ woman's reproductive years of life.
- During pregnancy the vaginal opening becomes small so that the baby stays inside the womb. During labor the cervix opens (dilates) so that the baby leaves the womb and enters the world through the vagina through the "birth canal". The walls of the vagina are elastic and can stretch to allow the passage of the baby's head and body.

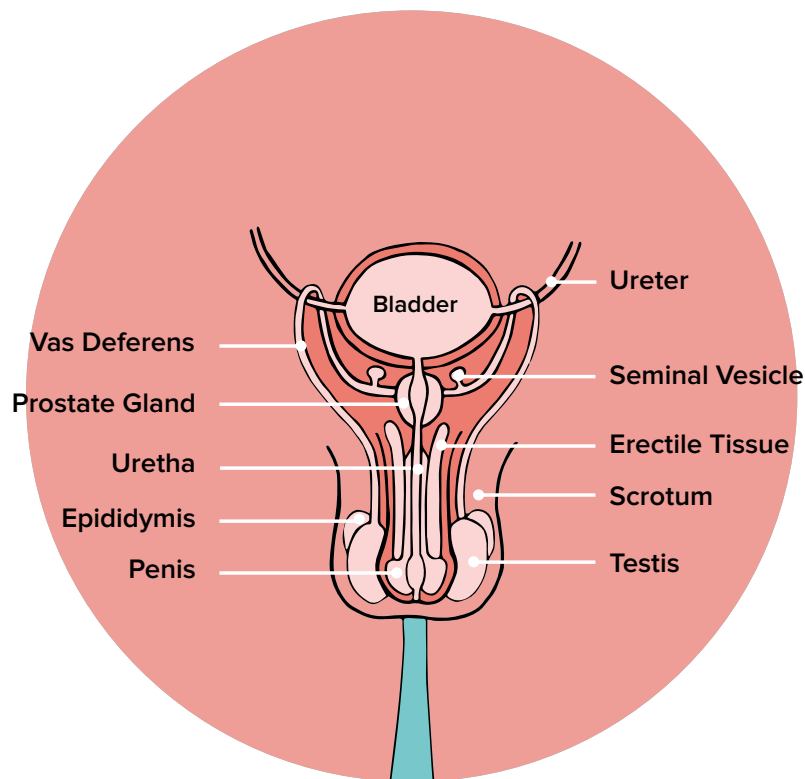
3.3.3 The Breast

The main external feature of the breast is the nipple and the dark skin around it, called the areola. A hormone called estrogen causes the tissues and glands in the breasts to grow so that when a woman becomes pregnant, she produces and stores milk. Often, both breasts swell slightly during the menstrual period. In many women, one breast is larger than the other.

3.4 The Male Reproductive Organs

The reproductive organs of the male are those parts

that are directly involved in sexual activity; they consist of the external and internal parts.



3.4.2 External Reproductive Organs

These are the organs that are on the outside and can be seen or felt. They comprise the penis, the scrotum and the testes.

The Penis

- The penis is the organ that carries the semen with the sperm into the vagina. During sexual arousal, blood is pumped into the muscles of the penis. This makes the penis stiffen and become erect so it can easily enter the vagina. Although both semen and urine pass through the tube called the urethra in the penis, at the time of ejaculation the opening from the bladder is closed so that only semen comes out of the penis. After ejaculation, the blood quickly drains away into the body and the penis returns to its normal state.
- The penis has a prepuce also called the foreskin that protects the head of the penis. Usually, the penis produces a whitish creamy substance called smegma, which helps the foreskin to slide back smoothly. When smegma accumulates under the foreskin, it causes a bad smell or even infection. The foreskin can be easily pulled back for young boys from about the age of 5 or 6 years; to wash the penis, boys must wash underneath the foreskin with clean water every day.

The Scrotum

- The scrotum is a sack of skin containing two egg-shaped organs called the testes, found in front of and between the thighs. The scrotum protects the testes from physical damage and helps to regulate the temperature of the sperm.

The Testes (Testicles)

- These are two sex glands that produce sperm and male hormones. At the onset of puberty in boys, the testes begin to produce sperm. This usually happens between the ages of 12 and 15, although it can also happen earlier or later.
- From puberty until old age, a man's testes produce sperm; millions of sperm cells are released every time he ejaculates, or reaches climax, during sexual activity.
- The sperm fertilize the woman's egg to start the process of reproduction. During ejaculation, the sperm is carried in a liquid called semen that is produced by the man's reproductive organs. The semen passes through a tube called the vas deferens and out of the penis. One of the millions of sperm may reach an egg and fertilize it and the rest simply die in a few days and disappear.

3.4.2 Internal Reproductive Organs

- The internal male reproductive organs lie within the lower part of the abdomen called the pelvis and are protected by bones and muscles. They consist of the epididymis, the vas deferens, the seminal vesicles, the prostate gland, and the Cowper's gland.

How to Keep the Male Reproductive Organs Clean

- Wash the external genitalia at least daily with soap and water, as you wash the rest of the body. Boys who are not circumcised need to pull back the foreskin and gently wash underneath it with clean water.
- Be aware of any abnormal fluids coming from your penis; do not confuse this with the presence of normal fluids.
- If you see any abnormal fluid or wound, please visit a health professional.

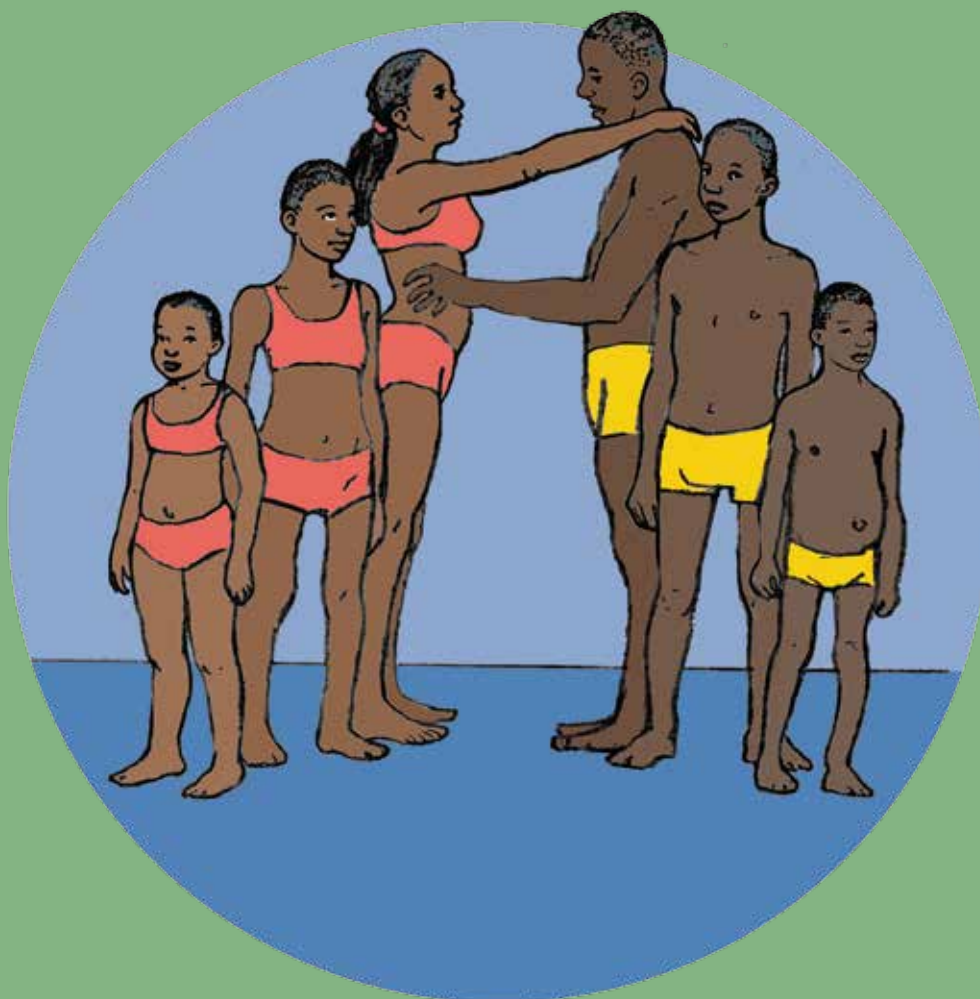
3.4 Myths and Facts related to sex

Myths	<ol style="list-style-type: none"> Youth ask about sex because they plan to engage in sexual activity. Masturbating can cause sickness. Girls do not masturbate. A girl cannot become pregnant the first time she has sex. When a boy has an erection, he has to have sex.
Facts	<ol style="list-style-type: none"> Not all young people are asking about sex because they are planning to have sex immediately. Most are just curious. Having the right knowledge and information is vital for them. Masturbation does not cause any kind of sickness or infertility. It is not harmful unless a person becomes overly preoccupied with it. It is possible for a girl to become pregnant the first time she has sex, even if she has not had her first menstruation. Her period is the first visible sign of fertility, but before her first menstruation, an egg could have been released and could be fertilized. When a boy has an erection, he does not need to have sex or ejaculate. If he waits, his erection will go down.



REPRODUCTIVE ANATOMY, PHYSIOLOGY AND RELIGION: KEY ADVOCACY POINTS FOR RELIGIOUS LEADERS

- Religious leaders must invest in acquiring the latest knowledge and information about the human body and its complexity. This handbook is a great reference tool. They should share this knowledge and information with adolescents.
- They must encourage parents, guardians, teachers and others in positions of power and influence to support adolescents as they seek to come to terms with the rapid changes in their bodies. They should promote dialogue between these influencers and adolescents.
- They should interact with professionals to be impartial and generous in their information about physiology, sex and sexuality to adolescents.
- They should be approachable and friendly so that adolescents are confident to approach them.



CHAPTER | 4

ADOLESCENT SEXUAL & REPRODUCTIVE HEALTH

CHAPTER 4: ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

“So ask the people of the Reminder (those with knowledge) if you do not know.”

Quran 21:7

“My people are destroyed for lack of knowledge; because you have rejected knowledge.”

Hosea 4:6

4.1 Introduction

This chapter will define adolescence, sexuality, reproductive maturation, health, socialization, children's rights as well as other rights and religion. The chapter will also highlight the barriers to ASRHR.

While all children are born with their sex and sexuality as an intrinsic part of who they are, most children begin to encounter changes in their physiology during the period of their adolescence or puberty. During this period, the body begins to mature biologically and sexuality develops: girls begin to grow breasts and menstruate, and boys may experience wet dreams. Unless adolescents manage this period appropriately, they may rush into sex without fully understanding the consequences of their actions.

4.2 Adolescence

Though adolescence is a developmental phase, there is no universally accepted definition for adolescence.

- Essentially, adolescence is the period of psychological and social transition between childhood and adulthood. Puberty refers to bodily changes that enable reproduction and often occurs in adolescence.

- Every child goes through this developmental phase. However, children may experience this phase at different ages in their life. Some children experience puberty at an early age while other children experience it late, in what is called delayed puberty.
- Bearing these differences in mind, the World Health Organization defines adolescents as those between 10–19 years of age, and young people as those in the age bracket of 10–24 years of age.
- While some children experience their puberty from as early as 10 years old, others may not experience it until they are in their late teens.

4.3 Sexuality

Sexuality is an important part of being human. It is a complex and interacting group of inborn biological characteristics and acquired behaviors learnt from families and broader society. Sexuality may lead to relationships, which may lead to sexual activity. Every society will regulate how sexual expression should occur, defining parameters. Written and unwritten codes that regulate sexual activity exist in many communities; these codes highlight what is acceptable and normal and what is unacceptable and abnormal.



The silence by parents, guardians and religious leaders normally pushes adolescents to rely on their peers as well as on information sources like the internet, movies, videos and magazines. This information is often inaccurate, confusing, misleading and false. Decisions about sex have far-reaching consequences. Understanding the basic facts about sex, pregnancy and childbirth will help young people make intelligent decisions that are right for them.

- Clearly, the option of silence on the part of adults is more dangerous than mastering the courage to openly speak about sexuality with adolescents and young people to help them make informed decisions.
- Censoring information is not an option either, especially because young people will access the censored information from other sources. These other sources may be inaccurate.
- Responsible CSE must therefore be available so that young people can navigate their way through the maze of sexuality.

4.4 Reproductive maturation

Sexual differentiation in most human beings is apparent at birth; the differences between males and females are accentuated only from puberty however. This is when the reproductive system matures and secondary sexual characteristics develop (like breasts in females), with the bodies of males and females becoming more distinctive.

SECONDARY SEXUAL TRAITS - GIRLS	SECONDARY SEXUAL TRAITS - BOYS
<ul style="list-style-type: none"> • Growth of breasts; • Start of menstruation; • Growth of hair in the pubic region and the underarm; • Rounding of the hips and buttocks. 	<ul style="list-style-type: none"> • Enlargement of the testes; • Growth of the penis; • The onset of wet dreams (usually at about 11 or 12 years of age); • Growth of hair in the pubic region and underarm; • Appearance of facial hair; • Deepening of voice; • A period of rapid growth.

Adolescents at this stage in their development will likely sexually experiment with their bodies. In addition, any sexual activity may result in pregnancy for the girls while boys may impregnate girls and women.

Since most communities are ill prepared to deal with this reproductive maturation of adolescents, the result in many communities has been:

- The early onset of sexual activity;
- Multiple sexual partners;
- Low condom use;
- STIs, including HIV and AIDS;
- Low use of contraceptives and unintended pregnancy;
- A greater risk of violence within a sexual relationship;

- A limited ability to negotiate for safer sexual practices;
- A greater use of harmful practices, such as a self-induced abortion;
- Rejection of sexual diversity;
- Transactional sex i.e. having sex for financial/material gain and favors.

4.5 Adolescent Health Challenges

When adolescents are not properly guided through their transitional development from childhood to adulthood, they often end up compromising their physical and mental health.

ADOLESCENT GIRLS - HEALTH CHALLENGES	ADOLESCENT BOYS – HEALTH CHALLENGES
<ul style="list-style-type: none"> • Unprotected sex leading to STIs including HIV and AIDS; • Unprotected sex leading to unintended pregnancy; • Unsafe abortions to get rid of unintended pregnancy; • Psychological trauma due to being ill-prepared for motherhood and contracting of STIs; • Trauma due to the social stigma that accompanies unintended pregnancy; • Early marriage as female adolescents are forced to marry the man responsible for their pregnancy; • Health complications during delivery of baby due to underdevelopment of the young adolescents' health reproductive system – obstructed labor, fistula and mortality. 	<ul style="list-style-type: none"> • Unprotected sex leading to STIs including HIV and AIDS; • Early marriage due to unintended impregnating of a sexual partner; • Psychological trauma due to the unpreparedness for fatherhood and contracting of STIs; • Some males also forced to marry women/girls they impregnate.

The full list of rights for children and young people under the age of 18 is set out in the United Nations Convention on the Rights of the Child, the most accepted standard on children's rights in the world.

UNICEF has drafted the full list of the 42 articles of the rights of children in child-friendly language. There are four general principles that underpin all children's rights:

4.4 Children's Rights

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There are four general principles that underpin all children's rights:

- **Non-discrimination** means that all children have the same right to develop to their potential in all situations and at all times. For example, every child should have equal access to education regardless of their gender, race, ethnicity, nationality, religion, disability, parentage, sexual orientation or other status.
- **The best interests of the child** must be "a primary consideration" in all actions and decisions concerning a child, and must be used to resolve conflicts between different rights. For example, when making national budgetary decisions affecting children, government must consider how cuts will impact on the best interests of the child.
- **The right to survival and development** underscores the vital importance of ensuring access to basic services and to equality of opportunity for children to achieve their full development. For example, a child with a disability should have access to suitable education and health care to achieve their full potential.

- **The views of the child** requires the voice of the child to be heard and respected in all matters concerning his or her rights. For example, those in power should consult with children before making decisions that will affect them.

Religious leaders, as strategically-positioned persons in the community, must acquaint themselves with the rights of children in general, but also on how the rights of children have a bearing on ASRHR. Article 16 (right to privacy) could refer to confidentiality from health professionals and care workers. Article 17 (right to access information) is useful in developing appropriate sexuality education and information for young people.

Article 3 (the best interests of the child) is a simple reference tool when dealing with young people.

It is important to note that these rights do not contradict central teachings in the Bible and the Qur'an. Religious leaders therefore must emphasize the convergence of rights of children and parental obligations as stated in scriptures.



ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH: KEY ADVOCACY POINTS FOR RELIGIOUS LEADERS

- Take a leading role in promoting adolescent rights. Support parents, guardians, teachers and others in safeguarding the rights of adolescents.
- Use sacred texts creatively to promote adolescent rights. The interpretation of sacred texts should be dynamic and supportive of the rights of adolescents.
- Liaise with other stakeholders, especially parents, to ensure that adolescents live in environments that allow them to thrive.



CHAPTER 15

PUBERTY

CHAPTER 5: PUBERTY

“He made of him a pair male and female.”

Quran 75:39

“And Jesus increased in wisdom and in years,
and in divine and human favor.”

Luke 2:52

5.1 Introduction

This chapter describes the changes that girls and boys go through during puberty.

5.2 PUBERTY IN GIRLS

Girls' puberty usually begins at about 8–13 years of age; the reproduction maturation of boys lags about two years behind. The physical changes of female puberty include breast development, rounding of the hips and buttocks, growth of the hair in the pubic region and the underarm, and the start of menstruation. For some individuals, acne – a skin disorder marked by pimples and boils – usually develops on the face and back.

Girls cope with the competing demands of school, family, community, livelihood, and self because of the pressures inherent in hegemonic femininity. Religious leaders and parents need to ensure that girls attain their goals and objectives in life.

5.2.1 Physical Changes in Girls during Puberty

- The menstrual cycle which signifies the start of puberty.
- Breasts grow during the teenage years, reaching full growth by the age of 18 years.
- Hair growth in the pubic area and the armpits are also observed. The normal cycle of hair growth that is seen in adults is reached by the average age of 14 years.
- The adolescent years are also marked by a rapid growth spurt. In girls this growth spurt starts at the age of 11 or usually around the time she reaches menarche (the first occurrence of menstruation) and slows down by the age of 16.

5.2.2 The Menstrual Cycle (Menstruation or “Period”)

Menarche (the first occurrence of menstruation) occurs at the average of 12.8 years, but it may start earlier or several years later. After the menstrual period, the lining of the womb starts to build up and prepare itself to receive a fertilized egg (this is the ovulation phase of the menstrual cycle). If no fertilized egg reaches the womb within 2–3 weeks, this built-up lining of the womb breaks down, and bits of tissues leave the womb during the menstrual period about a week later. This is called menstruation and is often referred to as “having a period”. Although the bleeding can last from 2–8 days, 4–6 days is the average. Menstruation continues throughout women's reproductive lives. Although the ages may vary, periods usually stop altogether between the ages of 40 and 50 years; this is known as menopause.

The length of the menstrual cycle is the interval from the beginning of one period to the beginning of the next period (see figure below). On average it is 28 days but can vary between 21 and 35 days, or even more. The first day of the menstrual period is counted as “Day 1” of the cycle. The length of each period, as well as the amount of bleeding, varies from woman to woman and is often moderated or increased by certain psychological or physical circumstances at that time. A woman can get pregnant only if she has sexual intercourse with a sexually mature male just before ovulation, or the day she ovulates. This is a small window period. For example, in an average 28-day cycle, a woman can get pregnant if she has intercourse on days 11–14. But the rest of the month cannot be considered a safe period for sexual intercourse.

“There is a time for everything, and a season for every activity under heaven: a time to be born and a time to die, a time to plant and a time to uproot, a time to kill and a time to heal, a time to tear down and a time to build, a time to weep and a time to laugh, a time to mourn and a time to dance, a time to scatter stones and a time to gather them, a time to embrace and a time to refrain, a time to search and a time to give up, a time to keep and a time to throw away, a time to tear and a time to mend, a time to be silent and a time to speak, a time to love and a time to hate, a time for war and a time for peace.”

Ecclesiastes 3: 1–8



5.2.3 Analysis of Menstrual Cycle from a Religious Perspective

Sexual development in girls brings many emotional and physical changes. It is different for each girl. The role of religious leaders is to help girls understand what is normal about their development and support them emotionally.

5.2.4 Menstruation Problems

Menstruation is a normal biological process, but it may cause distressing physical or psychological symptoms in some girls and women. Two common problems are dysmenorrhea and premenstrual tensions.

- **Dysmenorrhea** (painful menstruation) is characterized by cramps in the lower abdomen, backache, a bloated feeling, nausea, vomiting, diarrhea, and loss of appetite. Any drug such as aspirin or ibuprofen that blocks the effects of prostaglandins will usually be effective in alleviating some of the symptoms of dysmenorrhea.

- **Premenstrual tension** involves negative mood changes and physical symptoms associated with the time immediately preceding the onset of menses, (hence the name premenstrual). A more serious condition known as Premenstrual Syndrome (PMS) is experienced by a smaller number of women.

5.2.5 Ovulation

Each month, a mature egg (ovum) is released from one or two of the ovaries and moves to the fallopian tube; this is called ovulation (the release of the egg). The egg can survive for about one day (24 hours) in the fallopian tube. If a sperm does not fertilize it within that time, it dissolves or flows out of the body.



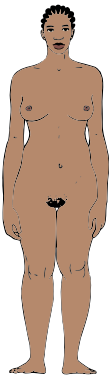
Ovulation normally occurs in the middle of the menstrual cycle, or about halfway between periods (depending on the length of the menstrual cycle). However, it is often difficult to know when ovulation is taking place if women have irregular menstrual cycles.

5.2.6 Conception

The process of conception involves the fusion of an egg (ovum) from a woman's ovary with a sperm from a man. Every month during a woman's fertile years, her body prepares itself for conception and pregnancy. An egg ripens in one of her ovaries and is released from its follicle. The egg, about the size of a pinpoint, is then drawn into the fallopian tube through which it travels to the uterus. The journey takes three to four days.

5.2.7 Issues that Teenage Girls contend with

- **Ideal Girlhood and Womanhood:** society has set a certain image of what an ideal girl or woman looks like. However, in real life such an image is difficult to achieve.
- **Peer Relationships:** girls negotiate relationships with their peers in a time when social relationships are highly important to them. An emphasis on healthy and meaningful relationships should be made.
- **Physical and Emotional Changes:** many bodily and emotional changes occur and there is need for religious leaders and parents to understand this.
- **Conflicting Messages from the Media:** some media images tend to objectify women and put girls under pressure to appear "sexy."
- **Sexual Identity:** girls need messages about positive sexual health and identity.

AGE GROUP	PHYSICAL CHANGES	EMOTIONAL CHANGES
10–14 	<ul style="list-style-type: none"> • Grow taller, bigger (often before boys) • Breasts begin to enlarge • Hips widen • Acne develops • Hair grows around genitals and under arms • Ovaries mature, menstruation begins, able to become pregnant 	<ul style="list-style-type: none"> • Values and beliefs primarily determined by family • Experiences mood swings, behavior driven by feelings • Confused about emotional changes, preoccupied with physical appearance • Self-esteem determined by others • Seeks acceptance by fostering relationships
15–19 	<ul style="list-style-type: none"> • Development continues • Breasts enlarge, hips widen, hair grows around genitals and under arms 	<ul style="list-style-type: none"> • Compares their development to peers, determine self-image • May challenge rules and test limits of gender norms, desire more control over life • Increased interest in sex, aware of own sexuality • Desire to be loved may influence decision-making in sexual relationships • Peers influence leisure activities, appearance, substance use, and initial sexual behaviors
20–24 	<ul style="list-style-type: none"> • Development finishes 	<ul style="list-style-type: none"> • Develops more stable relationships • Understands consequences of behaviors, prepare for parenthood • Clearer about self in relation to others, including spouse • Learns to cope with the competing demands of school, family, spouse, community, livelihood, and self • Becomes able to recognize and seek help when needed

5.3 PUBERTY IN BOYS

“People who celebrate the praises of Allah, standing, sitting, and lying down on their sides, and contemplate the [wonders of] creation [in themselves] in the heavens and the earth (with the thought): “Our Lord! Not for nothing have you created [all] this! Glory to Thee! Save us from the penalty of the fire.”



Surah 3:190

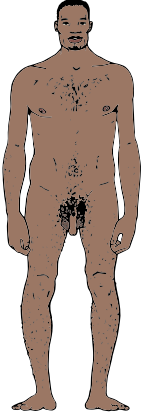
Physical changes in boys include enlargement of the testes, development of pubic hair, growth of the penis, the onset of wet dreams (usually at about 11 or 12 years of age), deepening of the voice, the appearance of

facial hair, and a period of rapid growth. Estrogen and progesterone bring the physical changes of puberty, testosterone from the testes, and androgen from the adrenal glands.



Erections start from the womb, not adolescence. Parents accept this in a baby, but as boys grow, social or cultural norms may make boys feel bad for having erections. Religious leaders should help boys understand the changes are happening to their bodies and to reinforce that this is normal. Parents should be concerned if the baby boy does not experience an erection as a precursor to urinating as it may indicate poor development of the erectile muscles that may lead to poor sexual functioning at puberty.

AGE GROUP	PHYSICAL CHANGES	EMOTIONAL CHANGES
10–14 	<ol style="list-style-type: none"> 1. Growth spurts occur; 2. Muscles enlarge; 3. Voice deepens; 4. Acne/common skin disease showing hard reddish pimples may develop; 5. Sperm matures, wet dreams begin. 	<ol style="list-style-type: none"> 1. Values and beliefs primarily determined by family; 2. Experiences mood swings, behavior driven by feelings; 3. Confused about emotional and physical changes; 4. Begins to have sexual feelings and curiosities; 5. Begins to seek acceptance by peers through competition and achievement.
15–19 	<ol style="list-style-type: none"> 1. Development continues; 2. Genitals enlarge; 3. Hair grows around genitals, under arms, and on chest. 	<ol style="list-style-type: none"> 1. Challenges rules and test limits 2. Feelings contribute to behavior but do not control it, can analyze potential consequences; 3. Compares own development to peers and becomes concerned with self-image; 4. May have a girlfriend and wants to experiment or act on sexual desire; 5. Peers influence leisure activities, appearance, substance use, and initial sexual behaviors.

AGE GROUP	PHYSICAL CHANGES	EMOTIONAL CHANGES
20-24 	<ul style="list-style-type: none"> • Development finishes 	<ol style="list-style-type: none"> 1. Develops more serious relationships; 2. Understands consequences of behaviors; 3. Struggles with adult roles and responsibilities; contends with modern versus traditional values; 4. Makes own decisions, peers have less influence; 5. Copes with the competing demands of school, family, spouse, community, livelihood, and self.

The above illustration shows common changes for these age groups. Individual boys and girls will develop physically and emotionally at different rates, some faster and some slower. This is normal and should not be a concern. The role of religious leaders and parents is to help boys and girls understand what is normal about their development and support them emotionally.

5.3.1 Masturbation

Masturbation is self-led sexual stimulation of a male or female's genitals for the purposes of pleasure. Masturbation does not cause health problems such as infertility, blindness, or lack of virility. For boys and

girls, it can be a safe alternative to acting on sexual feelings, thus preventing early sex. It is an alternative for couples hoping to abstain from sexual intercourse until marriage.

Scholars of Islamic law have differed on masturbation. Some argue that it is forbidden because Allah asked us to protect our genitals except in marriage. Others say that masturbation is obligatory if a person fears getting into unsanctioned sexual relationships, because masturbation is the lesser of two evils (therefore it is disliked but not a sin). Some add that these views also apply to girls and women.

“In this same way, husbands ought to love their wives as their own bodies. He who loves his wife loves himself. After all, no one ever hated his own body, but he feeds and cares for it, just as Christ does the church — for we are members of his body. For this reason a man will leave his father and mother and be united to his wife, and the two will become one flesh.”

Ephesians 5:28–31

“And among His signs is this that He created for you wives from among yourselves that you may find repose in them and He has put between you affection and mercy. Verily in that are indeed signs for a people who reflect”.

Surah 30:21

“O humankind! Revere your Lord, who created you from a single person, created, of like nature, his mate, and from them the two scattered [like seeds] countless men and women — Fear Allah, through whom you demand your mutual [rights], and [reverence] the wombs [that bore you], for Allah ever watches over you.”

Surah 4:1

Despite emphasizing the importance of marriage before getting pregnant and having children, some women become pregnant before they are married or have been married but are now single.

One of the roles of religious leaders is to refer young people to professional medical services. If a woman has

had unprotected sex and thinks she may be pregnant, she should see a health care provider to confirm it. A doctor or nurse can determine if she is pregnant and instruct her on how best to take care of herself and prepare for the baby.



PUBERTY: KEY ADVOCACY POINTS FOR RELIGIOUS LEADERS

- Promote knowledge of physical changes in boys and girls. Support parents, guardians, teachers and others to accept the physical changes in boys and girls and not make them feel ashamed.
- In collaboration with other stakeholders, ensure that health centres are youth friendly. Encourage health centres to make young people feel at ease when visiting them.
- Without being judgmental, provide support to boys and girls as they negotiate the challenges of growing up.





CHAPTER | 6

MENSTRUAL HEALTH MANAGEMENT

CHAPTER 6: MENSTRUAL HEALTH MANAGEMENT

6.1 Introduction

This chapter introduces the issue of menstrual health management. Reading this chapter alongside the preceding chapter is useful.

6.2 Background

In most societies across the world, menstruation is often associated with shame and secrecy. Adolescent girls experience challenges relating to menstruation, particularly the lack of access to menstrual pads. Indeed, it is hard to find a society or religion that does not find some way to make women feel dirty, guilty, unworthy or dangerous due to menstruation. This has prevented effective menstrual health management, like clean water and sanitation. It is, therefore, important for families, men and religious leaders to be aware of key issues relating to menstrual health management.

6.3 Beliefs and Taboos related to Menstruation

Some of the beliefs and taboos associated with menstruation in different communities include:

- A menstruating girl/woman is regarded as “dangerous”.
- A menstruating girl/woman must not attend a religious function/play a significant role at religious gatherings.
- A menstruating girl/woman must not cook/apply salt to food.
- A menstruating woman causes her husband to be attacked by wild animals if he goes hunting.
- Menstrual blood carries toxic bacteria.
- A menstruating girl/woman should not touch a plant, as it will die.

Although some sacred texts have restrictions for menstruating women, they emerged when societies had a greater fear of blood. There is need to appreciate that menstruation is a biological and natural process for all women of reproductive age. Religious leaders are well placed to encourage more open and culturally-appropriate approaches to menstrual health management.

6.4 Key Issues in Menstrual Health Management

There are some key issues relating to menstrual health that need to be highlighted. These include:

- Recognizing that menstrual health management has implications for the economy. When some women miss work due to challenges relating to menstruation, the economy suffers.
- Girls missing school due to expensive sanitary products (pads, tampons, sanitary napkins and menstrual cups). Therefore, it is important for various stakeholders to reflect on distributing pads for free or removing duty on all sanitary products to bring down the prices.
- The availability of water (in the home, at school, religious institutions, etc) as a critical issue. Further, hand-wash facilities must have soap.
- Restrooms/toilets for adolescent girls at school must have individual cubicles for privacy (to allow girls to change their pads and tampons as frequently as they ought and wish to), as well as sanitary products disposal units.
- Inadequate facilities in rural areas, with no water or privacy.



Menstrual health management is not merely a “women’s issue.” Gender norms and values in most communities have created the impression that menstrual health management is a private and embarrassing subject. Further, there is the tendency to exclude boys and men from menstrual health management. However, boys and men have strategic roles to play in menstrual health management. They can play an advocacy role (for example, in insisting on access to water and facilities), as well as in removing the stigma around menstruation.



PUBERTY: KEY ADVOCACY POINTS FOR RELIGIOUS LEADERS

- Recognise the role of boys and men in addressing menstrual health management. They should acquire knowledge and information relating to menstrual health management.
- Be actively involved in de-stigmatising menstruation and accepting it as a natural biological process.
- Advocate for water and sanitation hygiene as a basic human right. This will help girls and young women to be at ease in different settings, such as at home, at school or at places of worship.



CHAPTER | 7

POSITIVE SEXUAL BEHAVIOR FOR ADOLESCENTS

CHAPTER 7: POSITIVE SEXUAL BEHAVIOR FOR ADOLESCENTS

7.1 Introduction

This chapter focuses on positive sexual behavior for adolescents. Parents, guardians, religious leaders and faith communities must empower adolescents with life skills that will help them adopt positive sexual behaviors. It is important that adolescents' decisions must be based on relevant and adequate information provided by parents, guardians and religious leaders.

Young people and adolescents equipped with life skills will be able to:

- Make positive sexual health choices;
- Make informed decisions on sexual matters;
- Practice healthy sexual behaviors;
- Recognize and avoid situations and behaviors that are likely to pose risks to sexual health and have full ownership over sexual experience (vs. peer pressure). Positive sexual behavior translates into a wide range of activities, including delayed sexual activity. While many religious leaders, parents, guardians and teachers promote virginity (no sexual intercourse),

not every young person or adolescent will succeed in delaying their sexual activity. For such persons, choosing to have safe(r) sex and limiting the number of sexual partners is a more reasonable expectation to have. Choosing to use contraceptives to avoid pregnancy and using condoms to minimize the risk of contracting an STI are also positive sexual behaviours.

7.2: What are life skills?

Life skills are the skills, characteristics, qualities and values that young people need to help them negotiate a safer, healthier and happier life path. With these life skills, they have a greater probability of becoming responsible, fulfilled, adaptable, and mature adults who can achieve their potential, while maintaining healthy and stable relationships.

Such equipped young people can confidently function in their community and in the wider world.



"Life skills are the strategies, abilities, expertise or competences that enable adolescents to develop positive attitudes and responsible sexual behaviors, leading towards a healthy lifestyle. As such a life skill refers to a person's ability or competence."

7.2.1 Types of life skills

Among the many life skills that young people can acquire, some are especially important for enacting positive sexual behavior. The following life skills are arguably most important:



Effective communication



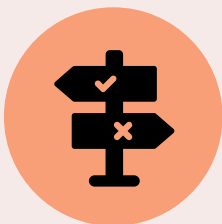
Peer resistance



Assertiveness



Interpersonal relationship skills



Decision making



Self awareness



Self esteem

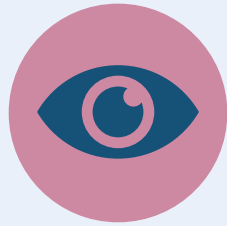


Critical thinking



7.2.1.1 Effective communication

Effective communication is the ability of expressing oneself clearly and effectively during interactions with other people in any given circumstance. Such effective communication is not always verbal (such as listening). Effective communication is a skill that can be learned and developed through constant practice and involves:

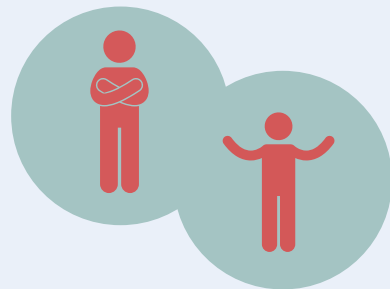


Observation



Respect for others' feelings

Effective use of verbal and body language



Active listening



7.2.1.2 Peer resistance

One of the greatest threats to positive sexual behavior among adolescents and young people is the pressure that is exerted on them by their peers and friends, and older members of a community. Being “cool” is expected and pressure is applied to be this. Young people are thus forced to prove that they are neither foolish, “nerdy” nor backward, and consequently find themselves in risky situations they may not be ready for.

It is therefore necessary for adults, parents and religious leaders to equip adolescents and young people with the skill to resist peer pressure. The following are examples of abilities in resisting peer pressure:

- Maintain your own beliefs about when to become sexually active.
- Refuse alcohol or drugs, even if others are partaking in them; if not, drink responsibly.
- Decide to remain faithful to one partner, no matter what others say.
- Remain a virgin, even if friends say it is backward to do so.
- Maintain your religious identity, even if peers are disowning their faiths.

In many cases where young people and adolescents look back and reflect, most regrets are largely blamed on actions that were done due to peer pressure. Peer resistance is the ability to say, “You can go ahead, but without me.”



POSITIVE SEXUAL BEHAVIOUR FOR ADOLESCENTS: KEY ADVOCACY POINTS FOR RELIGIOUS LEADERS

- Support young people as they make key decisions about their lives, without demonising them. They should create time for young people and encourage parents, guardians, teachers and others to be available and approachable.
- Call for systems that enable young people to thrive in their families, communities and nations. This implies calling for resources to be allocated to the health and well-being of young people.
- Avail full details and information on ASRHR, without withholding key facts. Religious leaders should liaise with parents, guardians, teachers, service providers and others to ensure that all the relevant information on ASRHR is available.
- Stand with those young people who would have failed to live up to the ideals of the religious community, while encouraging those who are succeeding in doing so. They should be available to support young people who have fallen pregnant/impregnated, instead of spending time denouncing them or using them as examples of failures.



CHAPTER | 8

SEXUALLY TRANSMITTED INFECTIONS AND THEIR PREVENTION

CHAPTER 8: SEXUALLY TRANSMITTED INFECTIONS AND THEIR PREVENTION

“God will never change the destiny of a society until its people change that society.”

Quran 13:11

8.1 Introduction

This chapter will discuss sexually transmitted infections (STIs), their impact on young children and ways to prevent them.

8.2 What are STIs?

Sexually Transmitted Infections are commonly referred to as STIs or Sexually Transmitted Diseases - STIs.

These are infections spread from man to woman, from woman to man and between two people of the same

sex through body fluids including semen, vaginal fluids and blood through sexual intercourse. They can also be transferred from mother to child. It is critical to take STIs seriously because of their potentially deadly consequences. Therefore, preventing STIs and seeking medical attention in time cannot be stressed enough.

8.2.1 Types of STIs and their Effects

The following includes basic information about STIs

STI	NOTES
Gonorrhea	This is the most common STI. It affects both men and women. In males, the disease usually causes pain or a burning sensation when passing urine and is accompanied by a thick discharge from the penis. Gonorrhea in women may not be recognized easily as symptoms may not be obvious.
Chlamydia	This is an infection of the tissues lining the urethra, throat, rectum and the opening of the uterus. If not treated it has the same symptoms of gonorrhea.
Syphilis	The initial symptom only consists of a soft, small painless sore in the genital area, penis or vagina. It is caused by germs and transmitted during sexual intercourse with an infected person. It develops in stages: 1. A small and painless sore in the genital area or vagina is seen. 2. Fever and pain occur in the bones and muscles. 3. Syphilis will continue to have effects for as long as 20 years after its initial contraction.
Cancroid (Genital Sore)	This disease causes shallow, painful sores or ulcers around the genital area and inside the vagina.
Genital Herpes	Herpes is a viral disease that causes pain or itching, swollen blisters or sores on the penis, vulva and vagina, the pubic area or at the entrance of the anus.
Genital Warts	Genital warts usually appear as small, hard painless bumps in the vaginal area, around the penis or around the anus. If untreated, they may grow and develop a fleshy cauliflower-like appearance. A person who has genital warts should have a check up with a trained health professional every year.
Candidiasis	This is an infection caused by a fungus. It is characterized by thick, whitish discharge resembling curdled milk. It is extremely itchy and may be associated with swelling of the labia in females. Men can be carriers without showing any symptoms. It is therefore important to treat both partners even though the male partner may have no symptoms. It might also be a result of other health issues and not only as an STI.

8.3 The Relationship between STIs and HIV and AIDS

The human immunodeficiency virus (HIV) is an STI. Although there are several modes of infection, the main mode is through sexual intercourse. Other ways of getting HIV include the use of contaminated sharp instruments, blood transfusion with infected blood and mother-to-child transmission. A person with STI has

a higher risk of becoming infected with HIV if he/she has sexual intercourse with a person infected with HIV. This is because many of the open wounds and sores associated with STIs allow easier entry of the HIV virus into the body.



Because there are serious and long-term health risks posed by having an STI, it is particularly important for adolescents/young people to avoid them.

8.4 How to avoid STIs

The following are ways to avoid STIs:

- Abstaining from sexual intercourse.
- Getting tested with your partner before sexual intercourse.
- Only having one sexual partner.
- Proper and consistent use of a condom in all sexual relationships.

Awareness alone is not enough to prevent risky behaviors. Thus adolescents must:

- Make informed decisions to protect themselves and others.
- Resist peer pressure that may lead to unhealthy behavior.
- Learn to assert and affirm themselves in their decision/s.
- Fight against denial and discrimination.
- Establish and cultivate a good relationship with their partner.
- Exercise skills in communication, i.e. listening to partners, informing, and persuading their peers.



All STIs, except HIV, can be cured if they are identified early enough. If STIs are not identified and treated, serious consequences include blindness, infertility and death. For HIV, anti-retroviral treatment has proven to be successful, hence the need for testing.

It is not always possible for young people to abstain from sex or be faithful in relationships, hence the need to encourage early treatment for both partners should an STI be contracted. Further, sexually-active youth

should be encouraged to use condoms consistently and properly to reduce STI and the risk of unintended pregnancy. If a person has multiple partners, he or she should be prompted to reduce the number of partners.



Religious leaders can have a positive role to educate, support and guide adolescents/young people to seek professional care when at risk or exhibiting symptoms of STIs or HIV, either through local health centers and hospitals or specialized clinics, such as voluntary counseling and testing (VCT) sites and youth centers. Religious leaders could strive to ensure that they are familiar with such centers in their communities.

8.5 Religious Teaching on Sexually Transmitted Infections

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

1 Peter 5:8

“Do you not know that your body is a temple of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore honor God with your body.”

1 Corinthians 6: 19–20

“Tell the believing men to lower their gaze and to be mindful of their chastity: this will be most conducive to their purity — [and] verily, Allah is aware of all that they do. And tell the believing women to lower their gaze and to be mindful of their chastity.”

Surah 24:30–31

8.6 Some common questions related to STIs


<p>True or False? STIs are not a problem for adolescents/ young people in Africa.</p>	<p>FALSE STIs are a serious health problem for adolescents/young people in Africa. It is estimated that up to one in four sexually active youth between the ages of 13 and 19 are infected with an STI each year. HIV infections are more frequent among those under 24 than in any other age group.</p>
<p>True or False? STIs can lead to serious health problems, especially if left untreated.</p>	<p>TRUE STIs, if left untreated, can cause serious reproductive health problems for men and women.</p>
<p>True or False? It is easy for adolescents/young people to know if they have an STI, because they will experience uncomfortable symptoms.</p>	<p>FALSE Only some STIs show symptoms. There are often no symptoms or it may take years before symptoms appear.</p>
<p>True or False? Having an STI puts people at greater risk for contracting HIV.</p>	<p>TRUE Having an STI puts people at greater risk for contracting HIV. If a person has an STI, it means they have had unprotected sex with a partner who may be having unprotected sex with other partners. Sex is the main route of HIV transmission. Some STIs cause sores around the genital, oral, and anal areas. Open sores make it easier for HIV to enter the body.</p>
<p>What is the best way for young people to protect themselves against STIs?</p>	<p>For adolescents/young people, the best protection against an STI is to choose not to have sex. For young people who do choose to have sex, the best choice is to use quality condoms consistently and correctly. It is also important to first get tested with a partner.</p>
<p>What should adolescents/young people do if they think they may have an STI?</p>	<p>Adolescents/young people who think they have an STI should go to a clinic, voluntary testing center, youth center or see a doctor.</p>

8.7 Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)

Once HIV enters the body of a healthy person (by any one of its modes of transmission), it enters human blood cells that fight against infections, multiplies and slowly destroys the immune system of the body. The person infected with HIV may not show signs of infection for years, but if the illness is untreated, it leads to death. HIV tests may not appear positive during the three-

month window period, therefore a second test three months after suspected contraction must be done. Once the immune system is destroyed, the person is prone to getting a variety of diseases, as her/his body cannot fight against any infections. This condition is known as Acquired Immunodeficiency Syndrome (AIDS). But, people living with HIV can live healthy and long lives should they manage their illness and take their medication.

8.7.1 How HIV can and cannot be spread

HIV CAN BE SPREAD BY	HIV CAN NOT BE SPREAD BY
<ul style="list-style-type: none"> • Sexual intercourse with an infected person; • Blood transfusion of HIV-infected blood; • Use of syringes, needles and other instruments if infected with HIV (used by the HIV infected person); • An infected mother to her unborn child; 	 <ul style="list-style-type: none"> • Mosquito bites; • Hugging; • Touching; • Sharing food and utensils; • Shaking hands or holding hands; • Kissing; • Looking after an infected person; • Sitting next to an infected person.

8.8 HIV Testing Services (HTS)

“If a people provides itself with the capital of faith and performs good and worthy deeds it will be triumphant on the stage of life and win the vicegerency of the earth.”

Quran 24:45

“It is God’s will that you should be sanctified: that you should avoid sexual immorality; that each of you should learn to control his own body in a way that is holy and honorable, not in passionate lust like the heathen, who do not know God.”

1 Thessalonians 4: 3-5

Information on where to go (or refer people) for HIV testing services (HTS) can be obtained from local health clinics, medical professionals, health workers and NGOs. HTS centers offer the best means to find out one’s status and to provide an effective health strategy. Many people, especially youth, are afraid of going to visit an HTS center primarily because they are thought of as ‘scary’ places to visit and because of the stigma associated with going to visit one.

HTS centers have helped:

- Reduce HIV transmission.
- HIV positive people learn to lead healthier and more positive lives.
- Initiate support/care groups.
- Empower people to deal with stigma.
- Act as a prime motivational and educational service to ensure that people who have been tested negative remain so.

The following persons will benefit from HTS referrals and information:

- A person who is serious about behavior change.
- A person who is planning marriage or venturing into a new relationship.
- An individual or a couple considering pregnancy (or a woman who is already pregnant).
- A person with more than one sexual partner (now or in the past).
- A person whose partner has more than one sexual partner.
- A person with an STI.
- A person working and living away from his/her spouse and family.
- A person who has had a blood transfusion.
- A person who is constantly feeling unnaturally sick (with or more of the signs or symptoms of HIV and AIDS).

HTS BENEFITS FOR HIV NEGATIVE PERSONS:	HTS BENEFITS FOR HIV POSITIVE PERSONS:
<ul style="list-style-type: none"> • Clients learn how to stay negative. • Couples can marry without having doubts. • Couples can plan for future pregnancies without having doubts. • The reduction of anxiety over past risky behavior. • The offering of motivation to remain HIV negative. 	<ul style="list-style-type: none"> • Counselling services to help clients avoid passing the virus to anyone else. • Access to anti-retroviral therapy. • Education on health care. • Education on TB and STI treatment, prevention of mother to child transmission, family planning and social support.

8.8.1 Medical treatment for HIV and AIDS

While the HIV vaccine has not yet been fully developed, there have been major treatment advances in controlling the effects of HIV. Three of these include:

1. The use of ARVs, which help the body to directly fight HIV. ARVs can improve quality of life, and significantly delay the onset of AIDS.
2. “Positive Living” which focuses health and wellness. This includes eating fresh fruits and vegetables, drinking a lot of clean water, and getting plenty of

rest. An infected person must ensure that he/she eats balanced diets. This means a balance of proteins which can be found in milk products, eggs, fish and meat; carbohydrates which can be found in rice, maize, millet, sorghum, wheat, barley, potatoes, sweet potatoes, cassava and yams; and fats which are important for maintaining weight and enhancing energy. Fats are found in butter, margarine, cream, avocados, curds and cheese.

3. The treatment of opportunistic diseases like TB.



With the availability of ARV treatment in most places, religious leaders should encourage people living with HIV to adhere to treatment, even as they pray for healing. Effective treatment of HIV and AIDS involves more than just prescribing drugs; people living with HIV need regular consultations, testing of their viral loads and CD4 counts. If treatment fails, they need regular testing for drug resistance.



SEXUALLY TRANSMITTED INFECTIONS AND THEIR PREVENTION: KEY ADVOCACY POINTS FOR RELIGIOUS LEADERS

- Support CSE for adolescents to acquire accurate and up-to-date information on sexuality and STIs. Religious leaders should promote access to information on sexuality and STIs for young people by being friendly and approachable.
- Support parents, guardians, teachers and others in interacting with adolescents and to reinforce key teachings.
- Collaborate with stakeholders to ensure that health centers are youth friendly to enable young people to access information and treatment of STIs.
- Contribute to HIV prevention and promote treatment adherence and not force people living with HIV to abandon medication.



CHAPTER | 9

TEEN PREGNANCY

CHAPTER 9: TEEN PREGNANCY

Say, “Are those who know equal to those who do not know?”

Quran 39: 9

“Impress them on your children. Talk about them when you sit at home and when you walk along the road, when you lie down and when you get up.”

Deuteronomy 6:7

9.1 Introduction

Teen pregnancy refers to pregnancy of girls between the ages of 13 and 19 and is often referred to as Early and Unintended Pregnancy. Factors that lead to teen pregnancy include social pressures, economic pressures, as well as peer pressure. Religious

communities are sometimes responsible for nurturing practices and customs that encourage adolescents to marry early and to become mothers immediately after marriage. Teens growing up in lower socio-economic communities are more likely to become pregnant.

9.2 Causes of Teen Pregnancy

CAUSE	COMMENTS
Social	<ul style="list-style-type: none"> Girls are pressured into early marriage and expected to become mothers soon after marriage. Adolescents are constantly told that they are now grown-up women. Where a peer has been married, teens are constantly informed that she is now their role model. Peer pressure. In some communities, the belief that young teenage girls are sexually-inexperienced virgins is desirable and valued by men.
Economic	<ul style="list-style-type: none"> Poor families typically marry their daughters in their early teens. Poor girls become sexually active early to survive. Poor girls work as maids and are easily abused by employers. Availability of older men who provide cash and material gifts.
Sexuality Education	<ul style="list-style-type: none"> There is a lack of appropriate sexuality education for adolescents in most communities. Girls become sexually active early without full information on sex and contraception. Girls lack the requisite skills to negotiate for safer sex because of the lack of appropriate education and information.
Religious	<ul style="list-style-type: none"> There are beliefs that once a girl is biologically mature, they are ready for marriage and child-bearing. Inter-generational marriages where young girls are married off to elderly men.

9.3 Health Challenges of Teen Pregnancy

Teen pregnancies can lead to many health challenges for the teen.



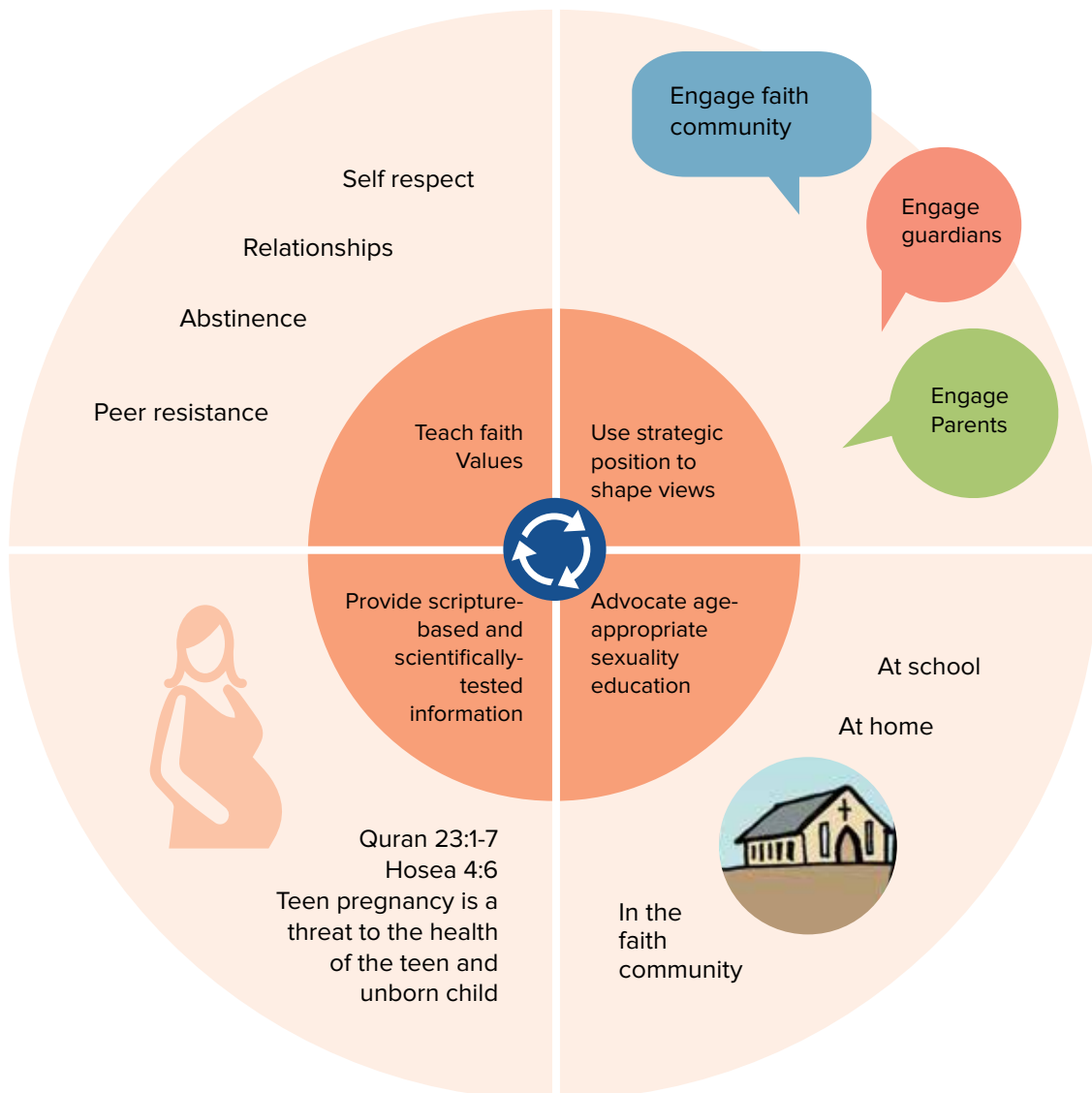
9.4 Other Challenges Faced by Pregnant Teenagers

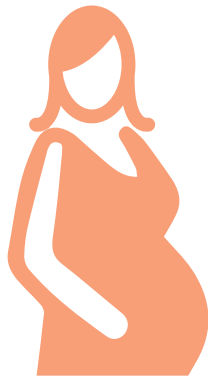
While the health challenges to teen pregnancy are some of the most researched, there are others present:



9.4 Religious Leaders for the Prevention of Teen Pregnancy

Research indicates that the effective involvement of faith communities and religious leaders tends to improve community health. This can be extended to the role religion can play in ASRHR.





The strategic positioning of religious leaders can be put to good use in engaging young people, parents and other stakeholders on the sexuality of young people. Even though religious communities may have contributed to the staggering numbers of teen pregnancy, religious leaders can help turn the tide around.

Support girls and young women who fall pregnant out of wedlock.

According to the Holy Quran 23:1-7,

“Certainly will the believers have succeeded: They who are during their prayer humbly submissive. And they who turn away from ill speech. And they who are observant of zakah [obligatory charity]. And they who guard their private parts except from their wives or those their right hands possess, for indeed, they will not be blamed—But whoever seeks beyond that, then those are the transgressors.”



TEEN PREGNANCY: KEY ADVOCACY POINTS FOR RELIGIOUS LEADERS

- Denounce child marriage.
- Support girls and young women who fall pregnant out of wedlock.
- Mobilize the faith community not to stigmatize girls who fall pregnant out of wedlock.
- Support boys and young men who impregnate girls and young women to take full responsibility for their role, and to provide support during and after their partner's pregnancy.
- Collaborate with parents of children involved in teenage pregnancy (both the boy and the girl).
- Advocate for CSE to minimize teen pregnancies.
- Provide a space for honest and open dialogue on sex and sexuality.
- Support teenage mothers to return to an accommodating school environment.



CHAPTER | 10

CHILD MARRIAGE

CHAPTER 10: CHILD MARRIAGE

“O You who have chosen to be graced with belief! It is not lawful for you to force women into marrying or holding on to them in marriage against their will.”

Quran, 4:19

9.1 Introduction

This chapter addresses the issue of child marriage. Religious leaders are encouraged to contribute significantly towards ending child marriage.

10.2 What is child marriage?

Child marriage, also known as early marriage, is defined as a marriage that happens when the person is below 18 years of age. It is a major concern because the girl would not be ready physically, physiologically, and psychologically ready to bear the challenges that come with marriage. Marriage is a formalized, binding partnership between consenting adults, which sanctions sexual relations and gives legitimacy to any offspring.

Marriage is still a respected and valued social institution throughout the world, taking different forms in different cultures. Child marriage, on the other hand, involves either one or both spouses being children and may take place with or without formal registration, and under civil, religious or customary laws.

Child marriage goes against the Convention on the Rights of the Child, particularly Article 3 which refers to the need to prioritize the best interests of the child in all cases.

10.3 What are the Causes of Child Marriages?

In almost all societies, child marriage is illegal, however, throughout the world, child marriage continues to flourish for many different reasons:

10.3.1 Family Ties

In some societies, the marriage or betrothal of children is valued as a means of consolidating powerful relations between families, for sealing deals over land or other property, or for settling disputes.

10.3.2 Gender Inequality

Gender inequality persists in most societies despite global statements of commitment to empower women and to foster gender equality.

10.3.3 Poverty and Economic Survival Strategies

In traditional societies – where infant mortality was high and survival depended on a family's ability to produce

its own food or goods for sale, child marriage helped to maximize the number of pregnancies and ensure enough surviving children to meet household labor needs.

Child marriage is valued as an economic coping strategy that reduces the costs of raising daughters. In this sense, poverty becomes a primary reason for child marriage because of perceived benefits to the family and the daughter. Additionally, poor families tend to marry off girls to help generate high income on marriage ceremony payments.

10.3.4 Control over Sexuality and Protecting Family Honor

Girls in rural communities may be withdrawn from school at first menstruation to restrict their movements in order to protect their sexuality. Child marriage is sometimes traditionally recognized as necessary for controlling girls' sexuality and reproduction.

10.3.5 Tradition and Culture

The reality for many women and girls in rural areas is that customary laws dictate their daily lives. In communities where child marriage is prevalent, there is strong social pressure on families to conform. Invariably, perceptions on the ideal age for marriage, the desire for submissive wives, extended family patterns and other customary requirements (e.g. dowries or bride price), are all enshrined in local customs or religious norms.

The use of religion and tradition to justify child marriages shows an urgent need for developing effective strategies for collaboration with religious and traditional leaders.

10.3.6 Insecurity

Situations of insecurity and acute poverty, particularly during disasters such as war, famine or the HIV and AIDS epidemic, can prompt parents or guardians to resort to child marriage as a protective mechanism or survival strategy. Among some populations which have been disrupted by war (e.g. in Burundi, Somalia, Northern Uganda and South Sudan), marrying a young daughter to a warlord or someone who can protect her may be a strategy for physical security or family

support. Displaced populations living in refugee camps may feel incapable of protecting their daughters from rape, and so marriage to a warlord or other authority figure may provide improved protection.

10.4 Problems Associated with Child Marriages impacting on the Girl Child and Boy Child

Critically, child marriage hampers the achievement of the Sustainable Development Goals that focus on reducing maternal and child mortality, poverty and HIV and AIDS infections, and ensuring universal primary education by 2030.

10.4.1 Health

The majority of young brides have limited access to contraception and reproductive health services and information. They are exposed to early and frequent sexual relations and to repeated pregnancies and childbirth before they are physically mature and psychologically ready.

Obstetric fistula is one of the most devastating consequences, affecting over two million girls and young women. Pregnancy related deaths are the leading cause of mortality in 15-19 year old girls, and girls age 15 years or under are five times more likely to die than those that are over 20 years of age.

10.4.2 Education

Many government reports and human rights monitoring bodies have shown that child marriage, pregnancy and domestic chores are the greatest obstacles to girls' education. The children of young, uneducated mothers are also less likely to attain high levels of education, perpetuating cycles of low literacy and limited livelihood opportunities. The curtailment of girls' education in this way directly undermines national and international efforts to achieve targets on education and gender equality.

10.4.3 Poverty

Poverty is linked to child marriages in many countries and reinforces intergenerational cycles of poverty.

10.4.4 Domestic Violence

Child marriages tend to make affected young women vulnerable to violence. Child brides are more likely to experience domestic violence and less likely to act against this abuse. Sex with a child is an act of violence, legally considered rape.

10.5 Child Marriage among Boys

Child marriage affects girls in far greater numbers than boys. Data on the number of boys affected by child marriage are limited, making it difficult to draw definitive conclusions on its status and impact.



CHILD MARRIAGE: KEY ADVOCACY POINTS FOR RELIGIOUS LEADERS

- Initiate or join campaigns against child marriage within communities of faith. They can collaborate with organisations that are challenging child marriage in their communities.
- Challenge the abuse of scripture, culture and tradition in child marriage. They should encourage positive interpretations of scripture, culture and tradition to end child marriage.
- Support investment in the education of the girl child. This will include mobilizing resources within their faith community to support disadvantaged girls who might be forced into early marriages.
- Engage with parents and guardians to fight against child marriage to end the practice.



CHAPTER 11

GENDER-BASED VIOLENCE AGAINST ADOLESCENTS AND YOUNG PEOPLE

CHAPTER 11: GENDER-BASED VIOLENCE AGAINST ADOLESCENTS AND YOUNG PEOPLE

The best among the believers is whose character is the best and the best among you is one who is best to his wife.”

– Hadith authenticated by Imam Tirmidhi and Imam Ibn Hibban – Hadith 1162 and 417 respectively.

“But she answered him, “No, my brother! She said to him. “Don’t force me! Such a thing should not be done in Israel. Don’t do this wicked thing.”

2 Samuel 13: 12

9.1 Introduction

This chapter seeks to define gender and gender-based violence (GBV). The chapter explores the causes of gender-based violence, highlighting the impact this has on at-risk adolescents and young people.

11.2 Gender and Gender Norms

Gender is a sociocultural construct that refers to power differences between males and females. These differences manifest themselves in roles, responsibilities, expectations, privileges, rights, limitations, opportunities and access to services. While gender differences appear to be natural, in some religious communities’ sacred texts, such as Genesis 2-3, gender differences are divinely ordained. Most communities reinforce gender differences and inequalities using patriarchal ideology, which assigns power and authority to men and fathers over women and children.

With a few exceptions, most communities in Africa are organized patriarchally and gender norms reflect this bias towards men:

- Cultural and social norms often socialize males to be aggressive, powerful, unemotional, and controlling. This contributes to the “men as dominant” main narrative.
- Similarly, women must be passive, nurturing, submissive, and emotional. This reinforces women’s

roles as weak, powerless, and dependent on men.

- The socialization of both men and women has resulted in an unequal balance of power.
- In many societies, children learn that men are dominant and that violence is an acceptable means of asserting power and resolving conflict.
- Women as mothers and mothers-in-law unknowingly perpetuate violence by socializing boys and girls to accept men’s dominance and to meet their demands.
- Mothers and fathers teach their daughters to accept the roles that society assigns them.

11.3 GBV

In general, GBV refers to the violence that occurs between men and women, especially driven by the gender identities of the victim and the perpetrator. According to the UNFPA, GBV is violence involving men and women, in which the female is usually the victim; it is derived from unequal power relationships between men and women.

While there are cases of men who have suffered violence at the hands of women and her relatives/ friends and while these cases demand attention, there is staggering empirical evidence that shows that most cases of GBV are perpetrated by men on women.

The table below shows the different forms of partner violence and the different modes of expression:

FORM OF VIOLENCE	MODE OF EXPRESSION
Physical	Slaps, punches, attack with a weapon, femicide.
Sexual	Rape, coercion and abuse, including use of physical and verbal threats or harassment to have sex, unwanted touching or physical advances, forced participation in pornography or other degrading acts, such as anal sex.
Psychological/ emotional	Belittling the woman, preventing her from seeing family friends, intimidation, withholding resources, preventing her from working, or confiscating her earnings.

11.3.1 Adolescents are at Greater Risk of GBV

The following groups of adolescents are at a greater risk of GBV:

- Young people who live in extreme economic poverty.
- Young people who live separately from their parents.
- Young people with a physical or mental disability, or a mental illness.
- Young people who abuse drugs or alcohol.
- Young people who have family members who abuse drugs or alcohol.
- Orphans.
- Young people whose caregiver was physically or sexually abused as a child.
- Young people who live in a home where other forms of abuse or sex work occur, or with transient adults.
- Young people who are in a juvenile home or in jail.
- Young homosexual people who may be at greater risk because they are often socially marginalized.
- Young people who are vulnerable to homophobic or “corrective rape”.

11.4 Effects of GBV on adolescents and society in general

GBV threatens family structures and community cohesion in many ways. Unless properly addressed, GBV threatens the very existence of family units and communities that hold on to common customs and practices. Some of the effects of GBV are as follows:

- Children suffer emotional damage when they witness their mothers and sisters at the receiving end of GBV.
- Two-parent homes may break up, leaving the new female heads of household to struggle against increased poverty and negative social repercussions.
- The perpetrator may end up in jail for the abuses committed and where such individuals were breadwinners, the family is left exposed to greater poverty and difficulties.
- Traumatized children may fail to excel in their education, condemning them to the cycle of poverty.
- Conflicts among members of the community will threaten community unity if the perpetrator is a member of the same community (social or religious) as the victim.
- Stigmatization of victims, especially where the perpetrator is a respected family or community member.

In addition to these social challenges that affect victims of GBV, there are also severe psychological and health repercussions:

- Victims/survivors of gender violence may vent their frustrations on their children and others.
- Children, on the other hand, may come to accept violence as an acceptable means of conflict resolution and communication. It is in these ways that violence is reproduced and perpetuated.
- GBV can result in women’s deaths and injuries.
- Mental health problems resulting from trauma, alcohol and illicit drug abuse.
- Rise in HIV infection rates and suicidal attitudes.

A society characterized by GBV will spend more resources in fighting consequences of GBV than on development projects that empower its members. Religious leaders can take a central role in transforming people’s attitudes towards gender and GBV because the cost of inaction is high.

11.5 Religious Leaders against GBV

Religious communities may have been complicit in the abuses of children, adolescents and young people. Therefore, these communities can act to oppose all forms of GBV.

The following texts are important for recovering the “alternative man” while rejecting the “dominant man” that has led to much suffering. Through these examples and many more from the Bible and the Qur’an, religious leaders and faith communities can develop a new curriculum for socializing sons and daughters to embrace each other as equal.



11.5.1 Biblical texts that counter GBV

Genesis 1:26-28: God created all human beings in God's own Image to be partners in stewarding God's creation. No one is above the other.

Genesis 39: Joseph, when presented with an opportunity to be intimate with the Master's wife, runs away because it was wrong.

1 Samuel 20: Even when Jonathan stood to benefit from his father's hatred and desire to kill David, he opts to take the side of David because he saw that what his father was doing was wrong.

Jeremiah 8:18: The prophet mourns for his people, for he is overtaken by the grief that will soon befall his people. A man who cries for his people is indeed a great man.

In Matthew 19, Luke 7, 8 & 10 Jesus takes positions that were not associated with real men of his time, he accepted children and women and sent out his disciples in a vulnerable state, making them dependent and not independent.

Galatians 3:28: Paul clearly reiterates the equality established in creation by pointing out the insignificance of differences between men and women.

11.5.2 Qur'anic texts that counter GBV

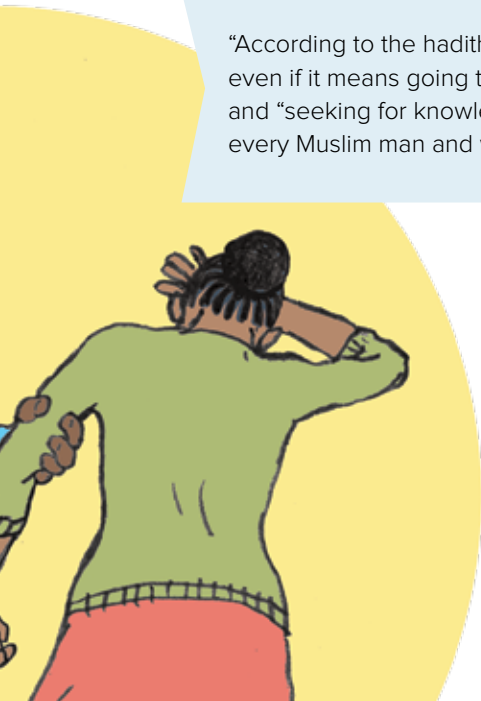
Qur'an 4:34: Men have a responsibility to provide food, shelter and education for their families. Fathers must, therefore, take sexuality education as one of their responsibilities to their children.

"The prophet (PBUH) said "wouldn't one of you be shy to beat his wife during the day and later coming to her in the night to ask for sex?"

"According to the hadith "seek for knowledge even if it means going to seek for it in China" and "seeking for knowledge is mandatory for every Muslim man and woman."

Qur'an 30:21 "And among His signs is this: that He created for you mates from among yourselves so that you may dwell in tranquility with them. He has put love and mercy between your hearts; in that are signs for those who reflect." "...either remain together on equitable terms, or separate with kindness..." (Qur'an 2:229) "...live with them on a footing of kindness and equity..." (Qur'an 4:19).

Quran 33:35, it states that men and women are equal, that the Qur'an was revealed equally for women.



Gender-Based Violence on Adolescents and Young People: Key Advocacy Points for Religious Leaders:

COMMITMENT	STRATEGIES
Make the problem of GBV a priority	<ul style="list-style-type: none"> • Always speak openly and consistently on the right of women and girls to be free from violence and worthy of respect. Emphasize gender equality in all aspects of social and economic life. Use passages from Sacred Texts that support this message. • Develop some easy-to-use but theologically-sound materials to share with your community on the subject. Teaching must be given to all: children, adolescents, young people, parents, guardians and community leaders.
Make the religious community a safe environment for victims and survivors of GBV	<ul style="list-style-type: none"> • Make the community a place of refuge for survivors and victims of GBV, embracing those that come to it, comforting them and assuring them that it is not their fault they have been abused. • Encourage community members to be trained on offering quality assistance and counselling services to survivors. • Create or collect and provide relevant information that addresses survivor concerns, such as referrals to healthcare providers, legal services and advocacy groups. • Proclaim zero-tolerance to GBV, equal treatment of women, and include information and activities on GBV into existing activities such as Bible studies and teachings for men's, women's and youth groups.
Outreach and Education	<ul style="list-style-type: none"> • Develop or collect relevant materials on GBV to initiate community-wide discussions on GBV, potential victims and likely perpetrators. • Integrate CSE in Sunday school (for children). • Create study and discussion groups through which GBV information will be channelled. Young people, adolescents, children and youths should be included. • Encourage community members to create support groups to defend, protect and assist survivors of GBV. • Encourage confidentiality to safeguard survivor's physical well-being, in cases where perpetrators can cause more and greater harm.
Life skills development for youths and adolescents	<ul style="list-style-type: none"> • Create or collect resources on life skills to be shared, learned and discussed with young people within the context of the religious tradition. • Staff and volunteers working with young people must be vetted to ensure that child abusers are not provided an opportunity to harm more young people. • Include young people in the design, implementation and evaluation of programs and activities that affect their lives and needs. • Train young people to constructively confront their peers about GBV in a supportive framework.
Partner with other service providers	<ul style="list-style-type: none"> • Actively seek out partnerships and networks with religious and secular allies, who are involved in GBV survivor service and advocacy. • Adopt and adapt resources of other religious and secular groups on GBV. • Collaborate with other institutions to facilitate the state protocols for the perpetrators of GBV, who must be held accountable for their misdeeds, irrespective of their status.



CHAPTER | 12

ALCOHOL AND SUBSTANCE ABUSE

CHAPTER 12: ALCHOL AND SUBSTANCE ABUSE

“And do not destroy yourselves by your own hands.”

Surah 2:195

“Wine is a mocker and beer a brawler; whoever is led astray by them is not wise.”

Proverbs 20:1

“Wisdom will save you from the ways of wicked men, from men whose words are perverse, who leave the straight paths to walk in dark ways, who delight in doing wrong and rejoice in the perverseness of evil, whose paths are crooked and who are devious in their ways.”

Proverbs 2:12–15

“Invite people to the way of your Lord with wisdom, and with beautiful preaching; reason with them in ways that are best and most gracious; for your Lord knows best who has strayed from His path, and those who are guided.”

Luke 2:52

12.1 Introduction

Drugs and drug abuse (including alcohol abuse) have emerged as major challenges for adolescents in contemporary families and societies. This chapter is devoted to the theme of drugs and drug abuse and the role of religious leaders in responding to these challenges.

12.2 Drugs and Drug Abuse

Understanding the reasons adolescents/youth start using drugs or alcohol, as well as their reasons for continuing or discontinuing use, is crucial to developing effective substance abuse interventions. Most teens cite that they use or abuse drugs due to social pressure and experimentation. The use, and more dangerously, the abuse of drugs, are increasing among adolescents/young people around the world.

Drug abuse is a maladaptive pattern of use of any substance that persists despite adverse social, psychological, or medical consequences. Three-quarters of all countries report heroin abuse and two-thirds report cocaine abuse. Drug abuse can develop into drug dependence, also known as addiction.

12.2.1 Physical Dependence

The hallmarks of physical dependence on a drug are tolerance and withdrawal. Tolerance occurs when the body adapts to the repeated effects of a drug so that higher doses are required to achieve the same effect. Physical addiction occurs if a withdrawal syndrome follows interruption of use of the drug.

Withdrawals occur because the user's body gradually becomes accustomed to high levels of the drug, and when the drug is withdrawn, the body must rapidly adjust to the sudden drop in the concentration of the drug.

12.2.2 Psychological Dependence

Psychological dependence involves an intense repetitive need or craving for the changes in feelings and mood that drugs provide.

12.3 Staying off Drugs

Teenagers should know that:

- You do not need to take drugs to be liked by other people.
- You do not need to take drugs to feel brave or courageous.
- You do not need drugs to cope with sorrow or disappointments.
- You do not need to take drugs to have fun.
- You have, inside you, the strength and inner resources to deal with any situation and any problem.
- Whatever problem you are facing, there are people available to help you. You can talk to a friend, a teacher, a parent, or a trusted person at your church or mosque.

Below are some ways young people can avoid getting involved with drugs
(Adopted from Watson and Brazier, 2009):

Get active:	Get involved in activities at your church/ mosque and in sport groups. These things will fill your time and will help you feel good about yourself. You won't be bored and you won't need to look to drugs for entertainment.
Respect Yourself:	Do not take drugs or alcohol to impress other people or to find the courage to do something. Respect yourself and other people will respect you, you will find the courage to do whatever you want to do.
Seek positive acceptance:	There are many ways to feel accepted and liked by other people and they are more beneficial than taking drugs or alcohol. Join groups of people who are focused on doing something like singing, playing sports, acting, studying, or helping people in the neighborhood. Find people who will like you for who you are and what you can do; people who are not wasting their time with drugs.
Have your own values:	Look at yourself. What are your values? What is right for you? Standup for yourself and what you believe in.
Have goals:	What are your dreams? Look into the future, see where you want to go and then go there.
Get help:	If you are feeling under pressure to take drugs, talk to a youth counselor. Get help. If you think you have a drug problem, try to find counseling and treatment. It is never too late.



DRUGS AND DRUG ABUSE: KEY ADVOCACY POINTS FOR RELIGIOUS LEADERS

- Recognise and appreciate the existence of the challenge of drugs and drug abuse among youths.
- Raise awareness of the challenge of drugs and drug abuse, especially within families and faith communities. Preaching, talks by professionals, and community theatre are awareness-raising strategies.
- Collaborate with other professionals to set up recovery centres.
- Invest in recreation activities for adolescents as a contribution to prevention against drugs and drug abuse.
- Work with adolescents' parents to curb drug abuse: "Prevention is better than Cure".



CHAPTER | 13

COUNSELLING

CHAPTER 13: COUNSELLING

“O mankind, indeed has come to you from your Lord and a healing lesson for diseases (which be) in the chest and guidance and mercy for the believers.”

Quran 10: 57

“You must understand this, my beloved: let everyone be quick to listen, slow to speak.”

James 1:19

13.1 Introduction

Adolescents, like people in other age groups, benefit from counselling. This chapter reflects on counselling practices like listening, refraining from advice-giving and collaboratively finding solutions to problems.

It is not about telling people what measures to take or not. It is also not about influencing the client to take this or that type of contraception nor about awareness creation or knowledge transfer. Counselling is non-judgmental.

13.2 What is Counselling?

Counselling is a two-way communication process where the service provider (in the context of this handbook, a religious leader) and the client (in the context of this handbook, the adolescent), are engaged in open discussions, understanding and exchanging ideas and learning from each other. Counselling is not providing advice to a person or just giving information.

In the context of sex and sexuality, counselling involves giving options to the client so that he/she can confidently respond to issues such as unintended pregnancy, STIs, and HIV and AIDS. Counselling can offer a space where creative solutions are found for an existing problem related to the client's sexual and reproductive health.



Counselling knowledge and skills are important instruments that help solve different adolescent sexual and reproductive health and rights (ASRHR) related problems. The most important thing is the need to be well informed about the issues, which are raised in the counselling session.

13.3 Who Provides Counselling Services?

Trained professionals usually give counselling. However, other people can be involved in counselling. These include:

- Religious leaders and adolescents/young people who have been trained in ASRHR issues.
- Those who have strong communication skills with some experience in peer education programs as peer educators.
- Youth leaders that have experience working with young people.
- Young people willing to serve as peer counsellors.

language) and adequate knowledge of ASRHR.

- Respect for the client's feelings, sympathy for their problems and the ability to be supportive.
- Belief in family planning services.
- Respect for an individual's belief system and values.
- Respect for the SRH rights of young people.
- Ability to maintain confidentiality.
- Knowledge of his/her role and responsibilities as a counsellor.
- Ability to listen and give attention to the client.
- Ability to ask questions that will help the client to openly reveal his/her feelings and needs.
- Ability to speak in the language of choice of the client.
- Ability to help the client to assess his/her own behaviors and identify components that lead to vulnerability of the client to SRH problems.

13.3.1 Characteristics and Skills of an Effective Counsellor

An effective counsellor should have, among others, the following characteristics and skills:

- Effective communication skills, (ability to communicate clearly and in ways that include body

13.3.2 Role of the Peer Counsellor

- Assisting the client/peer to make informed decisions by assessing the client's own personal behaviors and attitudes that make them vulnerable to unintended pregnancy and STIs.
- Identifying myths and facts about SRH issues with the client.
- Providing priority consideration to the needs and feelings of the client.
- Preparing and making supportive educational material, such as a penis model for condom demonstration and different types of contraceptives.
- Keeping simple records.
- Maintaining client confidentiality.
- Referring clients to ASRHR clinics/centers for further services if needed.

The counsellor should NOT

- Assume he/she knows what is best for the consulting client.
- Pressurize the client to accept his/her decision. The counsellor's role is to provide the most complete and accurate information.
- Act in a judgmental way.

13.3.4 Knowledge of the Counsellor

- The counsellor should have full knowledge about and the skills to explain:
 1. Reproductive organs and their functions;
 2. Sexuality and gender;
 3. Drug and drug abuse;
 4. STIs including HIV;
 5. Contraceptive methods;
 6. Life skills and how to refer clients to ASRHR services and the referral system;
 7. The peer counsellor needs to update her/himself with current issues and developments in the field.



It is not possible for the counsellor to provide answers to all questions that young people may raise. Therefore, when and if the counsellor faces questions for which the counsellor is not confident to answer, the counsellor should refer the client to a professional who can answer the question.

13.4 Procedures of Counselling Sessions

The counselling service requires a defined-skills set and has standard operating procedures. Accordingly, the counsellor needs to be trained to acquire these skills. As the service needs a favorable environment, the following are useful tips:

13.4.1 Creating an Appropriate Atmosphere for Counselling

Since counselling deals with individuals' personal issues, it needs to be carried out in a quiet and conducive atmosphere, without interruption or fear of invasion of privacy. Sit face to face with the client, with a fair, but natural distance between you. Allow the client to feel comfortable and ask questions. If you are conducting the counselling outdoors, make sure you choose a quiet place where you can sit.

Ensure the confidentiality of your conversation with the client. The counsellor should ask her/himself the following questions to make sure that he/she is ready to provide the service:

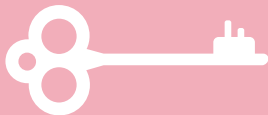
1. Am I ready to provide the service? (Knowledge and feeling wise)
2. Have I managed to create a favorable environment?
3. Can I provide enough attention without distraction?
4. Is the place I chose conducive enough for discussion?
5. Is the place clean and free of other people?
6. Do we have enough comfortable seats for the session?
7. Do I have enough forms for referral?
8. Do I have enough samples of contraceptive methods for demonstration purposes?
9. Do I have the models and pictures of the menstrual cycle, reproductive organs etc.?

13.4.2 Referral for specialist counselling

Referral is when a service provider sends a client to a higher level of health care because the client has a reproductive health problem or a need that the service provider is not able to meet.

All or any one of the following could be the reason for referring a client:

1. The service to be provided is not part of the service provider's job description.
2. The service provider has no expertise, training or technical ability to handle the situation.
3. To allow the person referred to get more appropriate services from a person with better technical expertise.
4. The service to be provided is not available.



COUNSELLING: KEY ADVOCACY POINTS FOR RELIGIOUS LEADERS

- Press for youth-friendly counselling services. This could include influencing political leaders to increase counselling services in their communities.
- Promote non-judgemental and youth friendly counselling within families and faith communities.
- Develop simplified counselling material for leaders of the various groups within faith communities. This handbook provides some basic tools and guidelines. Such material could be distributed through the channels offered by the faith communities.
- Be sensitive to the challenges facing adolescents living with HIV. Encourage support groups of adolescents living with HIV within the faith community.
- Be sensitive to the challenges facing adolescents living with disability. Develop deliberate programmes to reach out to adolescents living with disability.



GLOSSARY

Abstain:	To avoid doing something, for example abstain from sex or from drugs and alcohol.
Antenatal:	The period before birth, for example antenatal care is the care needed by a woman throughout pregnancy/before birth.
Caesarean section:	A medical operation to take the baby out of the uterus by making a cut in the woman's abdomen. This operation is performed when a woman is not able to deliver the baby through the vagina.
Cervical vault caps:	A soft rubber cap contraceptive method covering only the cervix.
Cervix:	The lower end of the womb that connects with the upper part of the vagina.
Cancroid:	Painful swelling and sores or ulcers around the genital area and inside the vagina.
Chlamydia:	An infection of the tissues lining the urethra and the opening of the womb with signs similar to those of gonorrhea.
Circumcision:	In a man: when the loose fold of the skin (foreskin) at the end of the man's penis is removed. In a woman: when part or all of the woman's genitals are removed.
Clitoris:	A small, sensitive organ above the vagina that responds to stimulation and makes sexual intercourse pleasurable.
Combined oral contraceptive:	The pill that contain both estrogen and progestogen hormones.
Condom:	A soft rubber tube that is put on a man's penis before sexual intercourse. Condoms provide protection against pregnancy and sexual transmitted diseases.
Contraceptive sponge:	A round sponge containing spermicide.
Diaphragm:	A shallow rubber cup with a rim inserted in the vagina as a barrier method.
Egg:	Ovaries produce an egg every month, which, if fertilized by sperm, will grow into a baby.
Ejaculation:	The release of semen from a man's penis.
Emergency contraception:	A contraceptive method that can be used to prevent pregnancy after unprotected sex, such as if the condom broke or slipped. It must be taken within a few days of unprotected intercourse.
Erection:	When the penis becomes hard and stiff as a result of feelings of sexual excitement.
Estrogen:	Female hormone produced by the ovaries, greatly influencing the growth, development, and function of the entire female body, and the reproductive organs, throughout a woman's life.
Fallopian tubes:	The two tubes that lead from the female ovaries to the uterus. After an egg is released from one of the ovaries, it travels down these tubes to the uterus.

Female circumcision	A traditional practice in which all or part of the female genitals is removed (it is known as FGM in some parts of the world). The practice has negative health consequences and is considered by many people to be a violation of girls' and woman's' rights.
Fertilization:	Is a process in which the sperm of a man finds and attaches itself to the egg released from the ovary.
Fistula:	It is usually caused by several days of obstructed labor, without timely medical intervention - typically a Caesarean section to relieve the pressure. The consequences of fistula are life shattering: The baby usually dies, and the woman is left with chronic incontinence. Because of her inability to control her flow of urine or faeces, she is often abandoned or neglected by her husband and family and ostracized by her community.
Gender:	Is socially determined or acquired characteristics, roles, and ideas, attitudes and beliefs that the culture of a society attributes to males and females.
Genitals:	The private parts; the external sexual organs.
Genital herpes:	Is a non-curable disease caused by a virus resulting in a painful, swollen blisters or sore on the penis is a man, and in the vagina of a woman. It can also cause sores in the anus.
Gonorrhea:	Is the most common STD that causes burning sensation when passing urine and a thick discharge from the penis. Some women have the same symptoms – pain with urination and discharge from the vagina.
HIV/AIDS:	HIV, or Human Immunodeficiency Virus, is the virus that causes AIDS. This term is often used because infection with HIV eventually leads to AIDS without treatment, which is the Acquired Immuno Deficiency Syndrome. A person has AIDS (rather than just being infected with HIV) when the immune system gets so weak it can no longer fight off common infections and illnesses.
Hormones:	(As related to reproductive organs.) Hormones are chemical elements such as estrogen and progesterone produced by the female body or artificially that greatly influence the growth, development and function of the entire body.
Implantation:	Indicates the process in which the fertilized egg moves from the fallopian tube into the womb and attaches itself to the lining of the womb.
Implants (Norplant):	A contraceptive method in which six small thin plastics tubes containing a hormone that prevents ovulation are placed in the upper arm of the woman through a minor operation.
Injectable:	Long acting injection containing hormones (artificial) that prevent ovulation. It is given to a woman every 2-3 months.
Intrauterine devices:	Are plastic devices inserted into the womb through the vagina by a trained person. They are left in place to prevent pregnancy for up to five years after insertion.
Labia majora	Are the outer folds of skin of the female genitals that are thick and covered with hair.

Labia minora:	Are the two thin inner folds of skin that cover and protect the vaginal opening and form a hood around the clitoris.
Learning cycle:	Is a participatory experiential learning process that starts with identifying and sharing experiences, goes to analysis of causes and effects and then passes to planning and action. Through this action a new experience is created and thus the learning starts again making the cycle complete.
Learning heads:	The principle of participatory learning that proposes the use of the mind, hands and emotions in the process of the learning cycle.
Life skills:	Personal abilities, competencies or social skills that enable us to deal effectively with the demands of the everyday life, including sexual life.
Lining of the womb:	The wall surrounding the inside of the womb.
Menarche:	The time at which the menstrual periods start, usually between the ages of 12 and 15 years.
Menopause:	The age at which the menstrual period ends, usually between the ages of 40 and 50 years.
Menstruation:	Also called menstrual period or monthly period, the flow of blood and tissue from the uterus out of a woman's body, usually occurring every 28 days. Menstruation starts during adolescence and ends between the ages of 45 to 55.
Mime:	To mime is to act without speaking, using body movement.
Natural methods:	Methods that do not involve contraception involving sexual abstinence during the time of the month when ovulation occurs, with no devices or drugs used.
Ovaries:	Two female internal reproductive organs that produce the egg. They are of the size of a small nut and are placed on either side of the womb.
Ovulation:	The release of an egg from one of the ovaries. It usually occurs 14 days before the next menstrual period.
Ovum, Ova (plural):	A female egg cell, which, when released from a woman's ovary, may be fertilized by a man's sperm.
Pelvic:	The bone parts of the female body that protects the reproductive organs.
Pelvic Inflammatory disease:	An infection of female reproductive organs causing constant lower abdominal pain, painful menstruation and menstrual disorders, fever and bad smelling of vaginal discharge.
Penis:	The male sex organ, also used to pass urine.
Postnatal/postpartum:	The time after childbirth or delivery.
Progestogen:	Female hormone produced by the ovaries, greatly influencing the growth, development, and function of the entire female body, especially the reproductive organs, throughout a woman's life.

Progestogen-only pills:	Oral contraceptive pills that contain only progestogen hormones.
Puberty:	The period of life when a person changes physically from a child into an adult, usually between 10 and 16 years of age.
Scrotum:	A sac of skin in front of and between the thighs of a male that holds the testes.
Semen:	A liquid that is produced by the man's reproductive organs and carries the sperm through vas deferens and out of the penis.
Seminal vesicles:	Two glands in the male reproductive system where semen is made.
Sex:	Sex, as opposed to gender, is an inborn or biologically determined characteristic or role of man and woman that cannot change: a woman can menstruate, become pregnant and breastfeed and a man can impregnate: not vice versa. Sex refers to anatomy. Not all women can become pregnant and not all men can impregnate.
Sperm:	Male reproductive substance, similar to the female egg, which is produced in testes and released into the vagina in millions when ejaculating during sexual intercourse.
Spermicide:	Chemical contraceptives, such as creams, jellies, foam, tablets, suppositories.
Sterilization:	Is small cuts of vas deferens in male or cutting of each fallopian tube and tying them in females.
SDGs:	Sustainable Development Goals refer to global development targets and aspirations.
STIs/STDs:	Sexually transmitted diseases or infections which are passed from one person to another through sexual contact.
Syphilis:	Is an STD caused by germs and transmitted during sexual intercourse with an infected person. It develops in three stages: 1. consists of a small and painless sore in the genital area or vagina. 2. Is marked by fever and pain in the bones and muscles. 3. May appear after as long as 15 or 20 years.
Testes:	Are two egg-shaped internal reproductive organs of a male located in front of and between the thighs within a sack of skin known as the scrotum. Testes produce the sperm from puberty until old age.
Traditional Methods:	Cultural practices used as contraceptives, such as charms, spells, tying a string or amulets around the waist, drinking teas from certain leaves or roots, or eating certain food or taking holy water.
The tools of planning:	A technique of planning using the adverbs Why? What? Who? How? When?
Trichomonas:	Is an STD caused by germs or bacteria. The signs are increased fluid from the vagina, fluid that looks frothy and causes itching and pain during urination.
Tubal Ligation:	Female sterilization in which the fallopian tube is cut in two and tied.
Urethra (as in males):	A tube through which both semen and urine pass through into the penis.



Uterus: Is the womb, which is about the size of small mango or it is about nine centimeters long, and weighs only 60 grams. The fertilized egg attaches itself to the lining on the inside of the womb.

Vagina: Is the channel between the womb and the outside of the body. Menstrual blood flows out of the womb through the vagina. The vagina is the “birth canal”: During childbirth the baby leaves the womb and enters the world through the vagina, the wall of which is elastic and can stretch to allow the passage of the baby’s head and body.

Vas deferens: A tube through which the sperm produced in testes passes and enters the penis.

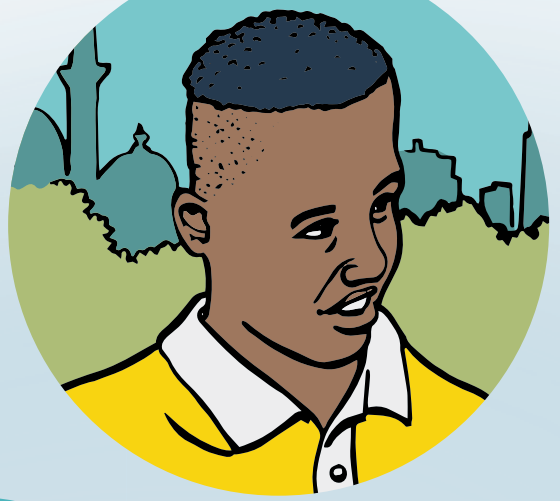
Vulva: Is the area around the opening of the vagina, which can be seen from the outside.

Vasectomy: Male sterilization performed by making a small cut in the vas deferens.



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Girls are
not a
source of
income

Religious leaders
should be models in
ending Gender-based
violence

Teenage
pregnancies
are our
collective
failure

A criança decide
sobre a seu futuro

Act for the
African
Child:
Say No
to child
marriage

Children's
rights should
be honoured by
saying No
to child
marriage

Gender based
violence is abuse
against
society

Tolerancia Zero:
ao abuse de
menores

Violence
against youth
of both gender
is abuse
against
society

Casamento
das Crianças

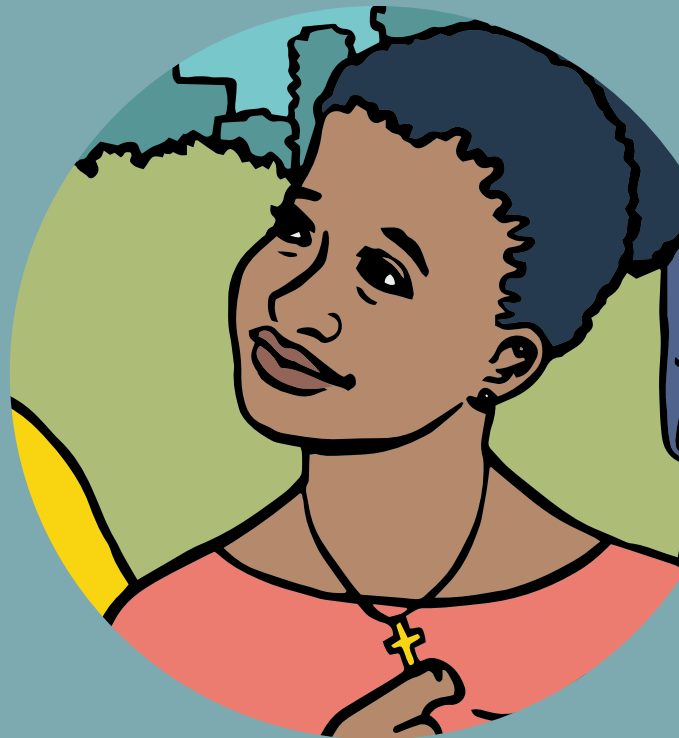
There's
no rush:
enjoy your
childhood

#Religious leaders
have the power to stop
teenage pregnancies –

ACT NOW!

Garder les
filles à l'école
met fin au
mariage
des
enfants





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SAVE THE CHILDREN SWEDEN

Adolescent Sexual Reproductive
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