United Nations
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REGIONAL MODULE FOR

Teacher Training on Comprehensive Sexuality Education for East and Southern Africa

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Regional Module for Teacher Training on Comprehensive Sexuality Education for East and Southern Africa

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TABLE OF CONTENTS

ABBREVIATIONS

AIDS	*Acquired Immune Deficiency Syndrome*
CSE	*Comprehensive Sexuality Education*
HIV	*Human Immunodeficiency Virus*
UNAIDS	*United Nations Joint Programme on HIV/AIDS*
UNESCO	*United Nations Educational, Scientific and Cultural Organization*
UNFPA	*United Nations Population Fund*
WHO	*World Health Organization*

BACKGROUND

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 and to build decision-making, communication and risk reduction skills about many aspects of sexuality.

Source: UNESCO. International Technical Guidance on Sexuality Education. An evidence-informed approach for schools, teachers and health educators. Paris: UNESCO, 2009.

The primary goal of sexuality education is to equip children and young people with the knowledge and skills to make responsible choices about their sexual and reproductive health—an urgent responsibility within the region where HIV prevalence among young people remains very high and where ignorance and misinformation can be life-threatening.

Sexuality education seeks to:

- Increase knowledge and understanding
- Explain and clarify feelings, values and attitudes
- Develop or strengthen skills; and
- Promote and sustain risk-reduction behavior

Studies show that effective sexuality education programs can:

- Reduce misinformation
- Increase correct knowledge
- Clarify and strengthen positive values and attitudes
- Increase skills to make informed decisions and act upon them
- Improve perceptions about peer groups and social norms
- Increase communication with parents or other trusted adults

In addition, research shows that sexuality education programs can help to:

- Abstain from or delay the debut of sexual relations
- Reduce the frequency of unprotected sexual activity
- Reduce the number of sexual partners
- Increase the use of protection against unintended pregnancy and STIs during sexual intercourse.

School settings provide an important opportunity to reach large numbers of young people with sexuality education before they become sexually active, as well as offering an appropriate structure within which to do so. Equipping teachers with the knowledge, skills and comfort level for effectively delivering sexuality education is critical to leverage such opportunity. Preparing teachers to deliver sexuality education will help ensure that learners receive accurate and age-appropriate information that will help guide them through adolescence and enable them to make responsible decisions that impact their current and future sexual and reproductive health and overall well-being.

ASSUMPTIONS, PURPOSE AND OVERVIEW OF THE MODULE

In line with the International Technical Guidance on Sexuality Education developed by UNESCO, UNFPA, WHO and UNAIDS, this document is based upon the following assumptions:

- Sexuality is a fundamental aspect of human life: it has physical, psychological, spiritual, social, economic, political, and cultural dimensions.
- Sexuality cannot be understood without reference to gender.
- Diversity is a fundamental characteristic of sexuality.
- The rules that govern sexual behavior differ widely across and within cultures. Certain behaviors are seen as acceptable and desirable while others are considered unacceptable. This does not mean that these behaviors do not occur, or that they should be excluded from discussion within the context of sexuality education.

The module was developed as a resource to support pre-service training of teachers for the delivery of school-based sexuality education in East and Southern Africa. Designed for trainers who are delivering pre-service training on sexuality education in the region, the material provides a core set of lesson plans to equip teachers with the basic knowledge and skills necessary to deliver effective sexuality education in the classroom. While the material is focused on training teachers for school-based sexuality education, the material can be adapted to out-of-school environments. Further, given the importance of local realities within which sexuality education is being delivered, trainers are encouraged to further adapt the lessons to their particular country contexts where possible. Examples of such opportunities for adaptation are noted within the material.

The module includes nine core sessions lasting approximately 38 hours, requiring a total of 42 hours in its totality, inclusive of "stepping out" time described further below. Trainers can use the module to tailor trainings according to the number of days/hours available for training teachers. A 5-day sample training agenda is included in Appendix I.

The nine core sessions in the module are as follows:

1. Introductions and Launch of the Training
2. Adolescent Sexual and Reproductive Health in East and Southern Africa
3. Talking About Sexuality Education
4. Getting Ready to Teach Sexuality Education
5. Effective Teaching Methodologies for Sexuality Education
6. Knowing Your Content
7. Classroom Management
8. Application, Practice and Resources
9. Understanding Human Rights Agreements, Legal, and Professional ethics

Each session includes activities that specify learning objectives, total time required, materials and resources needed, and instructions.

The core sessions are significantly informed by the *National Teacher Preparation Standards for Sexuality Education* developed by FoSE in the United States. These standards were developed to identify areas of competency necessary for teachers to effectively teach sexuality education, listed below:

National Teacher Preparation Standards for Sexuality Education by FoSE

Standard 1: Professional Disposition

Teachers demonstrate comfort with, commitment to, and self-efficacy in teaching sexuality education.

Standard 2: Diversity and Equity

Teachers show respect for individual, family, and cultural characteristics and experiences that may influence student learning about sexuality.

Standard 3: Content Knowledge

Teachers have accurate and current knowledge of the biological, emotional, social, and legal aspects of human sexuality.

Standard 4: Legal and Professional Ethics

Teachers make decisions based on applicable laws, regulations and policies, as well as professional ethics.

Standard 5: Planning

Teachers plan age- and developmentally-appropriate sexuality education that is aligned with standards, policies, and laws and reflects the diversity of the community.

Standard 6: Implementation

Teachers use a variety of effective strategies to teach sexuality education.

Standard 7: Assessment

Teachers implement effective strategies to assess student knowledge, attitudes, and skills in order to improve sexuality education instruction.

NOTES ON THE TRAINING STRATEGY

The training module is highly participatory and relies on modeling activities, integration of critical assessment of activities throughout the training, called "Stepping Out," and ultimately application and practice (Teach Backs).

Modeling

Throughout the training, activities are "modeled" so that while teachers are participants in the training, in so doing, they are experiencing good practice for delivering sexuality education. The session "Knowing Your Content" is especially important for modeling good practice as trainers are delivering sexuality education to teachers while using activities that can be applied in the classroom. In addition, lesson plans provided for the "Teach Backs," allow teachers to practice their skills and apply what they have observed through modeling and assessment of activities until that point. Further, these lesson plans focus on core sexuality education content, thereby also serving to educate teachers on key topics peer–to–peer.

Stepping Out

To facilitate reflection by teachers on activities used throughout the training, teachers will "step out of" and analyze after experiencing these in the training. As part of this pre–service training, not only will teachers be learning content that is important for them to master in order to deliver sexuality education in the classroom, but as they learn content, they will also be learning skills and techniques for delivering such content in the classroom by observing the trainers.

For each activity delivered during the training, teachers will be asked to literally "step out" of that activity to analyze the trainer's process in facilitating that activity so that they can analyze it and apply what they have observed in their own classrooms. The questions that teachers will be asked to answer include the following and are located in the handout "Stepping Out" to be distributed on the first day of the training.

SESSION ONE

Introductions and Launch of the Training

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Identify particular aspects about their colleagues, including family, preferences, experiences, and interests.
2. Articulate their own expectations for the training.
3. Describe the goal, objectives, and main content areas and strategies of the training.
4. Agree upon ground rules for the training.

ACTIVITIES

Activity 1 Find Someone Who

Activity 2 Expectations and Review of Training Goal, Objectives and Agenda

Activity 3 Ground Rules

Activity 1: Find Someone Who

TOTAL TIME REQUIRED

30 minutes

MATERIALS NEEDED

- ✔ Pens or pencils

RESOURCES NEEDED

- ✔ Find Someone Who Handout

LEARNING OBJECTIVES

By the end of the activity, teachers will be able to:

1. Identify particular aspects about their colleagues, including family, preferences, experiences, and interests.

INSTRUCTIONS

1. Tell teachers that the purpose of this activity is to get acquainted with each other.
2. Keep it light, use humor, and have fun.
3. Distribute the Find Someone Who handout and tell teachers that you will be asking them to get up, move around the room, and introduce themselves to others in order to find colleagues that fit the statements noted on the sheet.
4. Indicate that when they find a colleague that can relate to a statement, to ask for their signature beside it and learn a bit about them. Tell teachers that they should move around the room fairly quickly to engage with different colleagues in order to obtain a mix of signatures across the different statements and to fill the sheet.
5. Let teachers know that you will be asking for a few volunteers at the end of the activity to share some things that they learned about their colleagues, so be sure to only share information about yourself that you would be comfortable sharing with the whole group.
6. Give teachers 10 minutes to collect a signature for every statement.
7. After about 10 minutes, call time and ask teachers to take their seats.
8. Ask teachers the following questions:
   - ✔ How did it feel to participate in this activity?
   - ✔ What are some things that you noticed while participating in this exercise?
   - ✔ What are some things you learned about your colleagues? What was funny, interesting, or similar or different to your own experiences?
   - ✔ How might this exercise be useful to the work that you do in the classroom?
9. Conclude the activity by noting that getting to know each other and doing so in a fun, active way is important to establishing a positive learning environment.

Adapted from Life Planning Education, Advocates for Youth. 2014.

Find Someone Who...

STATEMENT	SIGNATURE
Has sisters or brothers. If yes, how many, what ages?	
Has broken a bone. If yes, which one?	
Wishes that they were a different age? If so, what age and why?	
Has a favorite singer, actor or writer? If yes, who?	
Thinks it is sometimes hard to say "No" to their friends? If so, when/why?	
Loves something about the work that they do. What is it/why?	
Would have a favorite subject if they were in school today. What would it be/why?	
Had a teacher they really liked when they were in school. Why?	
Has children. How many/what ages?	
Thinks that sexuality education is important for young people's health and well-being. If so, why?	
Speaks more than one language—if so, which ones?	
Would enjoy traveling to a place they have never been to. Where would it be/why?	
Feels proud of something they did recently. What was it?	

Adapted from Life Planning Education, Advocates for Youth. 2014.

Activity 2: Expectations and Review of Training Goal, Objectives, and Agenda

TOTAL TIME REQUIRED

1 hour

MATERIALS NEEDED

- ✔ Flip chart
- ✔ Markers

RESOURCES NEEDED

- ✔ Copies of the Agenda
- ✔ Stepping Out Handout

LEARNING OBJECTIVES

By the end of the activity, teachers will be able to:

1. Articulate their own expectations for the training.
2. Describe the goal, objectives, and main content areas and strategies of the training.

INSTRUCTIONS

Sharing expectations

1. Tell teachers that the purpose of this activity is for them to share their expectations for this training so that facilitators can seek to ensure that these are met and/or clarify where the scope of the training may differ from expectations.
2. Lead a brainstorm by asking teachers to share the expectations that they have and write these down on flip chart paper.
3. Summarize the expectations and indicate that next we will go over the training goal and objectives and see how these align with the expectations.

Review training goal, objectives, strategies and agenda

4. Review the training goal, objectives, and strategies for the training. Begin by stating the goal of the training followed by the objectives and agenda. You can do this by asking teachers to take turns reading off the agenda.
5. Next explain the purpose and describe the Stepping Out method through which teachers will "step out" of each activity to assess the delivery of the activity and reflect on its use/relevance to their work.
6. Lastly, note/reference expectations match the program and indicate if there are any expectations that will not be addressed in the training.
7. Negotiate any adjustments to the schedule.
8. Review housekeeping issues and answer any questions.

Stepping Out Handout

As part of this pre–service training, not only will you be learning content that is important for you to master in order to deliver sexuality education in the classroom, but as you learn this content, you will also be learning skills and techniques for delivering such content in the classroom.

For each activity that you engage in, you will literally "step out" of that activity to analyze the trainer's process in facilitating that activity so that you can apply what you observe to your own teaching in the classroom. Questions to ask yourself are:

1. Did the trainer note the purpose of the activity? Was the goal clear?

2. What types of activities did the trainer use?

3. What AV equipment, props or materials were used?

4. How was the room set up?

5. What preparation do you think the trainer did before leading the activity?

6. Why do you think this activity was placed at this point in the agenda?

7. What questions did the trainer ask at the end? What kind of questions were these?

8. Did the trainer offer concluding remarks?

9. If you were to do this activity, would you do anything differently?

10. How would you adapt the activity to your situation/conditions in the classroom?

Adapted by Advocates for Youth, 2014, from, "ZOOM!," developed by Rutgers University and the Adolescent Pregnancy Prevention Campaign of North Carolina.

Activity 3: Ground Rules

TOTAL TIME REQUIRED
15 minutes

MATERIALS NEEDED
- ✔ Flip chart
- ✔ Markers

RESOURCES NEEDED
- ✔ None

LEARNING OBJECTIVES
At the end of the activity, teachers will be able to:

1. Agree upon ground rules for the training.

INSTRUCTIONS
1. Indicate that identifying ground rules is especially important when training on sexuality education because topics can be sensitive and personal.

2. Lead a brainstorm by asking teachers to share ground rules by which they would like to abide during the training. If not mentioned, be sure to include the following:

- ✔ To respect each other
- ✔ To agree to disagree
- ✔ To commit to this being a confidential space—in other words personal stories that are shared in the room, stay in the room
- ✔ To use "I" statements when expressing opinions, rather than “we” or generalized statements
- ✔ To not be judgmental

3. Conclude by thanking teachers for their participation and noting the important work that will follow to build knowledge, skills, comfort, and capacity to deliver quality sexuality education.

SESSION TWO

Adolescent Sexual and Reproductive Health in East and Southern Africa

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Describe youth sexual and reproductive health trends in the region.
2. Articulate at least three sexual and reproductive health statistics related to young people in the country.
3. Describe at least three sexual and reproductive health challenges facing young people in their local community.

ACTIVITIES

Activity 1 Overview of Adolescent Sexual and Reproductive Health in East and Southern Africa

Activity 2 Overview of Adolescent Sexual and Reproductive Health in the Country

Activity 1: Overview of Adolescent Sexual and Reproductive Health in East and Southern Africa

TOTAL TIME REQUIRED

30 minutes

MATERIALS NEEDED

- ✔ Projector
- ✔ Laptop computer

RESOURCES NEEDED

- ✔ PowerPoint on Youth Sexual and Reproductive Health Snap Shot, East and Southern Africa
- ✔ Pages 12–20 in Young People Today. Time to Act Now, by UNESCO, located here: *http://unesdoc.unesco.org/images/0022/002234/223447e.pdf*

LEARNING OBJECTIVES

By the end of this activity, teachers will be able to:

1. Describe youth sexual and reproductive health trends in the region.

INSTRUCTIONS

1. Explain that you are going to start off by sharing an overview of adolescent sexual and reproductive health in the region so that teachers can get a sense of some of the main trends impacting adolescents' lives as it relates to their sexual and reproductive health and rights.
2. Present the PowerPoint and facilitate discussion with teachers either as you go along or at the end of the presentation.
3. If possible, provide teachers with the indicated pages from the second resource.

Youth Sexual and Reproductive Health Snap Shot East and Southern Africa Region

Youth Sexual and Reproductive Health Indicators

- 33 percent of the population in the region is aged 10-24
- Age of sexual debut varies—anywhere from before 15 to around 17-18
- Adolescent pregnancy rates are high: by age 17-20% of young women started child bearing in 6 of the 21 countries
- 34 percent of women aged 20-24 are married by age 18
- Sexual and gender based violence is a reality for many young people

HIV in the Region

- In 2011, there were an estimated 1.2 million new HIV infections compared to 1.7 million in 2001. Declining trends are attributed to:

  - ✓Natural course of the HIV epidemic
  - ✓Changes in sexual behaviour (especially among young people in most countries in the region)
  - ✓Much wider access to ART
  - ✓Progress in preventing new HIV infections among children
  - ✓Levels of reported condom use have been increasing
  - ✓Declines in the number of multiple sexual partners

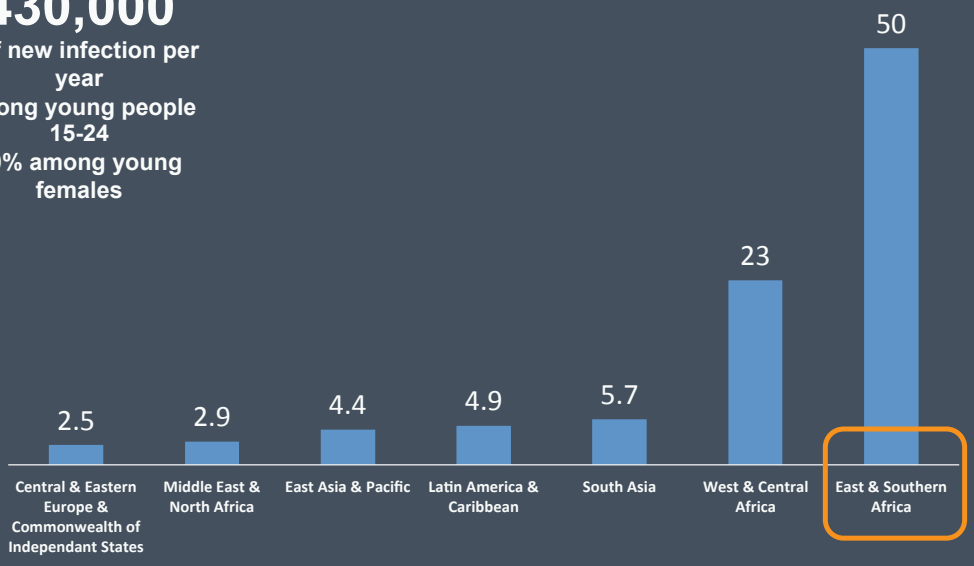
HIV and Young People in the Region

- HIV prevalence among 15 to 24 year olds has decreased by more than a third between 2001 and 2010.
- However the number of new infections is still high
- 430,000 young people infected with HIV per year
  - 50 young people infected per hour
  - Young women up to 2.5 x more affected
- Young people's knowledge levels on HIV remain low with less than 41% having sufficient knowledge on HIV prevention

12/21/15

New HIV Infections Among Young People, by Region

430,000
# of new infection per year among young people 15-24
60% among young females

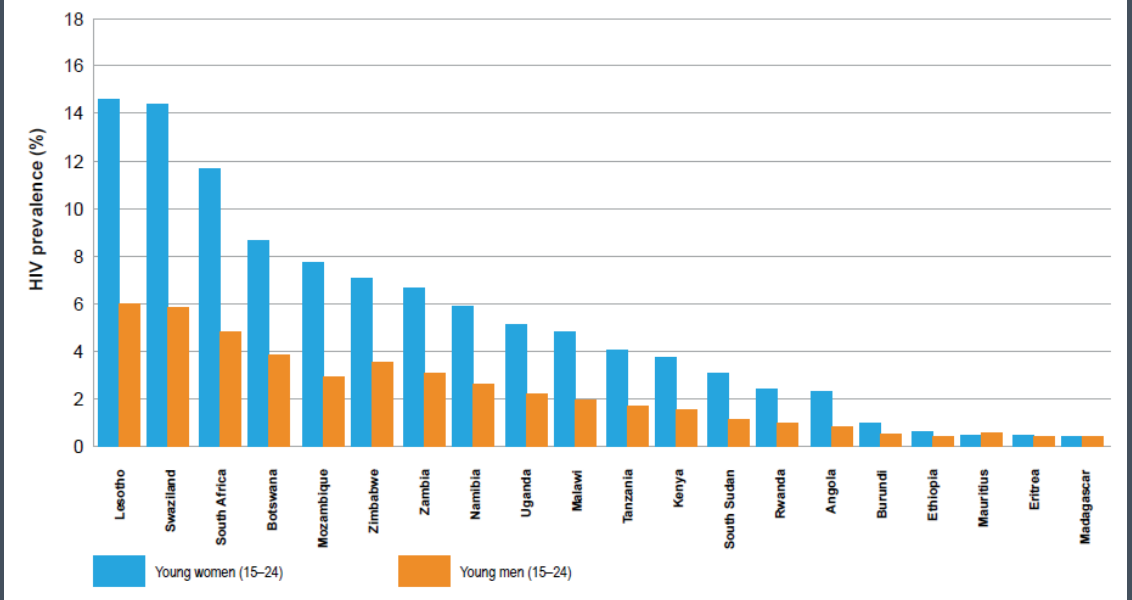


12/21/15

Regional Support Team for Eastern and Southern Africa

UNAIDS 2012, ESA Report

Estimated HIV prevalence among young women and men (aged 15-24 years) in eastern and southern Africa, 2011
Source: UNAIDS



In Summary

While there is variation across countries, in the region there are:

- High levels of unintended pregnancy among adolescent girls and young women
- Early childbearing that puts adolescent girls and young women at risk of maternal mortality and morbidity
- High levels of sexually transmitted infections, including new HIV infections among youth, especially adolescent girls and young women
- Sexual and gender-based violence and persistent gender inequality

Sources

- Machawira, P. PowerPoint presentation entitled Comprehensive Sexuality Education in Eastern and Southern Africa Region, 2013.
- UNESCO, Young People Today. Time to Act Now. Paris: UNESCO, 2013.

Activity 2: Overview of Adolescent Sexual and Reproductive Health in the Country

TOTAL TIME REQUIRED

30 minutes

MATERIALS NEEDED

- ✔ Pens/pencils
- ✔ To be determined by guest speaker

RESOURCES NEEDED

- ✔ Pre-prepared quiz based on the country profile within the resource below.
- ✔ Country Profiles on Adolescent Sexual and Reproductive Health and Sexuality Education in Young People Today. Time to Act Now, by UNESCO located here: *http://unesdoc.unesco.org/images/0022/002234/223447e.pdf*

LEARNING OBJECTIVES

By the end of this activity, teachers will be able to:

1. Articulate at least three sexual and reproductive health statistics related to young people in the country.
2. Describe at least three sexual and reproductive health challenges facing young people in their local community.

INSTRUCTIONS

1. Prior to this activity, invite a resource person with expertise in sexual and reproductive health to present country-based information on adolescents. If this is not possible, prepare a short true/false quiz using information from the country profiles in the resource noted here. List 5–10 statements and mix them up so that some are true and some are false. Be sure to include statements on sexual and reproductive health, behaviors, and services.

2. Explain that now that you have a basic understanding of adolescent sexual and reproductive health issues within the region, we will take a closer look at adolescent sexual and reproductive health at the country level.

3a. If you have a guest speaker, introduce them and indicate the purpose of their visit, which is to share information about sexual and reproductive health as it relates to adolescents in the country. Either as part of the visitor's presentation or thereafter, facilitate a brief discussion asking teachers to share what sexual and reproductive health challenges they see young people facing in their communities. At the end of the visit, thank the speaker and if necessary, summarize the main points raised during the activity. Distribute any handouts that the guest speaker may have brought.

3b. If you do not have a guest speaker, introduce the quiz activity by indicating that teachers will be taking a true/false quiz in groups to better understand sexual and reproductive health among adolescents in the country.

- Ask teachers to count off in order to form teams of five.
- Distribute the quiz and ask the teams to take 15 minutes to discuss and complete the quiz.
- Call time and ask for a volunteer group to share their answer to the first true/false statement. If the answer is wrong, ask if any other groups would like to share their answer if it was different. If no group has the correct answer, give the correct answer.

Activity 2: Overview of Adolescent Sexual and Reproductive Health in the Country

INSTRUCTIONS (CONTINUED)

- Continue this process until all of the statements have been reviewed, with the correct answer provided.
- Next, facilitate a discussion asking teachers to share what sexual and reproductive health challenges they see young people facing in their communities.

4. At the end of the activity, ask the following questions:

- ✔ What was it like to take this quiz and reflect on challenges facing young people in your community?
- ✔ What did you notice as your group was working to complete the quiz?
- ✔ What lessons can you draw from working on the quiz and from the discussion?
- ✔ What can teachers and schools do to address these needs of young people considering how much time they spend in school?

5. Conclude by noting some of the key findings identified in the true/false statements, with particular attention to any surprising information. Underscore that these challenges that adolescents are facing, such as unintended pregnancy, HIV, gender–based violence, and lack of information and services are what makes sexuality education all the more important and a responsibility that they can deliver on as teachers.

6. If possible, provide teachers with the resources noted above as handouts.

SESSION THREE

Talking About Sexuality Education

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Define sexuality education and describe its benefits.
2. Locate at least four learning objectives by age–range and topic in the International Technical Guidance on Sexuality Education.
3. Appreciate efforts undertaken to date to advance school–based sexuality education and describe the status of its implementation.
4. Share and acknowledge some of the social cultural and contextual factors that can impact sexuality education.
5. Correct at least three common myths about sexuality education.

ACTIVITIES

Activity 1 Defining Sexuality Education and its Benefits

Activity 2 International Technical Guidance on Sexuality Education

Activity 3 Review of Sexuality Education Country Curriculum and Framework

Activity 4 Discussion on Social Cultural and Contextual Realities and their Impact on Sexuality Education

Activity 5 Debunking Myths About Sexuality Education

Activity 1: Defining Sexuality Education and Its Benefits

TOTAL TIME REQUIRED

1 hour

MATERIALS NEEDED

- ✔ Flip chart
- ✔ Markers
- ✔ Projector
- ✔ Laptop computer

RESOURCES NEEDED

- ✔ PowerPoint on Sexuality Education

LEARNING OBJECTIVES

By the end of this activity, teachers will be able to:

1. Define sexuality education and describe its benefits.

INSTRUCTIONS

1. Explain that now that everyone has a sense of some of the sexual and reproductive health challenges facing young people in the region and in the country, let's take a moment to define and talk about one of the things that schools can do to address these challenges—that is, provide comprehensive sexuality education.
2. Divide teachers into groups of five and give each group a flip chart with markers. Ask each group to take 15 minutes to brainstorm how they would define sexuality education and to note these on a flip chart. Let teachers know that you will be asking for volunteers to share what they have come up with.
3. Call time and ask for a group to volunteer to post their flip chart on a wall and share their definition. Once they have done so, ask the remaining groups to follow and circle similarities within definitions as each group presents.
4. Summarize by crafting a definition that encompasses the various contributions and say that now we will see how it is defined in the International Technical Guidance on Sexuality Education and review the benefits of sexuality education and the purpose of the International Technical Guidance using the PowerPoint.
5. Ask participants if they think that the content they identified is in line with the definition and lead a discussion requesting their perspectives/observations along these lines.
6. Conclude the PowerPoint by noting that having a clear, common definition of sexuality education and understanding of its breadth and benefits is important for teachers responsible for delivering sexuality education in order to be informed about what it means and the positive outcomes it can bring to learners.

Sexuality Education

Sexuality Education

- Sexuality Education provides young people with age-appropriate, scientifically accurate, non-judgemental, and culturally relevant information and opportunities to explore attitudes, practice decision-making, communication, and other skills needed to make informed decisions about their sexual and reproductive health and well-being.

Sexuality Education

Why is sexuality education needed?

- Lack of adequate preparation among learners for their sexual lives
- Resulting vulnerability to unintended pregnancy, STIs, and coercion
- Right to sexual and reproductive health information and services

Sexuality Education

What is sexuality education for?

- To equip learners with the knowledge and skills to be able to make responsible decisions about their sexual and reproductive health.

Benefits of Sexuality Education

- Reduction of misinformation
- Increased correct knowledge about sexuality, relationships and HIV
- Clarified and strengthened positive values and attitudes
- Increased skills to make informed decisions and act on them
- Improved perceptions about peer groups and social norms
- Increased communication with parents and other adults

Impact of Sexuality Education

Good quality and well implemented sexuality education programmes have been shown to:

- Delay initiation of sexual activity
- Reduce frequency of unprotected sexual activity
- Reduce number of sexual partners
- Increase use of protection against unintended pregnancy and STIs
- Foster empowerment of girls and women and greater gender equality

International Technical Guidance on Sexuality Education

- To address the absence of international standards in sexuality education;
- To provide an evidence-informed justification for sexuality education and to strengthen existing sexuality and HIV education programmes

Use of Volume I and Volume II of the Guidance

Volume I provides a **wealth of evidence** to show that comprehensive sexuality education does no harm and has many benefits

Volume II provides guidance for curriculum development on sexuality education, organized by six key concepts and by age (5-8; 9-12; 12-15; 15-18)

What is the International Technical Guidance?

A set of international standards –

- ✓ Motivated by the **urgent need to address the knowledge gap on HIV prevention** amongst young people
- ✓ **Based on the most current evidence on the impact of sexuality education** programmes on sexual behaviour
- ✓ Developed with a **comprehensive approach** to sexuality education – and includes attention to **human rights** issues and **gender**
- ✓ Providing a global template that can be **adapted to national needs**

Assumptions for the Guidance

- **Sexuality is a fundamental aspect of human life:** it has physical, psychological, spiritual, social, economic, political, and cultural dimensions.
- Sexuality cannot be understood without reference to **gender**.
- **Diversity** is a fundamental characteristic of sexuality.

Assumptions for the Guidance

- The rules that govern sexual behaviour differ widely across and within cultures. Certain behaviours are seen as acceptable and desirable while others are considered unacceptable. This does not mean that these behaviours do not occur, or that they should be excluded from discussion within the context of sexuality education.

What is inside Volume II?

Key Concept 1: Relationships *Friendship, love, romantic relationships, parenting*	**Key Concept 2: Values, Attitudes and Skills** *Values, decision-making, communication*	**Key Concept 3: Culture, Society and Human Rights** *Sexuality, culture and rights, gender, sexual abuse and violence*
Key Concept 4: Human Development *Reproduction, Puberty, Bodily Integrity*	**Key Concept 5: Sexual Behaviour** *Sex, sexuality and the sexual life cycle; sexual behaviour*	**Key Concept 6: Sexual and Reproductive Health** *Pregnancy prevention, HIV and STI Risk Reduction, HIV Stigma*

How do risk and protective factors fit in?

Studies of curriculum-based sex and STD/HIV education programs have underscored the importance of addressing the following factors:

1. Knowledge
2. Perception of risk
3. Personal values
4. Perception of peer norms
5. Self-efficacy
6. Intentions
7. Parent-child communication

Knowledge

- Facts, information, and skills acquired by a person through experience or education
  - For example, getting facts about contraception

Perception of Risk

- The perception of negative consequences that result from a course of action or behavior.
  - For example, increasing the perception that having unprotected sex even just once can lead to an unintended pregnancy.

Values

What we value and consider important in life:

- They serve as guidelines for behavior.
- When we act in accordance with our values, we feel good about our actions.
- When we act in a way that violates our values, we feel bad about our actions.
- For example, understanding one's personal value of education/staying in school .

Perception of Peer Norms

- Perceived peer norms are what we perceive to be standards of acceptable behaviors (norms) among peers
- All of us are affected by our perceptions of what others are doing and our perceptions of what others think we should be doing.
- We do this because we often desire to conform to social norms (standards of acceptable behavior)
  - For example, countering the perception that peers are having unprotected sex

Self-Efficacy

- People's confidence in their ability to perform particular behaviors well.
- If people think they can do something well, they are more likely to try to do it.
  - For example, increasing the sense of self-efficacy to access contraception

Intentions

- Intentions are courses of actions that people expect to follow.
  - –For example, developing a plan for using contraception.

Parent-child communication

- Parents communicate with their children about knowledge, beliefs, values, expectations and many other messages, all of which affect their children's behavior.
  - For example, interviewing parents about what puberty was like for them.

What you teach in addition to *how* you teach can address these factors (more on that later).

In Summary

- Young people face significant challenges to their sexual and reproductive health and realizing their full potential
- Sexuality education can reduce these vulnerabilities by building knowledge and skills that enable young people to reduce sexual risk behaviors
- The education sector has a critical role to play and tremendous opportunity to prepare learners for leading sexually healthy lives

Sources

- Machawira, P. PowerPoint presentation entitled Comprehensive Sexuality Education in Eastern and Southern Africa Region, 2013.
- Kirby, D., et al. Reducing Adolescent Sexual Risk: A Theoretical Guide for Developing and Adapting Curriculum-Based Programs. Scotts Vallye, CA: ETR Associates, 2011.
- UNESCO, International Technical Guidance on Sexuality Education. Paris: UNESCO, 2009.

Activity 2: International Technical Guidance on Sexuality Education

TOTAL TIME REQUIRED

1 hour

MATERIALS NEEDED

- ✔ Scissors
- ✔ Tape

RESOURCES NEEDED

- ✔ Half-page cut-outs from the Technical Guidance Search Activity Sheet
- ✔ The International Technical Guidance on Sexuality Education, Volume II located here: *http://unesdoc.unesco.orgimages/0018/001832/183281e.pdf*

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Locate at least four learning objectives by age-range and topic in the International Technical Guidance on Sexuality Education.

INSTRUCTIONS

1. Explain that now that everyone has a clear understanding of what constitutes sexuality education, why it is important, and its benefits, let's go a little deeper into understanding the types of content included in sexuality education by reviewing a key resource developed by UNESCO and other UN partners, the International Technical Guidance on Sexuality Education.
2. Using the same PowerPoint or pre-printed flip charts with the same information, explain what the guidance is; the reason for its development and goals of its use; and the overall contents of Volume I and Volume II.
3. Next, explain that to further familiarize ourselves with the Guidance, we will be doing a "search" for suggested age-appropriate content for sexuality education.
4. Ask teachers to count off in order to form teams of six. Explain that each group will form a team and supply each team with a copy of Volume II of the International Technical Guidance.
5. Next, distribute half sheets to each team, which request that the team find learning objectives on certain topics for certain age-ranges.
6. Tell the teams that they have 10 minutes to search through the guidance to identify the requested learning objectives and that at the end, each team will be asked to read their findings to the group.
7. Call time and any teams with learning objectives for the age group 5-8 to share their topic and learning objective. Repeat for the remaining three age groups.
8. Ask participants the following questions:

- ✔ What was it like to engage in this game?
- ✔ What did you notice as your team was searching for the learning objectives?
- ✔ What did you find useful about the technical guidance? Unexpected?
- ✔ How can this inform your work to teach sexuality education in the classroom? Does the breadth and depth of topics respond to some of the challenges identified within the region/country?

Activity 2: International Technical Guidance on Sexuality Education

INSTRUCTIONS (CONTINUED)

9. Conclude the activity by noting that the International Technical Guidance provides recommendations for sexuality education content and skills across six topics and four age ranges. These guidelines can be used by teachers, curriculum developers, and others working to educate young people in order to ensure that they receive comprehensive, quality, and age–appropriate information and skills in support of their well–being and sexual and reproductive health.

Technical Guidance Search Activity Sheet

TEAM #1

Find ONE illustrative learning objective for the following topics for the indicated age range.

1. Puberty, ages 9–12

2. Gender Based Violence, Sexual Abuse, and Harmful Practices, ages 5–8

3. Understanding, Reducing, and Recognizing STIs Including HIV, ages 15–18

4. Pregnancy Prevention, ages 12–15

TEAM #2

Find ONE illustrative learning objective for the following topics for the indicated age range.

1. HIV and AIDS Stigma, Treatment, Care, and Support, ages 5–8

2. Privacy and Bodily Integrity, ages 9–12

3. Communication, Refusal, and Negotiation Skills, ages 12–15

4. Norms and Peer Influence on Sexual Behavior, ages 15–18

Technical Guidance Search Activity Sheet

TEAM #3

Find ONE illustrative learning objective for the following topics for the indicated age range.

1. Reproduction, ages 9–12

2. The Social Construction of Gender, ages 12–15

3. Communication, Refusal, and Negotiation Skills, ages 5–8

4. Pregnancy Prevention, ages 15–18

TEAM #4

Find ONE illustrative learning objective for the following topics for the indicated age range.

1. Understanding, Reducing, and Recognizing STIs Including HIV, ages 12–15

2. Gender Based Violence, Sexual Abuse, and Harmful Practices, ages 9–12

3. Sexual and Reproductive Anatomy and Physiology, ages 5–8

4. Sexuality and the Media, ages 15–18

Technical Guidance Search Activity Sheet

TEAM #5

Find ONE illustrative learning objective for the following topics for the indicated age range.

1. Norms and Peer Influence on Sexual Behavior, ages 12–15

2. Communication, Refusal, and Negotiation Skills, ages 9–12

3. Values, Attitudes, and Sources of Sexual Learning, ages 15–18

4. Sexuality and the Media, ages 5–8

TEAM #6

Find ONE illustrative learning objective for the following topics for the indicated age range.

1. Tolerance and Respect, ages 12–15

2. HIV and AIDS Stigma, Treatment, Care, and Support, ages 15–18

3. Sexual and Reproductive Anatomy and Physiology, ages 9–12

4. Understanding, Reducing, and Recognizing STIs Including HIV, ages 5–8

Activity 3: Review of Sexuality Education Country Curriculum and Framework

TOTAL TIME REQUIRED

1 hour

MATERIALS NEEDED

- ✔ To be determined by local presenters

RESOURCES NEEDED

- ✔ Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern African Handout

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Appreciate efforts undertaken to date to advance school–based sexuality education and describe the status of its implementation.

INSTRUCTIONS

1. In advance of the session, invite a resource person to present on the status of sexuality education implementation and the country's sexuality education curriculum and/or framework.
2. Explain that now that we have a good sense of what constitutes sexuality education and the International Technical Guidance on Sexuality Education, let's turn our attention to how sexuality education is supported within the region and particularly, the status of sexuality education implementation in the country.
3. Distribute the Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern African. Explain that stakeholders from the Ministers of Education and Health from 20 countries in Eastern and Southern Africa gathered in South Africa in December of 2013 to identify how best to support a vision of young Africans who are global citizens of the future, are educated, healthy, resilient, socially responsible, and informed decision–makers, and are equipped with the capacity to contribute to their community. As a result, leaders committed to the following by the end of 2015:
   - A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries
   - Pre– and in–service sexual and reproductive health and comprehensive sexuality education training for teachers, health and social workers are in place and being implemented in all 20 countries
4. Note that given these commitments, countries across the region have been working toward realizing these targets and that this country is no exception. Explain that next teachers will hear from a representative who is involved in the curriculum development processes and who will discuss the status of sexuality education implementation and the country's curriculum on sexuality education and framework.
5. Introduce the guest speaker and provide 20 minutes for the presentation followed by 15 minutes for questions and answers.

Activity 3: Review of Sexuality Education Country Curriculum and Framework

INSTRUCTIONS (CONTINUED)

6. Thank the guest speaker for their time and then ask participants the following questions:

- ✔ What was it like to hear about the commitment for sexuality education in the region and the status of its implementation in your country?
- ✔ Was this information new to you and your peers?
- ✔ What information was particularly important from this presentation?
- ✔ How does this inform the work that you will do in the classroom?

7. Conclude the session by noting that as sexuality education teachers, it's important to know that your efforts to build life skills among learners and to equip them with information and skills to support their sexual and reproductive health is part of a regional commitment to improving young people's lives. As sexuality education teachers, you are also contributing to country–level efforts that are already underway to making this commitment a reality.

Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern African Handout

FINAL VERSION AFFIRMED 7th December

Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African (ESA)

1.0 Preamble

We, the Ministers of Education and Health from 20 countries in Eastern and Southern Africa[1] , gathered in Cape Town, South Africa on 7 December 2013, working towards a vision of young Africans who are global citizens of the future who are educated, healthy, resilient, socially responsible, informed decision-makers and with the capacity to contribute to their community, country and region, hereby:

1.1. ***Affirm*** our commitment to the right to the highest possible level of health, education, non-discrimination and well-being of current and future generations;

1.2. ***Recognize*** the responsibility of the State to promote human development, including good quality education and good health, as well as to implement effective strategies to educate and protect all children, adolescents and young people, including those living with disabilities, from early and unintended pregnancy, unsafe abortion, sexually transmitted infections (STIs) including HIV, risks of substance misuse and to combat all forms of discrimination and rights violations including child marriage;

1.3. ***Reiterate*** our conviction that the education and health sectors, working jointly, have enormous potential to promote the good health and wellbeing of all individuals and communities, and to prevent early and unintended pregnancy, the transmission of HIV and other STIs and to facilitate access to care and support, particularly for adolescents and young people living with HIV (YPLHIV) or those with heightened vulnerability to STIs including HIV;

1.4. ***Acknowledge*** that our countries are signatories to various conventions at international and regional levels including the Education for All (EFA) Dakar Framework for Action, Maputo

[1] Angola, Botswana, Burundi, Democratic Republic of Congo, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, South Sudan, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

Ministries of education and health in Rwanda were part of the ESA commitment process, but were unable to attend the high level ministerial meeting on 6-7 December due to other commitments.

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Plan of Action, Southern African Development Community (SADC) Protocol on Gender and Development, International Conference on Population Development (ICPD) Global Youth Conference, Abuja Declaration and Framework for Action on HIV/AIDS, the United Nations Convention on the Rights of the Child (CRC), the African Youth Charter, the Millennium Declaration and the African Union Second Decade of Education Plan of Action and a range of other regionally focused declarations;

1.5. ***Recognize*** the significant progress made by member states in Eastern and Southern Africa to address the needs of adolescents and young people with respect to ensuring access to life skills-based HIV and comprehensive sexuality education (CSE)[2] and youth-friendly sexual and reproductive health services;

1.6. ***Realize*** that in demographic terms, the region is experiencing major growth in the youth population which has major implications for education, health and development overall. Young people will drive the development of the region in the coming decades and beyond;

1.7. ***Recognize*** that working in collaboration with relevant ministries including ministries of gender, youth and others will greatly enhance the effectiveness of our efforts and ensure a coordinated, multi-sectoral approach that will benefit adolescents and young people;

1.8. ***Acknowledge*** that Eastern and Southern Africa remains the region that is most affected by HIV despite the positive signs that HIV prevalence is declining among young people in some countries. This region is also more heavily affected by adolescent maternal mortality and morbidity than other regions in the world;

1.9. ***Commit*** ourselves to strengthening HIV prevention, treatment, care and support, and sexual and reproductive health and rights (SRHR) efforts in Eastern and Southern Africa by ensuring access to good quality, comprehensive, life skills-based HIV and sexuality education (CSE) and youth-friendly sexual and reproductive health services for all adolescents and young people, recognizing each country's socio-cultural context.

2.0 Whereas

2.1 Several advances have been made in Eastern and Southern Africa there are still significant challenges:

2.1.1 HIV remains an urgent problem, with 430 000 new infections per year among young people aged 15-24[3]; with young women still more heavily affected and with an increase of 50% in deaths amongst adolescents living with HIV globally[4];

2.1.2 With the advent of antiretroviral (ARV) treatment and care, more children living with HIV are surviving, reaching adolescence and adulthood. Young people living with HIV also require good quality comprehensive sexuality education, services and

[2] Sexuality Education is defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision- making, communication and risk reduction skills about many aspects of sexuality. UNESCO (2009) *International Technical Guidance on Sexuality Education: An evidence informed approach for schools, teachers and health educators,* Paris.

[3] The CRC protects the rights of children, adolescents and young people below the age of 18 and this Commitment document includes young people up to the age of 24.

[4] Children and AIDS, 6th Stocktaking Report, UNICEF, New York, 2013.

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psychosocial support to be skilled for life, to make healthy sexual and reproductive health choices and in order to fulfill their potential;

2.1.3 Alcohol and substance abuse significantly increase risky behavior and sexual violence resulting in increased HIV and STI transmission, unintended pregnancy and unsafe, illegal abortions;

2.1.4 While trends show increases in HIV-knowledge levels in some countries, overall knowledge levels in the region are low with less than 40% of young men and women demonstrating desirable levels of knowledge about HV prevention (compared to the agreed international target of 95%);

2.1.5 School completion rates remain low with young people completing an average of less than 6.5 years of education, and low levels of progression from primary to secondary education is a great concern. Fewer adolescents and young people therefore have access to HIV prevention and life-skills based CSE before they become sexually active;

2.1.6 Early and unintended pregnancies in the Eastern and Southern Africa region remain high and by age 17, at least 1 in 5 young women in six countries in the region have started childbearing. This rises to over 35% amongst 19 year olds in 10 countries;

2.1.7 Health risks caused by adolescent pregnancy are high and include higher rates of maternal mortality than for older women. Sub-Saharan Africa accounts for 44% of all unsafe abortions among adolescents between the ages of 15 and 19 in the developing world (excluding East Asia);

2.1.8 Gender inequality continues to limit the potential and the achievement of girls in this region, through lower school completion rates (e.g. 28% of girls enroll in secondary school compared to 32% of boys), child marriage and cultural norms which define the roles of girls and boys;

2.1.9 Gender-based violence, including sexual violence, increases vulnerability to HIV transmission, remains a cause for concern with a high percentage of young women - between 15-35% - reporting having experienced sexual violence in nine ESA countries where data was available. For many girls and young women in this region, sex, marriage and pregnancy remain neither voluntary, consensual nor informed;

2.1.10 Child marriage remains a serious obstacle to the realization of all rights for young people, notably adolescent girls and young women, and has direct and negative impact on their education, health and social status;

2.1.11 All forms of discrimination, including that based on age, sex, health, marital, legal or social status, as experienced by children, adolescents and young people, including marginalized and key populations, undermines their rights and dignity[5];

2.1.12 Poverty and wealth inequality have a direct and detrimental impact on education and health outcomes, and increase vulnerability to HIV.

[5] Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. *UNAIDS (2011) Getting to Zero, UNAIDS Strategy 2011-2015, Geneva.*

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2.2 We acknowledge that:

2.2.1 Investment in quality education that includes comprehensive, life-skills based sexuality education fulfills the right to education whilst also contributing to well-being and future quality of life. Adolescents and young people aged 10-24 make up 33% of the population in the region. Investment in health and education will, together with the resulting reduction in fertility rates, contribute to the realization of demographic dividends in the future;

2.2.2 Faith and faith-based teachings on life, family, community, sexuality and reproductive issues play a major part in the beliefs, practices and norms of many communities in the region;

2.2.3 Families, carers, guardians and community members play a primary role in the education and guidance available to adolescents and young people as they transition to becoming young adults;

2.2.4 Most adolescents and young people in the region reported that they were not sexually active until age 18. However, Demographic and Health Survey data from the region indicate that a significant number of adolescents have their first sexual experience at an early age (ranging from 3.3% to 24.5% of females under age 15), and, in many cases do not use any form of protection to prevent pregnancy or sexually transmitted infections. Young people should be supported to delay sexual debut until they choose to be sexually active and ensure that it is voluntary and protected;

2.2.5 Comprehensive sexuality education starting from primary school onwards enables the gradual acquisition of information and knowledge necessary to develop the skills and attitudes needed for a full and healthy life as well as to reduce sexual and reproductive health risks. The most recent scientific evidence demonstrates that comprehensive sexuality education, including education on safer sex and condom use, does not lead to early sexual initiation. Instead, quality sexuality education can help to delay the initiation and frequency of sexual activity, reduce the number of sexual partners, increase the use of condoms and contraception, and reduce sexual risk-taking[6]. When sexuality education includes a strong focus on rights and gender, greater benefits are possible[7];

2.2.6 In order to fully exercise their right to health, including sexual and reproductive health, all adolescents and young people require safe, effective, acceptable and affordable access to a range of commodities and services, regardless of gender. These services include but are not limited to condoms, contraception, vaccinations, pregnancy prevention, ante-natal care, safe delivery and post-partum care, diagnostic testing, treatment and care for STIs including HIV, safe abortion (where legal), post-abortion care and treatment, care and support in response to sexual violence. Restrictive abortion laws lead to many abortions being performed in an

6 UNESCO (2009) Op cit.

7 Population Council (2009) It's All One Curriculum, New York.

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unregulated and unsafe environment which threatens the lives of adolescents and young women;

2.2.7 In-school and out-of-school life skills-based CSE must be linked to and supported by a comprehensive package of youth-friendly sexual and reproductive health services and commodities. Services delivered by trained youth-friendly health workers are more likely to be used;

2.2.8 Quality education and health outcomes which can be achieved through comprehensive sexuality education require us to invest in teachers who are well trained, resourced and supported to deliver programmes in and out of school. At the same time, CSE programmes need to be within the formal curriculum and examinable to ensure effective implementation;

2.2.9 A stronger research agenda in the region is necessary to improve the quality and effectiveness of programming for adolescents and young people including research into HIV testing and provision of condoms and other SRH commodities in schools.

3.0 Based on the above considerations, we the ministers of education and health, will lead by bold actions to ensure quality comprehensive sexuality education and youth-friendly sexual and reproductive health services in the ESA region. Specifically, we commit to:

3.1 ***Work together on a common agenda*** for all adolescents and young people to deliver comprehensive sexuality education and youth-friendly SRH services that will strengthen our national responses to the HIV epidemic and reduce new HIV/STI infections, early and unintended pregnancy and strengthen care and support, particularly for those living with HIV. Establish inter-sectoral coordination mechanisms led through the existing regional economic communities, EAC, SADC and ECSA. Where such mechanisms already exist they must be strengthened and supported.

3.2 ***Urgently review - and where necessary amend - existing laws and policies on age of consent, child protection and teacher codes of conduct*** to improve independent access to sexual and reproductive health services for adolescents and young people and also protect children. Laws, policies and practices regulating access to services and in child protection must recognise the need for a balance between protection and autonomy and the evolving capacity of adolescents as they begin to make their own choices about their education and health needs.

3.3 ***Make an AIDS-free future a reality*** by investing in effective, combination prevention strategies to build on current declines in HIV prevalence amongst young people in the region as well as addressing underlying structural factors including poverty and a lack of livelihoods. Concerted effort will be made to build the capacity of teachers, health service providers and young people and to particularly advocate for increasing HIV testing and counselling, treatment access and expansion of agreed essential SRH services especially in marginalised communities and hotspot areas and including in non-formal and out of school settings.

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3.4 ***Maximise the protective effect of education*** through Education for All by keeping children and young people in school which reduces HIV risk, maternal mortality and improves gender equality, whilst ensuring access to educational opportunities for those living with HIV or adolescent and young women who may be pregnant.

3.5 ***Initiate and scale up age-appropriate CSE during primary school education*** to reach most adolescents before puberty, before most become sexually active, and before the risk of HIV transmission or unintended pregnancy increases. Using agreed international standards, ensure that CSE is age, gender and culturally appropriate, rights-based and includes core elements of knowledge, skills and values as preparation for adulthood: decisions about sexuality, relationships, gender equality, sexual and reproductive health and citizenship[8]. Wherever possible, make in-school CSE programmes intra-curricular and examinable.

3.6 ***Ensure that the design and delivery of CSE and SRH programmes includes ample participation by communities and families*** - particularly adolescents, young people, civil society and other community structures including faith-based organisations. At the same time, adolescents and young people should be guaranteed safe spaces, the right to be their own advocates and agents of change in their own communities, and to recommend good practices and innovations which meet their needs.

3.7 ***Integrate and scale up youth-friendly HIV and SRH services*** that take into account social and cultural contexts to improve age-appropriate access to and uptake of high quality SRH services and commodities, including condoms, contraception, HPV vaccine, HIV counselling and testing (HCT), HIV/STI treatment and care, family planning, safe abortion (where legal), post abortion care, safe delivery, prevention of mother-to-child transmission (PMTCT) and other related services for young people in and out of school.

3.8 ***Ensure that health services are youth-friendly***, non-judgemental, and confidential and reach adolescents and young people when they need it most, and are delivered with full respect for human dignity, including for young people considered most at risk, young people living with disabilities, or young people experiencing any other forms of discrimination. Reliable, affordable commodities must be made available as part of service delivery through public, private and civil society channels.

3.9 ***Strengthen gender equality and rights*** within education and health services including measures to address sexual and other forms of violence, abuse and exploitation in and around school and community contexts whilst ensuring full and equal access to legal and other services for boys and girls, young men and women.

3.10 ***Mobilise national and external resources*** by exploring new, innovative finance mechanisms and seeking technical and financial support from national and international sources to fulfil these commitments.

8 UNESCO (2009) Op cit.

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4.0 Targets

To ensure effectiveness, impact and accountability, working together within a multi-sectoral and whole government approach, as education and health ministers we affirm our determination to achieve all of the aforementioned ten Commitments and the following targets by the end of 2015:

4.1 A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries;

4.2 Pre and in-service SRH and CSE training for teachers, health and social workers are in place and being implemented in all 20 countries;

4.3 By the end of 2015, decrease by 50% the number of adolescents and young people who do not have access to youth-friendly SRH services including HIV that are equitable, accessible, acceptable, appropriate and effective.

In the longer term, we will work towards reaching the following targets by the end of 2020:

4.4 Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections amongst adolescents and young people aged 10-24;

4.5 Increase to 95% the number of adolescents and young people, aged 10-24, who demonstrate comprehensive HIV prevention knowledge levels;

4.6 Reduce early and unintended pregnancies among young people by 75%;

4.7 Eliminate gender-based violence;

4.8 Eliminate child marriage;

4.9 Increase the number of all schools and teacher training institutions that provide CSE to 75%.

5.0 Accountability

5.1 There is a need for governments to renew, accelerate and improve the implementation of the commitments that they have previously made related to human rights, HIV and AIDS, sexual and reproductive health and the wellbeing of children, adolescents and youth. Strong efforts will be taken to ensure wide awareness among key stakeholders about the existence of the Commitment, its purpose and targets, and to ensure their full opportunity for engagement.

5.2 In order to ensure the achievement of the agreed Commitments, we hereby establish an inter-ministerial, multi-sectoral mechanism (aligned with, or utilising existing systems) to strengthen planning, coordination and to monitor the implementation of these Commitments. These country mechanisms will be convened by UNAIDS and will engage key stakeholders including government, civil society, young people, UN and other development partners. SADC and EAC will lead in regional monitoring of these Commitments, with support from development partners.

5.3 We agree to review and report on this Commitment annually at SADC and EAC Summits involving the relevant ministers through national status reports.

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5.4 We agree to institutionalise monitoring and evaluation systems in our respective ministries and improve on the collection of age- and sex- disaggregated data through existing monitoring and evaluation mechanisms such as EMIS and HEMIS. These will be supplemented by periodic adolescent and youth surveys on the education and health status of adolescents and young people.

Annex A

International and regional commitments/declarations

Education

- Dakar Framework for Education 2000
- Millennium Development Goals 2000
- SADC protocol on Education and Training 1997

Health

- Maseru Declaration 2003
- Maputo Plan of Action 2006
- Africa Health Strategy 2010–2015
- SADC Sexual and Reproductive Health and Rights Strategy 2006-2015
- SADC HIV and AIDS Strategic Framework 2010–2015
- Regional Strategic Plan on Sexual and Reproductive Health and Rights in East Africa: 2008–2013
- SADC Protocol on Gender and Development 2008
- Addis Ababa Declaration on Population and Development in Africa beyond 2014

Human rights

- Convention on the Rights of the Child 1990
- The Protocol to the African Charter on Human and People's Rights on the Rights of Women 2003
- Solemn Declaration on Gender Equality in Africa (SDGEA) 2004
- African Youth Charter 2006
- African Union Plan of Action for the Decade of Youth 2008-2019

Annex B:

The countries affirming this commitment are as follows:

Angola, Botswana, Burundi, Democratic Republic of Congo, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, South Sudan, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe[9].

9 Ministries of education and health in Rwanda were part of the ESA commitment process, but were unable to attend the high level ministerial meeting on 06-07 December due to other commitments.

Activity 4: Discussion on Social Cultural and Contextual Realities and Their Impact on Sexuality Education

TOTAL TIME REQUIRED

40 minutes

MATERIALS NEEDED

- ✔ Note cards

RESOURCES NEEDED

- ✔ None

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Share and acknowledge some of the social cultural and contextual factors that can impact sexuality education.

INSTRUCTIONS

1. Explain that while all these efforts are underway, it's also important to talk about some of the challenges facing implementation of sexuality education. The purpose of this next activity is to allow for teachers to share some of these challenges faced to date.
2. Distribute note cards to the teachers and ask that everyone think about some of the social or cultural realities in their communities that may impact the teaching of sexuality education. Ask them to write down two of these on their note card.
3. Next, divide teachers into pairs and ask that they take a total of 15 minutes to share the issues that they wrote down on their note card with each other. Note that once they have shared their thoughts among pairs, you will be asking for volunteers to talk about some of the issues raised in the discussions.
4. After 10 minutes, call time and ask for volunteers to share highlights from their discussion. Note issues raised by teachers on a flip chart as they share these with the group.
5. Ask teachers the following questions:
   - ✔ What was it like to share some of the social and cultural factors and realities that may impact teaching sexuality education?
   - ✔ What were some of the issues raised by your colleagues—how were they similar or different?
   - ✔ What were some of the most common challenges you heard?
   - ✔ How can being aware of these challenges impact how you approach and teach sexuality education?
6. Conclude by noting that even given the substantial benefits that sexuality education brings to young people, there are still many challenges to its implementation in terms of contextual factors such as cultural and social norms and attitudes. Sharing these challenges with each other in order to be able to better anticipate obstacles is important to developing strategies for your school and community.

Activity 5: Debunking Myths About Sexuality Education

TOTAL TIME REQUIRED

1 hour and 20 minutes

MATERIALS NEEDED

- ✔ Note cards
- ✔ Tape
- ✔ Scissors

RESOURCES NEEDED

- ✔ Debunking Myths Activity Sheet
- ✔ Note cards with the concern taped on one card and the response taped on a corresponding card. Make enough pairs of note cards by duplicating them so that each pair of teachers will receive two concerns with corresponding responses.

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Counter at least three common myths about sexuality education.

INSTRUCTIONS

1. Explain that now that everyone has shared some of the social, cultural, and contextual realities that impact sexuality education efforts, it's time to practice addressing some of the classic concerns about sexuality education in order to be able to address these with accurate information.
2. Take 15 minutes to brainstorm common concerns and share ways to address them.
3. Ask teachers to split up into pairs and explain that next, they will be doing a role-play where one of them pretends to be the person who is concerned about sexuality education and the other person will pretend to be the teacher who tries to counter the concerned person's arguments.
4. Distribute a pair of note cards to each pair of teachers with a concern about sexuality education noted on one card and a response noted on the other card. If possible, screen the note cards to use the ones most identified by teachers during the brainstorm.
5. Indicate that each pair has 5 minutes to role-play the scenario where one expresses concern and the other defends sexuality education using the note cards as a basis for the conversation.
6. Once the role-plays are complete, ask teachers to share what was difficult about the conversation and any tactics used by the teachers to counter the concerned person's arguments.
7. Take about 10 minutes to note these tactics on flip chart paper.
8. Ask for one or two pairs to volunteer to do their role-play in front of the larger group. Ask the others to observe the role-play and search for use of the noted tactics.
9. At the end of the role-play(s), ask those who were the concerned person in the role-play to share whether they were convinced by the teacher and if so why. Ask those who were the teachers to share what tactics they used to put forward their arguments. Then ask everyone else to share any observations about what worked well and/or any further suggestions to strengthen arguments for sexuality education. If any additional tactics are mentioned, add them to the list.

Activity 5: Debunking Myths About Sexuality Education

INSTRUCTIONS (CONTINUED)

10. Ask participants the following questions:

- ✔ What was it like to engage in this role–play activity?
- ✔ What was it like to try to address a concern about sexuality education?
- ✔ Are these concerns ones that you have come across in your community or that you have yourself?
- ✔ How can you prepare yourself to address concerns like these?

11. Conclude the activity by noting that there is often controversy around sexuality education, but many times it is unfounded and/or based on misinformation or misconceptions. As a teacher of sexuality education, it is important to anticipate some of these concerns and be able to address them.

Debunking Myths Activity Sheet

CONCERN	RESPONSE
SEXUALITY EDUCATION LEADS TO EARLY SEX.	Research from around the world clearly indicates that sexuality education rarely, if ever, leads to early sexual initiation. Sexuality education can lead to later and more responsible sexual behavior or may have no discernible impact on sexual behavior.
SEXUALITY EDUCATION DEPRIVES CHILDREN OF THEIR 'INNOCENCE'.	Getting the right information that is scientifically accurate, non–judgmental, age–appropriate, and complete in a carefully phased process from the beginning of formal schooling is something from which all children and young people benefit. In the absence of this, children and young people will often receive conflicting and sometimes damaging messages from their peers, the media or other sources. Good quality sexuality education balances this through the provision of correct information and an emphasis on values and relationships.
SEXUALITY EDUCATION IS AGAINST OUR CULTURE OR RELIGION.	Sexuality education stresses the need for cultural relevance and local adaptations, through engaging and building support among the custodians of culture in a given community. Key stakeholders, including religious leaders, must be involved in the development of what form sexuality education takes. However, it's also important to change social norms and harmful practices that are not in line with human rights and increase vulnerability and risk, especially for girls and young women.
IT IS THE ROLE OF PARENTS AND THE EXTENDED FAMILY TO EDUCATE OUR YOUNG PEOPLE ABOUT SEXUALITY.	Traditional mechanisms for preparing young people for sexual life and relationships are breaking down in some places, often with nothing to fill the void. Sexuality education recognizes the primary role of parents and the family as a source of information, support, and care in shaping a healthy approach to sexuality and relationships. The role of governments through ministries of education, schools and teachers, is to support and complement the role of parents by providing a safe and supportive learning environment and the tools and materials to deliver good quality sexuality education.

Debunking Myths Activity Sheet

CONCERN	RESPONSE
PARENTS WILL OBJECT TO SEXUALITY EDUCATION BEING TAUGHT IN SCHOOLS.	Parents and families play a primary role in shaping key aspects of their children's sexual identity, and sexual and social relationships. Schools and educational institutions where children and young people spend a large part of their lives are an appropriate environment for young people to learn about sex, relationships, and HIV and other STIs. When these institutions function well, young people are able to develop the values, skills, and knowledge to make informed and responsible choices in their social and sexual lives. Teachers should be qualified and trusted providers of information and support for most children and young people. In most cases, parents are among the strongest supporters of quality sexuality education programs in schools.
SEXUALITY EDUCATION MAY BE GOOD FOR YOUNG PEOPLE, BUT NOT FOR YOUNG CHILDREN.	Sexuality education is built upon the principle of age–appropriateness with flexibility to take account of local and community contexts. Sexuality education encompasses a range of relationships, not only sexual relationships. Children are aware of and recognize these relationships long before they act on their sexuality and therefore need the skills to understand their bodies, relationships, and feelings from an early age. Sexuality education lays the foundations, such as by learning the correct names for parts of the body, understanding principles of human reproduction, exploring family and interpersonal relationships, learning about safety, and developing confidence. These can then be built upon gradually, in line with the age and development of a child.

Debunking Myths Activity Sheet

CONCERN	RESPONSE
TEACHERS MAY BE WILLING TO TEACH SEXUALITY EDUCATION BUT ARE UNCOMFORTABLE, LACKING IN SKILLS OR AFRAID TO DO SO.	Well–trained, supported, and motivated teachers play a key role in the delivery of good quality sexuality education. Clear sectoral and school policies and curricula help to support teachers in this regard. Teachers should be encouraged to specialize in sexuality education through added emphasis on formalizing the subject in the curriculum, as well as stronger professional development and support.
SEXUALITY EDUCATION SHOULD PROMOTE VALUES.	Sexuality education encourages young people to explore their values and be able to communicate these to others. At the same time, sexuality education itself is grounded in a rights–based approach in which values such as respect, acceptance, tolerance, equality, empathy, and reciprocity are inextricably linked to universally agreed human rights. It is not possible to divorce considerations of values from discussions.

SESSION FOUR

Getting Ready to Teach Sexuality Education

LEARNING OBJECTIVES

At the end of this session, teachers will be able to:

1. Recall what it was like to be an adolescent.
2. Contrast and arrange the stages of adolescent development and acknowledge characteristics of healthy adolescent development.
3. Define the circles of sexuality and describe at least one component of each circle.
4. Define what values are.
5. Demonstrate awareness of personal values, beliefs, biases, and experiences related to sexuality.
6. Recognize how personal values, beliefs, biases, and experiences can influence teaching of sexuality education and the importance of not asserting one's beliefs and biases onto learners.

ACTIVITIES

Activity 1 Taking a Trip into Adolescence

Activity 2 Stages of Adolescent Development

Activity 3 Circles of Human Sexuality

Activity 4 Values Clarification

Activity 1: Taking a Trip into Adolescence

TOTAL TIME REQUIRED

15 minutes

MATERIALS NEEDED

- ✔ None

RESOURCES NEEDED

- ✔ None

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Recall what it was like to be an adolescent.

INSTRUCTIONS

1. Explain that now that we have a good understanding of what sexuality education is and its benefits, it's time to take a moment to think about what it was like to be an adolescent.
2. To do this, we will be taking a trip but we won't need to get on a motorbike, bus or a plane, we will do so through a visualization exercise. Note that while this exercise often brings up happy thoughts, it could also bring up unhappy memories and if you feel uncomfortable, you do not have to engage in the visualization.
3. Ask teachers to close their eyes and lead them in taking a couple of deep breaths. Ask them to relax and think back to when they were an adolescent—that is sometime between the ages of 10–19 and lead the visualization by slowly stating the following (be sure to adapt the visualization narrative to your local context ahead of time):
   - Do you remember when you were in (name the classes that would correspond to ages 13–16). What were you like?.....What were some of the changes that you were experiencing in your life, in your body? What were they?.....How did you feel about your body?
   - Did you have a friend that you liked and would become nervous around? What was he or she like? Do you remember something about them—their eyes, their hair, the way they walked or dressed?..... What did you feel when you spoke to them? Or did you not dare to? When was the first time you met or saw each other? Was it in school? In church? At a family member's home? Under the mango tree?
   - What were you like when you had your first boyfriend or girlfriend? How old were you? Where were you living? What would you enjoy doing together? Would you go get water together, go to church together, or go to the market? Were you in school together? Did you ever kiss???? If you did, do you remember that first kiss? How did you feel? Were you excited? Happy? Worried? Scared? Did you tell your friends? Your parents, an aunt or uncle, sisters, or brothers?

Activity 1: Taking a Trip into Adolescence

INSTRUCTIONS (CONTINUED)

4. Let some time elapse after these last words and then say that it's time to come back to the training now and to please slowly come back to the room by opening their eyes. Thank the teachers for taking the trip and for being such great travelers.

5. Ask the teachers (an open question to the group for anyone who may want to share):

- ✔ How was the trip? What was it like to travel back to your adolescence?
- ✔ What did you notice as you were traveling? How were you feeling?
- ✔ Did the trip remind you of anything in particular about being an adolescent—what was it?
- ✔ How is this relevant to the work you will be doing in the classroom?

6. Conclude the exercise by noting that: Adolescence can be a wonderful time of life but also a difficult time with the challenges facing young people, such as puberty and vulnerabilities to HIV, unintended pregnancy or violence. How we experienced our own adolescence and sexuality is part of who we are but should not influence how we teach sexuality education, which needs to be delivered in a non-judgmental way and provide complete and age-appropriate information and skills-building.

Activity 2: Stages of Adolescent Development

TOTAL TIME REQUIRED

1 hour

MATERIALS NEEDED

- ✔ As many rolls of tape as there are groups of 5
- ✔ Scissors

RESOURCES NEEDED

- ✔ Stages of Adolescent Development Table Handout
- ✔ Stages of Adolescent Development In-Depth Handout
- ✔ Sets of the large-print Stages of Adolescent Development Activity Sheet (one set per group of 5 teachers)

LEARNING OBJECTIVES:

By the end of this session, teachers will be able to:

1. Contrast and arrange the stages of adolescent development and acknowledge characteristics of healthy adolescent development.

INSTRUCTIONS

1. Explain that now that we have travelled back to our own adolescence, we will focus on understanding adolescent development, the different stages of adolescent development, and what characterizes these different stages in terms of social, emotional, cognitive, and physical changes. Note that adolescents include children and young people ages 10–19. Underscore that understanding these stages is important in order to better understand where learners are coming from, the changes that they are facing, and how vulnerabilities that they face relate to what is actually healthy and normal development.
2. Ask groups to count off to form groups of five.
3. Distribute a set of large-print cut-outs of the Stages of Adolescent Development to each group, mixing them up so that they are scrambled, along with a role of tape.
4. Indicate that what they have is a scrambled set of headings (which are in bold) and characteristics of adolescent development that they have to organize into a three-column chart on a wall.
5. Provide 30 minutes for each group to develop their chart by taping the headings and characteristics in the form of a table. Tell the groups that not all columns will necessarily have the same number of characteristics. Ask teachers not to tape the sheets together as chances are they will be moved when each group presents their table.
6. Note that at the end of the 30 minutes, you will ask for a brave group to volunteer to share their stages of adolescent development and be the example off of which to make corrections to the location of the characteristics.
7. Circulate while teachers are working and offer support but no answers.
8. Expect there to be a lot of debate during this exercise. Often there is disagreement about certain characteristics with resistance around the age at which adolescents begin to identify with groups and initiate some separation from the family/growing their own identity. Be sure to underscore that these stages vary and are not set in stone but that generally, these are characteristics that one can expect as adolescents grow and develop.

Activity 2: Stages of Adolescent Development

INSTRUCTIONS (CONTINUED)

9. Expect for there also to be controversy around sexual orientation, which is one of the developmental characteristics noted in the last stage. Be ready to express that this is a normal part of development. Understanding one's sexual orientation begins to emerge by adolescence and is apparent/secured by late adolescence or sooner.
10. Call time after 30 minutes, providing a warning ten minutes prior.
11. Ask for a volunteer group to talk through their table.
12. Once they have finished, thank them and offer applause for their and the other groups efforts. Note that now you will walk through each stage and characteristic to ask if their colleagues have any suggested changes. The idea here is to correct placement of the characteristics by asking others to identify characteristics that may be misplaced so that:
    - If someone makes a correct suggestion, make the change.
    - If someone makes an incorrect suggestion, indicate that it is not correct.
    - If no one makes a suggested change to a characteristic that is misplaced, ask whether this one may need to go somewhere else and ultimately guide its relocation to the proper column.
13. Systematically walk through each characteristic until all of the characteristics are correctly placed.
14. Distribute the handouts and indicate that one is a simplified table that was the basis for the exercise and that the other is a more in depth table that organizes the characteristics by social, emotional, cognitive, and physical changes.
15. Ask the teachers:

- ✔ What was it like to do this exercise?
- ✔ What was challenging? What was surprising to you?
- ✔ What stands out to you as important upon reviewing the stages of adolescent development?
- ✔ How might knowing these stages and the different changes that adolescents are going through impact your approach to teaching sexuality education?

Activity 2: Stages of Adolescent Development

INSTRUCTIONS (CONTINUED)

16. Conclude the exercise by noting that:

- Adolescence is a time of tremendous change—physical change, cognitive change, emotional change, and social change.
- Adolescents' development impact how they look, how they think, how they feel, and how they interact with others.
- Many of the behaviors that adults may dislike or look down upon that adolescents engage in are in fact expressions of their normal development —such as not anticipating consequences (lack of abstract thinking); feeling preoccupied with the size of their breasts or penis (often during puberty); testing adult authority; becoming curious about sex; identifying more with their peers; or lacking empathy towards others.
- It's important for teachers who are teaching sexuality education to be aware of these stages and the various physical, cognitive, emotional, and social changes that their learners are facing as they impact adolescents' ability to navigate their sexual and reproductive health and minimize sexual risks.
- Sexuality education can provide young people with information and skills to help them avoid sexual risk–taking behavior and live healthier lives.

Stages of Adolescent Development Table Handout

EARLY ADOLESCENCE FEMALES AGES 9–13 MALES AGES 11–15	LATE ADOLESCENCE FEMALES AGES 16+ MALES AGES 17+	LATE ADOLESCENCE FEMALES AGES 16+ MALES AGES 17+
Puberty is the main event during this stage Adjustment to pubertal changes, such as secondary sexual characteristics Concern with body image Beginning of separation from family Beginning of increased parent–child conflict Start of presence of social group cliques Beginning to identify in reputation based groups Beginning of concentration on relationships with peers Concrete thinking, beginning of new ability in abstract thinking	Increasing independence from family Increasing importance of peer group Experimentation with relationships and behaviors Increasing ability to think abstractly	Autonomy nearly secured Body image and gender role definition nearly secured Empathetic relationships Attainment of abstract thinking Defining of adult roles Transition to adult roles Greater intimacy skills Sexual orientation nearly secured

Source: National Commission on Adolescent Sexual Health

Stages of Adolescent Development In-Depth Handout

ASPECT OF DEVELOPMENT	EARLY ADOLESCENCE (8–12)	MIDDLE ADOLESCENCE (13–16)	LATE ADOLESCENCE (17–19+)
PHYSICAL	Significant physical/ sexual maturation Intense concern with body image Physical maturation occurs faster than cognitive, emotional, and social development	Continuing physical/ sexual changes Less concern with body image Increased need for sleep and physical rest	Physical/sexual changes complete Greater acceptance of physical appearance Eating disorders may occur Can experience strong sexual feelings
COGNITIVE	Concrete thinking Developing self-control Learning is rapid Developing own opinions, but continue to need help in solving problems Events are understood in terms of direct experience Begin to question rules and beliefs previously accepted at face value	Growth of capacity to think abstractly Attention, memory, and problem-solving abilities improve Do not always see the consequences of their actions Feelings of being all-powerful, all knowing, and invulnerable are common Developing their own set of values Goal setting and planning begin to be important	Capacity for abstract thought in place Greater ability to see different perspectives, resulting in more empathy and concern for others Refine and clarify values Greater capacity to set goals Better able to make decisions, act independently, and rely on themselves Express thoughts and ideas more clearly

Sources:
Adapted by Advocates for Youth in 2014 from:
-Rutgers University's Training Institute in Sexual Health Education
-ReCAPP (resource Center for Adolescent Pregnancy Prevention) www.recapp.etr.org
-Developmental Characteristics of Youth Program Basics: the Definitive Program Resource for Boys & Girls Clubs

Stages of Adolescent Development In-Depth Handout

ASPECT OF DEVELOPMENT	EARLY ADOLESCENCE (8–12)	MIDDLE ADOLESCENCE (13–16)	LATE ADOLESCENCE (17–19+)
EMOTIONAL	Growing independence in decision-making Continue to need love, attention, and approval from adults, but are less willing to ask for it Opinions of peers matter more than before Self-centered, but beginning to think of others Instant gratification is important	Development of sense of identity Exploration of ability to attract partners begins Greater sense of self-consciousness Begin to test adult authority Self-esteem is developing—some girls may be vulnerable to losing confidence and becoming self-critical Can have confusion over emerging sexuality Curiosity about sex increases and sexual experimentation may begin	Sense of identity established Independence increases Greater sense of self-control Movement from self-centeredness to real sharing and empathy All experiences are intense and emotional
SOCIAL	Increasing influence of peers Feeling attracted to others begins Developing self-esteem is important—earn status by doing something well Events are understood in terms of direct experience Begin to question rules and beliefs previously accepted at face value	Significant influence of peers/school environment Increase in sexual interest Beginning to learn how to enter groups, how to read social cues, and how to deal with conflict in a positive manner Relationships deepen and become more mutual and trusting	Family influence more in balance with peer influence Serious intimate relationships begin to develop Transition to work or tertiary level education, more independent living One-to-one relationships are important Friendships with the opposite sex become more common

Sources:
Adapted by Advocates for Youth in 2014 from:
-Rutgers University's Training Institute in Sexual Health Education
-ReCAPP (resource Center for Adolescent Pregnancy Prevention) www.recapp.etr.org
-Developmental Characteristics of Youth Program Basics: the Definitive Program Resource for Boys & Girls Clubs

Stages of Adolescent Development Activity Sheet

Early Adolescence
Females ages 9–13
Males ages 11–15

Puberty is the main event during this stage

Adjustment to pubertal changes, such as secondary sexual characteristics

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Concern with body image

Beginning of separation from family

Stages of Adolescent Development Activity Sheet

Beginning of increased parent–child conflict

Start of presence of social group clique

Beginning to identify in reputation based groups

Beginning of concentration on relationships with peers

Concrete thinking, beginning of new ability in abstract thinking

Stages of Adolescent Development Activity Sheet

Middle Adolescence
Females ages 13–16
Males ages 14–17

Increasing independence from family

Increasing importance of peer group

Experimentation with relationships and behaviors

Increasing ability to think abstractly

Stages of Adolescent Development Activity Sheet

Late Adolescence
Females ages 16+
Males ages 17+

Autonomy nearly secured

Body image and gender role definition nearly secured

Empathetic relationships

Attainment of abstract thinking

Stages of Adolescent Development Activity Sheet

Defining of adult roles

Transition to adult roles

Greater intimacy skills

Sexual orientation nearly secured

Activity 3: Circles of Human Sexuality*

TOTAL TIME REQUIRED

1 hour 45 minutes

MATERIALS NEEDED

- ✔ 7 sheets of flip chart paper
- ✔ Note cards
- ✔ Several rolls of tape

RESOURCES NEEDED

- ✔ Leader's Resource on Human Sexuality
- ✔ Leader's Resource on the Explanation of the Circles of Sexuality
- ✔ Circles of Sexuality Handout
- ✔ One pre-written flip chart with a circle divided into many pie pieces with "Sources of Sexual Learning" written at the top
- ✔ Circles of Sexuality Activity Sheet
- ✔ At least 60 note cards with names and definitions of components of each circle of sexuality cut out and pasted (from the Circles of Sexuality Activity Sheet) on cards, such that there is a set for each circle, but shuffled so that names are not matched to definitions.

RESOURCES NEEDED (CONTINUED)

- ✔ Five pre-written flip charts, each with one empty circle and the following as titles for the circles:
  1. Sensuality
  2. Intimacy
  3. Sexual identity
  4. Sexual health and reproduction
  5. Sexualization
- ✔ One flip chart with these questions pre-written:
  1. What would be an example of this component of sexuality in someone's real life?
  2. Why does this fit into this circle?
  3. Is this something you normally think of when you think of sexuality? Why or why not?

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Define the circles of sexuality and describe at least one component of each circle.

INSTRUCTIONS

1. Explain that in addition to understanding the stages of adolescent development, in order to teach sexuality education, understanding human sexuality is also of tremendous importance. Next, we will define sexuality and learn about what it encompasses.

** "Circles of Sexuality" is based on the original work of Dennis M. Dailey, Professor Emeritus, University of Kansas.*

Activity 3: Circles of Human Sexuality

INSTRUCTIONS (CONTINUED)

2. To start, explain that sexuality is an inherent part of being human and is something that we experience every day, beginning even before we are born within the womb and extending until we die.

3. Next, ask teachers to brainstorm all of the people, places, and things that teach us about sexuality, especially the sources of learning among adolescents and young people—that is, where people learn or hear about sexuality? For each contribution, write down the answer in one of the pie pieces of the circle and continue until they are filled in. If teachers suggest more, divide one of the pie pieces in two to make room for another source(s). Be sure to include some of the following examples: friends/peers; parents; other family members; religion; health providers/clinics; boyfriends/girlfriends/partners; books; ourselves; media; social media; internet; culture; music and art; social gatherings; animals; teachers/school; trainings and workshops; health education materials; youth clubs; laws and policies; pornography; fashion; or science and technology.

4. Ask teachers what they think about the circle and the many sources of information on sexuality and how this might impact learners in terms of what they hear or see.

5. Note that it's not uncommon for all of us, including young people, to be exposed to all sorts of information and messaging around sexuality from many different sources. Some of these are more reliable than others and this can lead to confusion and misinformation about sexuality.

6. Further explain that as sexuality education teachers, it is important to know that learners will learn about sexuality from the different sources identified anyway so why not take an active role in imparting factual, balanced information and opportunities for them to process the types of information they receive from the various sources.

7. Write "sexuality" on a flip chart and draw a box around the letters s–e–x. Point out that s, e, and x are only three of the letters in the word sexuality.

Activity 3: Circles of Human Sexuality

INSTRUCTIONS (CONTINUED)

8. Next, explain that when many people see the words "sex" or "sexuality," they most often think of sexual intercourse. Others also think of other kinds of physical sexual activities. Tell teachers that sexuality is much more than sexual feelings or sexual intercourse. It is an important part of who every person is. It includes all the feelings, thoughts, and behaviors of being female or male, being attracted and attractive to others, and being in love, as well as being in relationships that include sexual intimacy and physical sexual activity.

9. Display the five flip chart papers that you have pre-written, each with one empty circle and the heading of that circle, taped up on a wall. Explain that this way of looking at human sexuality breaks it down into five different areas: Sensuality, Intimacy, Sexual Identity, Sexual Health and Reproduction, and Sexualization.

10. Beginning with the circle labeled Sensuality, explain each circle briefly (refer to the Leader's Resource on the Explanation of the Circles of Sexuality). Take five minutes to read the definitions of each of the circles aloud.

11. Explain that everyone is going to now work in groups to go deeper into each circle and discuss components of these. Ask teachers to count off to form groups of no more than 5 or 6 people.

12. Explain that each group will receive note cards consisting of the various components of one of the circles of sexuality. The note cards include a mix of the names of the components and a description of the components. Distribute the sets and indicate which circle each group gets as you do so.

13. Ask each group to work together to match the names of the components of the circle with the descriptions and in doing so, discuss and share reactions to each component of that circle. Questions that the groups can use to help their discussion (but not required) are the following, which you can have up on a flip chart for reference.

    - What would be an example of this component of sexuality in someone's real life?
    - Why does this fit into this circle?
    - Is this something you normally think of when you think of sexuality? Why or why not?

Activity 3: Circles of Human Sexuality

INSTRUCTIONS (CONTINUED)

14. Give 15 minutes for the group work and note that when everyone is done, you will ask for volunteer groups to come present their components, share a couple of highlights from their discussion, and tape them on the flip chart in the circle they were working on.

15. Call time and ask for a group that worked on the Sensuality circle to come share the components of that circle with a couple of highlights from their discussion. Repeat this until all of the circles have been filled. After each presentation, ask if there are any questions or comments before moving onto the next one.

16. Once all of the circles have been fully described and the note cards taped, ask teachers:

- ✔ What was it like to identify the components of some of the circles of sexuality?
- ✔ Which of the five sexuality circles feels most familiar? Least familiar? Why do you think that is so?
- ✔ Why do you think it is important for teachers to understand the components of sexuality?
- ✔ How is this helpful in supporting your work as a teacher of sexuality education?

17. Conclude the activity by distributing the Circles of Sexuality handout and by noting that sexuality is much more than just about sex and that it is an inherent part of being human. In fact, human rights are reflected across all of the circles of sexuality—the right to pleasure, to sexuality information, to choose if and whom to be intimate with, to live free from violence and discrimination, and to decide if, when and how many children to have.

18. Note that understanding what sexuality encompasses is important for sexuality educators to ensure that learners are receiving truly comprehensive sexuality education that addresses all of what constitutes sexuality, as reflected in the five circles of sexuality and the International Technical Guidance reviewed earlier.

Leader's Resource on Human Sexuality

Many people cannot imagine that everyone—babies, children, adolescents, adults, and the elderly—are sexual beings. Some believe that sexual activity is reserved for adolescents, young adults, and people who are younger than 40 or so. Adolescents often feel that, by the time they are in their 40s, adults are too old for sexual intercourse. Sexuality, though, is much more than sexual intercourse and humans are sexual beings throughout life.

Sexuality in Infants and Toddlers—Children are sexual even before birth. Males can have an erection while still in the uterus, and some boys are born with an erection. Infants touch and rub their genitals because it provides pleasure. Children can experience orgasm from masturbation although boys will not ejaculate until puberty. By about age two, children know their own gender. They are aware of differences in the genitals of males and females and in how males and females urinate.

Sexuality in Children (ages 3 to 7)—Preschool children are interested in everything about their world, including sexuality. They may practice urinating in different positions. They are highly affectionate and enjoy hugging other children and adults. They begin to be more social and may imitate adult social and sexual behaviors, such as holding hands and kissing. Many young children play 'doctor' during this stage, looking at other children's genitals and showing theirs. This is normal curiosity. By age five or six, most children become more modest and private about dressing and bathing.

Children of this age are aware of marriage and understand living together, based on their family experience. They may role-play about being married or having a partner while they play house. Most young children talk about marrying and/or living with a person they love when they get older. School-age children may play sexual games with friends of their same sex, touching each other's genitals and/or masturbating together. Most sex play at this age happens because of curiosity.

Sexuality in Preadolescent Youth (ages 8 to 12)—Puberty, the time when the body matures, begins between the ages of nine and 12 for most children. Girls begin to grow breast buds and pubic hair as early as nine or 10. Boys' development of penis and testicles usually begins between ages 10 and 11. Children become more self-conscious about their bodies at this age and often feel uncomfortable undressing in front of others, even a same-sex parent.

Masturbation increases during these years. Preadolescents do not usually have much sexual experience, but they often have many questions. They usually have heard about sexual intercourse, petting, oral sex, and anal sex, homosexuality, rape and incest, and they want to know more about all these things. The idea of actually having sexual intercourse, however, is unpleasant to most preadolescents.

Same-gender sexual behavior is common at this age. Boys and girls tend to play with friends of the same gender and are likely to explore sexuality with them. Masturbating with one's same-gender friends and looking at or caressing each other's genitals is common among preadolescent boys and girls. Such same-gender sexual behavior can be unrelated to a child's sexual orientation.

Preadolescents may attend parties that have guests of both genders, and they may dance and play kissing games. By age 12 or 13, some young adolescents may pair off and begin having a girlfriend or boyfriend.

Leader's Resource on Human Sexuality

Sexuality in Adolescent Youth (ages 13 to 19)—Once youth have reached puberty and beyond, they experience increased interest in romantic and sexual relationships and in genital sex behaviors. As youth mature, they experience strong emotional attachments to romantic partners and find it natural to express their feelings within a sexual relationship. There is no way to predict how a particular adolescent will act sexually. Overall, most adolescents explore relationships with one another, fall in and out of love, and participate in sexual intercourse before the age of 20.

Adult Sexuality—Adult sexual behaviors are extremely varied and, in most cases, remain part of an adult's life until death. At around age 50, women experience menopause, which affects their sexuality in that their ovaries no longer release eggs and their bodies no longer produce estrogen. They may experience several physical changes. Vaginal walls become thinner and vaginal intercourse may be painful as there is less vaginal lubrication and the entrance to the vagina becomes smaller. Many women use various therapies to relieve physical and emotional side effects of menopause. Use of vaginal lubricants can also make vaginal intercourse easier. Most women are able to have pleasurable sexual intercourse and to experience orgasm for their entire lives.

Adult males also experience some changes in their sexuality, but not at such a predictable time as with menopause in women. The testicles slow testosterone production after age 25 or so. Erections may occur more slowly once testosterone production slows. Males also become less able to have another erection after an orgasm and may take up to 24 hours to achieve and sustain another erection. The amount of semen released during ejaculation also decreases, but men are capable of fathering a baby even when they are in their 80s and 90s, although recent research indicates that children fathered by men who are in their 50s and older are more likely than other children to develop schizophrenia as young adults. Sometimes, older men develop an enlarged or cancerous prostate gland. If a doctor deems it necessary to remove the prostate gland, a man's ability to have an erection or an orgasm is normally unaffected. Today, there are also medications that help older men to achieve and maintain erections.

Although adults go through some sexual changes as they age, they do not lose their desire or their ability for sexual expression. Even among the very old, the need for touch and intimacy remains, although the desire and ability to have sexual intercourse may lessen.

Source: Advocates for Youth. Life Planning Education: A Youth Development Program. Washington, DC: Advocates for Youth, revised 2014.

Leaders' Resource on the Explanation of the Circles of Sexuality

Sexuality is much more than sexual feelings or sexual intercourse. It is an important part of who a person is and what she/he will become. It includes:

- All the feelings, thoughts, and behaviors associated with a person's gender
- Being attracted to others and being attractive to them
- Being in love
- Being in relationships that include sexual intimacy and sensual and sexual activity
- It also includes enjoyment of the world as we know it through the five senses: taste, touch, smell, hearing, and sight

CIRCLE #1—SENSUALITY

Sensuality is awareness of and feelings about your own body and other people's bodies, especially the body of a sexual partner. Sensuality enables us to feel good about how our bodies look and feel and what they can do. Sensuality also allows us to enjoy the pleasure our bodies can give us and others. This part of our sexuality affects our behavior in several ways.

1. **Body Image**—Feeling attractive and proud of one's own body and the way it functions influences many aspects of life. The media creates unrealistic expectations for how people should look, so young people are often disappointed by what they see in the mirror. They may be especially dissatisfied when the mainstream media does not portray or does not positively portray physical characteristics that adolescents see in the mirror, such as color of skin, type of hair, shape of eyes, height, or body shape.
2. **Human Sexual Response Cycle**—is the way people experience sexual pleasure. Sensuality allows a person to experience pleasure when certain parts of the body are touched. People also experience sensual pleasure from taste, touch, sight, hearing, and smell, and these may or may not be part of the human sexual response
3. **Skin Hunger**—The need to be touched and held by others in loving, caring ways is often referred to as skin hunger. Adolescents typically receive considerably less touch from their parents than do younger children. Many adolescents satisfy their skin hunger through close physical contact with peers. Sexual intercourse may sometimes result from a person's need to be held, rather than from sexual desire.
4. **Fantasy—**The brain also gives people the capacity to have fantasies about sexual behaviors and experiences. Adolescents sometimes need help understanding that sexual fantasy is normal and also that one does not have to act upon sexual fantasies.

CIRCLE #2—INTIMACY

Intimacy is the ability to be emotionally close to another human being and to accept closeness in return. Several aspects of intimacy include:

1. **Sharing**—Sharing intimacy is what makes personal relationships rich. While sensuality is about physical closeness, intimacy focuses on emotional closeness.
2. **Caring**—Caring about others means feeling their joy and their pain. It means being open to emotions that may not be comfortable or convenient because an intimate relationship is possible only when we care.

Leaders' Resource on the Explanation of the Circles of Sexuality

3. **Liking or Loving Another Person**—Having emotional attachment or connection to others is a manifestation of intimacy.

4. **Risk-Taking**—To have true intimacy with others, a person must open up and share feelings and personal information. Sharing personal thoughts and feelings with someone else is risky, because the other person may not feel the same way. But it is not possible to be really close with another person without being honest and open with her/him.

5. **Vulnerability**—To have intimacy means that we share and care, like or love, and take emotional risks. That makes us vulnerable—the person with whom we share, about whom we care, and whom we like or love has the power to hurt us emotionally. Intimacy requires vulnerability, on the part of each person in the relationship.

CIRCLE #3—SEXUAL IDENTITY

Sexual identity is a person's understanding of who she/he is sexually, including a person's sense of their gender. Sexual identity consists of three pieces that, together, affect how each person sees him/herself. The three pieces of sexual identity are gender identity, gender role, and sexual orientation. Each is important.

1. **Bias**—Gender bias means holding stereotyped opinions about people according to their gender. Gender bias might include believing that women are less intelligent or less capable than men, that men who cry are weak, that men cannot raise children without the help of women, that women cannot be analytical, that women are overly emotional. Many times, people hold fast to these stereotyped opinions without giving rational thought to the subject of gender.

2. **Gender Identity**—Knowing whether one is male, female, neither, or somewhere in between. Most young children have a sense of their own gender identity by as early as age two. Sometimes, the sex a person is assigned at birth is not the same as their gender identity—this is called being transgender.

    - Sometimes people use the acronym "LGBT" when referring to individuals of diverse sexual orientations or gender identities. L stands for "lesbian," G stands for "gay," B stands for "bisexual," and T stands for "transgender."

    - "Transphobia" is a term that refers to the negative feelings about and actions toward transgender people, which can lead to feeling devalued, unsafe, and isolated. Transphobia also affects the person who holds this bias and hatred because it narrows and limits the ways in which they can interact with and enjoy other people.

3. **Gender Role**—Identifying actions and/or behaviors for each gender. Most gender roles are socially/culturally constructed.

    - There are many "rules" about what men and women can/should do that have nothing to do with the way their bodies are built or function. This aspect of sexuality is especially important for adolescents to understand, since pressures from peers, family, and culture to be masculine or feminine increase during the adolescent years.

4. **Sexual Orientation**—A person's sexual orientation is defined by their primary attraction to people of the other gender (heterosexuality) or to the same gender (homosexuality) or to both genders (bisexuality). Sexual orientation begins to emerge by adolescence.

Leaders' Resource on the Explanation of the Circles of Sexuality

- Sometimes people use the acronym "LGBT" when referring to individuals of diverse sexual orientations or gender identities. L stands for "lesbian," G stands for "gay," B stands for "bisexual," and T stands for "transgender," discussed above.
- "Homophobia" is a term that refers to negative feelings about and actions toward gay, lesbian, and bisexual people, which can lead to feeling devalued, unsafe, and isolated. Homophobia also affects the person who holds this bias and hatred because it narrows and limits the ways in which they can interact with and enjoy other people.
- Men who are attracted to women and women who are attracted to men are called "heterosexual." Some people will call themselves "straight." Men who are attracted to other men and women who are attracted to other women are called "gay" or "lesbian." People who feel attraction for others where gender is not necessarily the defining factor might call themselves "bisexual" or "pansexual."
- Some people who are lesbian, gay or bisexual will use the term "queer," although when that term is used by heterosexual people to describe them, it is considered offensive. Different countries, ethnic groups, and religious communities will have different laws, attitudes, values, and beliefs relating to sexual orientation and gender identity, ranging from completely open, affirming and accepting to virulent opposition that results in serious human rights violations, physical harm, and even death.

CIRCLE #4—SEXUAL HEALTH AND REPRODUCTION

This aspect of sexuality relates to a person's capacity to reproduce and to the behaviors and attitudes that can make sexual relationships healthy and enjoyable.

1. **Feelings and Attitudes**—These encompass sexual expression and feelings about reproduction as well as one's feelings about other sexual health topics such as STIs, HIV and AIDS, contraceptive use, abortion, pregnancy, and childbirth.
2. **Sexual Intercourse**—Sexual intercourse is one of humanity's most common behaviors. Sexual intercourse is a behavior that may produce sexual pleasure and that often ends in orgasm in females and males. Sexual intercourse may also result in pregnancy and/or STIs. In programs for youth, discussion of sexual intercourse is often limited to the bare mention of penile–vaginal intercourse. However, youth need accurate health information about all forms of sexual intercourse—vaginal, oral, and anal.
3. **Physiology and Anatomy of Reproductive Organs**—This topic includes the male and female body and the ways in which bodies actually function in sexual ways. Adolescents need to learn to protect their reproductive and sexual health. This means that they need information about all the effective methods of contraception available, how they work, where to obtain them, their effectiveness, and their side effects as well as how to use latex condoms to prevent STIs, including HIV. Even adolescents who have never had sexual intercourse need to know how to prevent pregnancy and/or disease.
4. **Sexual Reproduction**—The actual processes of conception, pregnancy, delivery, and recovery following childbirth are important parts of sexuality. Youth need information about sexual reproduction—the process whereby two different individuals each contribute half of the genetic material to create a child. The child is, therefore, not identical to either parent.

Leaders' Resource on the Explanation of the Circles of Sexuality

5. **Factual Information**—This is necessary so youth will understand how male and female reproductive systems function and how conception and/or STI infections occur. Adolescents often have inadequate information about their own and/or their partner's body. Yet, they need this information so they can make informed decisions about sexual expression and about protecting their health.

CIRCLE #5—SEXUALIZATION

Sexualization is that aspect of sexuality in which people behave sexually to influence, manipulate, or control other people. Often called the "shadowy" side of human sexuality, sexualization spans behaviors that range from the relatively harmless to the sadistically violent, cruel, and criminal. These sexual behaviors include flirting, seduction, withholding sex from an intimate partner to punish her/him or to get something, sexual harassment, sexual abuse, rape, and incest. Adolescents need to know that no one has the right to exploit them sexually and that they do not have the right to exploit anyone else sexually.

1. **Seduction**—This is the act of enticing someone to engage in sexual activity. The act of seduction implies a deliberate manipulation, depriving the other person of informed choice and may be harmful for the one who is seduced.

2. **Sexual Harassment**—In many places, this is an illegal behavior. It means harassing someone else because of their gender. It could mean making personal, embarrassing remarks about someone's appearance, especially characteristics associated with sexual maturity, such as the size of a woman's breasts or of a man's testicles and penis. It could mean unwanted touching, such as hugging a subordinate or patting someone's bottom. It could mean demands by a teacher, supervisor, or other person in authority for sexual intercourse in exchange for grades, promotion, hiring, raises, etc. All these behaviors are manipulative. In many countries there are laws to provide protection against sexual harassment. Adolescents need to know that they have the right to complain to authorities if they are sexually harassed and that others may complain of their behavior if they sexually harass someone else.

3. **Withholding Sex**—This is when one partner deliberately refuses to have sex with the other partner as a means of manipulating or punishing the other. Of course, anyone has the right to refuse to engage in sexual intercourse, but to do so as an act of manipulation is unfair to the partner and to the relationship.

4. **Rape**—This means coercing or forcing someone else to have genital contact with another. Sexual assault can include forced petting as well as forced sexual intercourse. Force can include use of overpowering strength, threats, and/or implied threats that arouse fear in the person raped. Adolescents need to know that rape is a human rights violation and never okay. Refusing to accept no and forcing the other person to have sexual intercourse always means rape.

5. **Incest**— This means forcing sexual contact on someone who is related to the perpetrator. When incest occurs between an adult family member and a child or young person, it betrays the trust that children and youth give to their families. Moreover, because the older person knows that incest is usually unaccepted, they try to hide the crime and will blame the child or young person. The triple burden of forced sexual contact, betrayed trust, and self–blame makes incest particularly damaging to survivors of incest.

Source: Adapted from: Advocates for Youth. Life Planning Education: A Youth Development Program. Washington, DC: Advocates for Youth, revised 2014.

Circles of Sexuality Handout

Leader's Resource

Circles of Sexuality

SENSUALITY

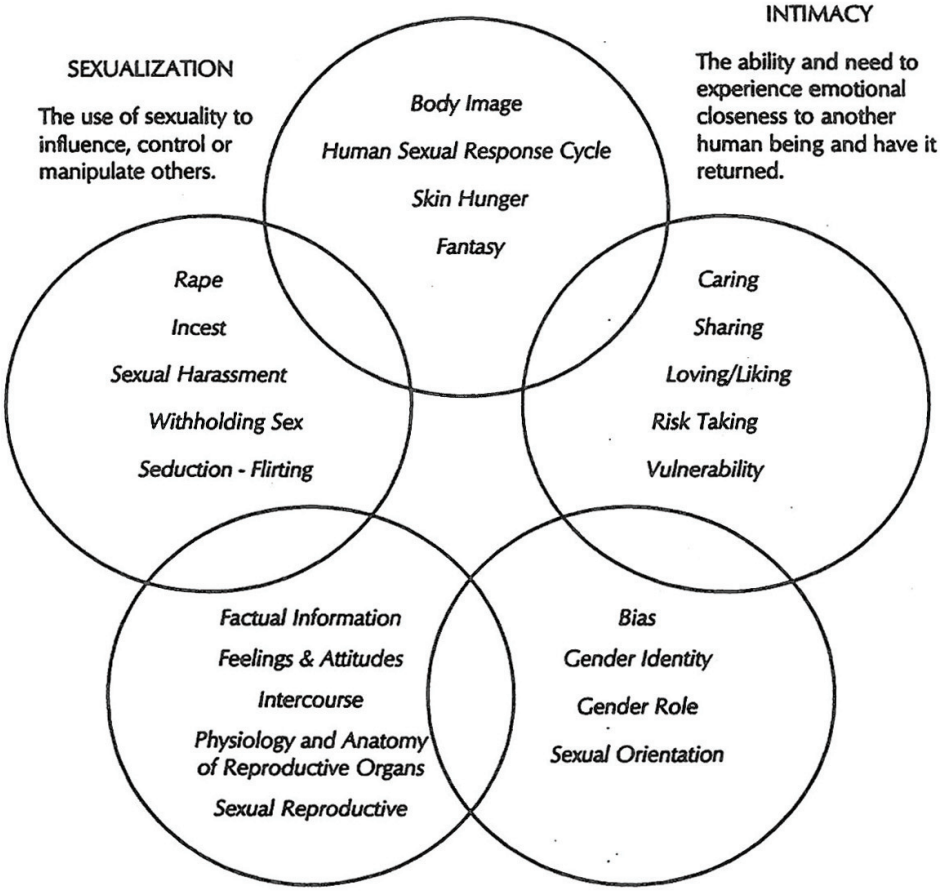
Awareness, acceptance of and comfort with one's own body; physiological and psychological enjoyment of one's own body and the bodies of others

INTIMACY

The ability and need to experience emotional closeness to another human being and have it returned.

SEXUALIZATION

The use of sexuality to influence, control or manipulate others.



SEXUAL HEALTH AND REPRODUCTION

Attitudes and behaviors related to producing children, care and maintenance of the sex and reproductive organs, and health consequences of sexual behavior.

SEXUAL IDENTITY

The development of a sense of who one is sexually, including a sense of maleness and femaleness.

Circles of Sexuality Activity Sheet

NAME	DEFINITION
BODY IMAGE	Feeling attractive and proud of one's own body and the way it functions influences many aspects of life. The media creates unrealistic expectations for how people should look, so young people are often disappointed by what they see in the mirror. They may be especially dissatisfied when the mainstream media does not portray or does not positively portray physical characteristics that adolescents see in the mirror, such as color of skin, type of hair, shape of eyes, height, or body shape.
HUMAN SEXUAL RESPONSE CYCLE	The way people experience sexual pleasure. Sensuality allows a person to experience pleasure when certain parts of the body are touched. People also experience sensual pleasure from taste, touch, sight, hearing, and smell, and these may or may not be part of the human sexual response.
SKIN HUNGER	The need to be touched and held by others in loving, caring ways. Adolescents typically receive considerably less touch from their parents than do younger children. Many adolescents satisfy this need through close physical contact with peers. Sexual intercourse may sometimes result from a person's need to be held, rather than from sexual desire.
FANTASY	The brain also gives people the capacity to have fantasies about sexual behaviors and experiences. Adolescents sometimes need help understanding that sexual fantasy is normal and also that one does not have to act upon sexual fantasies.

Circles of Sexuality Activity Sheet

NAME	DEFINITION
SHARING	This is what makes personal relationships rich. While sensuality is about physical closeness, this focuses on emotional closeness.
CARING	This means feeling someone's joy and pain. It means being open to emotions that may not be comfortable or convenient because an intimate relationship is possible only with this.
LIKING OR LOVING	Having emotional attachment or connection to others.
RISK-TAKING	Opening up and sharing feelings and personal information. Sharing personal thoughts and feelings with someone else is risky, because the other person may not feel the same way. But it is not possible to be really close with another person without being honest and open with her/him.

Circles of Sexuality Activity Sheet

NAME	DEFINITION
VULNERABILITY	We share and care, like or love, which means we let our defenses down—the person with whom we share, about whom we care, and whom we like or love has the power to hurt us emotionally.
GENDER IDENTITY	Knowing whether one is male, female, neither, or somewhere in between. Most young children determine their own gender identity by age two. Sometimes, the sex a person is assigned at birth is not the same as their gender identity—this is called being transgender. Sometimes people use the acronym "LGBT" when referring to individuals of diverse sexual orientations or gender identities. L stands for "lesbian," G stands for "gay," B stands for "bisexual," and T stands for "transgender."
GENDER ROLE	Identifying actions and/or behaviors for each gender. Most gender roles are socially/culturally constructed.
SEXUAL ORIENTATION	This is defined by whether a person's primary sexual attraction is to people of the other gender (heterosexuality) or to the same gender (homosexuality) or to both genders (bisexuality). This begins to emerge by adolescence. Sometimes people use the acronym "LGBT" when referring to individuals of diverse sexual orientations or gender identities. L stands for "lesbian," G stands for "gay," B stands for "bisexual," and T stands for "transgender."

Circles of Sexuality Activity Sheet

NAME	DEFINITION
BIAS	This means holding stereotyped opinions about people according to their gender. It might include believing that women are less intelligent or less capable than men, that men who cry are weak, that men cannot raise children without the help of women, that women cannot be analytical, that women are overly emotional. Many times, people hold fast to these stereotyped opinions without giving rational thought to the subject of gender.
FEELINGS AND ATTITUDES	These encompass sexual expression and feelings about reproduction as well as one's feelings about other sexual health topics such as STIs, HIV and AIDS, contraceptive use, abortion, pregnancy, and childbirth.
SEXUAL INTERCOURSE	This is one of humanity's most common behaviors. It is a behavior that may produce sexual pleasure and that often ends in orgasm in females and males. It may also result in pregnancy and/or STIs. In programs for youth, discussion about this is often limited to penile–vaginal intercourse. However, youth need accurate health information about all forms of sexual intercourse—vaginal, oral, and anal.
PHYSIOLOGY AND ANATOMY OF REPRODUCTIVE ORGANS	This topic includes the male and female body and the ways in which bodies actually function in sexual ways. Adolescents need to learn to protect their reproductive and sexual health. This means that they need information about all the effective methods of contraception available, how they work, where to obtain them, their effectiveness, and their side effects as well as how to use latex condoms to prevent STIs, including HIV. Even adolescents who have never had sexual intercourse need to know how to prevent pregnancy and/or disease.

Circles of Sexuality Activity Sheet

NAME	DEFINITION
SEXUAL REPRODUCTION	The actual processes of conception, pregnancy, delivery, and recovery following childbirth are important parts of sexuality. Youth need information about sexual reproduction—the process whereby two different individuals each contribute half of the genetic material to create a child. The child is, therefore, not identical to either parent.
FACTUAL INFORMATION	This is necessary so youth will understand how male and female reproductive systems function and how conception and/or STI infections occur. Adolescents often have inadequate information about their own and/or their partner's body. Yet, they need this information so they can make informed decisions about sexual expression and about protecting their health.
SEDUCTION	This is the act of enticing someone to engage in sexual activity. The act of seduction implies a deliberate manipulation, depriving the other person of informed choice and may be harmful for the one who is seduced.
SEXUAL HARASSMENT	In many places, this is an illegal behavior. It means harassing someone else because of their gender. It could mean making personal, embarrassing remarks about someone's appearance, especially characteristics associated with sexual maturity, such as the size of a woman's breasts or of a man's testicles and penis. It could mean unwanted touching, such as hugging a subordinate or patting someone's bottom. It could mean demands by a teacher, supervisor, or other person in authority for sexual intercourse in exchange for grades, promotion, hiring, raises, etc.

Circles of Sexuality Activity Sheet

NAME	DEFINITION
WITHHOLDING SEX	This is when one partner deliberately refuses to have sex with the other partner as a means of manipulating or punishing the other. Of course, anyone has the right to refuse to engage in sexual intercourse, but to do so as an act of manipulation is unfair to the partner and to the relationship.
RAPE	This means coercing or forcing someone else to have genital contact with another. Sexual assault can include forced petting as well as forced sexual intercourse. Force can include use of overpowering strength, threats, and/or implied threats that arouse fear in the person raped. Adolescents need to know that rape is always a human rights violation and is cruel. Refusing to accept no and forcing the other person to have sexual intercourse always means rape.
INCEST	This means forcing sexual contact on someone who is related to the perpetrator. When incest occurs between an adult family member and a child or young person, it betrays the trust that children and youth give to their families. Moreover, because the older person knows that incest is usually unaccepted, they try to hide the crime and will blame the child or young person. The triple burden of forced sexual contact, betrayed trust, and self–blame makes incest particularly damaging to survivors of incest.

Source: Adapted from: Advocates for Youth. Life Planning Education: A Youth Development Program. Washington, DC: Advocates for Youth, revised 2014.

Activity 4: Values Clarification

TOTAL TIME REQUIRED

1 hour 30 minutes

MATERIALS NEEDED

- ✔ Flip chart
- ✔ Markers
- ✔ Tape

RESOURCES NEEDED

- ✔ Leader's Resource on Values Voting Statements
- ✔ How to conduct a Values Voting Exercise Handout
- ✔ One pre-written flip chart with the following written on it:
    1. Your values are things you are for (or against).
    2. Your values are things you have chosen freely—no one else can force you to choose your values, although your family and others can certainly influence you.
    3. Your values are things you believe in and are willing to stand up for.
    4. Your values guide your behavior and your life.

RESOURCES NEEDED (CONTINUED)

- ✔ One pre-written sign/paper with "Agree" in large visible print
- ✔ One pre-written sign/paper with "Disagree" in large visible print

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Define what values are.
2. Demonstrate awareness of personal values, beliefs, biases, and experiences related to sexuality.
3. Recognize how personal values, beliefs, biases, and experiences can influence teaching of sexuality education and the importance of not asserting one's beliefs and biases onto learners.

INSTRUCTIONS

1. Explain that now that we have a good understanding of sexuality in addition to adolescent development, another key element to teaching sexuality education is to reflect on one's own values about sexuality. To do this, let's first explore what values are.
2. Place several coins or bills of different value on a desk or table and ask for a volunteer to come up to the table.
3. Ask the volunteers to choose a coin or bill and to display to everyone else what they chose.
4. Now ask the volunteer how they chose that coin or bill. If necessary, help the volunteer to say that they chose the one with the highest value.

Activity 4: Values Clarification

INSTRUCTIONS (CONTINUED)

5. Thank your volunteer and ask them to return the coin or bill to the desk or table and to be seated.

6. Next, write the word value on the flip chart. Explain that in this situation, value refers to the worth of each coin or bill. Ask the group for other examples of what has value. If the group only lists tangible things, ask for examples of intangibles that cannot be seen or touched but that have value. (Answers might include things like status, good grades, love, honesty, friendship, kindness, hard work, and talent).

7. List responses on the flip chart and add, if necessary, any important intangibles that teachers may have forgotten.

8. Now ask for three volunteers. Ask the volunteers to each choose one of the intangible things on the list and explain why they consider it important. Circle their choices. When the volunteers have finished, point out that it may be easy to know which tangible things have the most value, but it can be more difficult to define the value of what is intangible.

9. Explain that value has several meanings. One is the monetary worth of an object or item—that is how much something might cost. Another meaning is a more personal measure of worth, such as how important things, beliefs, or principles are to an individual. Different people value intangible things differently, meaning they have more or less value to each individual. The ideals, beliefs, and principles that are of worth to you shape your values.

10. Note that our values help define who we are and help determine our behavior. For example:

    - A person who values family cares about their life, parents, siblings, and home life.
    - A person who values beauty may want to live surrounded by art and nature.
    - A person who values health may choose a healthy diet, exercise regularly, and avoid using drugs.

Activity 4: Values Clarification

INSTRUCTIONS (CONTINUED)

11. Next, display the flip chart you have prepared and go through each statement, explaining how a person can tell what their values are:
    - Your values are things you are for (or against).
    - Your values are things you have chosen freely—no one else can force you to choose your values, although your family and others can certainly influence you.
    - Your values are things you believe in and are willing to stand up for.
    - Your values guide your behavior and your life.
12. Now ask teachers:

- ✔ Where do you think we get our values? (Answers could include family, religion, culture, and friends)
- ✔ What is one example of a value your family feels is important?
- ✔ Does anyone have an example of a religious value you hold and have been taught?
- ✔ Which of your values come from your culture?
- ✔ What is a value that is widely held in this country that may be less important in other countries?
- ✔ Can you think of a value someone else has that you do not share? What is it?

13. Explain that now that we have a good understanding of what values are, a key element to teaching sexuality education is to reflect on one's own values about sexuality. Doing so is important because while we may feel very strongly about certain things related to adolescents and sexuality, as teachers delivering sexuality education in schools, the goal is not to impose individual values on learners but rather to educate with age–appropriate information and skills. Part of sexuality education is enabling learners to assess and become more aware of their own values as they evolve, but it is not the teacher's role to tell them what values to adopt.

Activity 4: Values Clarification

INSTRUCTIONS (CONTINUED)

14. Explain that you will be reading a series of statements out loud and that after each one, you will ask the group to physically position themselves either under the "Agree" sign or the "Disagree" sign. Point to the signs, which should be taped on walls at opposite sides of the room and where there is room for people to stand closely. Warn teachers that it may be hard at times to pick a side and if so, you can position yourself somewhere in between.

15. Let teachers know that once everyone has positioned themselves, you will ask for volunteers to share why they chose to agree or disagree. Note that the purpose of sharing is not to try to convince others to agree with you but to simply express why you chose to stand where you did. Underscore that there are no wrong answers.

16. Say that since this activity can be a bit contentious quickly review the ground rules established earlier in the training.

17. Begin by reading a statement from the Values Statement Resource and ask teachers to position themselves either at the agree or disagree sign.

18. Ask for volunteers to share their perspectives. Try to select teachers on both sides of the spectrum and limit this to a couple of people per side. That said, some statements may demand a bit more discussion while others will inspire less urgency for sharing.

19. Continue doing the same with each statement until you are done. Pacing is important—do not allow the discussion to go on too long, but make sure to hear diverse points of view. Remember that processing statements and sharing reasons for participants' positions is the most valuable part of this activity.

20. In cases where there is only one person or a small number on one side of the room, move towards them as you facilitate the discussion to offer support as they may feel isolated or judged.

Activity 4: Values Clarification

INSTRUCTIONS (CONTINUED)

21. After the last statement is done, ask participants:

- ✔ How easy or difficult was it to decide your position?
- ✔ What did you notice about how you felt when you were expressing reasons for standing where you did?
- ✔ What did you learn about your values and that of your colleagues during this activity?
- ✔ How might your values impact how you teach sexuality education? What might help to keep your personal values from interfering with teaching sexuality education?

22. Conclude by noting that issues around sexuality can incite strong feelings driven by our values. However, personal values about sexuality and young people need to remain just that, personal. Taking the time to examine one's own values is important and empowers teachers to become more self–aware in order to avoid imposing personal values on learners.

Leader's Resource on Values Voting Statements

1. Selling illicit drugs to young people is a very bad thing to do.

2. It's okay for a man to cry.

3. Adolescent girls and boys should know about puberty and the menstrual cycle.

4. It's best to wait until marriage to have sex.

5. A young woman who keeps condoms in her purse can't be trusted.

6. Boys are always up to no good.

7. You should only have sex with someone you love.

8. When a man and woman have sex, contraception is the woman's responsibility.

9. Adolescents should know about how you can get pregnant and contraception.

10. Dating someone of a different ethnicity or religion is wrong.

11. Contraception should be available to students without parental consent.

12. Abstinence (choosing not to engage in sexual intercourse) is the best choice for young people.

13. A girl who comes to school wearing sexy clothes is trying to get lots of attention from other people and deserves to be called names.

14. Boys who are not interested in having lots of girlfriends are probably gay.

15. Parents should be the only people teaching their children about sexuality.

16. There is really such a thing as love at first sight.

SESSION FIVE

Applying Effective Teaching Methodologies for Sexuality Education

LEARNING OBJECTIVES

1. Identify and apply at least three principles of learning.
2. Develop and apply questions that take learners through the stages of the experiential learning cycle.
3. Characterize commonly used activities and describe at least three techniques for assessment.
4. Identify and demonstrate at least three characteristics of an effective facilitator.

ACTIVITIES

Activity 1 Experiential Learning

Activity 2 Review of Types of Activities and Assessment

Activity 3 Facilitation Skills

Activity 1: Experiential Learning

TOTAL TIME REQUIRED

2 hours

MATERIALS NEEDED

- ✔ Flip chart
- ✔ Markers
- ✔ Note cards
- ✔ Tape

RESOURCES NEEDED

- ✔ Principles of Learning Handout
- ✔ Experiential Learning Cycle Diagram Handout
- ✔ Pre-written flip chart with the five empty circles of the experiential learning cycle and "Experiential Learning Cycle" written at the top
- ✔ Rating Behaviors for HIV Risk Lesson Plan Handout
- ✔ Note cards with one risk behavior (provided in the above resource) written on each card
- ✔ Half sheets of flip chart paper pre-written with:
    1. Definitely a risk
    2. Probably a risk
    3. Probably not
    4. Definitely not

RESOURCES NEEDED (CONTINUED)

- ✔ Pre-written flip chart with these assessment questions:
    1. Do the questions allow learners to share about the actual experience of engaging in the exercise?
    2. Do the questions ask the learners something that probes them to analyze the experience?
    3. Do the questions ask learners to draw a conclusion from the exercise?
    4. Do the questions ask learners to relate this to their lives?

LEARNING OBJECTIVES

By the end of the session, teachers will be able to:

1. Describe at least five core principles of learning.
2. List the five stages of the experiential learning cycle and describe how to bring learners from one step to the next by experiencing activity and practicing creating and facilitating process questions to bring learners through the entire cycle.

Activity 1: Experiential Learning

INSTRUCTIONS

1. Remind teachers that effective sexuality education is not just about what you teach but how you teach it.
2. Explain that next we will begin by reviewing some core principles of learning and then explore the experiential learning cycle, which integrates some of these principles, so that teachers can maximize learning through its application.

Principles of Learning (30 minutes)

3. Distribute the Principles of Learning handout and review these using the handout by reading through them or asking one teacher at a time to read one principle until the full list has been read.
4. Ask teachers to share any examples of situations where they have seen any of the core principles of learning in action; additional principles of effective learning that they may want to share, or any questions or comments that they may have about the principles on the list.

Experiential Learning Model (30 minutes)

5. Indicate that now that we have identified some overarching core principles, we will go into more depth on one learning model that addresses several of these principles, such as engagement, organizing of concepts, and application.
6. Ask teachers if they have heard of the experiential learning cycle.
7. Ask anyone who has to please explain their understanding of the cycle.
8. If needed, complement what teachers have shared by noting that the experiential learning model is a theory of learning characterized by a 4–stage cycle and a holistic perspective that combines experience, perception, cognition, and behavior. Most associated with the educational theorist, Kolb (1984), the theory promotes the idea that we learn best from experiencing something and reflecting on that experience.
9. Show the flip chart with the five empty circles and talk teachers through the five different circles, starting with the first one and filling it in, followed by drawing an arrow to the next one and filling it in, until all the circles are complete and well described as follows:

Activity 1: Experiential Learning

INSTRUCTIONS (CONTINUED)

Circle 1: Experience (the activity, perform it, do it)

10. First, explain that experiential learning concerns an individual having an experience and then processing it in order to gain something useful—that is knowledge.

11. Explain that gaining knowledge from experience is not automatic. Instead, compare experience to empty plots of land. In order for anything useful to be gleaned from barren, untouched fields, a process must be followed. This process usually involves ploughing, sowing, irrigating, and cultivating the soil. Similarly, learning from experience is not instant but rather, requires a process be followed to transform the experience into knowledge.

12. Explain that the first step in the cycle is the actual experience, which in the case of learners, is the activity that you as teachers engage them in to build their knowledge and skills, such as a brainstorm, a role–play, a lecture, or a simulation exercise.

Circle 2: Share (sharing what the experience was like)

13. Explain that the second step in the cycle is to share reactions to that experience—these are immediate reactions to what it was like to engage in the experience. This part of the learning cycle necessitates that the learner consider their emotions, thoughts and behaviors related to their experience. How to elicit sharing from learners would include asking them about what they just did, how it felt, and what they saw or heard.

Circle 3: Process (analyzing the experience through observations of what happened, patterns or comparisons)

14. Note that the third step in the cycle is to process or review their experience for the purpose of making careful observations and reflections. How to elicit processing among learners would include asking them about what they noticed during the experience, what issues came up, why, or how.

Activity 1: Experiential Learning

INSTRUCTIONS (CONTINUED)

Circle 4: Generalize (identifying the overarching lesson)

15. Say that the fourth step in the cycle is to generalize their experience by bringing into account previous experiences in an attempt to uncover common patterns or similarities that relate to their lives. How to elicit processing among learners would include asking them about what they take away from the experience: what does this mean to them in their daily lives, how does it relate to what they are learning, or whether and how they might have experienced something similar before.

Circle 5: Apply (expressing how this lesson can be used in real life or how it relates to what is being taught)

16. Explain that the fifth step in the cycle is to apply their experience by identifying how the generalizations or lessons that they have noted from the experience apply to their daily lives. How to elicit application among learners would include asking them about how they can use what they have learned or how they can apply what they have learned to future situations.

17. As you describe the circles, consider sharing an example to illustrate what each circle consists of. For example: Grace learned from experiential learning when, at age three, she burned her finger by putting it into a flame (a concrete experience). She felt scared when it happened and automatically pulled her finger out (her reaction). She noted that the flame burned her finger which made it hurt (observation and reflection). She understood that a flame will burn you and is dangerous (generalization/lesson). She later knew to keep her hands from touching fire when she was first learning to burn wood in order to cook food (application in new situation).

18. Note that the learner realizes that their generalizations and lessons are applicable in some situations but not others. It is possible that the learner may not find any situation in which their generalizations fit; consequently, they are stored until recalled in a future experience, as was the case with Grace, when she began learning how to burn wood years after experiencing and learning from burning her finger.

Activity 1: Experiential Learning

INSTRUCTIONS (CONTINUED)

19. Note that applying the experiential learning model in the classroom facilitates learning but is often different from how many of us currently teach.

20. Distribute the Experiential Learning Cycle Diagram handout. Note that we will now put the experiential learning model into practice by applying it to a typical activity for sexuality education, called Rating Behaviors for HIV Risk. Explain that you will quickly simulate the lesson on HIV risk and that right at the end of it, you will be asking teachers to take over as if they had just led the lesson themselves by asking them to develop the questions that they would have to ask at the end of the lesson in order to take their learners through the experiential learning cycle.

Rating Behaviors for HIV Risk (30 minutes)

21. Take 30 minutes to lead the activity as described in the resource: Rating Behaviors for HIV Risk Lesson Plan handout; however, instead of processing the activity with questions at the end, conclude the activity once all the behaviors have been rated.

Application of Experiential Learning Model to Rating Behaviors for HIV Risk (30 minutes)

22. Next, divide teachers into groups of five and give them 20 minutes to develop questions that would guide their learners through the experiential learning process if they were to replicate this activity in their classroom. Provide each group with a copy of the Rating Behaviors for HIV Risk Lesson Plan handout and flip chart paper to write four questions (one per circle subsequent to the experience of the experiential learning cycle) that they might ask at the end of the risk rating exercise.

23. Call time and ask teachers to post their questions and quickly look around to see what other groups wrote.

24. Meanwhile, post the flip chart with the assessment questions.

25. Ask for one or two groups to volunteer to share their questions.

Activity 1: Experiential Learning

INSTRUCTIONS (CONTINUED)

26. After each group presents, read the assessment questions noted on the flip chart, asking for teachers to provide feedback. If there are experiential questions presented by the groups that need amending, ask for group members to suggest a modification (or others to do the same if one is not given by the group).

27. Once the two groups have presented their experiential learning questions and any changes have been made, ask the following:

- ✔ What was it like to do this exercise?
- ✔ What did you notice as you were developing questions? Were some questions harder than others to come up with? Why do you think it's important to tag questions like these onto activities?
- ✔ How might you use the experiential learning model when conducting activities in the classroom?

28. Conclude the activity by noting that experiential learning is key to active engagement of learners through learning by doing and reflection on those activities. This process empowers them to be able to apply new knowledge and skills about sexuality to their current or future life experiences.

Principles of Learning Handout

1. Learning is promoted when students **learn about topics relevant to their lives**.

2. Learning is promoted when **material is tailored** to the students' age, knowledge level, level of sexual experience, and gender.

3. Learning is promoted when **new knowledge is demonstrated** rather than simply described.

4. Learning is promoted:
   - When **complex concepts or skills are broken down** into a progression of smaller concepts or skills
   - When the **smaller concepts or skills are taught first**
   - When there is then **a logical progression to more complex skills**

5. Learning is promoted when **multiple examples and perspectives are provided**.

6. Learning is promoted when **existing knowledge is activated** as a foundation for new knowledge.

7. Learning is promoted when **students are actively engaged** in solving problems.

8. Learning is promoted when **students organize their new concepts and skills**.

9. Learning is promoted when **new knowledge is applied multiple times** to solve problems.

10. Learning is promoted when students **are given the proper balance of challenge and support**.

11. Learning is promoted when **students are encouraged to apply** or integrate their new knowledge or skill into their everyday lives.

12. Learning is promoted when **instruction is individualized**.

13. Learning is promoted when effective teachers **use an array of type of teaching activities,** because there is no single, universal approach that suits all situations.

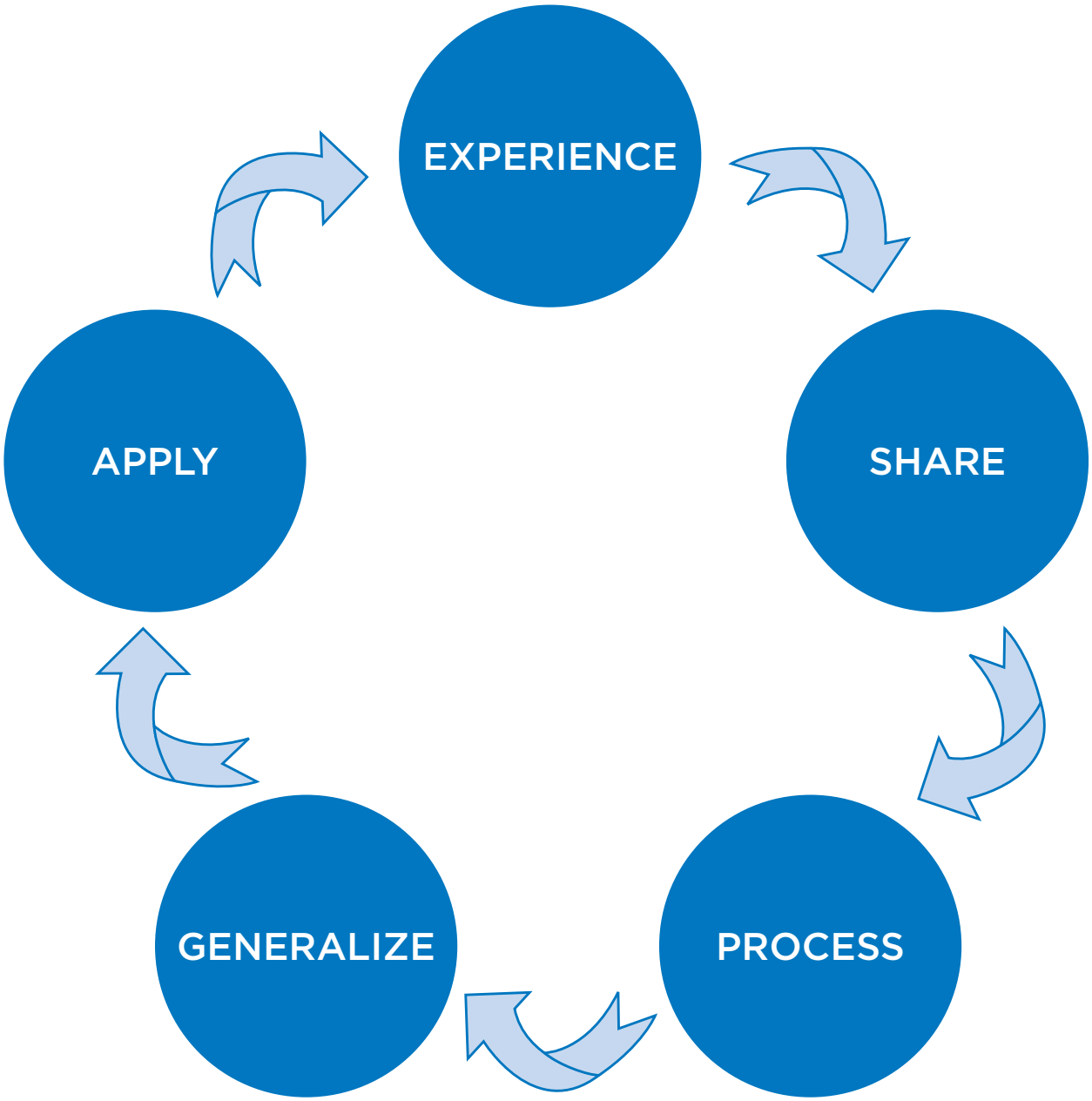
14. Learning is promoted when students **work regularly and productively with other students**.

15. Learning is promoted when **students invest time** and make a committed effort.

16. Learning is promoted when **students are assessed appropriately and understand the assessment criteria**.

Source: Kirby, D. Reducing Sexual Risk Behavior Among Young People. A Training Tool Kit for Curriculum Developers. Scotts Valley, CA: ETR Associates, 2013.

Experiential Learning Cycle Diagram Handout



Source: 5–Step Learning Cycle (UC–STEL, 2005).

Rating Behaviors for HIV Risk Lesson Plan Handout

Rating Behaviors for HIV Risk

Purpose: To identify sexual behaviors that transmit HIV and those that do not

Materials: Leader's Resource, "Answers for Rating Behaviors for HIV Risk"(pdf); newsprint and markers; masking tape; index cards

Time: 30 minutes

Instructions:
Prepare four signs that say:
Definitely a risk
Probably a risk.
Probably not a risk. and
Definitely not a risk.
Post signs in a row on a wall.

Copy the 18 behaviors from the Leader's Resource onto individual index cards for Step 2.

Know that listing "Kissing" in the "Probably not a risk" category is likely to raise questions. Be prepared to answer their concems, noting that "dry" kissing is certainly "safe", but French or "deep" kissing might pose a risk **if there is blood in either mouth, due to bleeding gums, sores or cuts**. Explain that no cases of HIV infection have been traced to deep kissing but that scientists are unwilling to say that it is completely Impossible.

Know that latex condoms can help prevent the spread of HIV infection. Researchers have studied couples in which one sexual partner was infected and the other was not. When the couples used condoms and a lubricant consistently and correctly every time they had sex, none of the non infected partners became infected with HIV.

1. Explain that this activity will identify which behaviors risk HIV infection and which do not. To test knowledge about risky behaviors, they will rate activities along a continuum of riskiness, from "Definitely a risk" to "Definitely not a risk." Point out the signs on the wall.
2. Distribute index cards to participants. If you have more than 18 participants, have the group form pairs.
3. Have teens come forward one/two at a time to the signs. After reading the card aloud, they will tape the card under one of the categories.
4. After each card is placed, ask the teen why she or he chose that category. Ask if the group agrees. Using the Leader's Resource, correct any misinformation and be sure that the index card is moved to the correct category.
5. Remind the group that the behaviors that most risk HIV infection are having anal, vaginal or oral intercourse without latex condoms or barriers and sharing any kind of needles.
6. Conclude the activity using the Discussion Points.

Your Experiential Learning Questions:

1.

2.

3.

4.

5.

Rating Behaviors for HIV Risk Lesson Plan Handout

Leader's Resource

Answers for Rating Behaviors for HIV Risk

Behavior	Definitely a risk	Possibly a risk	Probably not a risk	Definitely not a risk
Not having sexual intercourse (abstinence)				X
Sharing needles for drug use	X			
Sharing needles for body piercing, tattooing and so on	X			
Vaginal, oral or anal intercourse without latex condoms	X			
Kissing			X	
Getting a blood transfusion			X	
Donating blood				X
Using a public telephone				X
Shaking hands with a person with AIDS				X
Hugging a person with AIDS				X
Being coughed on by a person infected with HIV				X
Going to school with a person with AIDS				X
Being born to a mother with HIV	X			
Being bitten by a mosquito				X
Swimming in a pool				X
Sharing a toothbrush or razor			X	
Intercourse with a condom		X		

*Adapted from Stephen Sroka and Leonard Calabrese, *Educators Guide to AIDS and Other STDs*, Lakewood, OH: Health Education Consultants, 1987.

Activity 2: Types of Activities and Assessment

TOTAL TIME REQUIRED

1 hour and 30 minutes

MATERIALS NEEDED

- ✔ Flip chart
- ✔ Note cards
- ✔ Tape
- ✔ Scissors

RESOURCES NEEDED

- ✔ Types of Activities Handout
- ✔ Types of Activities Activity Sheet (for making the note cards)
- ✔ Sets of note cards (depending on the number of groups you have). Each set of note cards will consist of cards with the name of an activity per card and characteristics of an activity per card, all mixed up (so that teachers can match names to characteristics).
- ✔ Formative and Summative Assessment Handout

LEARNING OBJECTIVES

By the end of the session, teachers will be able to:

1. Characterize commonly used activities and describe at least three techniques for assessment.

INSTRUCTIONS

1. Explain that now that we have a good understanding of the experiential learning method, let's talk about the actual types of activities that you can use to deliver sexuality education in the classroom. While some of these may already be defined in your curriculum, it's also helpful to understand what different types of activities are good for. Ultimately, using a diversity of activities can enhance learning and is a characteristic of effective sexuality education programs.
2. Take five minutes to ask teachers to quickly brainstorm some types of activities that can be used in the classroom and list them on a flip chart.
3. Explain that next we will be reviewing a number of activities that can be used in the classroom by playing a matching game. Divide teachers into teams with no more than 4–6 people per team.
4. Distribute a set of note cards to each team in addition to a few blank cards and ask them to match the name of the activity with the proper definition. Let teachers know that they can also add activities to their cards by filling in blank ones. Ask each team to also pick one activity and be prepared to describe it in plenary along with an example of how they might use it to deliver a sexuality education lesson. Give teachers 15 minutes to complete this activity.
5. Circulate among the groups while they are working in case they need assistance.
6. Once everyone has matched names of activities to their descriptions, take about 15 minutes to ask for volunteers to take turns reading an activity with its respective description. If there is an error, ask others to suggest what description might be the better one for that activity and affirm the correct answer. Be sure to ask for volunteers to share any new activities that were added.
7. Distribute the Formative and Summative Assessment handout and ask teachers to read through the document and to note at least three assessment techniques that they either like or had not heard of. Allow about 10 minutes for them to review the document.

Activity 2: Types of Activities and Assessment

INSTRUCTIONS (CONTINUED)

8. Next, group teachers into triads and ask them to take 5 minutes each to describe one of the assessment techniques that they picked to their other two colleagues and how they might use it in the classroom. Ask teachers to share different techniques.

9. Call time and invite a couple of triads to share some of the techniques that their group had selected and why.

10. Ask participants:

- ✔ What was it like to match the activity names to descriptions and to review techniques for assessment?
- ✔ Were you familiar with some activities and assessment techniques and not others?
- ✔ Why is it important to think about the different types of activities that you can use in the classroom? Which activities are especially good for addressing certain types of factors? What are some ways you can assess learning?
- ✔ How might this impact the activities you choose and how you assess them in the classroom?

11. Conclude by noting that using a diversity of activities is a characteristic of effective sexuality education programs. Note that learning is not just about knowledge and that to impact behavior and reduce sexual risk among adolescents, it's essential to address different factors in addition to knowledge, including perception of risk, understanding of values and attitudes, perception of peer norms, self–efficacy, intentions, and parent–child communication. Using formative and summative assessments are also key and there are many techniques that teachers can use to evaluate learning.

Types of Activities Handout

1. Anonymous Question Box

This provides youth with an opportunity to ask questions without having their names associated with the question. This may help to elicit more meaningful questions, especially when teaching about a sensitive topic. This type of activity can address multiple factors, depending on the questions, but tends to be good for increasing knowledge.

2. Brainstorming

This is often used to generate ideas and lists. All ideas are recorded. For example, a facilitator may ask a group of youth, "What are some contraceptive methods that you have heard of?" All answers to this question are accepted and recorded. This technique encourages broad participation and helps students consider all possibilities. This type of activity can address multiple factors, depending on the question asked of participants, and is often used in conjunction with other activities that follow.

3. Competitive Games

These often mimic what is seen on some television shows, in sports, and contests in which teams win by correctly answering questions or completing specific tasks such as matching or sorting information. These often can encourage interaction among youth, be fun, reduce embarrassment discuss sensitive topics, and reinforce learning.

4. Pamphlets/Written Materials

Written materials like these can provide information about a particular topic relatively efficiently. They are commonly used to teach about the reproductive system, contraceptive methods, and STIs through words and/or pictures. These are a good way to give students information that they can take home or refer to in the future.

5. Guest Speakers

These can add a personal perspective and interest to class sessions (e.g., someone who has been living with HIV can share his/her experience or someone from the clinic can come share information about contraceptive methods). These should have a special area of expertise or experience and should be skilled at talking with youth about their particular topic.

6. Homework Assignments

These are generally given to students to help reinforce learning or explore a topic more deeply. These can also provide an opportunity for parents and youth to communicate about an important topic since it is done at home.

7. Large-Group/Whole-Class Discussions

These are generally led by a facilitator. Information to be discussed is sometimes presented first through a short lecture, video, or skit. After the information is presented, the facilitator allows for recall, analysis, generalization, and application of the information.

Types of Activities Handout

8. Problem-Solving Activities

Many effective curricula provide these types of activities where students have to make decisions, either individually or in small groups, about what they believe should be done. Sometimes, these are presented as letters to a columnist in a newspaper or magazine asking for advice related to relationships or sexual behavior. Other times, they are presented as questions from friends or advice to give younger brothers or sisters. This often requires learners to discuss, weigh the risks of various alternative behavioral solutions, and reach a decision about the best approach. This type of exercise can equip learners with a sense of what they would plan to do should they encounter a similar situation.

9. Quizzes

These can be self-assessments and myth/fact sheets used as ways to assess how much information participants have about a subject, what they need to learn about a subject, and/or what they have learned from a session. Reviewing the answers with a group also provides additional opportunities to teach or reinforce information.

10. Role-Plays

These, scripted and unscripted, provide an opportunity for learners to practice skills. For example, after learning the steps for refusal, they may apply the steps to a hypothetical scenario. These are particularly effective at teaching skills and increasing learners' sense that they can master and apply those skills.

11. Brief Lectures

This is delivered orally and may or may not include visual aids (such as charts, diagrams, and slides). This is generally used to present factual material in a direct and logical manner, to entertain or to inspire an audience. These appeal to those learners who learn by listening.

12. Skill Demonstrations

The facilitator models the steps that must be taken to do something (e.g., refusing sex, negotiating condom use, or using a condom correctly). Afterward the facilitator elicits feedback on his or her modeling of the steps and sometimes has the students practice as well.

13. Skits

These are dramatic presentations of situations that can serve as input for a large- or small-group discussion. These are effective at engaging an audience because the performance is live and often involves the participants as actors. These can be especially useful in illustrating positive attitudes or behaviors in a normative way. These can also be used to show a main character that learners can identify with overcoming difficulties so that they too can see themselves able to do the same.

14. Small-Group Discussions or Other Activities

These generally allow for more youth to be involved and express their ideas. Generally, learners are given a set of guidelines or instructions for completing a task together (e.g., read and analyze a case study by answering a set of questions). Then summarize their work for the larger group.

Types of Activities Handout

15. Simulations

These attempt to demonstrate how something works in a hypothetical but realistic situation. These can contribute to learners' sense of ability to do something that they may not have tried yet or have lacked the confidence to do by taking them through a process. These can also be used to illustrate risks and consequences of actions taken in a hypothetical situation. These are often followed by large– or small–group discussions of the major points.

16. Statistics on Incidence and Prevalence

Presenting data about teen pregnancy and/or STIs helps youth understand the scope of the problem and helps them understand their risk.

17. Videos and Discussion

These are often very popular with youth and are effectively used to stimulate group discussions and reinforce learning. One challenge with these is that they can become outdated with respect to the information they provide on youth fashion, slang, and culture.

18. Worksheets

These require youth to think about the topic at hand and review important/critical points by working through a document, usually with some questions to answer.

19. Values Voting

This is used to bring learners to think about and communicate personal values and to listen to those of others. The role of the facilitator is to help group members clarify their own personal values, not to impose his/her values on learners.

20. Surveys/Questionnaires

This is used to take a count of attitudes or behaviors anonymously in order to inform an understanding of how common or uncommon something is. For example, teachers could ask learners to use this to gather data about attitudes about pregnancy during school. They would then be asked to share their findings in aggregate form with the larger group. This can be especially useful when the reality counters common perceptions that can be harmful to students or encourage high risk behaviors.

21. Making a Plan

This can be used to ask learners to write down steps that they would take in a given situation and/or into the future. This helps learners think about actions that they would wish to take, usually in order to attain a particular goal.

22. Songs

These can be used for a variety of things, such as to help learners recall information to build knowledge, enumerate steps in a process to strengthen intention or foster self–efficacy, or address attitudes and values.

23. Treasure Hunt

This consists of requiring that learners quickly identify specific material within a resource material such as a book, manual, or guide thereby building familiarity with the resource and strengthening knowledge of its content and self–efficacy for its use.

Types of Activities Handout

24. Gallery Walk

This consists of allowing learners to walk and look over materials developed by other learners. It provides the opportunity for learners to assess and appreciate the work of others and compare and contrast information/presentations.

25. Case Studies

A specific case (a detailed story, either true or fictional) that students analyze in detail to identify the underlying principles, practices, or lessons it contains.

26. Think/Pair/Share

This consists of having learners reflect on something and then turn to someone near them to summarize what they're learning, to answer a question posed during the discussion, or to consider how and why and when they might apply a concept to their own situations. The objectives are to engage participants with the material on an individual level, in pairs, and finally as a large group.

27. Write/Pair/Share

This consists of having learners write their thoughts down (as opposed to reflecting as in think/pair/share) and then turning to someone near them to summarize what they've written regarding what they are learning, to answer a question posed during the discussion, or to consider how and why and when they might apply a concept to their own situations. The objectives are to engage participants with the material on an individual level, in pairs, and finally as a large group.

28. Jigsaw Teamwork

A general topic is divided into smaller, interrelated pieces (such as a puzzle is divided into pieces) and each member of a team or groups are assigned to read and become an expert on a different piece of the puzzle. Then, each teaches the other team about that puzzle piece so that after each person has finished teaching, everyone knows something important about every piece of the puzzle.

Types of Activities Activity Sheet

ACTIVITY NAME	ACTIVITY CHARACTERISTIC
1. ANONYMOUS QUESTION BOX	This provides youth with an opportunity to ask questions without having their names associated with the question. This may help to elicit more meaningful questions, especially when teaching about a sensitive topic. This type of activity can address multiple factors, depending on the questions, but tends to be good for increasing knowledge.
2. BRAINSTORMING	This is often used to generate ideas and lists. All ideas are recorded. For example, a facilitator may ask a group of youth, "What are some contraceptive methods that you have heard of?" All answers to this question are accepted and recorded. This technique encourages broad participation and helps students consider all possibilities. This type of activity can address multiple factors, depending on the question asked of participants, and is often used in conjunction with other activities that follow.
3. COMPETITIVE GAMES	These often mimic what is seen on some television shows, in sports, and contests in which teams win by correctly answering questions or completing specific tasks. These often can encourage interaction among youth, be fun, reduce embarrassment, discuss sensitive topics, and reinforce learning.
4. PAMPHLETS/WRITTEN MATERIALS	Written materials like these can provide information about a particular topic relatively efficiently. They are commonly used to teach about the reproductive system, contraceptive methods, and STIs through words and/or pictures. These are a good way to give students information that they can take home or refer to in the future.

Types of Activities Activity Sheet

ACTIVITY NAME	ACTIVITY CHARACTERISTIC
5. GUEST SPEAKERS	These can add a personal perspective and interest to class sessions (e.g., someone who has been living with HIV can share his/her experience or someone from the clinic can come share information about contraceptive methods). These should have a special area of expertise or experience and should be skilled at talking with youth about their particular topic.
6. HOMEWORK ASSIGNMENTS	These are generally given to students to help reinforce learning or explore a topic more deeply. These can also provide an opportunity for parents and youth to communicate about an important topic since it is done at home.
7. LARGE-GROUP/WHOLE-CLASS DISCUSSIONS	These are generally led by a facilitator. Information to be discussed is sometimes presented first through a short lecture, video, or skit. After the information is presented, the facilitator allows for recall, analysis, generalization, and application of the information.
8. PROBLEM-SOLVING ACTIVITIES	Many effective curricula provide these types of activities where students have to make decisions, either individually or in small groups, about what they believe should be done. Sometimes, these are presented as letters to a columnist in a newspaper or magazine asking for advice related to relationships or sexual behavior. Other times, they are presented as questions from friends or advice to give younger brothers or sisters. This often requires learners to discuss, weigh the risks of various alternative behavioral solutions, and reach a decision about the best approach. This type of exercise can equip learners with a sense of what they would plan to do should they encounter a similar situation.

Types of Activities Activity Sheet

ACTIVITY NAME	ACTIVITY CHARACTERISTIC
9. QUIZZES	These can be self–assessments and myth/fact sheets used as ways to assess how much information participants have about a subject, what they need to learn about a subject, and/or what they have learned from a session. Reviewing the answers with a group also provides additional opportunities to teach or reinforce information.
10. ROLE–PLAYS	These, scripted and unscripted, provide an opportunity for learners to practice skills. For example, after learning the steps for refusal, they may apply the steps to a hypothetical scenario. These are particularly effective at teaching skills and increasing learners' sense that they can master and apply those skills.
11. BRIEF LECTURES	This is delivered orally and may or may not include visual aids (such as charts, diagrams, and slides). This is generally used to present factual material in a direct and logical manner, to entertain or to inspire an audience. These appeal to those learners who learn by listening.
12. SKILL DEMONSTRATIONS	The facilitator models the steps that must be taken to do something (e.g., refusing sex, negotiating condom use, or using a condom correctly). Afterward, the facilitator elicits feedback on his or her modeling of the steps and sometimes has the students practice as well.

Types of Activities Activity Sheet

ACTIVITY NAME	ACTIVITY CHARACTERISTIC
13. SKITS	These are dramatic presentations of situations that can serve as input for a large- or small-group discussion. These are effective at engaging an audience because the performance is live and often involves the participants as actors. These can be especially useful in illustrating positive attitudes or behaviors in a normative way. These can also be used to show a main character that learners can identify with overcoming difficulties so that they too can see themselves able to do the same.
14. SMALL-GROUP DISCUSSIONS OR OTHER ACTIVITIES	These generally allow for more youth to be involved and express their ideas. Generally, learners are given a set of guidelines or instructions for completing a task together (e.g., read and analyze a case study by answering a set of questions). Then summarize their work for the larger group.
15. SIMULATIONS	These attempt to demonstrate how something works in a hypothetical but realistic situation. These can contribute to learners' sense of ability to do something that they may not have tried yet or have lacked the confidence to do by taking them through a process. These can also be used to illustrate risks and consequences of actions taken in a hypothetical situation. These are often followed by large- or small-group discussions of the major points.
16. STATISTICS ON INCIDENCE AND PREVALENCE	Presenting data about teen pregnancy and/or STIs helps youth understand the scope of the problem and helps them understand their risk.

Types of Activities Activity Sheet

ACTIVITY NAME	ACTIVITY CHARACTERISTIC
17. VIDEOS AND DISCUSSION	These are often very popular with youth and are effectively used to stimulate group discussions and reinforce learning. One challenge with these is that they can become outdated with respect to the information they provide on youth fashion, slang, and culture.
18. WORKSHEETS	These require youth to think about the topic at hand and review important/critical points by working through a document, usually with some questions to answer.
19. VALUES VOTING	This is used to bring learners to think about and communicate personal values and to listen to those of others. The role of the facilitator is to help group members clarify their own personal values, not to impose his/her values on learners.
20. SURVEYS/ QUESTIONNAIRES	This is used to take a count of attitudes or behaviors anonymously in order to inform an understanding of how common or uncommon something is. For example, teachers could ask learners to use this to gather data about attitudes about pregnancy during school. They would then be asked to share their findings in aggregate form with the larger group. This can be especially useful when the reality counters common perceptions that can be harmful to students or encourage high risk behaviors.

Types of Activities Activity Sheet

ACTIVITY NAME	ACTIVITY CHARACTERISTIC
21. MAKING A PLAN	This can be used to ask learners to write down steps that they would take in a given situation and/or into the future. This helps learners think about actions that they would wish to take, usually in order to attain a particular goal.
22. SONGS	These can be used for a variety of things, such as to help learners recall information to build knowledge, enumerate steps in a process to strengthen intention or foster self–efficacy, or address attitudes and values.
23. TREASURE HUNT	This consists of requiring that learners quickly identify specific material within a resource material such as a book, manual, or guide thereby building familiarity with the resource and strengthening knowledge of its content and self–efficacy for its use.
24. GALLERY WALK	This consists of allowing learners to walk and look over materials developed by other learners. It provides the opportunity for learners to assess and appreciate the work of others and compare and contrast information/presentations.

Types of Activities Activity Sheet

ACTIVITY NAME	ACTIVITY CHARACTERISTIC
25. CASE STUDIES	A specific case (a detailed story, either true or fictional) that students analyze in detail to identify the underlying principles, practices, or lessons it contains.
26. THINK/PAIR/SHARE	This consists of having learners reflect on something and then turn to someone near them to summarize what they're learning, to answer a question posed during the discussion, or to consider how and why and when they might apply a concept to their own situations. The objectives are to engage participants with the material on an individual level, in pairs, and finally as a large group.
27. WRITE/PAIR/SHARE	This consists of having learners write their thoughts down (as opposed to reflecting as in think/pair/share) and then turning to someone near them to summarize what they've written regarding what they are learning, to answer a question posed during the discussion, or to consider how and why and when they might apply a concept to their own situations. The objectives are to engage participants with the material on an individual level, in pairs, and finally as a large group.
28. JIGSAW TEAMWORK	A general topic is divided into smaller, interrelated pieces (such as a puzzle is divided into pieces) and each member of a team or groups are assigned to read and become an expert on a different piece of the puzzle. Then, each teaches the other team about that puzzle piece so that after each person has finished teaching, everyone knows something important about every piece of the puzzle.

Formative and Summative Assessment Handout

Formative assessment is ongoing assessment that is intended to improve an individual student's performance, student–learning outcomes at the course or program level, or overall institutional effectiveness. By its nature, formative assessment is used internally, primarily by those responsible for teaching a course or developing a program. Ideally, formative assessment allows the teacher to act quickly to adjust the contents or approach of a course or program. For instance, a faculty member might revise his or her next unit after reviewing students' performance on an examination at the end of the first unit, rather than simply forging ahead with the pre–designated contents of the course. Many instructors also solicit repeated brief evaluations of their teaching, and the data gleaned from these can be used to make adjustments that may improve learning, such as the introduction of more discussion into a class.

In contrast, summative assessment occurs at the end of a unit, course, or program. The purposes of this type of assessment are to determine whether or not overall goals have been achieved and to provide information on performance for an individual student or statistics about a course or program for internal or external accountability purposes. Grades are the most common form of summative assessment. Formative and summative assessment work together to improve learning. They should be central components of assessment at the course level, and where appropriate, at the program level.

Formative Assessment

When incorporated into classroom practice, the formative assessment process provides information needed to adjust teaching and learning while they are still happening. The process serves as practice for the student and a check for understanding during the learning process. The formative assessment process guides teachers in making decisions about future instruction. Here are a few examples that may be used in the classroom during the formative assessment process to collect evidence of student learning.

The more we know about students, the more we can help them. Observations, sometimes called student watching, can help teachers determine what students do and do not know. There are several instruments and techniques that teachers can use to record useful data about student learning.

Notes

Anecdotal Notes: These are short notes written during a lesson as students work in groups or individually, or after the lesson is complete. The teacher should reflect on a specific aspect of the lesson and make notes on the student's progress toward mastery of that learning target. The teacher can create a form to organize these notes so that they can easily be used for adjusting instruction based on student needs.

Anecdotal Notebook: The teacher may wish to keep a notebook of the individual observation forms or a notebook divided into sections for the individual students. With this method, all of the observations on an individual student are together and can furnish a picture of student learning over time.

Anecdotal Note Cards: The teacher can create a file folder with 5" x 7" note cards for each student. This folder is handy for middle and high school teachers because it provides a convenient way to record observations on students in a variety of classes.

Formative and Summative Assessment Handout

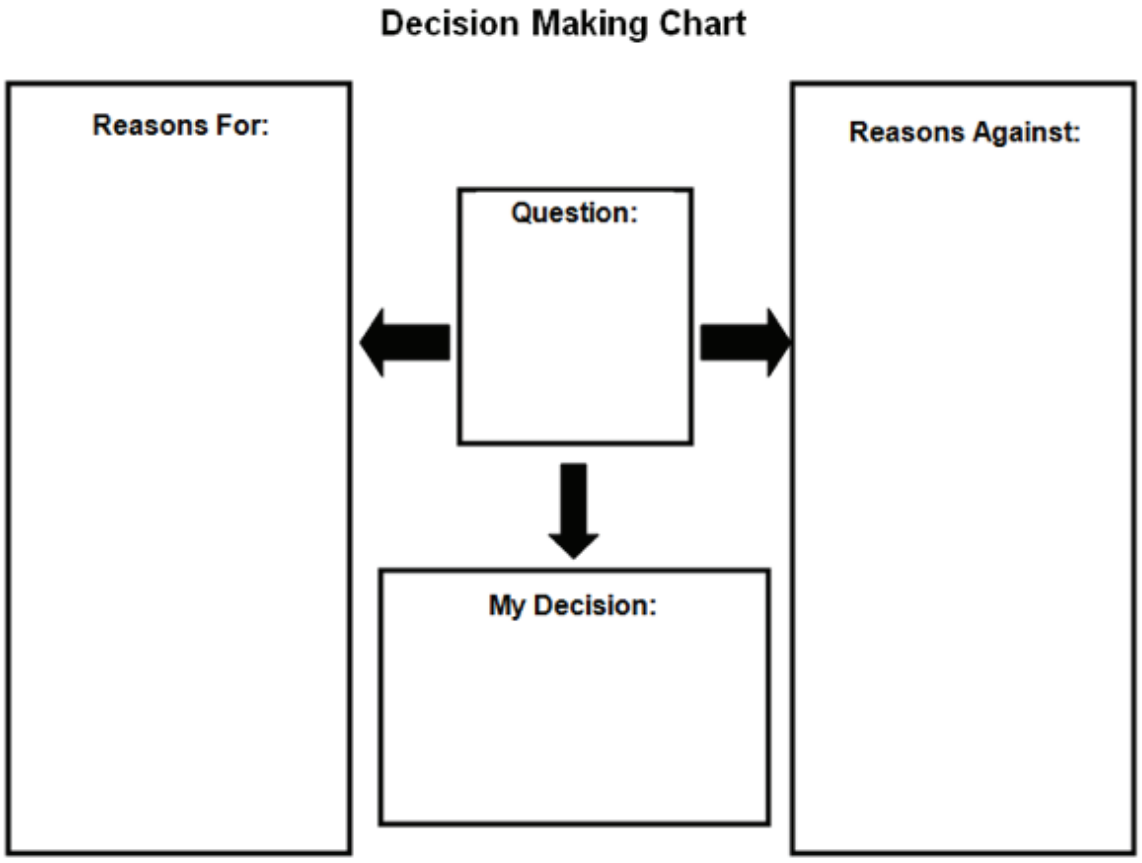
Whatever the method used to record observations on students' learning, the import thing is to use the data collected to adjust instruction to meet student needs.

Questioning

Asking better questions affords students an opportunity for deeper thinking and provides teachers with significant insight into the degree and depth of student understanding. Questions of this nature engage students in classroom dialogue that expands student learning. Questions should go beyond the typical factual questions requiring recall of facts or numbers.

Discussion

Classroom discussions can tell the teacher much about student learning and understanding of basic concepts. The teacher can initiate the discussion by presenting students with an open–ended question. The goal is to build knowledge and develop critical and creative thinking skills. Discussions allow students to increase the breadth and depth of their understanding while discarding erroneous information and expanding and explicating background knowledge (Black and Wiliam 1998; Doherty 2003). By activating students as learning resources for one another there is the possibility of some of the largest gains seen in any educational intervention (Slavin, Hurley and Chamberlain 2003). The teacher can assess student understanding by listening to the student responses and by taking anecdotal notes. To prepare students for the discussion, the teacher could have students complete the Decision Making Chart.



Formative and Summative Assessment Handout

Exit/Admit Slips

Exit Slips are written responses to questions the teacher poses at the end of a lesson or a class to assess student understanding of key concepts. They should take no more than 5 minutes to complete and are taken up as students leave the classroom. The teacher can quickly determine which students have it, which ones need a little help, and which ones are going to require much more instruction on the concept. By assessing the responses on the Exit Slips the teacher can better adjust the instruction in order to accommodate students' needs for the next class.

One–Minute Papers: The teacher ends class a few minutes early and asks one or two questions that students answer, on index cards or notebook paper, and hand in. Questions often asked are, "What were the main points of today's class?" or "What point or example in today's lecture would you like to see reviewed or clarified?" Even in a large class, reading through student responses takes relatively little time. At the next class session, teachers can address questions or problems students have raised.

Admit Slips are exactly like Exit Slips, but they are done prior to or at the beginning of the class. Students may be asked to reflect on their understanding of their previous night's homework, or they may reflect on the previous day's lesson if the question required a longer response time. Exit and Admit Slips can be used in all classes to integrate written communication into the content area.

Learning/Response Logs

Learning Logs are used for students' reflections on the material they are learning. In the log, students record the process they go through in learning something new, and any questions they may need to have clarified. This allows students to make connections to what they have learned, set goals, and reflect upon their learning process. The act of writing about thinking helps students become deeper thinkers and better writers. Teachers and students can use Learning Logs during the formative assessment process, as students record what they are learning and the questions they still have, and teachers monitor student progress toward mastery of the learning targets in their log entries and adjust instruction to meet student needs. By reading student logs and delivering descriptive feedback on what the student is doing well and suggestions for improvement, the teacher can make the Learning Log a powerful tool for learning.

Response Logs are a good way to examine student thinking. They are most often connected with response to literature, but they may be used in any content area. They offer students a place to respond personally, to ask questions, to predict, to reflect, to collect vocabulary, and to compose their thoughts about text. Teachers may use Response Logs as formative assessment during the learning process.

Peer/Self–Assessments

Peer and self–assessments help to create a learning community within the classroom. When students are involved in criteria and goal setting, self–evaluation becomes a logical step in the learning process. Students become more aware of their personal strengths and weaknesses. With peer assessment students begin to see each other as resources for understanding and checking for quality work against previously determined criteria. The teacher can examine the self–assessments and the peer assessments and identify students' strengths and weaknesses.

Formative and Summative Assessment Handout

An example:

Two Stars and a Wish

This peer assessment is particularly useful for the writing process. Students are paired and asked to read each other's written work. The reader must identify two things the author did well (stars) and one specific suggestion for improvement (the wish).

Before implementing this strategy, students must be trained on the process of providing appropriate feedback to their peers. The teacher can use this strategy as a formative assessment by circulating around the classroom and listening to the conversations between partners.

Kinesthetic Assessments

These examples of the formative assessment process require students to incorporate movement to demonstrate their understanding of a topic or concept. Although usually connected with the Arts (dance, playing a musical piece) or physical education (dribbling a basketball, serving a volleyball), kinesthetic assessments can be used in the core content classrooms to furnish teachers with insight into their students' understandings and misconceptions concerning a concept. Kinesthetic assessments are a good way to add movement in the classroom and allow teachers to determine the depth of student learning to inform their instructional decisions. Examples include:

Inside–Outside Circle

Inside–Outside Circle (Kagan, 1994) is a summarization technique that gets students up and moving. It provides a way to get students who normally would not talk to interact with others. After students read a section of text, the teacher divides the group. Half of the students stand up and form a circle with their backs to the inside of the circle. They are partner A. The other half of the students form a circle facing a partner from the first circle. These students are partner B. Partner A will speak first, quickly summarizing what they read. This takes about a minute. Then partner B speaks for the same length of time, adding to the summary. If the teacher stands in the center of the circle, he/she can easily monitor student responses.

Now it is time to move. Have the students who are partner A raise their right hands and then move two people to the right to meet with a new partner. Repeat the summary with partner B speaking first. For the third move, have all students who are partner B raise their right hand and move two people to the right. After they are with a new partner, they continue with the summary with partner A speaking first. Depending on the size of the class, teachers may have students move more or fewer times to complete the activity. Inside–Outside Circle holds all students accountable for having something to say. The teacher can use this activity as a formative assessment by standing in the center of the circle and listening to the conversations that take place.

Four Corners

Four Corners is a quick strategy that can be used effectively in the formative assessment process for gauging student understanding. It can engage students in conversations about controversial topics. The four corners of the classroom can be labeled as Strongly Agree, Agree, Disagree, and Strongly Disagree. Present students with a statement, like "All students should wear uniforms to school," and have them move to the corner that expresses their opinion.

Formative and Summative Assessment Handout

Students could then discuss why they feel the way they do. The teacher can listen to student discussions and determine who has information to support their opinion and who does not. Another way to use Four Corners is associated with multiple choice quizzes. Label the corners of the classroom as A, B, C and D. Students respond to a teacher–created question by choosing the answer they feel is correct. They must be able to give a reason for their answer.

Constructive Quizzes

Periodic quizzes can be used during the formative assessment process to monitor student learning and adjust instruction during a lesson or unit. Constructive quizzes will not only furnish teachers with feedback on their students, but they serve to help students evaluate their own learning. The process is outlined in the document below. By using quizzes to furnish students with immediate feedback, the teacher can quickly determine the status of each student in relation to the learning targets, and students can learn more during the discussions that immediately follow the quizzes, instead of having to wait until the next day to see the results of the assessment in the form of a meaningless grade on the top of a paper. The teacher should use the results of these quizzes to adjust instruction immediately based on student outcomes.

Constructive Quizzes: Quizzes are commonly used for formative assessments, but they are much more beneficial if students do not have to wait to receive feedback on their performance. To provide immediate feedback without the worry of students grading their own papers and changing answers or having students exchange their papers, use the following process.

Have students fold their notebook paper in half vertically and number along the left margin and again in the middle. They take the multiple–choice test and write their answers on the left half of the paper. They copy their answers to the right half and tear the halves apart before handing their quiz in to be graded.

	Name	
	1. D	1. D
	2. A	2. A
	3. C	3. C
	4. A	4. A
	5. D	5. D
	6. B	6. B
	7. B	7. B
	8. C	8. C
	9. D	9. D
	10. A	10. A

Formative and Summative Assessment Handout

After all papers have been collected, the teacher can go over the answers to the quiz and students can readily score their own papers. In this way, students can see what they scored on the quiz, as well as contribute to a class discussion about why answers were right or wrong.

Think–Pair–Share

Think–Pair–Share (Lyman, 1981) is a summarization strategy that can be used in any content area before, during, and after a lesson. The activity involves three basic steps. During the "think" stage, the teacher tells students to ponder a question or problem. This allows for wait time and helps students control the urge to impulsively shout out the first answer that comes to mind. Next, individuals are paired up and discuss their answer or solution to the problem. During this step students may wish to revise or alter their original ideas. Finally, students are called upon to share with the rest of the class. There is also a Think–Pair–Square–Share. In this strategy, partners discuss answers with another pair before sharing with the class. This activity ensures that all students are interacting with the information. Teachers can use this activity in the formative assessment process as they walk about the room listening to student conversations.

Summative Assessments

Summative assessments are cumulative evaluations used to measure student growth after instruction and are generally given at the end of a course in order to determine whether long term learning goals have been met. Summative assessments are not like formative assessments, which are designed to provide the immediate, explicit feedback useful for helping teacher and student during the learning process. High quality summative information can shape how teachers organize their curricula or what courses schools offer their students.

Although there are many types of summative assessments, the most common examples include:

- End–of–unit or chapter tests
- End–of–term or semester exams

Summative assessments are often created in the following formats:

- Selected response items
  - Multiple choice
  - True/false
  - Matching
- Short answer
  - Fill in the blank
  - One or two sentence response
- Extended written response
- Performance assessment

Adapted from: The West Virginia Department of Education, August 2014 http://wvde.state.wv.us/teach21/LearningResponseLogs.html
The University of North Carolina, School of Education, August 2014 http://www.learnnc.org/lp/pages/5233

Activity 3: Facilitation Techniques

TOTAL TIME REQUIRED

1 hour

MATERIALS NEEDED

- ✔ Note cards

RESOURCES NEEDED

- ✔ Effective Group Facilitation Handout
- ✔ Sets of five note cards with the following written on them:
    1. The teacher who is facilitating the group discussion
    2. The know it all/ expert learner
    3. The learner who talks too much/rambles
    4. The quiet learner who rarely speaks
    5. The learner that breaks a ground rule such as interrupting others

LEARNING OBJECTIVES

By the end of the session, teachers will be able to:

1. Identify and demonstrate at least three characteristics of an effective facilitator.

INSTRUCTIONS

1. Explain that now that we have a good understanding of experiential learning and a diversity of types of activities that can be used in the classroom that address different factors that impact adolescent sexual health, we're going to turn our focus to facilitation techniques. Even with a great experientially based lesson and the right type of activity, being a good facilitator is important to ensuring a safe, participatory learning environment for your learners.
2. Distribute note cards (one per participant) and ask teachers to take a couple of minutes to reflect individually about one of the best facilitators or trainers that they ever had at a workshop or meeting and what it was that they did that was so effective in terms of facilitation techniques. Ask teachers to write this down on the note card.
3. Ask for a few volunteers to share what they wrote down.
4. Take 15 minutes to review the handout on facilitation skills that ARE effective.
5. Ask teachers to indicate those they have used by putting a happy face next to them and those they find more challenging by putting an unhappy face.
6. Explain that our facilitation skills are often put to the test when we have difficult facilitation scenarios or challenging participants.
7. Divide teachers into groups of five and distribute note cards with the following roles written on them:
    1. The facilitator of a group discussion on gender norms
    2. The know it all/expert learner
    3. The learner who talks too much/rambler
    4. The quiet learner that rarely speaks
    5. The learner who breaks a ground rule such as interrupting others

Activity 3: Facilitation Techniques

INSTRUCTIONS (CONTINUED)

8. Ask the groups to take 10 minutes to act out a group discussion about gender stereotypes with the roles assigned to each person on the note cards. Indicate that those with the facilitator cards should do their best to apply some of the effective facilitation skills discussed earlier.

9. Note that the person who has the facilitator card will be the one to facilitate the discussion. If possible, provide that card to a teacher you've already identified as being skilled enough to facilitate a discussion well.

10. Call time and ask teachers:

- ✔ What was it like to engage in this group discussion? Was it frustrating, easy?
- ✔ What did you notice happened in the group? What roles were people playing?
- ✔ What facilitation techniques were used that were successful or unsuccessful and why?
- ✔ What skills do you think could enhance your teaching? Which ones would you like to strengthen more?

11. Conclude by noting that when facilitating activities, individual personalities and group dynamics can sometimes present challenges to the facilitator. To maximize the effectiveness of your activity, it is important to be aware of some of these typical challenges and apply effective facilitation skills to minimize disruption.

Effective Group Facilitation Handout

1. Speak in a loud, clear voice with a lot of expression.

2. Maintain eye contact with the whole group. Pick up on group members' nonverbal communication—signs of boredom, confusion, etc.

3. Call participants by name and make references to their earlier comments.

4. Use humor—but never at a participant's expense.

5. Keep a lively pace. Dead time encourages boredom and side conversations.

6. Keep the group on task but not in a controlling way.

7. Be yourself. Allow your real personality to emerge within the group.

8. Ask open-ended questions (rather than yes/no questions).

9. Use "I" language and encourage others to do the same.

10. Listen carefully and learn from participants.

11. Share the leadership. Avoid the urge to maintain control of everything that happens. Communication should be multi-directional.

12. Respond appropriately to challenging group dynamics—monopolizers, silent members, etc.
    - In the case of monopolizers who won't stop talking, kindly ask them to finish their point so that others can also contribute. If necessary, cut them off in order to move the conversation along and/or to allow others to speak
    - Similarly, in the case of know-it-alls, be careful not to call on them all the time but to call on others as well, even if they may not have the right answer
    - Call on silent members and/or encourage them to engage
    - If someone is breaking the rules, ask them to stop and to respect the rules

13. Be nonjudgmental and unshockable. You want to know what participants really think. Ask for "real" rather than "right" answers.

Adapted from: Pamela M. Wilson, Program Consultant and Trainer

SESSION SIX:
Knowing Your Content

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Identify and describe the functions of the male and female reproductive anatomy.
2. Define puberty correctly.
3. Identify at least five physical changes that occur during puberty.
4. Explain terms used in puberty (such as erection, menstruation, nocturnal emission, ovum, puberty, and sperm).
5. Illustrate emotional and social changes experienced during adolescence.
6. Describe at least two myths and two facts related to puberty and sexuality.
7. Describe the process of conception.
8. List several early symptoms of pregnancy.
9. Identify when a pregnancy test is needed and where people can access a confidential test.
10. Identify at least six methods of modern contraception and describe at least one advantage of each method.
11. Describe transmission, symptoms, effects, and treatment of some common sexually transmitted infections, including Chlamydia, Gonorrhea, Human Papilloma Virus (HPV), Syphilis, Herpes, and Human Immunodeficiency Virus (HIV).
12. Demonstrate how quickly STIs, including HIV can spread through unprotected sex and the effects of peer pressure.
13. Define stigma and discrimination and how these can affect people in one's community.
14. Show how one can express empathy towards people who are living with or affected by HIV or AIDS.
15. Define stigma and discrimination and how these can affect people in one's community.

Knowing Your Content (Continued)

16. Show how one can express empathy towards people who are living with or affected by HIV or AIDS.
17. Identify common gender norms faced by the boys/men and girls/women in their communities.
18. Describe how some of these gender norms can negatively affect the sexual behavior of learners.
19. Acknowledge the importance of being aware of one's gender biases and not allowing these to influence the delivery of sexuality education.
20. Explore types of traditional harmful practices and define female genital cutting/mutilation and its consequences.
21. Identify health risks of using drugs, including risks to sexual health.
22. Identify and compare passive, assertive, and aggressive responses and possible consequences to a situation.

ACTIVITIES

Activity 1 Reproductive Anatomy and Physiology

Activity 2A Puberty, Physical Changes

Activity 2B Puberty, Emotional, and Social Changes

Activity 3 Pregnancy

Activity 4 Contraceptive Adverts

Activity 5 Sexually Transmitted Infections

Activity 6 HIV Transmission

Activity 7 HIV Counseling, Testing, and Treatment

Activity 8 Supporting People Affected by and Living with HIV or AIDS

Activity 9 Gender

Activity 10 Harmful Traditional Practices With a Focus on Female Genital Cutting/Mutilation

Activity 11 Drug Use and Sexual Risk

Activity 12 Communicating Assertively

Activity 1: Reproductive Anatomy and Physiology

TOTAL TIME REQUIRED

1 hour

MATERIALS NEEDED

- ✔ Flip chart
- ✔ Markers
- ✔ Pens/pencils

RESOURCES NEEDED

- ✔ Leader's Resource on Male and Female Body Parts and Functions Chart
- ✔ Leader's Resource on Anatomy and Physiology of Reproduction
- ✔ Male Genitals and Reproductive Organs Handout for participants
- ✔ Female Genitals and Reproductive Organs Handout for participants

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Identify and describe; the functions of the male and female reproductive anatomy.

INSTRUCTIONS

1. Explain that now that we have discussed ways of teaching, next, we will begin to model some typical exercises for learners, starting with a lesson on sexual and reproductive anatomy and physiology, a core content area of sexuality education. This lesson assumes an existing understanding of sexual and reproductive anatomy and physiology.
2. On a flip chart, write Male and on another flip chart write Female with a line down the middle. Lead a 15 minute brainstorm asking teachers to name reproductive system body parts and their functions, both internal and external, in the two columns.
3. Using the Leader's Resource on Male and Female Body Parts and Functions Chart for reference, fill in the parts that teachers don't mention. As you list the parts on the board, briefly define each body part, where it is in the body and what it does.
4. Next, ask teachers to go into pairs and hand out the Male and Female Genitals and Reproductive Organs handouts. Each set includes illustrations of the male and female reproductive organs and corresponding blank lines.
6. Ask each pair to take 15 minutes to fill in the blanks.
7. Once everyone has completed the pictures, congratulate them on their efforts. Begin by systematically going through the diagrams and asking for volunteers to share their answers, noting the term and its function as they go along. Ask others to complement or correct information as they share. Be sure to correct any misinformation using the Leader's Resource on Anatomy and Physiology of Reproduction for reference.
8. Next, pose the following questions:

- ✔ What it was like to participate in this exercise?
- ✔ What did you notice as you worked in your team to identify the male and female reproductive anatomy?
- ✔ How aware do you think young people are of their reproductive anatomy?
- ✔ Why do you think knowing this information is important?

Activity 1: Reproductive Anatomy and Physiology

INSTRUCTIONS (CONTINUED)

9. Conclude by noting that it is okay to talk about the male and female reproductive systems and that knowing the male and female reproductive anatomy and their functions is an important part of enabling young people to understand their own bodies and empowering them to take care of themselves.

Adapted by Advocates for Youth, 2014 from: Family Life and Sexual Health, High School FLASH Public Health – Seattle & King County, accessed in June 2014 at: www.kingcounty.gov/health/flash.

Leader's Resource on Male and Female Body Parts and Functions Chart

MALE PART	WHAT IT IS / WHAT IT DOES
PENIS (made up of shaft, glans, and sometimes foreskin)	Allows passage of urine and of semen Provides sensation (has many nerve endings) The average penis measures 3–4" when it's not erect (flaccid) and 5–7" when erect
GLANS	The sensitive part at the end of the **penis**. The glans can be completely or partially covered by **foreskin,** except in men who have been **circumcised**
FORESKIN	Protects the glans of the penis Provides sensation Males who have been circumcised don't have one
SCROTUM	Muscular sac which is shorter when cold, longer when warm Holds testes Controls temperature Provides sensation
TESTES (also called testicles) singular = testis	Produce sperm and sex hormones (androgens, testosterone) Each is made of 500–1,200 feet of tightly coiled tubes
EPIDIDYMIS (plural = epididymes)	Allows maturation of sperm
VAS DEFERENS (plural = vasa deferentia—also called sperm ducts)	Provides storage for sperm Allow passage of sperm As big around as sewing thread They lead into the abdomen, where (behind the bladder) they widen into storage sacs
SEMINAL VESICLES	Contribute fructose (sugar) to semen for nourishing the sperm
PROSTATE GLAND	Produces most of the fluid that makes up semen

Source: Adapted by Advocates for Youth, 2014, from Family Life And Sexual Health (F.L.A.S.H.) Curriculum. Lesson 2, Grades 9–12, Reproductive Health System. Public Health Seattle and King County, 2011.

Leader's Resource on Male and Female Body Parts and Functions Chart

FEMALE PART	WHAT IT IS / WHAT IT DOES
UTERUS (made up of muscular walls, a lining called the endometrium, and a cervix. The uterus is also called "womb")	Houses and protects embryo/fetus/baby Allows nutrient and waste exchange with placenta Nourishes an embryo, before a placenta grows
CERVIX	The bottom section of the uterus Produces fluids to help sperm travel Produces a mucous plug to keep germs out during pregnancy
VAGINA	Allows passage of sperm Produces fluids to cleanse and lubricate itself and to help sperm travel Allows passage of shed endometrium during menstruation Allows passage of baby Provides sensation (has many nerve endings especially in the outer third) A collapsed tube, like a deflated balloon 3" long when not aroused, 5–6" when aroused,3 but very stretchy Is the middle of female's three openings
OVARIES (singular = ovary)	Provide storage for ova Allow maturation of ova Produce sex hormones (estrogen, progesterone, androgens)
FALLOPIAN TUBES	Allow passage of ova toward uterus Allow passage of sperm from uterus
VULVA (made up of labia majora, labia minora, and clitoris)	Protect openings of urethra and vagina, as eyelids protect eyes Provide sensation (has many nerve endings) Labia are folds of skin Outer labia (labia majora) have pubic hair

Source: Adapted by Advocates for Youth, 2014, from Family Life And Sexual Health (F.L.A.S.H.) Curriculum. Lesson 2, Grades 9–12, Reproductive Health System. Public Health Seattle and King County, 2011.

Leader's Resource on Male and Female Body Parts and Functions Chart

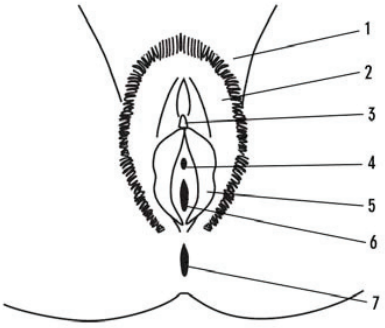
FEMALE PART	WHAT IT IS / WHAT IT DOES
CLITORIS (made up of shaft, crura [internal branches], glans, and hood)	Provides sensation (has many nerve endings) Each internal branch of erectile tissue is about 3½" long The glans (the visible part of the clitoris) is usually ¼–½" long, comparable in size to a pearl at front of vulva
CLITORAL HOOD	Protects the glans of the clitoris Provides sensation (has many nerve endings) Like a cap, mostly covers the clitoris, when it isn't erect

Source: Adapted by Advocates for Youth, 2014, from Family Life And Sexual Health (F.L.A.S.H.) Curriculum. Lesson 2, Grades 9–12, Reproductive Health System. Public Health Seattle and King County, 2011.

Leader's Resource on Anatomy and Physiology of Reproduction

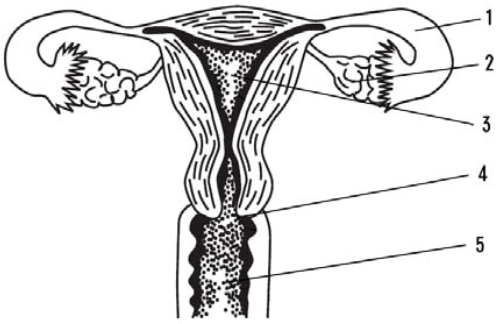
Anatomy and Physiology of Reproduction
(Leader's Resource)

Female Genitals



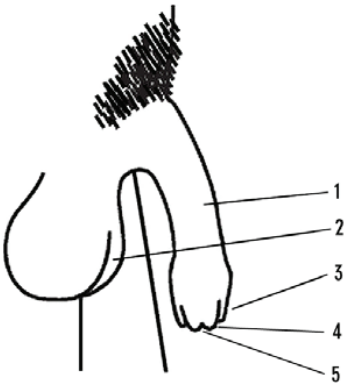
1. Vulva
2. Labia majora (outer lips)
3. Clitoris
4. Opening to the urethra
5. Labia minora (inner lips)
6. Opening to the vagina
7. Anus (not part of the genitals)

Female Reproductive Organs



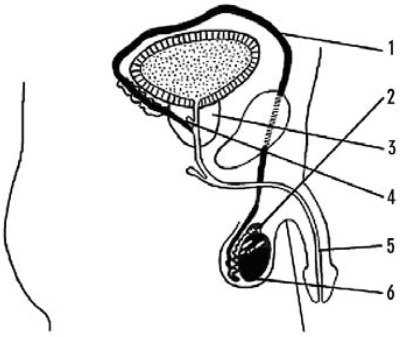
1. Fallopian Tubes
2. Ovaries
3. Uterus (womb)
4. Cervix
5. Vagina

Male Genitals



1. Penis
2. Scrotum
3. Foreskin
4. Glans
5. Opening to the urethra

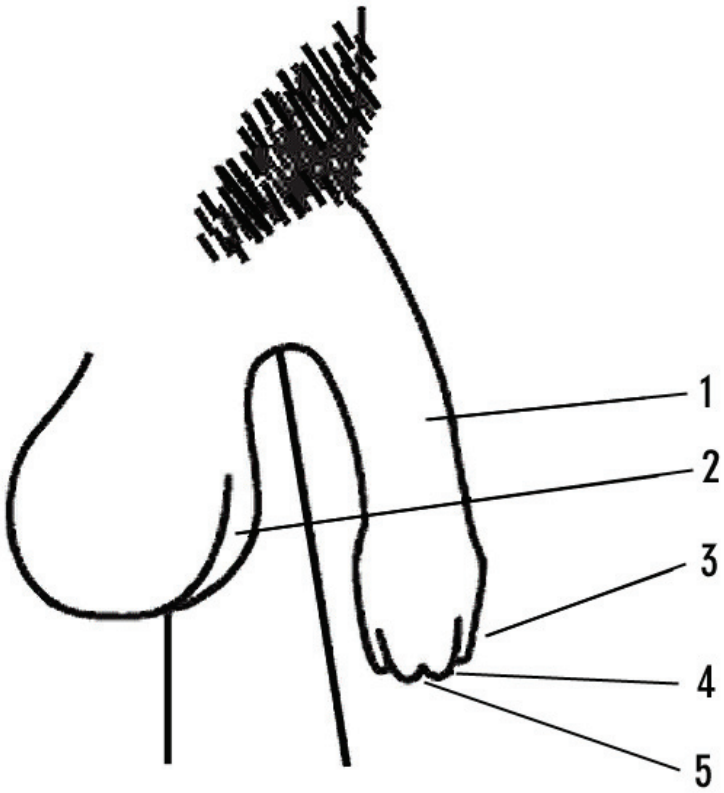
Male Reproductive Organs



1. Vas deferens
2. Epididymis
3. Prostate gland
4. Seminal vesicles
5. Urethra
6. Testis

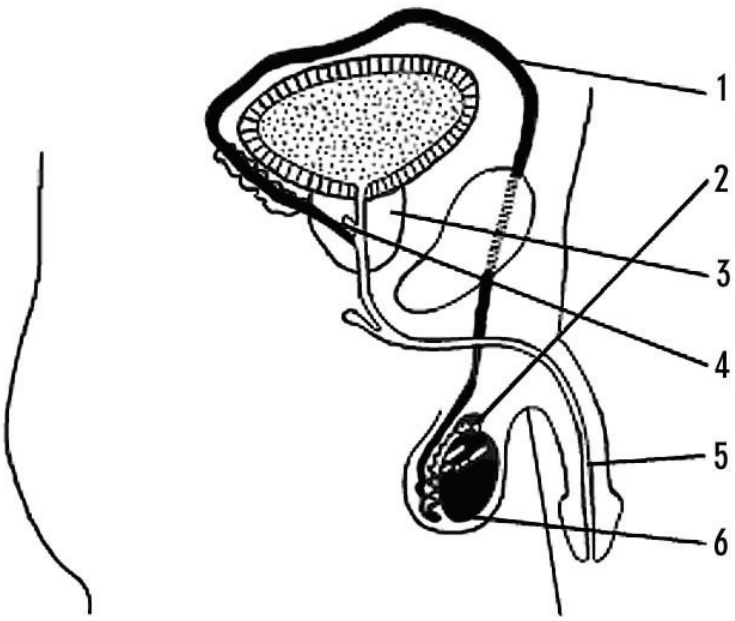
Male Genitals and Reproductive Organs Handout

Male Genitals



1. _____
2. _____
3. _____
4. _____
5. _____

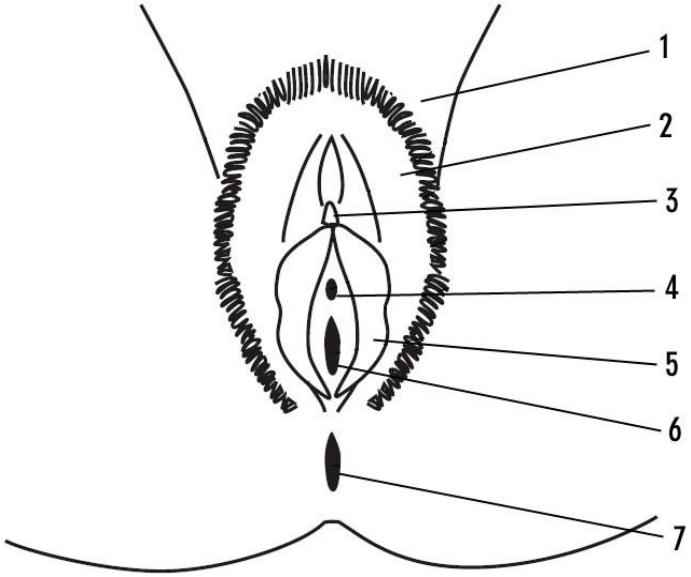
Male Reproductive Organs



1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

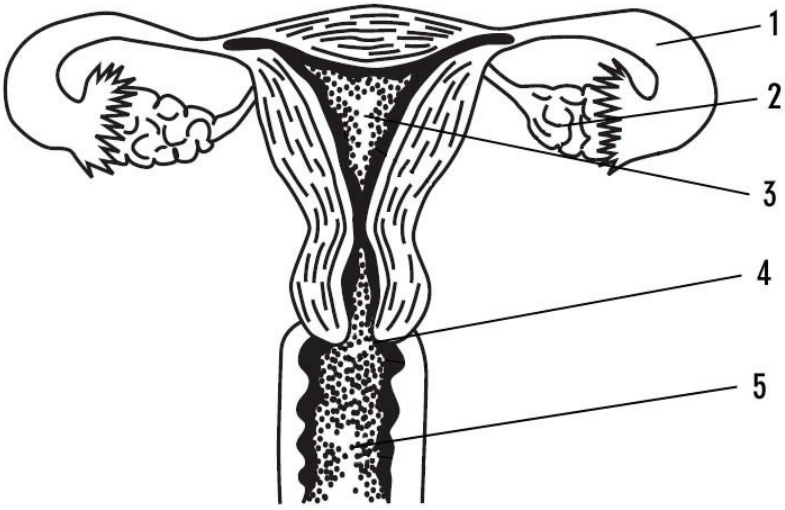
Female Genitals and Reproductive Organs Handout

Female Genitals



1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Female Reproductive Organs



1. _____
2. _____
3. _____
4. _____
5. _____

Activity 2A: Puberty, Physical Changes

TOTAL TIME REQUIRED

1 hour

MATERIALS NEEDED

- ✔ Flip chart
- ✔ Markers
- ✔ Pens/pencils

RESOURCES NEEDED

- ✔ Leader's Resource on Puberty, Physical Changes
- ✔ Flip chart with the following definition of puberty pre-written: "Puberty is a time when a person's body, feelings and relationships change from a child's into an adult's. These changes are physical, emotional, and social."
- ✔ Puberty Worksheet Handout for each participant
- ✔ Puberty Worksheet with Answer Key

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Define puberty correctly.
2. Identify at least five physical changes that occur during puberty.
3. Explain terms used in puberty (such as erection, menstruation, nocturnal emission, ovum, puberty, and sperm).

INSTRUCTIONS

1. Explain that now that we have discussed reproductive anatomy and physiology, next, we will be learning about puberty and the various changes that adolescents go through during puberty, including physical changes and emotional and social changes. In this lesson, we will be reviewing the physical changes.
2. Ask for a volunteer or two to define puberty. Build on what teachers share and wrap up the exchanges by sharing the following definition, pre-written on a flip chart: Puberty is a time when a person's body, feelings, and relationships change from a child's into an adult's. These changes are physical, emotional, and social.
3. Note that all adolescents experience puberty, but there is a lot of variation in terms of how and when they experience pubertal changes. For example, many girls start noticing changes as young as age 8–9 but others may not until ages 12–13. While most boys start noticing changes at ages 10–11 or others may not until ages 13–14. Often adolescents worry a lot about these changes and when they happen. It's important for them to know that it's okay if their experience is not the same as others because it's all normal and will be different for everyone.
4. Take 15 minutes to lead a brainstorming session, asking teachers to say some of the physical changes of puberty they have heard of. As teachers share their responses, write them in one of three columns that you have not labeled yet, so it looks like this:

Grow hair on face/chest	Start to grow taller	Breasts develop and may start wearing a bra
Erections happen more often and for no reason	Develop pubic hair around genitals and under arms	Ovulation begins and menstrual periods
Voice gets deeper	Might get acne or pimples	Hips get wider

Activity 2A: Puberty, Physical Changes

INSTRUCTIONS (CONTINUED)

5. Once teachers have brainstormed a good number of the physical changes, make sure the list includes the following physical changes listed below. Ask them to look at the three categories you have created with their responses and suggest what each category is. Once they have figured out the answer, write **Boys, Both,** and **Girls** on the top of each column so it looks like this:

BOYS	BOTH	GIRLS
Grow hair on face/chest	Start to grow taller	Breasts develop and may start wearing a bra
Erections happen more often and for no reason	Develop pubic hair around genitals and under arms	Ovulation begins and menstrual periods
Voice gets deeper	Might get acne or pimples	Hips get wider
Shoulders get broader	Sweat or perspire more	Daily vaginal discharge
Sperm production begins and ejaculation is possible	Hormone changes cause more sexual feelings	
Nocturnal emissions happen to some, not all		

6. Next, take about 10 minutes to review and describe each change, further informing any previous discussion/ information shared using the Leader's Resource on Puberty, Physical Changes

7. Now, distribute the Puberty Worksheet to each teacher and give them five minutes to complete the worksheet.

8. Once the time has passed, review the correct answers together using the Puberty Worksheet with Answer Key for your reference.

Activity 2A: Puberty, Physical Changes

INSTRUCTIONS (CONTINUED)

9. Ask teachers the following questions:

- ✔ What was it like to review changes experienced during puberty?
- ✔ What are some changes that you remembered easily or others that you did not?
- ✔ How might these pubertal changes impact things like moods, sense of identity, relationships, and behaviors among learners? How might these changes impact affect girls and boys differently?
- ✔ How might you use this exercise to teach about puberty in your classroom?

10. Conclude the activity by noting that puberty is when a child's body turns into an adult's body, consisting of physical, emotional, and social changes. There are physical changes experienced by both girls and boys and some by only girls and others by only boys. These changes impact adolescents' feelings, how they interact with others, and how they behave. Many adolescents worry about the changes in their body and their feelings and whether or not what they are experiencing is "normal." It's important for them to know what these changes are, that it is "normal," and that not everyone experiences these changes the same way.

Leader's Resource on Puberty, Physical Changes

Physical changes experienced during puberty include:

1. **Height Growth Spurts (both)**—Explain that you grow most in your sleep.
2. **Shoulders Broaden (boys)**—Explain that this is a skeletal change.
3. **Hips Widen (girls)**—Explain that the idea is for her pelvic bones to form sort of a bowl, in order to support a pregnancy if she decides to have a biological child.
4. **Breasts Develop (girls and, to some extent, many boys)**—Explain that girls can expect that their breasts will develop. No matter what size or shape or color they end up being and even if they are different from one another, they will almost always be sensitive to sexual touch and able to nourish a baby. Note that many boys do experience some breast development and that it usually disappears within six months or a year.
5. **Acne Develops**—Explain that acne is caused by a combination of thicker skin than when you were younger and more oils, along with bacteria. Sometimes the new, thicker layer of skin blocks the pores or openings where the oils are supposed to flow, causing a pimple. If it gets infected it can become a blackhead. People should wash gently with mild soap a couple of times a day and after heavy exercise, but it will not prevent acne altogether.
6. **Stress-Related Sweating that Causes a Bad Odor Begins (both)**—Explain that everyone sweats when they are hot, but that at puberty another group of sweat glands starts to produce sweat also when you feel stressed or upset. This kind of sweat in adolescents and adults can have a strong odor. So some people prefer to bathe or shower more often after puberty than they did before and many use deodorants.
7. **Pubic and Underarm Hair Develops (both)**—Explain that pubic hair grows around a person's genitals (around the labia or penis) and that pubic and underarm hair is often coarser and sometimes a different color than the hair on the person's head.
8. **Facial Hair Develops and Body Hair May Thicken (boys and, to some extent, many girls)** —You can explain that the amount of hair a person gets on their face and body is genetic (inherited from a person's biological family). Explain that it isn't unusual for girls to notice new hair on the face or around the nipples and a girl might feel self-conscious if she didn't know it was common.
9. **Voice Deepens (both, though more in boys)**—Explain that the depth of the voice is a matter of air passing the vocal chords. The vocal chords are like the strings of a stringed instrument. If anyone in the class plays a stringed instrument, ask them which strings make the lower notes. They say it is the thicker ones. Well, your vocal chords thicken during puberty, no matter what sex you are. On average a boy's will get thicker than a girl's as he matures. The reason a boy may notice his voice cracking sometimes, is that the vocal chords don't always get thick evenly. There may be a time when one end of the vocal chord is thicker than another and as air pushes past, the pitch of his voice may change in mid-sentence.
10. **Genitals Enlarge (both)**—This is more obvious for a boy, since he looks at his penis and scrotum every time he uses the bathroom. A girl is less likely to notice, but her vulva (labia and clitoris) get bigger at puberty, too.

Leader's Resource on Puberty, Physical Changes

11. **Erections Happen More Frequently (more noticeable in boys)**—Explain that an erection is what you call it when the penis or the clitoris fills up with blood and gets harder and bigger. Everyone gets erections, even babies. In fact, ultrasounds show us that male fetuses in their mothers' uteruses are already getting erections. Presumably female fetuses do, too, but their clitorises would be too tiny to be visible in an ultrasound. Erection is perfectly healthy and it happens sometimes when you are thinking of something sexual or of someone you like, but it also can happen, especially at puberty, for no apparent reason. A boy may find it embarrassing when he has one in public, but he can just carry something in front of him if it does. And it may help to know that it happens at some point to almost all men.

12. **Sperm Production and Ejaculation Begin (boys)**—Explain that sperm are the microscopic cells from a man's body that can start a pregnancy, when they combine with a woman's egg cell. And ejaculation is what you call it when the sperm come out of his penis (in a fluid called "semen"). A man may ejaculate during sleep, masturbation, or sexual touch with a partner. Once he's able to ejaculate, he's able to help start a pregnancy. That's not to say he's ready to be a father yet, but it is biologically possible to make a baby.

13. **Nocturnal Emissions Begin (many boys)**—Sometimes nocturnal emission are called "wet dream." Some boys—not all—will ejaculate during their sleep. They may or may not have been dreaming at all. The wet dream can be their body's response to the higher level of hormones in their bloodstream during a growth spurt. But boys should know that not everyone has nocturnal emissions and there's nothing to worry about whether they do or don't.

14. **Ovulation and Menstruation Begin (girls**)—Ovulation is sometimes described as "releasing an egg" and menstruating as "having your period." Explain that about once a month, starting at puberty, one or the other of a girl's ovaries will allow an egg or, "ovum" to mature and pop out, which constitutes ovulation. The ovum usually travels into the nearest fallopian tube. If she has had sexual intercourse and there is sperm in that fallopian tube, it may fertilize the egg. The fertilized egg will then travel the rest of the way down the tube and, in a week or so, it will nest, or "implant," in the uterus to begin growing into a baby.

    In the meantime, the uterus has developed a thick, blood–rich lining that serves as a good nest in case she did get pregnant. If the ovum is not fertilized, though, it will live for only about 24 hours and then dissolve and be reabsorbed by her body. The uterus will wait a couple of weeks, in case the egg did get fertilized, with support from her body's hormones. Then, after a couple of weeks, if no egg has implanted, the hormone level will drop and the uterine lining where implantation would have occurred, sheds—this is called menstruating. The lining sheds in the form of blood and little pieces of tissue that dribble out through her vagina for 2 to 10 days. That's why girls need to where pads during menstruation to soak it up and keep her underwear and clothes from getting stained.

Source : Adapted from Family Life and Sexual Health–Grades 4–6 Lesson 9 : Puberty, Day 1. Public Health Seattle & King Country, Revised 2009. www.kingcounty.gov/health/flash

Puberty Worksheet Handout

Directions: Put the letter of each word next to the correct definition of the word.

A) Erection

B) Menstruation

C) Nocturnal Emission

D) Ovum

E) Puberty

F) Sperm

_____ 1. Having a period

_____ 2. The penis filling with blood and getting larger

_____ 3. The cell made in the testicles of a boy or man that can start a pregnancy

_____ 4. Semen coming out of the penis when a boy is asleep

_____ 5. The egg cell from a woman that can start a pregnancy

_____ 6. A child's body beginning to change into an adult's body

Puberty Worksheet with Answer Key

Directions: Put the letter of each word next to the correct definition of the word.

A) Erection
B) Menstruation
C) Nocturnal Emission
D) Ovum
E) Puberty
F) sperm

__B__ 1. Having a period
__A__ 2. The penis filling with blood and getting larger
__F__ 3. The cell made in the testicles of a boy or man that can start a pregnancy
__C__ 4. Semen coming out of the penis when a boy is asleep
__D__ 5. The egg cell from a woman that can start a pregnancy
__E__ 6. A child's body beginning to change into an adult's body

Activity 2B: Puberty, Emotional, and Social Changes

TOTAL TIME REQUIRED

1 hour

MATERIALS NEEDED

- Flip chart
- Markers
- Pens/pencils

RESOURCES NEEDED

- Leader's Resource on Onion Ball Questions
- Leader's Resource on Puberty, Emotional and Social Changes
- Leader's Resource on Puberty Myth vs. Fact Game Handout for each participant

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Illustrate emotional and social changes experienced during adolescence.
2. Describe at least two myths and two facts related to puberty and sexuality.

INSTRUCTIONS

1. Start by asking for a couple of volunteers to remind us what puberty is and make sure the following is explained, "Puberty is the process of growing up from a child into an adult and includes physical, social, and emotional changes that a young person experiences over a number of years."
2. Explain that having learned about the physical changes experienced during puberty, we will now examine some of the emotional and social changes by playing a game. This activity is called an onion ball and teams will stand in a circle and throw it gently from one person to the next. As a teacher catches it, they are to peel off the outside paper and answer the question, if they want to. They are also allowed to pass if they feel uncomfortable. Once the person has answered the question, the onion balls gets thrown to someone else in the circle and the process repeats until all of the layers of the onion have been peeled. Divide teachers into teams of ten and distribute one onion ball to each team and have them begin the activity.
3. After teams have completed answering all of the onion ball questions, have teachers return to their seats. Ask volunteers to share some of the changes that they shared or heard during the game and note these on a flip chart as they are mentioned. Complement the list by referencing the changes noted in the Leaders' Resource on Puberty, Emotional, and Social Changes and providing additional information as needed.
4. Next introduce the myth vs. fact game by stating the following, "Often when adolescents start to go through puberty, they are too embarrassed to talk or ask about what they are experiencing. Parents may be equally uncomfortable to talk about these topics and as a result, adolescents may hear or read things that aren't actually true without being able to verify what information is just a myth versus a fact."
5. Explain that during the next activity, you will be reading statements and that teachers must decide whether the statements are a myth, meaning they are not accurate, or fact, meaning that they are true. Ask teachers to stand up if they think the statement is a myth and to sit down if they think it is a fact.

Activity 2B: Puberty, Emotional, and Social Changes

INSTRUCTIONS (CONTINUED)

6. Ask if there are any questions about the directions and if not, proceed by reading the first statement.

7. Once the teachers have responded, make sure to share the answer and take time using the points listed under each statement to explain why the statement is a myth or fact. Use as many statements as time allows.

8. Ask teachers the following questions:

- ✔ What was it like to play this game?
- ✔ Are some of these myths prevalent in the community?
- ✔ How might knowing these facts and myths affect learners' decisions and behaviors?
- ✔ How might you use this activity in your classroom?

9. Conclude the lesson by telling teachers that puberty and growing up is an exciting time that can also be confusing to learners. There is a lot of misinformation about puberty and this is why it's important to provide learners with accurate information about what to expect during puberty and to dispel myths that could lead to risky behaviors.

Source: Adapted by Advocates for Youth, 2015. When I'm Grown Grades 5–6, Advocates for Youth, Myth Information Game, Pages 115–117 and You, Your Life, Your Dreams, Family Care International, Adolescence: The Big Change, The Big Challenge, pages 1–44.

Leader's Resource on Onion Ball Questions

Directions: Make enough copies of this sheet for every onion ball you plan to create. Generally one onion ball for each group of 10 learners works well. Once copied, then cut each strip of paper and crumple it on top of the others to create a ball with 10 layers of questions.

1. When you were an adolescent, what is one thing that excited you about growing up?

2. What is one thing you're anxious about related to growing up?

3. What is one change you remember related to choices that you could make when you were growing up as an adolescent?

4. What do you remember about when you first became aware of having that feeling of really liking someone?

5. What is one change related to moods that you experienced when you were growing up as an adolescent?

6. What is one change that you remember about how you treated adults when you were growing up?

7. What is one change that you remember feeling growing up as an adolescent related to how you thought about others?

8. When you were an adolescent, what is one change that you felt in how adults treated you?

9. As you grew into an older adolescent, how did your sense of self change?

10. When you were an adolescent, what is one topic you wish more adults would have talk with you about related to growing up?

Leader's Resource on Puberty, Emotional, and Social Changes

Emotional and social changes experienced during puberty include:

1. **Feelings of Attraction/Really Liking Someone May Begin (both)**—Although small children can get excited about liking someone else, these feelings become more intense during puberty. It is the feeling of really wanting someone to like you—of having your tummy feel funny when they walk in the room or when you hear their voice. Everybody will feel this eventually, but some will notice these feelings earlier than others. These feelings of attraction may be towards people of their own sex, the other sex, or both. It may or may not predict how they will feel when they're grown. That is, really liking someone of a different sex doesn't necessarily mean you will eventually be heterosexual (straight). Likewise, really liking someone of your own sex doesn't necessarily mean you will eventually be gay or lesbian.
2. **Self-Consciousness May Increase (both)**—Everybody goes through a time of worrying what other people think of them. Learners may have noticed that they may be spending more time worrying about their appearance and getting ready for school than they used to. This is normal and part of pubertal changes and healthy adolescent development.
3. **Concern for Others May Grow (both)**—As adolescents start focusing more on other people's feelings and needs, they will become less self-conscious.
4. **Sudden Mood Changes May Begin (both)**—Feeling happy one minute and in tears the next, sometimes for no apparent reason, isn't unusual during puberty. The hormones that are in the blood during puberty influence how adolescents feel.
5. **Friction with Parents or Guardians May Grow (both)**—Explain that adolescents and a parent or guardian probably both want the same thing in the long run…to grow up and become more independent. Sometimes adolescents may feel like a child and want to get taken care of and other times they feel more adult-like and want to think for themselves. At the same time, the adults go through similar feelings, sometimes wanting to make decisions for their children because they're afraid they will get hurt and other times wanting to let them make their own choices and take on more responsibility. If adolescents and parents or guardians are not feeling the same thing at the same time, there can often be tension and struggles between them. This does not mean that there is less love for each other—it is just part of growing up.
6. **Freedom to Make Decisions Grows (both)**—People's parents and guardians often trust them with more of their own choices, especially as they take on more responsibilities.
7. **Understanding of Self May Grow (both)**—Adolescents begin to gain more of a sense of who they are and in so doing, become more self-confident.

Note on mental health—Going through puberty can be challenging given the changes adolescents experience physically, socially, and emotionally, and having mood swings and worrying as noted above, is normal. That said, feeling very sad, hopeless, or worthless could be warning signs of a mental health problem, in which case the adolescent should seek medical attention.

Source : Adapted from Family Life and Sexual Health–Grades 4–6 Lesson 9 : Puberty, Day 1. Public Health Seattle & King Country, Revised 2009. www.kingcounty.gov/health/flash

Leader's Resource on Puberty Myth vs. Fact Game Handout

1. **You must exercise the penis through sex, otherwise it will stop functioning and decrease in size.**

   MYTH! Sex is not "exercise" for the penis. Your penis doesn't need exercise. It will work just fine without any sex at all. Sexual abstinence or "waiting"can never hurt your penis.

2. **Penis size is not affected by frequency of sex.**

   FACT! Your penis size is determined by the traits you inherit from your parents—not anything you do with it.

3. **A small penis cannot satisfy a woman.**

   MYTH! The size of the penis has little effect on women's enjoyment of sexual intercourse. This is because the main center of sexual sensation for a woman is the clitoris and the area around the opening of the vagina. The vagina itself does not have many nerves so it doesn't feel very much.

4. **You need to have sex whenever you get an erection.**

   MYTH! This is definitely not true, which is a good thing for you. Otherwise, what would you do if you got an erection in class? If you don't have sex, the erection will just go down on its own. You can't possibly injure yourself by not having sex when you get an erection.

5. **It is impossible for too much sperm to build up and cause problems.**

   FACT! Even though testicles produce millions of sperm, sperm does not build up and cause health problems.

6. **Wet dreams are a sign that you need to have sex.**

   MYTH! Wet dreams are just one way that your body gets rid of sperm and semen. It is not a sign that you need to have sex.

7. **Putting butter on the nipples or letting insects bite the nipples makes the breasts grow faster.**

   MYTH! It is hormones that make the breasts grow—nothing else will make any difference.

8. **The color of the ring around the nipples (the areola) is determined by the genetic traits you inherit from your parents.**

   FACT! Like the color of your skin, it has nothing to do with whether or not you have had sex.

9. **Breasts grow big when girls let boys touch them.**

   MYTH! The size of the breasts is genetically determined. Nothing you do will make them bigger or smaller.

Leader's Resource on Puberty Myth vs. Fact Game Handout

10. Girls with breasts that have drooped have already had sex, or they had an abortion or a baby.

MYTH! Breasts droop because of gravity. If you have big breasts they are more likely to droop because of the weight.

11. Wearing a bra helps prevent drooping.

FACT! Bras actually help prevent drooping because they support the breasts and prevent the skin and breast tissue from stretching and losing their elasticity.

12. If a girl misses her period, she is definitely pregnant.

MYTH! When girls first start menstruating, they often have irregular periods and may even skip a month or two at times. However, if a young girl has had sexual intercourse, missing a period can be a sign of pregnancy.

13. Generally girls begin puberty before boys.

FACT! Most girls begin puberty about one or two years earlier than boys.

14. Masturbating a lot can cause a boy to run out of sperm.

MYTH! Once a boy starts making sperm during puberty, his testicles never stop. So, even if he masturbates frequently, it is not possible for his body to run out of sperm.

15. Masturbation causes a person to go crazy.

MYTH! Masturbation is a normal part of sexual expression for most people. It will not cause a person to go crazy or blind. Many people of all ages masturbate, although some don't because it goes against their values. You're normal if you do it and you're normal if you don't.

16. Boys need sex more than girls do.

MYTH! Neither boys nor girls need sex more than the other. It's normal and healthy for boys and girls to have sexual feelings, however it's important for everyone to think seriously about what they want to do and not do when it comes to acting on those feelings. Sexual intercourse at an early age often leads to confusion, guilt, regret, and sometimes even unplanned pregnancy and STIs, including HIV. For these reasons, it's best to wait until you're older to start having sexual intercourse.

Activity 3: Pregnancy

TOTAL TIME REQUIRED

1 hour

MATERIALS NEEDED

- ✔ Flip chart
- ✔ Markers
- ✔ Pens/pencils

RESOURCES NEEDED

- ✔ Two Truths and a Lie Activity Handout (one copy per each team of 3–4 teachers)
- ✔ Two Truths and a Lie Answer Key (one copy for the trainer to read)
- ✔ Copies for each teacher of Pregnancy Visuals 1 and 2 Handouts

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Describe the process of conception.
2. List several early signs of pregnancy.
3. Identify when a pregnancy test is needed and where people can access a confidential test.

INSTRUCTIONS

1. Introduce the activity by explaining that now that we have talked about reproductive anatomy and physiology as well as puberty, next we will learn about pregnancy, a critical topic for learners to understand in order to be able to prevent unintended pregnancy.
2. Ask teachers to share a bit about what they know about pregnancy and call on volunteers.
3. Next, indicate that we will be talking about how pregnancy happens and signs of pregnancy, beginning with a review on conception, or the process by which a sperm and egg join and implant in a female's uterus.
4. Using the Pregnancy Visuals, start with Visual #1 and provide the following quick lecture to teachers about conception. Explain that women are born with thousands of eggs in their ovaries. During puberty hormones cause the ovaries to mature and to start releasing an egg (or ovum) each month. The ovum is about as big as a grain of sand. While a sperm, the male reproductive cells from a male's body, are much, much smaller. Both the ovum and sperm each contain 23 chromosomes, which are sometimes called genes. If a sperm and ovum join, these become 46 chromosomes or genes that join to determine the characteristics of the person they will become.
5. Next, display Visual #2 and explain that conception usually occurs when sperm from a man's body joins with an ovum from a woman's body, generally during unprotected vaginal sexual intercourse. When a man releases semen from his penis, he releases millions of sperm and they take a few days to travel from the vagina, through the cervix, into the uterus and up to the fallopian tube, where if there is an ovum present, they might join together. A woman becomes pregnant once that fertilized ovum has traveled back down the fallopian tube and implanted into the lining of the uterus.
6. Note that millions of sperm constitute about 10 percent of semen, the mucus-like fluid released upon ejaculation. Each sperm has a round body or head, and a long thin tail. The other 90% of the fluid is a milky liquid called semen or seminal fluid. Semen allows the sperm to swim, provides nourishment for them, and keeps them alive. After ejaculation, sperm live from 3–5 days. This is why a woman can become pregnant even if she has had sex before ovulating.

Activity 3: Pregnancy

INSTRUCTIONS (CONTINUED)

7. Before proceeding to the next step, ask teachers if they have any questions about these three processes. You can check for understanding by teachers to define fertilization (when sperm joins with the egg), and implantation (when the fertilized egg implants itself into the lining of the uterus).

8. Ask learners to brainstorm common early signs of pregnancy and write any correct signs they suggest on a flip chart. Explain a little about each one by noting that not all pregnant women experience the same things and for some, some signs are more present than others.

9. Note that if a young person has had vaginal sex and they are experiencing any of these things, it would be important for them to be able to recognize the signs of pregnancy in order to seek out a pregnancy test and an HIV test. Explain that getting a test would be important because they could be pregnant and have acquired HIV, in which case they need to know about both to seek pre-natal care and treatment for HIV to prevent transmission to the baby if continuing with the pregnancy.

10. Note that a pregnancy test can be purchased at a pharmacy and is performed by checking for a certain hormone in a woman's urine that is generally present 10–14 days after vaginal sex. There is also a test that is performed at a clinic that measures a hormone in the bloodstream to determine if a woman is pregnant, which is detectable within 10 days of fertilization. Meanwhile, an HIV test detects HIV antibodies either from a sample of saliva or blood, which can take up to three months to develop after infection.

11. Next, review the early signs of pregnancy:

    - **Missing a Menstrual Period.** Most women will stop having their menstrual periods while they are pregnant although some might continue to bleed lightly, called spotting.
    - **Tender, Swollen Breasts.** The hormonal changes during pregnancy often cause the breasts to feel tender, sore, fuller, or heavier.
    - **Fatigue.** The hormonal changes during early pregnancy often cause tiredness and having less energy.

Activity 3: Pregnancy

INSTRUCTIONS (CONTINUED)

- **Nausea With or Without Vomiting.** The hormonal changes especially during early pregnancy can cause a person to feel sick to their stomach and they may or may not vomit, often called "morning sickness". A pregnant woman might also notice that her sense of smell is much stronger and sometimes certain odors can cause her to feel nauseous.
- **Frequent Urination.** A common change early and later in a pregnancy is the feeling of having to urinate frequently.

12. Now ask for two volunteers—one person to be the host of a game and the other to keep score. Divide the rest of the teachers into teams of three or four and have each team choose a team name and captain.
13. Explain that the game we will be playing is called Two Truths and a Lie. The host will read three statements aloud to the class. Each team will then come together and decide which of the three statements they think is a lie, meaning it's not true. Their team captain will then raise one finger if they think the first statement is a lie, two fingers if they think the second statement is a lie, or three fingers if they think the third statement is a lie. The host will then read the answer aloud using the Answer Key.
14. Note that the scorekeeper will give 10 points to all the teams with the correct answer. Direct each team to cross out "lie" statements on their worksheets along the way so that by the end of the activity, each team will have a worksheet with all the correct answers.
15. Ask if there are any questions about the directions of the activity and if not, proceed with the game.
16. After the game is done, ask teachers:

- ✔ What was it like to review signs of pregnancy and how pregnancy occurs?
- ✔ Were some truths or lies easier than others to detect? Why were some harder?
- ✔ How do you think learners could benefit from this information about pregnancy?
- ✔ How might you use this activity to educate about pregnancy?

Activity 3: Pregnancy

INSTRUCTIONS (CONTINUED)

17. Conclude by noting that pregnancy begins when a fertilized egg implants in the uterus and that signs of pregnancy can vary greatly among women but generally include missing a period; tender breasts; fatigue; nausea; and frequent urination. Underscore that it is important for learners to know the signs of pregnancy so that they can seek out a pregnancy test and an HIV test if they have been sexually active in order to get appropriate care and prevent transmission of HIV to the baby.

Source: Adapted by Advocates for Youth from Family Life and Sexual Health – High School Version, Lesson 3: Pregnancy, Public Health – Seattle & King County, Revised 2011.

Two Truths and a Lie Activity

Team Name: _____

Directions: For each of the statements below, one is a lie. Which one is it?

A) Signs of Pregnancy

1. Everyone stops having periods as soon as they get pregnant.
2. Common pregnancy symptoms include breast tenderness and nausea.
3. Women can experience signs of pregnancy differently so that one woman's experience can be quite different from another's.

B) Pregnancy Testing

1. A person can purchase a pregnancy test at a pharmacy.
2. Pregnancy tests can show results as early as one hour after becoming pregnant.
3. The way a pregnancy tests works is by checking for a certain hormone in a woman's urine.

C) How Pregnancy Happens

1. The ovum and sperm meet in a female's fallopian tubes.
2. The pregnancy does not begin until the fertilized egg implants in the uterus.
3. It takes a million sperm to create a pregnancy.

Source: Adapted by Advocates for Youth from Family Life and Sexual Health – High School Version, Lesson 3: Pregnancy, Public Health – Seattle & King County, Revised 2011.

Two Truths and a Lie Answer Key

The Lies are underlined below with an explanation in italics:

A) Signs of Pregnancy

1. Everyone stops having periods as soon as they get pregnant. *Some women don't miss their period until they have been pregnant for a few months. Their menstrual periods might just seem lighter and shorter at first.*
2. Common pregnancy symptoms include breast tenderness and nausea.
3. Women can experience signs of pregnancy differently so that one woman's experience can be quite different from another's.

B) Pregnancy Testing

1. A person can purchase a pregnancy test at a pharmacy.
2. Pregnancy tests can show results as early as one hour after becoming pregnant. *Urine tests are usually only accurate 10–14 days after sexual intercourse while blood tests can detect pregnancy 7–12 days after conception. The sooner a woman knows she is pregnant the better.*
3. The way a pregnancy tests works is by checking for a certain hormone in a woman's urine.

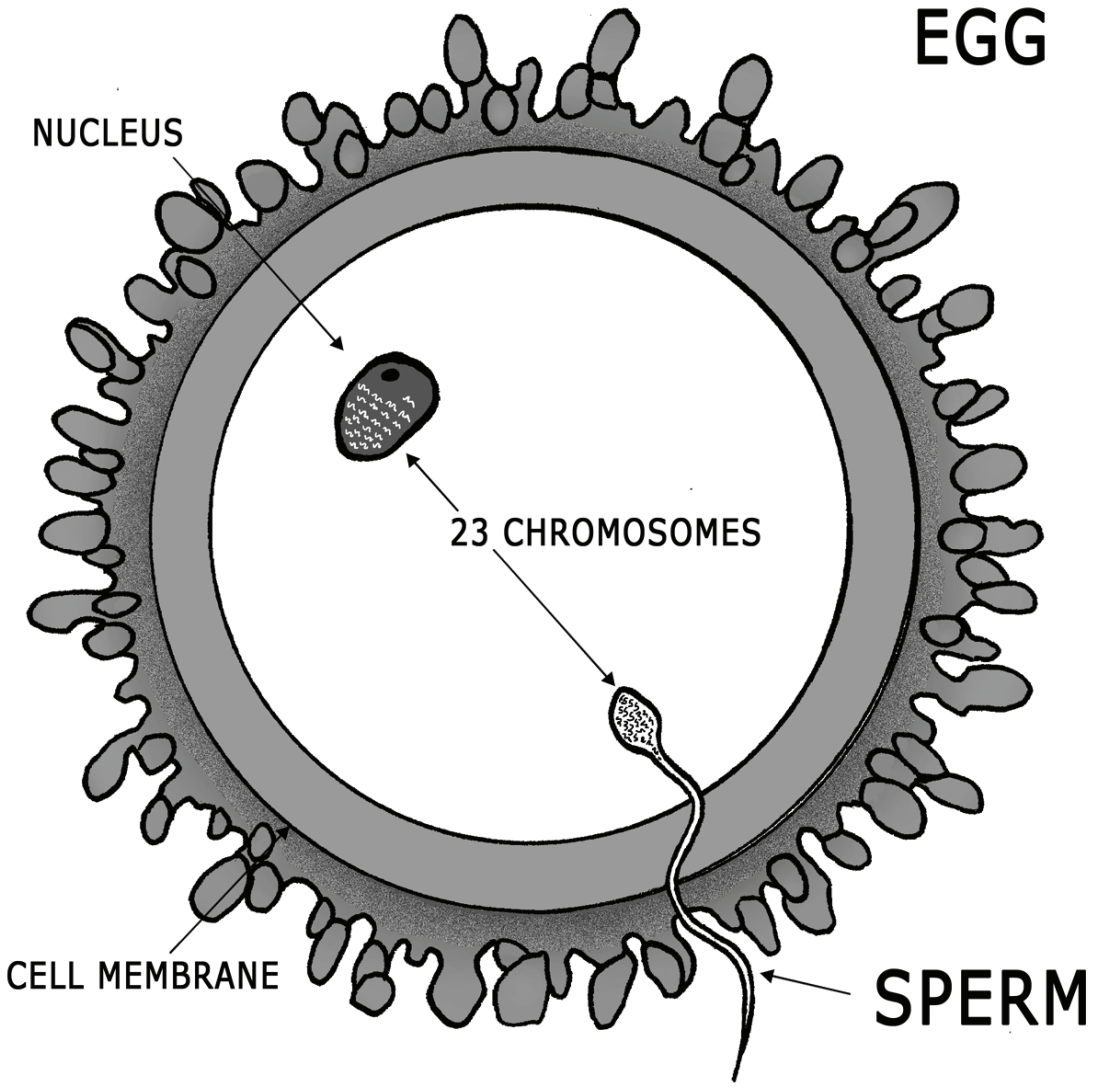
C) How Pregnancy Happens

1. The ovum and sperm meet in a female's fallopian tubes.
2. The pregnancy does not begin until the fertilized egg implants in the uterus.
3. It takes a million sperm to create a pregnancy. *Hundreds of millions of sperm are ejaculated from a man's penis but just one is able to fertilize an egg.*

Source: Adapted by Advocates for Youth from Family Life and Sexual Health – High School Version, Lesson 3: Pregnancy, Public Health – Seattle & King County, Revised 2011

Pregnancy Visual 1 Handout

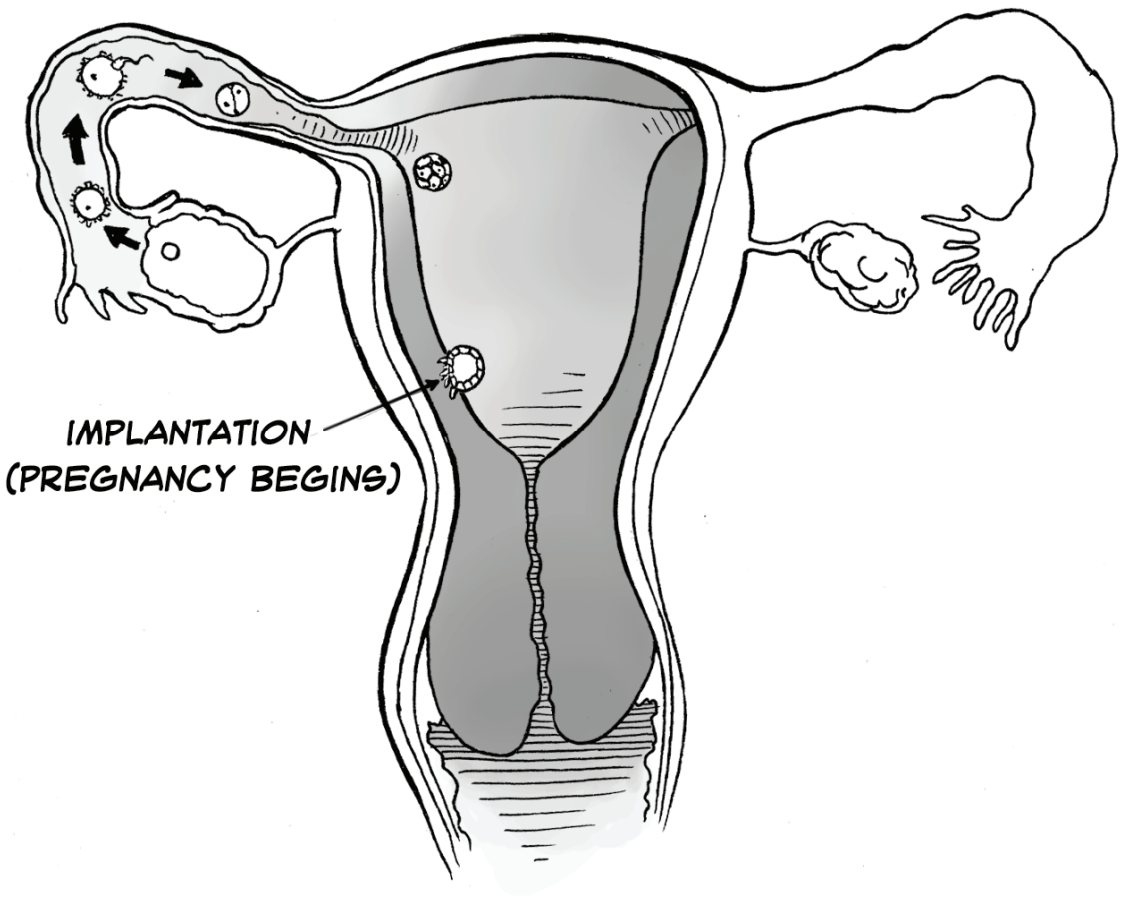
Sperm & Egg (Ovum)



Adapted from Family Life And Sexual Health (F.L.A.S.H.) Curriculum, Seattle and King County Family Planning Program.

Pregnancy Visual 2 Handout

The First Week



Adapted from Family Life And Sexual Health (F.L.A.S.H.) Curriculum, Seattle and King County Family Planning Program.

Activity 4: Contraceptive Adverts

TOTAL TIME REQUIRED

1 hour and 30 minutes

MATERIALS NEEDED

- ✔ Flip chart paper
- ✔ Markers
- ✔ Note card
- ✔ One male latex condom with information about the male condom in an envelope/small bag
- ✔ One female latex condom with information about the female condom in an envelope/small bag
- ✔ One set of oral contraceptive pills with information about the pill in an envelope/small bag
- ✔ Box or picture of injectables with information about injectables in an envelope/small bag
- ✔ Box or picture of implants with information about implants in an envelope/small bag

RESOURCES NEEDED

- ✔ Note card with ABSTINENCE written on it with information about abstinence in an envelope/small bag
- ✔ Summary Contraceptive Fact Sheets

RESOURCES NEEDED (CONTINUED)

- ✔ Flip chart paper with the following questions written on the paper:
  1. Does the method prevent pregnancy?
  2. Does the method prevent STIs and HIV?
  3. How effective is the method?
  4. Are there any side effects?
  5. Where can you obtain the method?

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Identify at least five methods of modern contraception and describe at least one advantage of each method.

INSTRUCTIONS

1. Let teachers know that next they will be learning about modern contraceptive methods with the purpose of becoming more familiar with them.
2. Ask teachers to count off in order to form six groups of no more than five people. If there are more people, add an extra group and duplicate one of the methods for that group(s).
3. Distribute a bag/envelope to each group and say that each bag contains a sample of a contraceptive method common in the country, along with written information about that method. If you are not able to access contraceptive methods and information, use the summary contraceptive fact sheets.

Activity 4: Contraceptive Adverts

INSTRUCTIONS (CONTINUED)

4. Tell them that they will be pretending to work for an advertising agency that promotes your method of contraception. Note that these advertising agencies must provide accurate and complete information about the methods—in other words, they are not allowed to lie or leave out information on purpose. Ask them to take 20 minutes to design a three–minute television or radio advert or poster to market the contraceptive method to young people. Ask teachers to emphasize what makes the method effective and easy to use but also address the following:
    - Whether the method prevents pregnancy
    - Whether the method prevents STIs and HIV
    - The effectiveness of the method
    - Whether there are side effects
    - Where you can obtain the method
5. Call time and ask each group to present their adverts to the group.
6. After each presentation, lead the group in a round of applause and correct any misinformation presented.
7. Ask the following questions:

- ✔ What was it like to do these commercials?
- ✔ What did you notice while they were preparing their commercial or watching others? What was the most effective method? (Answer: abstinence)? What is the biggest difference between condoms and other methods of birth control? (Answers: Condoms provide protection not only from pregnancy but also from most STIs, including HIV infection. Male condoms are the only method designed specifically for males to use).
- ✔ How does an exercise like this help inform learners about contraception? Why?
- ✔ How might you use or adapt this activity to build knowledge and understanding of contraception among learners?

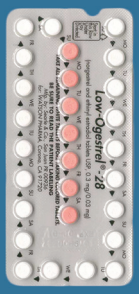
8. Conclude by noting that it is important for learners to know about contraception, the different methods available, and how they work. This exercise is designed for adolescents ages 12–15 and can be used and adapted to discuss contraceptive methods that are locally available.

Adapted from Life Planning Education, a comprehensive sex education curriculum. Washington, DC: Advocates for Youth, 2014.

Contraceptive Fact Sheet: The Pill

FACT SHEET : THE PILL

Remember, the pill **does not protect you from Sexually Transmitted Infections or HIV.** Always use condoms to protect yourself!



HOW DO BIRTH CONTROL PILLS WORK?

- Birth control pills contain hormones like the ones your body makes. These hormones stop your ovaries from releasing eggs. Without an egg, you cannot get pregnant.
- No method of birth control is 100% effective, but birth control pills are 99% effective if you take them each day.

HOW DO I START THE PILL?

- There are 2 ways to start the pill:
  - **Quick Start:** Take your first pill as soon as you get the pack.
  - **Next period:** Take your first pill soon after your next period begins.
- If you take your first pill *up to 5 days after the start of your period*, you are protected against pregnancy **right away**.
- If you take your first pill *more than 5 days after the start of your period*, you should **use condoms as back-up for the first 7 days.**

HOW DO I USE THE PILL?

- **Once you start using the pill**, take 1 pill each day. Take your pill at the same time each day.
- After you finish a pack of pills, you should start a new pack the next day. You should have NO day without a pill.

WHAT IF I MISS PILLS?

- **I forgot ONE pill:** Take your pill as soon as you can.
- **I forgot TWO pills or more:** Take your pill as soon as you can. Take your next pill at the usual time. **Use condoms for 7 days. Use emergency contraception (EC) if you have unprotected sex.**

WHAT IF I STOPPED TAKING THE PILL AND HAD UNPROTECTED SEX?

- Take Emergency Contraception (EC) **right away**. EC can prevent pregnancy up to 5 days after sex, and it works better the sooner you take it.

HOW DOES THE PILL HELP ME?

- The pill is safe and effective birth control.
- Your periods may be more regular, lighter, and shorter. You may have clearer skin.
- The pill lowers your risk of getting cancer of the uterus and ovaries.
- The pill has **no effect** on your ability to get pregnant in the future, after you stop taking it.

HOW WILL I FEEL ON THE PILL?

- You will feel about the same. In the first 2-3 months you may have nausea, bleeding between periods, weight change, and/or breast pain. These problems often go away after 2-3 months.

DOES THE PILL HAVE RISKS?

- The pill is very safe. Serious problems are rare. If you have any of the symptoms below, call your health provider.
- Leg pain, swelling, and redness
- Weakness or numbness on 1 side of your body
- Bad headache
- Vision problems
- Chest pain
- Your health provider can help you find out if these symptoms are signs of a serious problem.

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Contraceptive Fact Sheet: Injectable Contraception

FACT SHEET : THE SHOT/DEPO-PROVERA

Remember, Depo **does not protect you from Sexually Transmitted Infections or HIV.** Always use condoms to protect yourself!

HOW DOES DEPO WORK?

- Depo contains a hormone like the ones your body makes. This hormone stops your ovaries from releasing eggs. Without an egg, you cannot get pregnant.
- No method of birth control is 100% effective, but Depo is 99% effective if you get your shots on time.

HOW DO I USE DEPO?

- You get a Depo injection in the arm or in the buttocks.
- **Use condoms as back-up the first 7 days** after your first shot of Depo.
- You should get a shot every 3 months (every 12 weeks).

WHAT IF I AM LATE FOR THE NEXT SHOT?

- Depo works best if you get a new shot every 12 weeks.
- If your shot is more than 4 weeks late, you should get a pregnancy test before the next shot. You should **use condoms for the next 7 days**.

WHAT IF I AM LATE GETTING A SHOT AND HAD UNPROTECTED SEX?

- If your last shot was more than 16 weeks ago, take Emergency Contraception (EC) **right after** unprotected sex. EC can prevent pregnancy up to 5 days after sex, and it works better the sooner you take it.

HOW DOES DEPO HELP ME?

- Depo is safe & effective. It keeps you from getting pregnant for 3 months.
- The shot lowers your risk of cancer of the uterus.
- It is safe to breastfeed while on Depo.

HOW WILL I FEEL ON DEPO?

- You will most likely have spotting between periods. You may have weight gain, bloating, headaches and/or mood changes. Talk to your health care provider about treating any side effects.
- After the first 2-3 shots, you may have *no period at all*. This is normal.
- Your bones may become slightly weaker while you take Depo. Bone strength returns to normal once you stop getting the shot.
- After you stop Depo, it takes a few months for your fertility to return to normal. This means that it may take a while for you to get pregnant (even if you're trying) – but if you don't want to get pregnant, you need to use a new form of birth control after you stop Depo.

DOES DEPO HAVE RISKS?

- The shot is very safe. Severe problems are rare. If you have any of the symptoms below, call your doctor:
  - Severe headaches
  - Very heavy bleeding
- Your health care provider can help you find out if these symptoms are signs of a severe problem.

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Contraceptive Fact Sheet: Female Condom

FACT SHEET : FEMALE CONDOM

Remember, both the condom and the female condom **protect you from Sexually Transmitted Infections and HIV.** Always use them to protect yourself!

HOW DOES THE FEMALE CONDOM WORK?

- The female condom is a loose tube that blocks sperm from reaching the egg. If the sperm does not reach the egg, you cannot get pregnant.
- The female condom has a closed end with an inner ring that covers the cervix and an open end with an outer ring that stays outside the vagina.
- No method of birth control is 100% effective, but a female condom is 79-95% effective if you use it correctly.

WHEN DO I USE A FEMALE CONDOM?

- Use a new female condom each time you have sex.

HOW DO I INSERT A FEMALE CONDOM BEFORE SEX?

- Find a comfortable position (for example: lying down, standing with one leg on a chair).
- Squeeze the sides of the inner ring of the closed end and insert it into the vagina like a tampon. Push the inner ring until reaches the cervix (it feels like the tip of your nose).
- Remove your finger and let the outer ring of the open end hang outside the vagina.

HOW DO I REMOVE A FEMALE CONDOM AFTER SEX?

- Squeeze and twist the outer ring.
- Gently pull the condom out of the vagina and throw it away.

WHAT IF I STOPPED USING A FEMALE CONDOM AND HAD UNPROTECTED SEX?
WHAT IF THE FEMALE CONDOM BREAKS DURING SEX?

- Take Emergency Contraception (EC) **right away**. EC can prevent pregnancy up to 5 days after sex, and it works better the sooner you take it.

HOW DOES THE FEMALE CONDOM HELP ME?

- Easy to buy in a drug store
- Can be put on as part of sex play
- It has no hormones
- No need for erect penis to keep the female condom in place
- Protects you from Sexually Transmitted Infections and HIV

HOW WILL I FEEL USING THE FEMALE CONDOM?

- There are no side effects. You and your partner can feel the condom during sex.
- Some people find that the female condom decreases pleasure with sex. Others say it is noisy.

DOES THE FEMALE CONDOM HAVE RISKS?

- Female condoms are a safe and effective birth control method. There are no medical risks. A female condom may break or slip during sex; if this happens, take EC **right away**.

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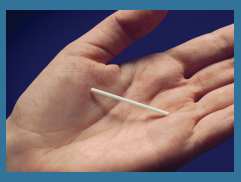
Contraceptive Fact Sheet: Progestin Implant

FACT SHEET : PROGESTIN IMPLANT

Remember, the implant **does not protect you from Sexually Transmitted Infections or HIV.** Always use condoms to protect yourself!



HOW DOES THE IMPLANT WORK?

- The implant is a thin plastic tube about the size of a paper matchstick. A health care provider inserts it under the skin of your upper arm.
- The implant releases progestin, a hormone like the ones your body makes. It works by making the mucus in your cervix too thick for sperm to pass through. If sperm cannot reach the egg, you cannot get pregnant.
- Each implant lasts up to 3 years.
- No method of birth control is 100% effective, but the implant is over 99% effective.

HOW DO I USE THE IMPLANT?

- After numbing your skin, a health care provider inserts the implant under the skin of your upper arm. This takes a few minutes. It is done in the office or clinic.
- You should not shower or bathe until 24 hours after you had the implant inserted.
- You should **use condoms as back-up during the first 7 days** after you get the implant.

HOW DOES THE IMPLANT HELP ME?

- The implant is safe and effective birth control. Once you have it, it works on its own – you don't have to do anything.
- You can use the implant while breastfeeding.
- You can use one implant for 3 years. If you want to use it longer, you can get a new implant after 3 years. If you don't like it or you decide to get pregnant, your health care provider can remove the implant before 3 years have passed.

HOW WILL I FEEL USING THE IMPLANT?

- The implant causes periods to change. **Most** women have off-and-on spotting. Spotting may last until you have the implant removed. This is normal.
- A **few** women have: mood changes, weight gain, headache, acne, and/or skin changes in the upper arm.
- Most side effects go away when you have the implant removed.

CAN PEOPLE SEE THE IMPLANT IN MY ARM?

- Most implants cannot be seen, but you can feel it if you touch the skin over the implant.

DOES THE IMPLANT HAVE RISKS?

- The implant is very safe.
- If you have any of the following symptoms **within the first week** after insertion, see your health care provider:
  - Redness, warmth, or drainage from your arm
  - Fever (>101^{0}F)
- If you have any of the following symptoms **at any time** while you have the implant, see your health care provider:
  - Feeling pregnant (breast pain, nausea)
  - Positive home pregnancy test

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Contraceptive Fact Sheet: Male Condom

FACT SHEET : CONDOM

Remember, the **condom protects you from Sexually Transmitted Infections and HIV.** Always use condoms to protect yourself!

HOW DOES A CONDOM WORK?

- A condom covers the penis during sex. It blocks sperm from reaching the egg. If the sperm does not reach the egg, you cannot get pregnant.
- No method of birth control is 100% effective, but the condom is 85-98% effective if you use it correctly.

WHEN DO I USE A CONDOM?

- Put on a condom only when the penis is partially or fully erect.
- Use a new condom each time you have sex.
- Make sure that the condom has not expired.

HOW DO I USE A CONDOM?

- Pull back the foreskin. (Skip this step if the man has no foreskin.)
- Place the rolled condom over the tip of the hard penis.
- Pinch the tip of the condom. Leave a half-inch space between the tip of the condom and the tip of the penis.
- Roll the condom all the way down to the base of the penis and smooth out any air bubbles.

HOW DO I REMOVE A CONDOM AFTER SEX?

- Hold the condom against the base of the penis as you withdraw the penis from the vagina.
- Remove the condom from the penis and throw it away.

WHAT IF I STOPPED USING A CONDOM AND HAD UNPROTECTED SEX? WHAT IF THE CONDOM BREAKS?

- Take Emergency Contraception (EC) **right away**. EC can prevent pregnancy up to 5 days after sex, and it works better the sooner you take it.

HOW DOES THE CONDOM HELP ME?

- Easy to get.
- Can be put on as part of sex play.
- Can help relieve early ejaculation.
- Protects against HIV and many other Sexually Transmitted Infections.

DO CONDOMS HAVE RISKS?

- Condoms are a safe and effective birth control method.
- There are no serious problems when using condoms. If you are allergic to latex, use polyurethane condoms.

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Activity 5: Sexually Transmitted Infections

TOTAL TIME REQUIRED

1 hour and 30 minutes

MATERIALS NEEDED

- ✔ Flip chart
- ✔ Markers
- ✔ Pens/pencils

RESOURCES NEEDED

- ✔ STI Fact Sheets:
  1. Chlamydia
  2. Gonorrhea
  3. Human Papilloma Virus (HPV)
  4. Syphilis
  5. Herpes
  6. Human Immunodeficiency Virus (HIV)
  7. Trichomoniasis
  8. Bacterial Vaginosis
- ✔ STD and HIV Brochure
- ✔ STI Chart Handout
- ✔ Leader's Resource on STI Regional Data

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Describe transmission prevention, symptoms, and treatment of some common Sexually Transmitted Infections (STIs), including Chlamydia, Gonorrhea, Human Papilloma Virus (HPV), Syphilis, Herpes, and Human Immunodeficiency Virus (HIV).

INSTRUCTIONS

1. Note that next we will be reviewing Sexually Transmitted Infections, including modes of transmission, symptoms, effects, and treatment.
2. Begin by leading teachers in a discussion. Ask if someone could share a definition of STIs—what is it? Be sure to articulate a correct definition if no one offers one—**Sexually transmitted infections (STIs) are infections that are spread primarily through person-to-person sexual contact. There are more than 30 different sexually transmissible bacteria, viruses, and parasites (WHO definition).**
3. Note that Sexually Transmitted Infections (STIs) and Sexually Transmitted Diseases (STDs) are two terms that often mean the same thing. STIs is now often used because medically, infections are only called diseases when they cause symptoms and many STIs don't have any symptoms. Therefore the term STI is technically more accurate.
4. Using the following question, lead teachers in a brief discussion, noting answers on flip chart paper. Complement their answers with the ones below if not mentioned.
   - **Why is it important for young people to learn about STIs?**
     - It helps them take care of their bodies.
     - Untreated STIs can jeopardize a person's health and future ability to have children.

Activity 5: Sexually Transmitted Infections

INSTRUCTIONS (CONTINUED)

- It helps young people to be able to discuss STIs with their partners.
- HIV is transmitted easier/faster if untreated STIs are present and condoms are not used during sexual intercourse.
- It helps recognize myths like "It's easy to tell if a person has an STI/HIV because he/she will look sick" that could prevent a person from using effective prevention methods or seeking needed treatments.

5. Next, ask teachers to brainstorm STIs that they have heard of and list them on a flip chart. If helpful, refer to the Leader's Resource on STI Regional Data to briefly reference STI prevalence rates for Africa or share country–level data if available.

6. Note that STIs can be viral, bacterial, or parasitic. Indicate that if a virus causes an STI, it is possible for it to remain asymptomatic for periods of time (meaning there are no symptoms). It is possible to have the virus and not know it, and it is possible to pass it to another person without either person knowing it. Viral STIs can be treated with medications, but not cured. STIs that are viral include genital warts (HPV), HIV, hepatitis B, hepatitis C, and genital herpes. Indicate that if bacteria or a parasite causes an STI, it needs to be treated with antibiotic or antimicrobial medication. STIs that are bacterial/parasitic include gonorrhea, chlamydia, syphilis, pubic lice, scabies, and vaginitis.

7. Next, distribute the STI Chart and divide teachers into triads (groups of three). Assign each group two specific STIs and give each group their respective STI pamphlets. If all STIs have been assigned, assign duplicates as needed. Explain that each triad is to become a group of "experts" on the STIs that they will be assigned. Explain that they will have 15 minutes to become "experts" by filling in the appropriate sections in the STI Chart. Let them know that after this they will be asked to educate other expert groups about their STIs multiple times and that they will also be seeking out information from other expert groups on the STIs that they are not experts on.

Activity 5: Sexually Transmitted Infections

INSTRUCTIONS (CONTINUED)

8. Ask teachers to take 10 minutes to complete the appropriate sections in the STI Chart using the information from the STI Fact Sheets.

9. Call time and ask groups to find a group with a different STI and present their findings to each other, so that each group has a chance to fill in the chart for a blank STI. Note that they have 5 minutes per group to share their expertise with each other.

10. Repeat this as many times as it takes until all groups have filled in the entire chart.

11. When all groups have finished, distribute the STD and HIV Brochure for their reference and ask teachers:

- ✔ What was it like to fill in their chart and then share information with other triads?
- ✔ Were you surprised by any of the STI information?
- ✔ What were some of the most important things to remember about the different STIs?
- ✔ How could you use an exercise like this in your class?

12. Conclude by making the following points:

    - STIs are common and young people are especially vulnerable because they lack knowledge about them, skills to protect themselves, and access to services because of stigma and other factors.
    - Learning about STIs is important for young people, especially since many STIs do not show visible symptoms and yet can cause serious health consequences.
    - Understanding what STIs are and how they are transmitted is key to helping young people protect themselves, seek treatment, and prevent possible further transmission in the event that they do acquire an STI.

Adapted from: Canada Federation of Sexual Health. (2005). Beyond the Basics: A Sourcebook on Sexuality and Reproductive Health Education.

STI Fact Sheet: Chlamydia

THE FACTS:

- Chlamydia (cla MI dee a) is a sexually transmitted infection (STI).
- Anyone can get chlamydia. It is very common among teens and young adults.
- Young, sexually active females need testing every year.
- Most people who have chlamydia don't know it. Often the disease has no symptoms.
- You can pass chlamydia to others without knowing it.
- Chlamydia is easy to treat and cure.
- If you do not treat chlamydia, it can lead to serious health problems.

HOW CAN I LOWER MY RISK FOR CHLAMYDIA?

- The **surest way** to prevent chlamydia is not to have sex or to have sex only with someone who's not infected and who has sex only with you.
- Condoms can reduce your risk of getting chlamydia if used the right way every single time you have sex.
- Washing the genitals, urinating, or douching after sex will **not** prevent any STI.

HOW DOES SOMEONE GET CHLAMYDIA?

- You can get chlamydia by having sex with someone who has it.
- "Having sex" means having anal, oral, or vaginal sex.
- If you are a pregnant woman who has chlamydia, you can pass the infection to your baby.

WHAT ARE THE SYMPTOMS OF CHLAMYDIA?

IF YOU ARE A WOMAN:

The majority of chlamydial infections in women do not cause any symptoms. You can get chlamydia in the cervix (opening to the womb), rectum, or throat. You may not notice any symptoms. But if you do have symptoms, you might notice:

- An unusual discharge from your vagina.
- Burning when you urinate.
- Discomfort or bleeding when you have sex.
- If the infection spreads, you might get lower abdominal pain, pain during sex, nausea, or fever.

STI Fact Sheet: Chlamydia

IF YOU ARE A MAN:

The majority of chlamydial infections in men do not cause any symptoms. You can get chlamydia in the urethra (inside the penis), rectum, or throat. You may not notice any symptoms. But if you do have symptoms, you might notice:

- A discharge from your penis.
- Burning when you urinate.
- Burning or itching around the opening of your penis.

HOW CAN I FIND OUT IF I HAVE CHLAMYDIA?

- Ask a doctor to give you a test for chlamydia. The test is easy and painless.

WHEN SHOULD I BE TESTED?

IF YOU ARE A WOMAN:

You should be tested for chlamydia at least once a year if you are:

- 25 years or younger and you're having sex.
- Older than 25 and you're having sex with more than one partner.
- Older than 25 and you have a new sex partner.
- Pregnant.

IF YOU ARE A MAN:

- See a doctor if you notice a discharge or feel a burning around your penis.

MEN AND WOMEN:

- See a doctor if your partner has chlamydia or symptoms that might be chlamydia.

IF I HAVE CHLAMYDIA, WHAT DOES THAT MEAN FOR MY PARTNER?

- Your partner may have chlamydia, too.
- Be sure to tell your recent sex partners, so they can get tested and treated.
- Avoid having sex until seven days after you've both started your treatment, so you don't re–infect each other.

HOW IS CHLAMYDIA TREATED?

- Chlamydia can be treated and cured with antibiotics.
- Finish all of the medicine to be sure you are cured.
- Do not share your medicine with anyone. You need all of it.
- If you still have symptoms after treatment, go back to see the doctor.
- You should get tested again about three months after you finish your treatment. This is especially important if you are not sure if your partner was also treated.

STI Fact Sheet: Chlamydia

CAN I GET CHLAMYDIA AGAIN AFTER I'VE BEEN TREATED?

- Yes, you can get chlamydia again. You can get it from an untreated partner or new partner.

WHAT HAPPENS IF I DON'T GET TREATED?

IF YOU ARE A WOMAN:

- If untreated, chlamydia can spread into the uterus or fallopian tubes and cause pelvic inflammatory disease (PID), a serious infection of the reproductive organs.
- PID can cause damage to your fallopian tubes. This damage may leave you unable to get pregnant or lead to an ectopic pregnancy (pregnancy outside the uterus.)
- PID may also cause chronic pain in your pelvic area.
- If you have untreated chlamydia, you could pass the infection to your baby when giving birth. Chlamydia can cause serious health problems for babies.

IF YOU ARE A MAN:

- Chlamydia rarely causes long–term health problems in men. You may get an infection in the tube that carries sperm from your testes. This infection can cause pain and fever. In rare cases, this infection may prevent you from fathering children.

A MESSAGE FOR EVERYONE:

- Protect yourself and your partner.
- Always see a doctor if your partner is being treated for chlamydia. You and your partner need to be treated. Also, see the doctor if you or your partner notice any symptoms, such as unusual discharge. Be sure to tell your recent sex partners, so they can get tested too. Talk openly and honestly with your partner about chlamydia and other STIs.

Adapted from [Chlamydia: The Facts], Centers for Disease Control and Prevention, United States Department of Health and Human Services.

STI Fact Sheet: Gonorrhea

THE FACTS:

- Gonorrhea (gon a REE a) is a sexually transmitted infection (STI)
- Anyone who is sexually active can get gonorrhea. It is more common among teens and young adults.
- Many people who have gonorrhea don't know it. Especially in women, the disease often has no symptoms.
- You can pass gonorrhea to others without knowing it.
- Gonorrhea can be cured with the right treatment.
- If you do not treat gonorrhea, it can lead to serious health problems.

HOW CAN I LOWER MY RISK FOR GONORRHEA?

- The **surest way** to prevent gonorrhea is not to have sex or to have sex only with someone who's not infected and who has sex only with you.
- Condoms can reduce your risk of getting gonorrhea if used the right way every single time you have sex.
- Washing the genitals, urinating, or douching after sex will **not** prevent any STI.

HOW DOES SOMEONE GET GONORRHEA?

- You can get gonorrhea by having sex with someone who has it.
- "Having sex" means having anal, oral, or vaginal sex.
- If you are a pregnant woman who has gonorrhea, you can pass the infection to your baby.

WHAT ARE THE SYMPTOMS OF GONORRHEA?

IF YOU ARE A WOMEN:

- You can get gonorrhea in the anus, eyes, mouth, throat, urinary tract, or uterus. You may not notice any symptoms. If you do have symptoms, they will vary depending on what part of your body is infected.

If you have gonorrhea in the uterus or urinary tract, you might notice these symptoms:

- Vaginal bleeding between your periods.
- Pain or burning when you pass urine.
- Increased vaginal discharge.

If you have gonorrhea in the rectum, you might notice these symptoms:

- Itching , soreness, bleeding, a discharge from your rectum, or painful bowel movements.

If you have gonorrhea in the throat, you might notice this symptom:

- Sore throat.

STI Fact Sheet: Gonorrhea

IF YOU ARE A MAN:

- You can get gonorrhea in the anus, eyes, mouth, penis, or throat. You may not notice any symptoms. If you do have symptoms, they will vary depending on what part of your body is infected.

If you have gonorrhea in the penis, you might notice these symptoms:

- Pain or burning when you pass urine.
- A discharge from your penis.
- Painful or swollen testicles.

If you have gonorrhea in the rectum, you might notice:

- Itching, soreness, bleeding, a discharge from your rectum, or painful bowel movements.

If you have gonorrhea in the throat, you might notice this symptom:

- Sore throat.

HOW CAN I FIND OUT IF I HAVE GONORRHEA?

- Ask a doctor to give you a test for gonorrhea.

WHEN SHOULD I BE TESTED?

IF YOU ARE A WOMEN:

You should be tested for gonorrhea if you have:

- Any symptoms, like pain or burning when you pass urine or vaginal discharge.
- A partner who has gonorrhea or symptoms that might be gonorrhea.
- Another STI, such as chlamydia.
- If you're pregnant, ask the doctor if you should be tested for gonorrhea.

IF YOU ARE A MAN:

You should be tested for gonorrhea if you have:

- A discharge from you penis. You may also feel pain inside your penis.
- Pain or burning when you pass urine.
- Itching, soreness, bleeding, or rectal discharge, if you have receptive anal intercourse.
- A partner who has gonorrhea or symptoms that might be gonorrhea.
- Another STI, such as chlamydia.

IF I HAVE GONORRHEA, WHAT DOES THAT MEAN FOR MY PARTNER?

- Your partner may have gonorrhea, too.
- Be sure to tell your recent sex partners, so they can get tested and treated.

STI Fact Sheet: Gonorrhea

- Avoid having sex until you've both finished your treatment, so you don't re–infect each other.

HOW IS GONORRHEA TREATED?

- Gonorrhea can be treated and cure with antibiotics.
- Finish all of the medicine to be sure you are cured.
- Do not share your medicine with anyone. You need all of it.
- If you still have symptoms after treatment, go back to see the doctor.

CAN I GET GONORRHEA AGAIN AFTER I'VE BEEN TREATED?

- Yes, you can get gonorrhea again. You can get it from an untreated partner or new partner.

WHAT HAPPENS IF I DON'T GET TREATED?

- Gonorrhea stays in your body if it is not treated. You may have a higher risk of getting HIV infection if you have unprotected sex with a partner living with HIV. Gonorrhea can also spread to the blood or joints. This condition can be very serious.

IF YOU ARE A WOMAN:

- If untreated, gonorrhea can spread into the uterus or fallopian tubes and cause pelvic inflammatory disease (PID), a serious infection of the reproductive organs.
- PID can cause damage to your fallopian tubes. This damage may leave you unable to get pregnant or lead to an ectopic pregnancy (pregnancy outside the uterus.)
- PID may also cause chronic pain in your pelvic area.
- If you have untreated gonorrhea, you could pass the infection to your baby when giving birth. Gonorrhea can cause serious health problems for babies.

IF YOU ARE A MAN:

- You may develop a painful condition in the testicles. In rare cases, this may prevent you from fathering children.

A MESSAGE FOR EVERYONE:

- Protect yourself and your partner.
- Always see a doctor if your partner is being treated for gonorrhea. You and your partner need to be treated. Also, see the doctor if you or your partner notice any symptoms, such as unusual discharge.
- If you have gonorrhea, you should be tested for other STIs. Be sure to tell your recent sex partners, so they can get tested too. Talk openly and honestly with your partner about gonorrhea and other STIs.

Adapted from [Gonorrhea: The Facts], Centers for Disease Control and Prevention, United States Department of Health and Human Services.

STI Fact Sheet: Genital Human Papilloma Virus (HPV)

THE FACTS:

- Genital human papillomavirus (/pap pil LO ma VY rus/) (HPV) is the most common sexually transmitted virus in the United States. Most sexually active people will have genital HPV at some time in their lives.
- Most people who have genital HPV don't know they have it. There are often no symptoms, and it goes away on its own—without causing any serious health problems.
- HPV is passed on through genital contact (such as vaginal and anal sex). You can pass HPV to others without knowing it.
- There is no cure for HPV, but there are treatments for the health problems that some types of HPV can cause, like genital warts and cervical cancer.

HOW CAN I LOWER MY RISK FOR HPV?

- The **surest way** to prevent HPV is not to have sex.
- If you decide to be sexually active, limit the number of partners you have. The fewer sex partners you have, the less likely you will be to get HPV.
- Condoms may lower chances of getting HPV, genital warts, or cervical cancer if used the right way every time you have sex. However, HPV can infect areas that are not covered by a condom—so you should not expect condoms to fully protect against HPV.
- Washing the genitals, urinating, or douching after sex will **not** prevent any sexually transmitted infection.
- Females and males can get vaccinated to protect against the types of HPV that most commonly cause health problems. These vaccines are given in 3 doses over 6 months. **The vaccines are most effective when all doses are received before a person has sexual contact with his or her first partner.**

HOW DOES SOMEONE GET HPV?

- Anyone who has ever had genital contact with another person can have genital HPV. Both men and women can get it—and pass it on—without even realizing it.

WHAT ARE THE HEALTH EFFECTS OF HPV?

- Genital HPV does not cause health problems for most people.
- There are many types of HPV. All HPV infections are either low-risk or high-risk. Low-risk HPV infections can cause genital warts. The warts are usually painless and not a serious problem. They can be flat or raised, single or in groups, and small or large. Without treatment, the warts may grow in size and number, or they may go away on their own.
- Women with HPV might have warts on the vagina, vulva, or cervix. Men with HPV might have warts on the penis, scrotum, or groin. Both men and women can have genital warts on the anus or thigh.

STI Fact Sheet: Genital Human Papilloma Virus (HPV)

- High–risk HPV infections can sometimes develop into cancer of the cervix (the opening of the womb). These infections may also lead to other cancers, such as anal cancer. In some people, high–risk HPV infections can persist and cause cell changes. If these cell changes are not treated, they may lead to cancer over time.
- It is only persistent HPV infections (the kind that don't go away for years) that put people at risk for cancer. The types of HPV that can cause cancer are not the same as the types that can cause genital warts.

MORE IMPORTANT INFORMATION ABOUT HPV:

IF YOU ARE A WOMAN:

- It's important to know about the link between HPV and cervical cancer and about the steps you can take to prevent this disease. Getting 3 doses of an HPC vaccine and getting regular screening can prevent cervical cancer. One HPV vaccine brand (Gardasil) can also prevent most genital warts.

IF YOU ARE A MAN:

- It's important to know that you can have genital HPV—and pass it to your partner—even if you have no symptoms. Some types of HPV can lead to cancer of the anus and penis, but these cancers are rare in men with healthy immune systems.
- There is one vaccine brand (Gardasil) to prevent the most common problem caused by HPV in men, genital warts. This vaccine is available for 9–to–26 year–old males.

DOES HAVING HPV MEAN I'LL GET CANCER?

- No. Most types of HPV infection don't lead to cancer. Women can protect themselves from cervical cancer by getting regular Pap tests and by getting treated early for any problems that could turn into cancer.

DO I NEED TO KNOW IF I HAVE HPV?

- There is no reason to be tested just to find out if you have genital HPV. Most people will have genital HPV at some time in their lives. Usually the infection goes away on its own. However, it is very important for women to get screened for cervical cancer that is caused by genital HPV.

IF YOU ARE A WOMEN:

- You should get regular Pap tests to check for changes in your cervix. The Pap test is the best way to screen for cervical cancer. Changes that are caught early can be treated before they lead to cancer.
- If you are 30 or over, or if the result of your Pap test is unclear, a doctor may also give you an HPV test. This test can help the doctor decide what other tests or treatment you should have.

IF YOU ARE A MAN:

- The U.S. Food and Drug Administration (FDA) has not approved a test for HPV in men. See your doctor if you have genital warts.

STI Fact Sheet: Genital Human Papilloma Virus (HPV)

CAN HPV BE TREATED?

- There is no treatment for genital HPV itself. Most of the time, though, your body fights off the virus on its own.
- There are treatments for the health problems that genital HPV can cause, like genital warts, cervical changes, and cervical cancer.
- Even after genital warts are treated, the virus may remain in the body. This means that you may still pass HPV to your sex partners.

WHAT ABOUT A VACCINE?

- Females and males can get vaccinated to protect against the types of HPV that most commonly cause health problems. These vaccines are given in 3 doses over 6 months. **The Vaccines are most effective when all doses are received before a person has sexual contact with his or her first partner.**
- Two brands of HPV vaccine (Cervarix and Gardasil) are available to protect females against the types of HPV that cause most cervical cancers. One of these vaccines (Gardasil) also protects against most genital warts.
- Doctors recommend that all 11– and 12– year–old girls get vaccinated against HPV. HPV vaccination is also recommended for women up to age 26 if they did not get all 3 vaccine doses when they were younger.
- Regardless of which brand of HPV vaccine a girl or women gets, it is important that she get the same one for all 3 doses. Even after receiving 3 vaccine doses, it is also important for women to get Pap tests as recommended. One available vaccine (Gardasil) protects males against most genital warts. This vaccine is available for boys and men, 9 through 26 years of age.

A MESSAGE FOR EVERYONE:

- Protect yourself and your partner.
- If you're a woman, it's **very** important to have regular Pap tests to check for problems that could develop into cervical cancer. Most women who get cervical cancer have not had regular Pap tests.
- There is no blame, no shame about having genital HPV. The virus is very common.
- If you have HPV, don't blame your current partner or assume your partner is cheating. People can have genital HPV for a very long time before it is detected. Talk openly and honestly with your partner about HPV and other sexually transmitted infections (STIs)

Adapted from [Genital HPV: The Facts], Centers for Disease Control and Prevention, United States Department of Health and Human Services

STI Fact Sheet: Syphilis

THE FACTS:

- Syphilis (SI fi lis) is a sexually transmitted infection (STI).
- Anyone can get syphilis.
- Many people who have syphilis don't know it. You can have syphilis even if you don't notice any symptoms.
- The first symptom is a painless, round, and red sore that can appear anywhere you've had sex.
- You can pass syphilis to others without knowing it.
- Washing the genitals, urinating, or douching after sex will not prevent syphilis.
- Syphilis is easy to treat and cure.
- If you do not treat syphilis, it can lead to serious health problems.

HOW DOES SOMEONE GET SYPHILIS?

- You can get syphilis by having sex with someone who has it. "Having sex" means having oral, anal, or vaginal contact.
- You can get syphilis when your mouth, genitals, or another part of your body touches a syphilis sore on a person who has the disease.
- If you are pregnant, you can pass syphilis on to your baby even if you don't know you are infected.

CAN I GET SYPHILIS BY HAVING ORAL SEX?

- Yes. Syphilis sores can be in the mouth as well as on the genitals. If you give or receive oral sex, you may expose yourself to syphilis. This is true even if you can't see a sore. Using a condom for oral sex can reduce your risk.

CAN PREGNANT WOMEN GET SYPHILIS?

- Yes, a woman can get syphilis when she is pregnant. Being pregnant does not protect you or your baby against any STI. If you are pregnant and you think you may have syphilis, see your doctor right away because you can pass the infection to your baby during pregnancy.
- Syphilis is extremely serious for babies. Your doctor can recommend medicine that is safe to take while you're pregnant.

WHAT ARE THE SYMPTOMS OF SYPHILIS?

- The disease has four stages: primary, secondary, latent, and tertiary.

Primary Stage Symptoms:

- During the primary stage of syphilis, you may have one or more painless sores on the genitals or in the mouth, anus, or rectum. The name for this type of sore is a chancre (SHANK er). The sore is likely to be wherever you had sex. If you had oral sex, it might be in your mouth or on your genitals. It does not hurt, so you might not even notice you have a sore unless you look for it. The sore lasts 3 to 6 weeks, and it heals on its own. If you don't get treatment, the disease will progress to the next stage.

STI Fact Sheet: Syphilis

Secondary Stage Symptoms:

- During the secondary stage of syphilis, you might have a rash on your hands and feet or on other parts of your body. Syphilis rashes are often red or brown and usually don't itch. Other symptoms may include fever, sore throat, muscle aches, headaches, hair loss, and feeling tired. These symptoms may go away on their own. If you don't get treatment, the disease will progress to the next stage.

Latent Stage Symptoms:

- In the latent stage of the disease, you have no symptoms, but the disease can be detected by a blood test from your doctor. Syphilis can remain hidden for many years in the latent stage.

Tertiary Stage Symptoms:

- Tertiary stage syphilis is very serious. It can begin after you've had untreated syphilis for a while, possibly many years—even if you never noticed symptoms. Symptoms of tertiary syphilis may include difficulty moving your arms and legs, paralysis, numbness, blindness, and heart disease.

WHEN SHOULD I BE TESTED?

You should be tested for syphilis right away if:

- You have any symptoms, such as a painless, round sore that may appear on your genitals or in your mouth.
- Your partner has syphilis or symptoms that might be syphilis, even if you don't have symptoms.
- Every pregnant woman should be tested for syphilis. Tell your doctor if you plan to become pregnant. How can I find out if I have syphilis? Ask your doctor to give you a blood test for syphilis.

HOW IS SYPHILIS TREATED?

- One shot of penicillin, an antibiotic, will cure a person who has had syphilis for less than a year. More doses are needed to treat someone who has had syphilis for longer than a year.

CAN I GET SYPHILIS AGAIN AFTER I'VE BEEN TREATED?

- Yes, you can get syphilis again. You can get it from an untreated partner or a new partner who is infected.

IF I HAVE SYPHILIS, WHAT DOES THAT MEAN FOR MY PARTNER?

- Your partner may have syphilis, too.
- Be sure to tell your recent sex partners, so they can get tested and treated.
- Avoid having sex until you've both been treated, so you don't re–infect each other.
- Avoid sexual contact with anyone if you see an unusual sore.

STI Fact Sheet: Syphilis

WHAT HAPPENS IF I DON'T GET TREATED?

- Syphilis stays in your body if it is not treated.
- It can damage your heart, brain, eyes, and other organs. This damage may not show up for many years and could kill you.
- You might also pass the disease on to other people.

DOES SYPHILIS AFFECT MY RISK OF GETTING HIV?

- Yes. If you have syphilis, you have a higher chance of getting HIV. If you have syphilis and HIV, you can spread both diseases more easily.

HOW CAN I LOWER MY RISK FOR SYPHILIS?

- The surest way to prevent syphilis is not to have sex or to have sex only with someone who's not infected and who has sex only with you.
- Condoms can reduce your risk of getting syphilis if used the right way every single time you have sex. But a condom protects only the area it covers. Areas the condom doesn't cover can become infected.
- Using drugs or alcohol may increase your risk of getting syphilis.
- Get a blood test from your doctor once a year in case you got syphilis and don't know it.

A MESSAGE FOR EVERYONE:

- Protect yourself and your partner.
- Always see a doctor if your partner is being treated for syphilis. You and your partner need to be treated. Also see the doctor if you or your partner notice any symptoms, such as a painless red sore.
- If you have syphilis, you should be tested for other STIs. Be sure to tell your recent sex partners, so they can get tested too. Talk openly and honestly with your partner about syphilis and other STIs.

Adapted from [Syphilis: The Facts], Centers for Disease Control and Prevention, United States Department of Health and Human Services

STI Fact Sheet: Genital Herpes

THE FACTS:

- Genital herpes (JEN i tell / HER pees) is a sexually transmitted virus.
- Genital herpes is common in both men and women in the U.S.
- Most people who have genital herpes don't know it. There are often no symptoms.
- If you have symptoms, the most common ones are painful blisters and sores.
- You can pass genital herpes to others without knowing it.
- There is no cure for genital herpes, but there are treatments for the symptoms.
- Genital herpes does not usually cause serious health problems.

HOW CAN I LOWER MY RISK FOR GENITAL HERPES?

- The surest way to prevent genital herpes is not to have sex or to have sex only with someone who's not infected and who has sex only with you.
- Condoms can reduce your risk of getting genital herpes if used the right way every single time you have sex. But a condom protects only the area of the body that it covers. Areas the condom doesn't cover can become infected.
- Washing the genitals, urinating, or douching after sex will not prevent any sexually transmitted infection (STI).

HOW CAN I FIND OUT IF I HAVE GENITAL HERPES?

- Ask a doctor. Blood tests may help determine if you have genital herpes.

WHAT ARE THE SYMPTOMS OF GENITAL HERPES?

Genital herpes often doesn't cause any symptoms. If you do have symptoms, you might notice:

- Painful blisters or sores on or around the genitals or anus. These sores typically heal within two to four weeks.
- Feeling like you have the flu when the sores are present.
- Sores that come back several times within a year. The presence of the sores is called an outbreak.

There are two types of genital herpes virus—HSV1 and HSV2. Both types can cause sores or blisters on or around the genitals. HSV1 can also cause sores on the mouth or lips, which are called fever blisters.

HOW DOES SOMEONE GET GENITAL HERPES?

- You can get genital herpes by having sex with someone who has it. "Having sex" means having anal, oral, or vaginal sex.
- You can also get genital herpes if your genitals touch the infected skin or secretions (like saliva through oral sex) of someone who has it.
- You can get genital herpes even if your partner shows no signs of the infection.

STI Fact Sheet: Genital Herpes

WHAT CAN I EXPECT TO HAPPEN IF I HAVE GENITAL HERPES?

MEN AND WOMEN:

- You can expect to have several outbreaks (usually four or five) a year. Over time you can expect to have fewer outbreaks.
- You have a higher chance of getting an HIV infection if you have unprotected sex with a partner living with HIV.
- Knowing that you have genital herpes may make you feel worried or sad. Talk with a doctor about your concerns.

PREGNANT WOMEN:

- In rare cases, you could pass the infection to your baby.
- If you have active genital herpes when you go into labor, the doctor may do a cesarean delivery ("C–section").
- Be sure to tell your doctor if you or your partner has genital herpes.

WHEN SHOULD I BE TESTED?

You should be tested for genital herpes if:

- You have any symptoms (like an unusual sore).
- Your partner has genital herpes or symptoms that might be genital herpes.

IF I HAVE GENITAL HERPES, WHAT DOES THAT MEAN FOR MY PARTNER?

- Your partner may have genital herpes, too.
- Be sure to tell your recent sex partners, so they can go to their doctors to be evaluated and maybe treated.
- Avoid having sex with an uninfected partner when you have visible sores or other symptoms.
- Be aware that even if you don't have symptoms, you can still infect your partner.

CAN GENITAL HERPES BE TREATED?

- There is no cure for genital herpes, but there are treatments for its symptoms.
- Some medicines can prevent the blisters or make them go away faster.
- If you have several outbreaks in a year, a treatment called daily suppressive therapy can reduce your chance of passing the infection to your sex partners.

A MESSAGE FOR EVERYONE:

- Always see a doctor if your partner is being treated for genital herpes. Also see the doctor if you or your sex partner notice any symptoms, such as an unusual sore.
- If you have genital herpes, you should be tested for other STIs. Be sure to tell your recent sex partners, so they can get tested too. Talk openly and honestly with your partner about genital herpes and other STIs.

Adapted from [Genital Herpes: The Facts], Centers for Disease Control and Prevention, United States Department of Health and Human Services

STI Fact Sheet: Human Immunodeficiency Virus (HIV)

STD FACTS

HIV Infection and AIDS

(caused by human immunodeficiency virus or HIV)

SIGNS AND SYMPTOMS

Early (weeks to months after exposure):
- Flu-like illness
- Swollen lymph nodes

Late (years after exposure):
- Persistent fevers
- Night sweats
- Prolonged diarrhea
- Unexplained weight loss
- Purple bumps on skin or inside mouth and nose
- Chronic fatigue
- Swollen lymph nodes
- Recurrent respiratory infections

Note: These symptoms are not specific for HIV and may have other causes. Most persons with HIV have no symptoms at all for several years.

TRANSMISSION

HIV is spread by:
- Vaginal sex
- Oral sex
- Anal sex
- Sharing needles to inject drugs, body piercing or tattooing
- Contaminated blood products (rare)
- Infected mother to newborn at birth or through breastfeeding

HIV infection cannot be spread by:
- Shaking hands
- A social kiss
- Cups
- Animals
- Hugging
- Swimming pools
- Toilet seats
- Food
- Insects
- Coughing

COMPLICATIONS

- HIV can spread to sex partners and persons sharing needles.
- There is no cure for HIV and without treatment most people eventually die from the disease.

HIV/AIDS and pregnancy
- HIV can be passed to unborn children from infected mother during pregnancy or childbirth.
- Infected mother may infect infant through breast milk.

PREVENTION

- Avoiding vaginal, oral or anal sex is the best way to prevent STDs.
- Limit the number of sex partners.
- Latex condoms, when used consistently and correctly, are highly effective in preventing the transmission of HIV, the virus that causes AIDS.
- Always use latex condoms during vaginal and anal sex.
- Use a latex condom for oral sex on a penis.
- Use a latex barrier (dental dam or condom cut in half) for oral sex on a vagina or anus.
- Limit or avoid use of drugs and alcohol.
- Don't share drug needles, cotton or cookers.
- Don't share needles for tattooing or piercing.
- Notify sex and needle-sharing partners immediately if HIV-infected.

TESTING AND TREATMENT

- Tests are available to detect antibodies for HIV through physicians, STD clinics, and HIV counseling and testing sites.
- There is no cure for HIV/AIDS.
- Early diagnosis and treatment can prolong life for years.
- Medications and treatments are available to keep immune system working.
- Medications are available to treat AIDS-related illnesses.
- Medications are available for HIV infected pregnant women to greatly reduce the chance of infection of newborn.
- There are experimental drug trials testing new medications.

MINNESOTA MDH DEPARTMENT OF HEALTH *Updated by the Minnesota Department of Health, STD and HIV Section, April 2011*

STI Fact Sheet: Trichomoniasis

Trichomoniasis - CDC Fact Sheet

What is trichomoniasis?

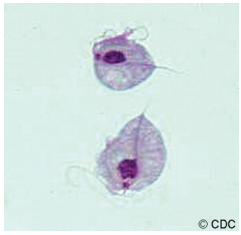
Trichomoniasis (or "trich") is a very common sexually transmitted disease (STD) that is caused by infection with a protozoan parasite called *Trichomonas vaginalis*. Although symptoms of the disease vary, most women and men who have the parasite cannot tell they are infected.

How common is trichomoniasis?

Trichomoniasis is considered the most common curable STD. In the United States, an estimated 3.7 million people have the infection, but only about 30% develop any symptoms of trichomoniasis. Infection is more common in women than in men, and older women are more likely than younger women to have been infected.

How do people get trichomoniasis?

The parasite is passed from an infected person to an uninfected person during sex. In women, the most commonly infected part of the body is the lower genital tract (vulva, vagina, or urethra), and in men, the most commonly infected body part is the inside of the penis (urethra). During sex, the parasite is usually transmitted from a penis to a vagina, or from a vagina to a penis, but it can also be passed from a vagina to another vagina. It is not common for the parasite to infect other body parts, like the hands, mouth, or anus. It is unclear why some people with the infection get symptoms while others do not, but it probably depends on factors like the person's age and overall health. Infected people without symptoms can still pass the infection on to others.



Two Trichomonas vaginalis *parasites, magnified (seen under a microscope)*

What are the signs and symptoms of trichomoniasis?

About 70% of infected people do not have any signs or symptoms. When trichomoniasis does cause symptoms, they can range from mild irritation to severe inflammation. Some people with symptoms get them within 5 to 28 days after being infected, but others do not develop symptoms until much later. Symptoms can come and go.

Men with trichomoniasis may feel itching or irritation inside the penis, burning after urination or ejaculation, or some discharge from the penis.

Women with trichomoniasis may notice itching, burning, redness or soreness of the genitals, discomfort with urination, or a thin discharge with an unusual smell that can be clear, white, yellowish, or greenish.

Having trichomoniasis can make it feel unpleasant to have sex. Without treatment, the infection can last for months or even years.

What are the complications of trichomoniasis?

Trichomoniasis can increase the risk of getting or spreading other sexually transmitted infections. For example, trichomoniasis can cause genital inflammation that makes it easier to get infected with the HIV virus, or to pass the HIV virus on to a sex partner.

How does trichomoniasis affect a pregnant woman and her baby?

Pregnant women with trichomoniasis are more likely to have their babies too early (preterm delivery). Also, babies born to infected mothers are more likely to have an officially low birth weight (less than 5.5 pounds).

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of STD Prevention

CS233825A

STI Fact Sheet: Trichomoniasis

How is trichomoniasis diagnosed?

It is not possible to diagnose trichomoniasis based on symptoms alone. For both men and women, your primary care doctor or another trusted health care provider must do a check and a laboratory test to diagnose trichomoniasis.

What is the treatment for trichomoniasis?

Trichomoniasis can be cured with a single dose of prescription antibiotic medication (either metronidazole or tinidazole), pills which can be taken by mouth. It is okay for pregnant women to take this medication. Some people who drink alcohol within 24 hours after taking this kind of antibiotic can have uncomfortable side effects.

People who have been treated for trichomoniasis can get it again. About 1 in 5 people get infected again within 3 months after treatment. To avoid getting reinfected, make sure that all of your sex partners get treated too, and wait to have sex again until all of your symptoms go away (about a week). Get checked again if your symptoms come back.

How can trichomoniasis be prevented?

Using latex condoms correctly every time you have sex will help reduce the risk of getting or spreading trichomoniasis. However, condoms don't cover everything, and it is possible to get or spread this infection even when using a condom.

The only sure way to prevent sexually transmitted infections is to avoid having sex entirely. Another approach is to talk about these kinds of infections before you have sex with a new partner, so that you can make informed choices about the level of risk you are comfortable taking with your sex life.

If you or someone you know has questions about trichomoniasis or any other STD, especially with symptoms like unusual discharge, burning during urination, or a sore in the genital area, check in with a health care provider and get some answers.

Where can I get more information?

Division of STD Prevention (DSTDP)
Centers for Disease Control and Prevention
www.cdc.gov/std

CDC-INFO Contact Center
1-800-CDC-INFO (1-800-232-4636)
Contact: www.cdc.gov/info

Resources

CDC National Prevention Information (NPIN)
P.O. Box 6003
Rockville, MD 20849-6003
E-mail: npin-info@cdc.gov
npin.cdc.gov/disease/stds

American Sexual Health Association (ASHA)
P. O. Box 13827
Research Triangle Park, NC 27709-3827
1-800-783-9877
www.ashastd.org

STI Fact Sheet: Bacterial Vaginosis

THE FACTS:

- Bacterial vaginosis (back TEER ee el / va gin NO sus) (BV) is a condition in which there is an overgrowth of some kinds of bacteria in the vagina. BV can cause symptoms such as vaginal discharge.
- BV is common in women of childbearing age.
- Washing the genitals, urinating, or douching after sex will not prevent BV or any sexually transmitted infection (STI).

HOW CAN I LOWER MY RISK FOR BV?

- Scientists do not fully understand BV and do not know the best ways to prevent it. However, it is known that having a new sex partner or having more than one sex partner increases your risk of getting BV.

To lower your risk of getting BV:

- Do not have sex.
- If you decide to be sexually active, limit the number of partners you have.
- Do not douche.
- Use all the medicine prescribed to treat BV, even if the symptoms go away.

HOW DO WOMEN GET BV?

Doctors don't fully understand how people get BV. The disease may spread between women who have sex with women. Any woman can get BV, but you're at higher risk of getting it if:

- You have a new sex partner or multiple sex partners.
- You use an intrauterine device (IUD) for birth control.
- You douche.

Women do not get BV from toilet seats, bedding, or swimming pools or from touching objects around them. Women who have never had sex rarely get BV.

HOW CAN I FIND OUT IF I HAVE BV?

- A doctor must examine you and take a sample of fluid from your vagina to determine if you have BV.

WHAT ARE THE SYMPTOMS OF BV?

Some women with BV don't know they have it because they have no symptoms. If you do have symptoms, you might notice:

- An unusual discharge, with a strong fish–like smell, from your vagina. You are most likely to notice this after you have sex.
- Itching around your vagina.

STI Fact Sheet: Bacterial Vaginosis

WHEN SHOULD I BE TESTED?

- You should be tested for BV if you have any symptoms (like a vaginal discharge) or if your female sex partner has BV or symptoms that could be BV.

CAN I GET BV AGAIN AFTER I'VE BEEN TREATED?

- Yes, you can get BV again.

WHAT HAPPENS IF I'M PREGNANT?

If you're pregnant and have BV:

- You're more likely to give birth prematurely.
- Your baby is more likely to be underweight (less than 5 pounds at birth). How is BV treated?
- BV can be treated and cured with antibiotics.
- Finish all of your medicine to be sure you are cured.
- Do not share your medicine with anyone. You need all of it.
- If you still have symptoms after treatment, go back to see your doctor.

WHAT HAPPENS IF I DON'T GET TREATED?

- You may have a higher risk of getting another STI, such as chlamydia or gonorrhea.
- You may have a higher risk of getting HIV infection if you have unprotected sex with an HIV–infected partner.

IF I HAVE BV, WHAT DOES THAT MEAN FOR MY PARTNER?

- Male partners do not need to be treated for BV, but BV may spread between women who have sex with women. This means that if you have BV and you have a female sex partner, your partner may have BV too.

A MESSAGE FOR EVERYONE

- Talk openly and honestly with your partner about STIs.

Adapted from [Bacterial Vaginosis: The Facts], Centers for Disease Control and Prevention, United States Department of Health and Human Services

STDs and HIV Brochure

STDs & HIV

get the facts
learn the risks
protect yourself

Rights. Respect. Responsibility.

Teens' Rights to Reproductive and Sexual Health Services

What are my rights to birth control, HIV and STD testing, and privacy?

Young people's access to birth control, confidential visits with a healthcare provider, and HIV and STD testing vary from state to state. Visit www.plannedparenthood.org to find your nearest Planned Parenthood clinic. Or Google your state, county, and/or community name and "Health Department" to find a local health department clinic.

In some states a doctor may have the right to inform your parents of the services they have provided you. Find the law in your state by visiting www.sexetc.org/state .

Clinics that receive a certain type of government funding are required by law to offer confidential services, including HIV and STD testing and prescriptions for birth control, to all young people. Over 4,600 clinics nationwide receive this type of funding. Planned Parenthood clinics, and many state and local health departments, hospitals, community health centers, and independent clinics offer confidential services. Some services offered by these clinics include:

- Pelvic exams and pap tests
- Safer sex counseling
- Prescriptions for birth control
- Administering Depo-Provera (the shot) or inserting an IUD
- Counseling about abortion and abortion services

Many clinics offer free or reduced services, and you can pay in cash. If you pay for your bill by using your family's health insurance, the bill may be sent to your parents. Some steps to make sure your visit is private are:

- Call the clinic or healthcare provider before you go to ask about its policies.
- Tell the clinic staff how to contact you personally.
- Ask about reduced pricing, and pay in cash.

Where Can I Get Help?

Talk to your doctor or visit a clinic where they do STD screening. Or get info online:

- Use the testing site locator at www.hivtest.org (locates sites which test for HIV, STDs, or both)
- Search for your city or county health department
- Find your local Planned Parenthood (www.plannedparenthood.org)

Visit www.amplifyyourvoice.org for more information about STDs and to get involved in youth activism around sexual and reproductive health and rights.

Where can I get condoms

You can get condoms for free at most clinics but you can also purchase them at any drug store regardless of how old you are. Condoms cost between $5-$20 per box. Make sure you check the expiration date on the box! The most common kind of condom is made out of latex. But if you or your partner is allergic to latex, you can also get condoms made out of polyurethane. Lambskin condoms do not protect against STDs.

STDs and HIV Brochure

How can I talk about condoms with my partner?

It can be hard to talk to a partner about condoms. But unprotected sex puts you both at risk. Here are a few tips to make the conversation a success:

Know what you want and don't want. Don't engage in any sexual behavior that makes you uncomfortable, but always protect yourself. Remember, consistent and correct condom use reduces your risk of STDs and pregnancy.

Discuss abstinence, sex, and safer sex. Be honest about your sexual history and your sexual health. Discuss and make mutual decisions on your safer sex options. Go together to get tested for STDs. Educate yourself about safer sex options and make sure you are prepared to discuss them.

State what you want, and don't want, clearly. Don't be afraid! You have the right to protect yourself and to state your needs. If your partner doesn't respond in a supportive way, then think about the relationship as a whole and if your partner respects and cares about you. No one should ever ask you to compromise your health and well-being!

Vaccine

There is a vaccine for HPV which can protect from genital warts and from the types of HPV that cause cancer. It is approved for
both males and females ages 9-26 and must be given by a doctor.

Advocates for Youth

Advocates for Youth champions efforts to help young people make informed and responsible decisions about their reproductive and sexual health. Advocates believes it can best serve the field by boldly advocating for a more positive and realistic approach to adolescent sexual health.

Check out Advocates for Youth's websites:

Advocates for Youth
www.advocatesforyouth.org

Amplify
An online youth activism hub with information, resources, and advocacy opportunities www.amplifyyourvoice.org

MySistahs
Information and support by and for young women of color
www.mysistahs.org

YouthResource
Information by and for gay, lesbian, bisexual, transgender, and questioning youth www.youthresource.org

2000 M STREET NW, SUITE 750
WASHINGTON DC 20036 USA
T:202.419.3420 F:202.419.1448
www.advocatesforyouth.org

Advocates for Youth
Rights. Respect. Responsibility.

how to use a condom

Talk to your partner about safer sex. Then, follow these steps for correct condom use.

1. Check the expiration date on the individual condom packet.

2. Once the penis is erect, open condom package with your fingers. Don't use your teeth, or any sharp object, because you might accidentally tear the condom!

3. Squeeze the tip of condom with your fingers and place the rolled condom on the head of the penis.

4. Leave a half-inch space at the tip of the condom to collect semen.

5. Hold the tip of condom and unroll until the penis is completely covered.

6. After ejaculation, while the penis is still erect, hold the condom at base of penis and carefully remove the condom without spilling any semen.

7. Wrap the condom in tissue, or tie it in a knot and throw it away. (Don't flush the condom down the toilet.)

8. Use a NEW condom for every act of vaginal, oral, and anal intercourse. Never use a condom more than once. Never use two condoms at the same time!

9. If using lubricant, use a water-based one like KY Jelly or Astroglide, NOT Vaseline or baby oil.

It is also helpful to practice – you can always use a banana!

Be prepared! Use protection the first time you have sex.

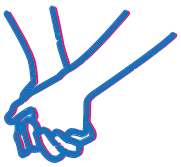
STDs and HIV Brochure

HOW TO BE SAFE

methods you can use that reduce the risk of STDs, including HIV

abstinence

100% EFFECTIVE
in preventing STDs, including HIV when used consistently and correctly every time



latex or polyurethane male condom

99% EFFECTIVE
against HIV, and also reduces the risk of many other STDs when used consistently and correctly every time

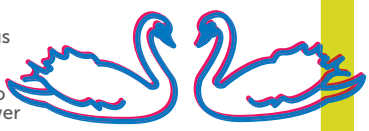
condoms can also reduce the risk of pregnancy

female condom

may reduce the risk of STDs, including HIV, when used consistently and correctly every time

monogamy

having a long-term mutually monogamous relationship with one partner who has been tested and is known to be uninfected can lower your risk of getting STDs including HIV



did you know?

Dental dams as a barrier between the mouth and genitals may reduce the risk of getting an STD, including HIV, through oral sex.

You have the right to decide if and when you want to have sex and to take steps to protect yourself from STDs and HIV.

Remember to use your protection method each and every time you have sex.

STDs

STD stands for Sexually Transmitted Disease. They are sometimes called STIs (sexually transmitted infections).

An STD is passed by body fluids or genital contact during anal, oral, and vaginal sex.

Human Immunodeficiency Virus (HIV)

is a virus that can be transmitted by anal, oral, or vaginal sex with an infected person, as well as through breast milk, during childbirth, and by coming into contact with the blood of an HIV positive person. Untreated, HIV can lead to AIDS, which compromises the immune system and puts the person at risk of illness and death. HIV cannot be transmitted by casual contact like hugging or sharing utensils.

SIGNS/SYMPTOMS

In its early stages HIV has no symptoms.

Once the illness has progressed, the first symptoms may include fever, rashes, and sores.

In its final stage a person with AIDS may suffer from a variety of illnesses, including pneumonia and cancer.

viral STDs can be treated but CANNOT be cured

TESTING

Get tested:

- if you have had unprotected sex
- if you have injected drugs with needles or shared drug equipment (needles, works) with others
- if you have a new sexual partner you should both get tested. A blood or urine test allows the doctor to determine if you have HIV.

A positive test result means you are infected with HIV. It doesn't mean you have AIDS or will get sick soon.

A negative test result means no HIV antibodies were found in your body. But, you could still be infected if you have been exposed to HIV in the last three months. Your body may not have made enough HIV antibodies to show up yet. Get tested again in three months.

TREATMENT

Medications, called anti-retrovirals, can prevent the virus from worsening and extend the lives of HIV positive people for decades.

Start treatment as early as possible in order to stay healthy for as long as possible.

There is NO cure for HIV.

Left untreated, STDs can damage your reproductive system and create other serious health risks.

STDs and HIV Brochure

Pelvic Inflammatory Disease (PID)

is an infection in the womb, ovaries, and fallopian tubes. PID affects WOMEN ONLY. Chlamydia, gonorrhea, and other STDs left untreated can cause PID.

SIGNS/SYMPTOMS
- Pain during intercourse
- Pain in lower abdomen
- Fever
- Smelly vaginal discharge
- Irregular bleeding
- Some women have NO SYMPTOMS

TESTING
The doctor will perform a vaginal exam, pap smear, or pelvic ultrasound.

TREATMENT
PID can be treated and cured with antibiotics.

Human Papillomavirus (HPV)

is a common viral STD that can be transmitted by anal, oral, or vaginal sex with an infected person. The body can fight off some HPV types, but others cause illness.

SIGNS/SYMPTOMS
- Genital Warts are small bump or groups of bumps in the genital area. They can be small or large, raised or flat, or shaped like a cauliflower
- Some HPV types can cause normal cells in the body to turn abnormal, and might lead to cancer over time
- Some people have NO symptoms

TESTING
A pap smear allows the doctor to determine if you have abnormal cervical cells which might indicate HPV; an HPV test can determine if you have HPV.

TREATMENT
- Genital Warts can be removed or treated with medicine.
- Abnormal Cervical Cells (found on a Pap test) can usually be treated to prevent cervical cancer from developing.
- There is NO cure for HPV.

Syphilis

is a bacterial STD passed on by a syphilis sore through anal, oral, or vaginal sex with an infected person. Syphilis has three stages: the primary, secondary, and the late and latent stage.

bacterial STDs can be treated and cured

SIGNS/SYMPTOMS
- The primary stage begins with a single sore (called a chancre), but there can also be multiple sores. If not treated at this stage it will progress to the secondary stage.
- The secondary stage consists of skin rash and lesions that usually appear on the palm of the hands or bottom of feet. If not treated at this stage it will progress to the late or latent stage.
- The late or latent stage, also called the hidden stage, begins when primary and secondary symptoms disappear, but the disease is still present. Without treatment, syphilis can lead to blindness and death.

TESTING
A microscopic exam of a chancre sore or a blood test will be used.

TREATMENT
Treatment can include a single antibiotic injection for someone infected less than a year. Additional doses are needed to treat someone infected longer than a year.

Chlamydia

is a bacterial STD. Chlamydia can be transmitted by having anal, oral, or vaginal sex with an infected person.

SIGNS/SYMPTOMS
- Pain during intercourse (females)
- Abdominal and lower back pain
- Burning sensation during urination (males/females)
- Abnormal discharge from vagina or penis
- People who are infected may have NO SYMPTOMS

TESTING
urine or a specimen from the penis or cervix may be collected

TREATMENT
Chlamydia can be treated and cured with antibiotics.

Gonorrhea

is a bacterial STD that can infect the genital tract, mouth or anus. Gonorrhea can be transmitted by having anal, oral, or vaginal sex with an infected person.

SIGNS/SYMPTOMS
- Pain when urinating (males/females)
- Pus-like discharge from penis or vagina
- Anal irritation and painful bowel movements
- People who are infected may have NO SYMPTOMS

TESTING
Urine sample, or sample from infected body parts (cervix, urethra, rectum, or throat) may be collected

TREATMENT
Gonorrhea can be treated and cured with antibiotics.

Herpes

is a viral infection caused by Herpes Simplex Virus (HSV1 or HSV2). Herpes can be transmitted through anal, oral, or vaginal sex with an infected person. Herpes can be transmitted between outbreaks and when there are no symptoms.

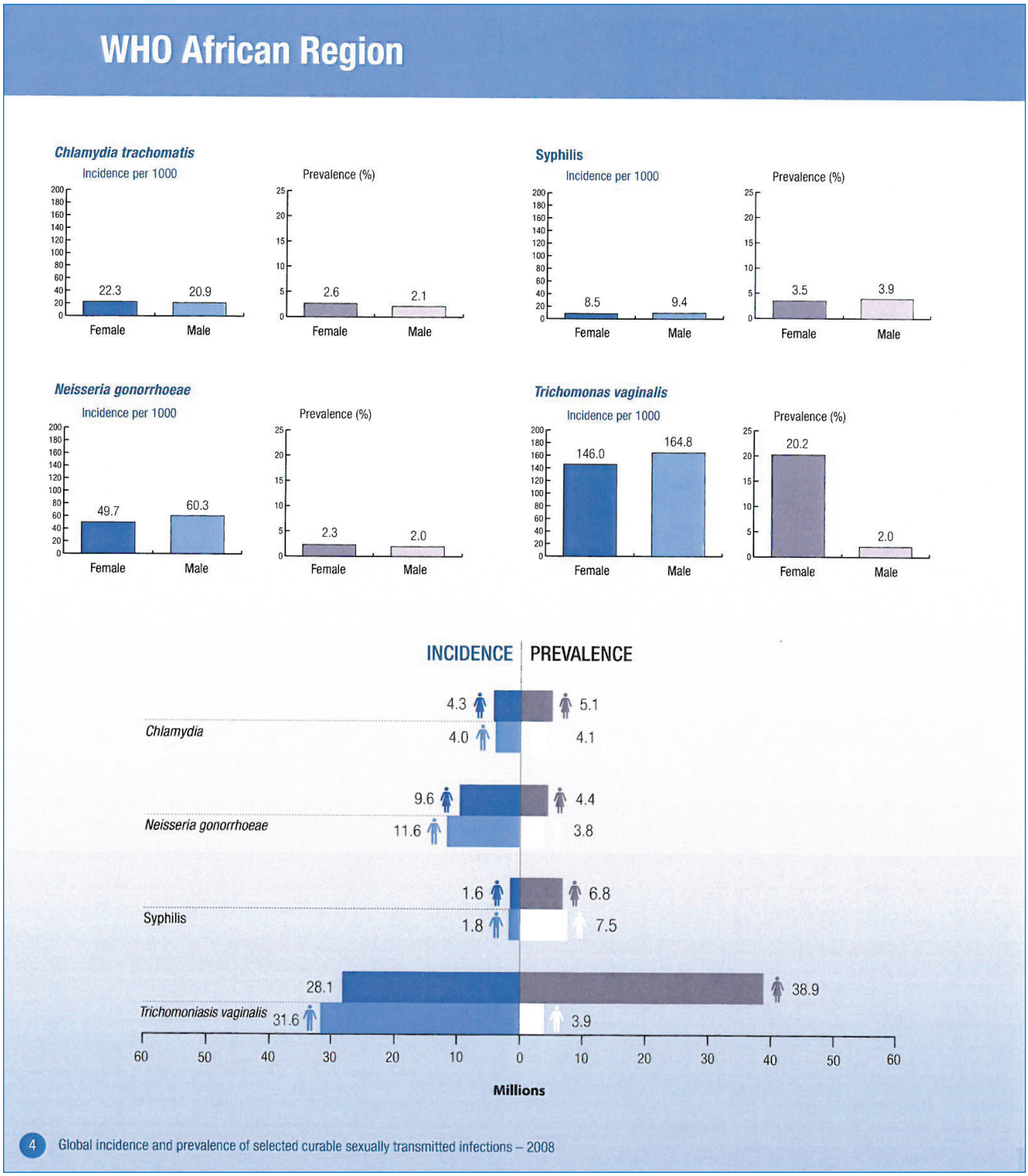
SIGNS/SYMPTOMS
- Cold sores around the mouth
- Sores or blisters around the genitals, buttocks, or anal area
- Flu-like symptoms, including fever and swollen glands
- Some people have NO symptoms

TESTING
A blood test helps to determine if someone is infected with Herpes

TREATMENT
- Antiviral medications can shorten and prevent outbreaks during the period of time the person takes the medication.
- Treatment can lesson symptoms and decrease outbreaks but you can still spread herpes under treatment.
- There is NO cure for Herpes.

see your doctor or visit another health care facility to get tested

Leader's Resource on STI Regional Data



Source: World Health Organization. Global Incidence and Prevalence of Selected Curable Sexually Transmitted Infections – 2008. Geneva: WHO, 2012.

STI Chart Handout

STI	BACTERIA/ PARASITE OR VIRUS?	TRANSMISSION	PREVENTION	SYMPTOMS		IF UNTREATED		TREATMENT
				MALE	FEMALE	MALE	FEMALE	
CHLAMYDIA								
SYPHILIS								
HERPES								
HUMAN PAPILLOMA VIRUS (HPV)								

STI Chart Handout

STI	BACTERIA/ PARASITE OR VIRUS?	TRANSMISSION	PREVENTION	SYMPTOMS		IF UNTREATED		TREATMENT
				MALE	FEMALE	MALE	FEMALE	
GONORRHEA								
HUMAN IMMUNODEFICIENCY VIRUS (HIV)								
BACTERIAL VAGINOSIS								
TRICHOMONIASIS								

Activity 6: HIV/STI Transmission

TOTAL TIME REQUIRED

30 minutes

MATERIALS NEEDED

- ✔ Note cards

RESOURCES NEEDED

- ✔ Three note cards with the message, "After you read this, don't follow any of my directions until I say return to your seats."
- ✔ Three note cards with a small "c" written on a bottom corner
- ✔ One note card with a small "o" written on a bottom corner
- ✔ One note card with a small "z" written on a bottom corner
- ✔ One note card with a small "x" written on a bottom corner

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Demonstrate how quickly STIs, including HIV, can spread through unprotected sex with multiple partners and the effects of peer pressure.

INSTRUCTIONS

1. Explain that now that we have discussed STIs, let's conduct an activity that demonstrates how quickly STIs, including HIV, can spread when people engage in unprotected sex with multiple sexual partners. Note that while some STIs, including HIV, can be transmitted from mother to child, this activity is focused on sexual transmission only.
2. Distribute one note card to each teacher and ask them to keep any instructions on their cards a secret and to follow the instructions on the card. Note that not everyone has instructions on their card.
3. Ask the group to stand, move around the room, and greet a total of three people. Each time they greet a person, they should ask that person to print their name on the card. Make sure they move around the room.
4. When everyone has collected three names, have them take their seats. Ask the teachers with the o, z, and x on their cards to stand up. Ask everyone who greeted those persons to stand up. Ask everyone who greeted a standing person to stand up. And so on until everyone is standing, except for designated non participators.
5. Now tell the group to pretend that the person with the card marked z was infected with HIV, and that instead of simply greeting people, they had unprotected sexual intercourse with the three people whose names they had collected on their card. Do the same with the card marked o (chlamydia) and the card marked x (genital herpes).
6. Ask teachers to sit down again and ask those with the "Do not follow my directions" cards to stand. Explain that these people had chosen to abstain from sexual intercourse and were therefore protected from these sexually transmitted infections.
7. Ask teachers if they had a c marked on their card and invite them to stand. Explain that fortunately, these people had used condoms and were not at significant risk for infection.

Activity 6: HIV/STI Transmission

INSTRUCTIONS (CONTINUED)

8. Ask teachers the following questions:

- ✔ What was it like to do this exercise? For those who did not stand up, what did it feel like not to? What did others feel when they tried to shake their hand?
- ✔ What did you observe about the movement in the room—did some people seem left out, why?
- ✔ What did you find most surprising as more and more people stood up?
- ✔ How might this exercise impact a learner's perspective on HIV and STI transmission? How might you use this type of activity?

9. Allow all teachers to sit down. Remind the group that this was a game to illustrate how quickly HIV and STIs can be transmitted through unprotected sexual intercourse but that while there are other ways HIV and STIs can be transmitted, such as from mother to child during pregnancy/birth, these are not transmitted by simply greeting people.

Adapted by Advocates for Youth, 2014, from Advocates for Youth's Life Planning Education Resource.

Activity 7: HIV Counseling, Testing, and Treatment

TOTAL TIME REQUIRED

45 minutes

MATERIALS NEEDED

- ✔ None

RESOURCES NEEDED

- ✔ Leader's Resource Quiz on HIV Counseling, Testing, and Treatment
- ✔ Leader's Resource Answer Key on HIV Counseling, Testing and Treatment

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Describe HIV Counseling, Testing, and Treatment.
2. Appreciate the importance of getting tested for HIV.

INSTRUCTIONS

1. Explain that next we are going to talk about HIV testing and counseling.
2. Note that many people living with HIV may not know their status because they have never been tested, whether they were born with HIV or acquired it over time. Getting tested for HIV, often called HIV testing and counseling, is the only way to really know if you are infected.
3. Ask teachers what they understand about HIV testing and counseling. Once you they have shared their thoughts, provide an overview of HIV testing, counseling, and treatment by sharing the following information:
   - Note that counseling can take place before and after taking an HIV test. **Pre-test counseling** includes counseling to explain the testing procedure and how the results will be given while providing a chance to ask questions about the test and share fears or concerns. **Post-test counseling** includes counseling to provide the test result and ensure understanding of the result as well as opportunity to talk it through and make immediate plans to access treatment, care, and support.
   - Explain that for the actual testing, there are different types of tests, including a rapid test using a blood sample, in addition to oral-swabs and urine tests. Samples are tested in a laboratory to see whether there are **antibodies** in the blood. Antibodies are chemicals produced by white blood cells to fight specifically against HIV. To be absolutely accurate, the test should be taken twice in three months giving HIV antibodies time to appear in the bloodstream after the time of infection. This is the 2–3 month period after infection when it can be too early for antibodies to have formed and is called the **window period.**

Activity 7: HIV Counseling, Testing, and Treatment

INSTRUCTIONS (CONTINUED)

- Underscore that young people are less likely than adults to be tested for HIV and therefore less likely to be linked to services, putting them at risk of late diagnosis and missed opportunities to initiate treatment, counseling, care, and other supportive services. Consent laws requiring a parent or caregiver's consent to HIV testing can also complicate access to testing and treatment for adolescents in particular. It's important to know the laws in your country and to be able to inform learners about whether or not they need parental or a caregiver's consent to get tested and where they can get tested.
- Explain that Antiretroviral therapy, known as "ART" is now available in many settings and consists of the combination of at least three antiretroviral (ARV) drugs to suppress the HIV virus and stop the progression of HIV disease. ART has resulted in tremendous reductions in rates of death and suffering, particularly in early stages of the disease.

4. Distribute the quiz and ask teachers to take a few minutes to respond to the questions.
5. Once everyone has completed the quiz, review the answers with the whole group.
6. Ask teachers the following questions:

- ✔ Was it helpful to review information about HIV counseling, testing, and treatment? How familiar were you with HIV testing, counseling, and ART?
- ✔ Why do you think it is important for young people to know their HIV status?
- ✔ What information about services would you need to seek out and be able to provide learners upon discussing HIV testing, counseling, and ART?

Activity 7: HIV Counseling, Testing, and Treatment

INSTRUCTIONS (CONTINUED)

7. Conclude by noting that it is critical for young people to know why getting tested for HIV is important, whether you test positive or negative, and to be able to get tested and access services. If positive, early knowledge of status can enable getting treatment needed to fight HIV and stay healthy. In addition, by being on effective HIV treatment, this also significantly reduces the likelihood of transmission to a sexual partner. Meanwhile, if negative, it's helpful to know this in order to be sure to take measures to stay negative such as by abstaining from sex; if sexually active, using a condom correctly every time you have sex; if sexually active with more than one person, reducing the number of sexual partners; if uncircumcised, considering voluntary medical male circumcision; and not sharing needles or cutting instruments.

Leader's Resource Quiz on HIV Counseling, Testing, and Treatment

Match the statements in Column A to the words in Column B.

COLUMN A	COLUMN B	
1. The test for HIV looks for these	A. Antiretroviral drugs (ARVs)	1 ____
2. These require a parent or caregiver's consent to HIV testing and can also complicate access to testing and treatment for adolescents in particular	B. Post–test counseling	2 ____
3. The 2–3 month period after infection when it can be too early for antibodies to have formed	C. Window period	3 ____
4. It's the only way to really know if you are infected with HIV	D. Antiretroviral Therapy (ART)	4 ____
5. This consists of the combination of at least three antiretroviral drugs	E. Parental consent laws	5 ____
6. Are less likely than adults to be tested for HIV and therefore less likely to be linked to services	F. Antibodies	6 ____
7. This includes counseling to provide the test result and ensure understanding of the result as well as opportunity to talk it through and make immediate plans to access treatment, care, and support	G. White blood cells	7 ____
8. These produce antibodies	H. Young people	8 ____
9. These drugs suppress the HIV virus and stop the progression of HIV disease	I. HIV Testing and Counselling (HTC)	9 ____

Leader's Resource Quiz on HIV Counseling, Testing, and Treatment

COLUMN A	COLUMN B
1. The test for HIV looks for these	A. Antiretroviral drugs (ARVs)
2. These require a parent or caregiver's consent to HIV testing and can also complicate access to testing and treatment for adolescents in particular	B. Post–test counseling
3. The 2–3 month period after infection when it can be too early for antibodies to have formed	C. Window period
4. It's the only way to really know if you are infected with HIV	D. Antiretroviral Therapy (ART)
5. This consists of the combination of at least three antiretroviral drugs	E. Parental consent laws
6. Are less likely than adults to be tested for HIV and therefore less likely to be linked to services	F. Antibodies
7. This includes counseling to provide the test result and ensure understanding of the result as well as opportunity to talk it through and make immediate plans to access treatment, care, and support	G. White blood cells
8. These produce antibodies	H. Young people
9. These drugs suppress the HIV virus and stop the progression of HIV disease	I. HIV Testing and Counselling (HTC)

1 F
2 E
3 C
4 I
5 D
6 H
7 B
8 G
9 A

Activity 8: Supporting People Affected by and Living with HIV or AIDS

TOTAL TIME REQUIRED

45 minutes

MATERIALS NEEDED

- ✔ Flip chart
- ✔ Markers

RESOURCES NEEDED

- ✔ Two copies of I'd Rather Stay Away – Role–Play Script Handout

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Define stigma and discrimination and how these can affect people in one's community.
2. Show how one can express empathy towards people who are living with or affected by HIV or AIDS.

INSTRUCTIONS

1. Explain that the next activity will focus on defining stigma and discrimination, how these can affect people living with or affected by HIV and AIDS, and how we can show support for those of us living with or affected by HIV or AIDS.
2. Note that it may be very likely that some of the teachers' learners are going to be living with HIV and know that they have HIV while others may have lost a parent or loved one to AIDS. Therefore, it is important for teachers to be extra sensitive to how learners might receive the lesson and the possible need to adjust it accordingly. It is also important to have information handy to provide learners about HIV counseling and testing.
3. Say that, "There are many people here and all over the world who are living with HIV or AIDS and who are stigmatized and treated with hate, mistrust, and rejection by others. Those of us living with HIV or affected by HIV and AIDS can also experience discrimination."
5. Ask teachers to share thoughts on what "stigma" means and jot these down on a flip chart. Then ask teachers to share thoughts on what discrimination means and also jot these down on a flip chart. Summarize a definition for stigma (a mark of disgrace associated with a particular circumstance, quality, or person). Summarize a definition of discrimination (the unjust treatment of different categories of people or things usually based on things like race, age, or gender).
6. Next, ask for two volunteers to act out a role–play that will help teachers understand how a person who has lost a parent to AIDS might feel and what support might be provided. Give the two volunteers the script I'd Rather Stay Away and let them assign roles and then read the role–play to the group.
7. After the volunteers have completed reading the role–play, thank them and have them return to their seats. Then have teachers find a partner to work with and ask them to imagine that they are in Peter's place and to describe how they would feel and what they would need if:
   - They lost their mother or father
   - They were living with HIV
   - Their friends stayed away from them because they were living with HIV

Activity 8: Supporting People Affected by and Living with HIV or AIDS

INSTRUCTIONS (CONTINUED)

8. Give teachers 5 minutes to have this conversation in pairs.
9. Call time and ask the pairs to share some of the key points they discussed.
10. Write their responses on the flip chart in four different sections as they share their points, as follows:
    1. Feelings if you were in Peter's position…
    2. Needs if you were in Peter's position…
    3. How you would want others to treat you if you were in Peter's position…
    4. What you would say to friends who were staying away from you due to HIV/AIDS…
11. Then, have teachers get back into their pairs and role-play the final scene between Martin and Fatima, incorporating things they could do to support Peter from the large group discussion. Make sure to mention that keeping someone's HIV status confidential—meaning you don't tell anyone else without that person's permission—is a way to show support.
12. Ask teachers the following questions:

- ✔ How did it feel doing the role-play?
- ✔ What did you say or do that was different from the original role-play?
- ✔ Why did you make these changes and why do you think they were important?
- ✔ How can this help you work with learners to better support people living with HIV or AIDS?

13. Conclude by saying; "People might avoid a person living with HIV or AIDS once they find out that they are positive. They also might reject children who have lost a parent to AIDS. But those of us living with or affected by HIV or AIDS need acceptance, understanding, and love. Learners need to know about the support that a person needs when they have HIV or when they have lost a parent or loved one to AIDS and how to provide that support.

Source: Education International, Education Development Center, World Health Organization, EFAIDS: Learning for Life – Classroom Activities for HIV and AIDS Education, Activity 10 – Supporting People Living with HIV and AIDs, pages 54–56

I'd Rather Stay Away – Role–Play Script Handout

I'd Rather Stay Away – Role–Play Script:

Fatina and Martin are 12 years old. They are friends and in the same class. Peter is also in their class. The three of them get along well and sometimes meet after school to go for a walk. But a few days ago, Peter suddenly left school. Fatina and Martin wonder why.

Fatina: I really don't understand why Peter dropped out of school! I wonder what's wrong. I haven't seen him since last week, and I don't even know where he lives.

Martin: I was wondering myself…he said he enjoyed coming to school. He didn't say a word, did he?—I mean about leaving…it's not very kind on his part!

Fatina: Have you heard nothing about him?

Martin: Well, actually my mother mentioned something, but it's hard to believe.

Fatina: What do you know? Come on, tell me the whole story!

Martin: I don't know if it's true, but my mother said that his mother died.

Fatina: Ah…I'm sorry…can you imagine how he must be feeling about that?

Martin: It's hard. I can't even think of it. He must be feeling very lonely. No one can fill the love of one's mother.

Fatina: But his mother was quite young, wasn't she? Was she ill?

Martin: According to what my mother was told, she died of AIDS, and Peter might be living with HIV.

Fatina: He lost his mother, and he is living with HIV! It can't be true. I'm really concerned about him. He's only 12…I can't believe it.

Martin: My mother told me to stay away from him. I really don't know what to do…perhaps we should avoid him! We might catch the disease.

Fatina: Hmm…we learned that HIV and AIDS can't spread by meeting with infected people. I think he needs our support. After all, he is our friend.

Martin: Maybe you're right. How can we support him?

Fatina: Without his mother I am sure he will need help in the house. I also remember my father saying a way to support a person affected by HIV or AIDS is to continue the friendship—spend some time with the person so that they can share feelings and get support. Imagine how we would feel if you or I lost our mother and people were avoiding us.

Martin: Yes, I would feel scared and lonely. Let's not waste time…let's go find him and talk with him.

Fatina and Martin went to Peter's place. They talked, played football, and made dinner. Peter was happy to have friends like Martin and Fatina.

Activity 9: Gender: Act Like a Man, Act Like a Lady

TOTAL TIME REQUIRED

1 hour

MATERIALS NEEDED

- ✔ Flip chart
- ✔ Markers
- ✔ Tape

RESOURCES NEEDED

- ✔ Frequently Asked Questions and Answers About Gender Equality Handout

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Identify common gender norms faced by the boys/men and girls/women in their communities.
2. Describe how some of these gender norms can negatively affect the sexual behavior of learners.
3. Acknowledge the importance of being aware of one's gender biases and not allowing these to influence the delivery of sexuality education.

INSTRUCTIONS

1. Explain that the purpose of this session is to increase awareness about gender norms and how these can impact the health and well–being of learners.
2. Let teachers know that we're going to start off by taking some time to explore our experiences as it relates to gender norms and how we feel about them.
3. Ask if anyone has ever been told to "act like a man," or something similar about how they should think, feel, act as a boy/man. Ask for volunteers to share some experiences and how this made them feel. Then ask them and the broader group why they think these things are said.
4. Now ask if anyone in the room has ever been told to "act like a lady," or something similar about how they should think, feel, act as a girl/woman. Ask for volunteers to share some such experiences and how this made them feel. Then ask them and the broader group why they think these things are said.
5. Next, in large letters, print on the top of a sheet of flip chart paper the phrase "Act Like a Man" and draw a large "box" around the perimeter of the flip chart paper. Ask participants what boys/men are told in their community about how they should think, feel, or behave. Write these on the flip chart paper.
6. When the group has no more to add to the list, facilitate a discussion with the questions listed below.
   - Which of these messages can be potentially harmful? Why?
   - How does living within the box impact/limit a boy's/man's health and the health of others, especially in relation to sexual and reproductive health?
   - How do these male gender norms affect women?
   - What happens to boys/men who try not to follow the gender rules? How are they treated?
7. Next, in large letters, print on the top of a sheet of flip chart paper the phrase "Act Like a Lady/Woman" and draw a large "box" around the perimeter of the flip chart paper. Ask participants what girls/women are told in their community about how they should think, feel, or behave. Write these on the flip chart paper.

Activity 9: Gender: Act Like a Man, Act Like a Lady

INSTRUCTIONS (CONTINUED)

8. When the group has no more to add to the list, facilitate a discussion with the questions listed below.
    - Which of these messages can be potentially harmful? Why?
    - How does living within the box impact/limit a girl's/woman's health and the health of others, especially in relation to sexual and reproductive health?
    - How do these female gender norms affect men?
    - What happens to girls/women who try not to follow the gender rules? How are they treated?

9. Ask participants:

- ✔ What was it like to think about gender norms in this way?
- ✔ What did you notice about characteristics that were in or out of the box?
- ✔ What conclusions can you draw about gender norms and how they might impact sexual behaviors? How they might impact your own teaching of sexuality issues to learners?
- ✔ Why do you think it is important for learners to explore gender norms as part of sexuality education? What can you do to minimize the influence of your own gender biases in teaching sexuality education?

10. Distribute the Frequently Asked Question and Answers About Gender Equality handout for teachers to have as a reference.

11. Conclude by noting that gender norms exist across cultures and greatly influence what is considered acceptable behavior for men and women in society, including behaviors that impact sexual health. Addressing gender norms constitutes part of sexuality education because of the influence these have on behaviors, including sexual risk behaviors. Further, teaching sexuality education free from gender biases is critical so as not to inadvertently reinforce harmful gender norms.

Adapted by Advocates for Youth, 2014, from Kirby, D. Reducing Sexual Risk Behavior Among Young People: A Training Toolkit for Curriculum Developers. Washington, DC: ETR Associates, 2013.

Frequently Asked Questions and Answers About Gender Equality Handout

By UNFPA

What is meant by gender?

The term gender refers to the economic, social, and cultural attributes and opportunities associated with being male or female. In most societies, being a man or a woman is not simply a matter of different biological and physical characteristics. Men and women face different expectations about how they should dress, behave, or work. Relations between men and women, whether in the family, the workplace, or the public sphere, also reflect understandings of the talents, characteristics, and behaviour appropriate to women and to men. Gender thus differs from sex in that it is social and cultural in nature rather than biological. Gender attributes and characteristics, encompassing, inter alia, the roles that men and women play and the expectations placed upon them, vary widely among societies and change over time. But the fact that gender attributes are socially constructed means that they are also amenable to change in ways that can make a society more just and equitable.

What is the difference between gender equity, gender equality and women's empowerment?

Gender equity is the process of being fair to women and men. To ensure fairness, strategies and measures must often be available to compensate for women's historical and social disadvantages that prevent women and men from otherwise operating on a level playing field. Equity leads to equality. Gender equality requires equal enjoyment by women and men of socially–valued goods, opportunities, resources, and rewards. Where gender inequality exists, it is generally women who are excluded or disadvantaged in relation to decision–making and access to economic and social resources. Therefore a critical aspect of promoting gender equality is the empowerment of women, with a focus on identifying and redressing power imbalances and giving women more autonomy to manage their own lives. Gender equality does not mean that men and women become the same; only that access to opportunities and life changes is neither dependent on, nor constrained by, their sex. Achieving gender equality requires women's empowerment to ensure that decision–making at private and public levels, and access to resources are no longer weighted in men's favour, so that both women and men can fully participate as equal partners in productive and reproductive life.

Why is it important to take gender concerns into account in programme design and implementation?

Taking gender concerns into account when designing and implementing population and development programmes therefore is important for two reasons. First, there are differences between the roles of men and women, differences that demand different approaches. Second, there is systemic inequality between men and women. Universally, there are clear patterns of women's inferior access to resources and opportunities. Moreover, women are systematically under–represented in decision–making processes that shape their societies and their own lives. This pattern of inequality is a constraint to the progress of any society because it limits the opportunities of one–half of its population. When women are constrained from reaching their full potential, that potential is lost to society as a whole. Programme design and implementation should endeavour to address either or both of these factors.

Frequently Asked Questions and Answers About Gender Equality Handout

What is gender mainstreaming?

Gender mainstreaming is a strategy for integrating gender concerns in the analysis, formulation, and monitoring of policies, programmes, and projects. It is therefore a means to an end, not an end in itself; a process, not a goal. The purpose of gender mainstreaming is to promote gender equality and the empowerment of women in population and development activities. This requires addressing both the condition, as well as the position, of women and men in society. Gender mainstreaming therefore aims to strengthen the legitimacy of gender equality values by addressing known gender disparities and gaps in such areas as the division of labour between men and women; access to and control over resources; access to services, information and opportunities; and distribution of power and decision–making. UNFPA has adopted the mainstreaming of gender concerns into all population and development activities as the primary means of achieving the commitments on gender equality, equity, and empowerment of women stemming from the International Conference on Population and Development.

Gender mainstreaming, as a strategy, does not preclude interventions that focus only on women or only on men. In some instances, the gender analysis that precedes programme design and development reveals severe inequalities that call for an initial strategy of sex–specific interventions. However, such sex–specific interventions should still aim to reduce identified gender disparities by focusing on equality or inequity as the objective rather than on men or women as a target group. In such a context, sex–specific interventions are still important aspects of a gender mainstreaming strategy. When implemented correctly, they should not contribute to a marginalization of men in such a critical area as access to reproductive and sexual health services. Nor should they contribute to the evaporation of gains or advances already secured by women. Rather, they should consolidate such gains that are central building blocks towards gender equality.

Why is gender equality important?

Gender equality is intrinsically linked to sustainable development and is vital to the realization of human rights for all. The overall objective of gender equality is a society in which women and men enjoy the same opportunities, rights, and obligations in all spheres of life. Equality between men and women exists when both sexes are able to share equally in the distribution of power and influence; have equal opportunities for financial independence through work or through setting up businesses; enjoy equal access to education and the opportunity to develop personal ambitions, interests and talents; share responsibility for the home and children and are completely free from coercion, intimidation and gender–based violence both at work and at home.

Within the context of population and development programmes, gender equality is critical because it will enable women and men to make decisions that impact more positively on their own sexual and reproductive health as well as that of their spouses and families. Decision–making with regard to such issues as age at marriage, timing of births, use of contraception, and recourse to harmful practices (such as female genital cutting) stands to be improved with the achievement of gender equality.

Frequently Asked Questions and Answers About Gender Equality Handout

However it is important to acknowledge that where gender inequality exists, it is generally women who are excluded or disadvantaged in relation to decision–making and access to economic and social resources. Therefore a critical aspect of promoting gender equality is the empowerment of women, with a focus on identifying and redressing power imbalances and giving women more autonomy to manage their own lives. This would enable them to make decisions and take actions to achieve and maintain their own reproductive and sexual health. Gender equality and women's empowerment do not mean that men and women become the same; only that access to opportunities and life changes is neither dependent on, nor constrained by, their sex.

Is gender equality a concern for men?

The achievement of gender equality implies changes for both men and women. More equitable relationships will need to be based on a redefinition of the rights and responsibilities of women and men in all spheres of life, including the family, the workplace, and the society at large. It is therefore crucial not to overlook gender as an aspect of men's social identity. This fact is, indeed, often overlooked, because the tendency is to consider male characteristics and attributes as the norm, and those of women as a variation of the norm.

But the lives of men are just as strongly influenced by gender as those of women. Societal norms and conceptions of masculinity and expectations of men as leaders, husbands or sons create demands on men and shape their behaviour. Men are too often expected to concentrate on the material needs of their families, rather than on the nurturing and caring roles assigned to women. Socialization in the family and later in schools promotes risk–taking behaviour among young men, and this is often reinforced through peer pressure and media stereotypes. So the lifestyles that men's roles demand often result in their being more exposed to greater risks of morbidity and mortality than women. These risks include ones relating to accidents, violence, and alcohol consumption.

Men also have the right to assume a more nurturing role, and opportunities for them to do so should be promoted. Equally, however, men have responsibilities in regard to child health and to their own and their partners' sexual and reproductive health. Addressing these rights and responsibilities entails recognizing men's specific health problems, as well as their needs and the conditions that shape them. The adoption of a gender perspective is an important first step; it reveals that there are disadvantages and costs to men accruing from patterns of gender difference. It also underscores that gender equality is concerned not only with the roles, responsibilities and needs of women and men, but also with the interrelationships between them.

To access this page, go to://www.unfpa.org/resources/frequently-asked-questions-about-gender-equality

Activity 10: Harmful Traditional Practices: Female Genital Cutting/Mutilation

TOTAL TIME REQUIRED

45 minutes

MATERIALS NEEDED

- ✔ None

RESOURCES NEEDED

- ✔ Leader's Resource on Harmful Traditional Practices, Female Genital Cutting/Mutilation (FGC/M)

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Explore types of traditional harmful practices and define female genital cutting/mutilation and its consequences.

INSTRUCTIONS

1. Explain that the purpose of this session is to discuss a harmful traditional practice known as female genital cutting/mutilation and its consequences.
2. Ask teachers what they understand by the phrase harmful traditional practices.
3. Once you have heard several responses, note that all over the world, violence and discrimination against women and girls violates their human rights and severely compromises young people's sexual and reproductive health. Explain that while all violations of women's and girls' rights may be described as harmful practices, there are some practices that stem from tradition, culture, or religion. These are known as harmful traditional practices and include female genital cutting/mutilation, femicide, child marriage, honor killings, among others.
4. Explain that female genital cutting/mutilation is the partial or total removal of the external genitalia of women and girls. Note that it is an age–old practice. It is most prevalent in parts of West, East, and Northeast Africa, though also practiced in Asia and the Middle East. In many countries, it forms a part of the rites of passage, marking the coming of age of the girl child. Reasons behind the practice include the belief that it will control a girl's sexuality and ensure a woman's virginity before marriage and fidelity thereafter.
5. Say that you will read several sentences on female genital cutting/mutilation. Some of these sentences are false and others are true. You will be asked to stand up if you think it is true or sit if you think this is false. If you are not sure—that's okay—this is why we are doing this activity together, to learn and to be able to teach others.
6. Using the Leader's Resource on Harmful Traditional Practices, Female Genital Cutting/Mutilation(FGC/M), read the statements one by one and ask teachers to stand up if they think it is true and to sit down if they think it is false. If there are teachers who choose correctly, ask for a volunteer or two to say why they selected what they did. Then, confirm whether it is true or false and complete their explanations with those noted below:

Activity 10: Harmful Traditional Practices: Female Genital Cutting/Mutilation

INSTRUCTIONS (CONTINUED)

7. Ask participants:

- ✔ How did it feel to discuss harmful traditional practices and FGC/M?
- ✔ Were there any surprises as to what was true or false?
- ✔ Why is it important to know what FGC/M is and its consequences?

8. Conclude by noting that FGC/M is a harmful traditional practice that has long existed. In many communities, it's hard to give up such practices, but the risks that girls and women face are increasingly understood and are considered a human rights violation.

Leader's Resource on Harmful Traditional Practices, Female Genital Cutting/Mutilation (FGC/M)

1. FGC/M is a traditional practice that has been practiced for generations.

   True. Among some, FGC/M existed even before the emergence of religions.

2. FGC/M is practiced in Tanzania, Kenya, Uganda, Ethiopia, and South Sudan.

   True. These are the countries within the East and Southern Africa region where FGC/M is practiced.

3. The practice of excision is concentrated in 50 countries worldwide.

   False. The practice of excision is concentrated in 29 African countries and the Middle East.

4. FGC/M is illegal in only a couple of countries in Africa.

   False. Eighteen countries in Africa—Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Mauritania, Niger, Senegal, South Africa, Tanzania, and Togo—have enacted laws criminalizing FGC/M. The penalties range from a minimum of three months to a maximum of life in prison. Several countries also impose monetary fines.

5. Upon experiencing FGC/M, the possible consequences are pain, blood loss, possible infections, including HIV, injury to nearby organs, and even death.

   True. FGC/M can result in serious complications, putting the health and life of the girl/woman at risk.

6. Once FGC/M is complete, there are no subsequent harmful consequences.

   False. Additional consequences of FGC/M include lower abdominal pain, infertility, complications during childbirth, and increased newborn deaths.

7. FGC/M contributes to maintaining virginity and fidelity of women.

   False. The behavior of a woman is not bound to a physical change in her genitals.

8. FGC/M is recognized internationally as a violation of the human rights of girls and women.

   True. FGC/M constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

Activity 11: Drug Use and Sexual Risk

TOTAL TIME REQUIRED

1 hour

MATERIALS NEEDED

- ✔ A container
- ✔ Flip chart
- ✔ Markers
- ✔ Scissors

RESOURCES NEEDED

- ✔ One copy of the Leader's Resource on Myths and Facts about Drugs and Their Use Statements (cut up into individual statements)
- ✔ One copy of the Leader's Resource on Myths and Facts about Drugs and Their Use Answers

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Identify health risks of using drugs, including risks to sexual health.

INSTRUCTIONS

1. Explain that the purpose of this session is to increase awareness about drug use, its harmful effects, and its effects on sexual health.
2. Ask teachers what substances people put in their bodies and jot these down on flip chart paper. Responses should include drugs, alcohol, tobacco, medicines, steroids, and so on.
3. Point out that some substances, such as vitamins and medications, have positive effects on health when used as prescribed, but can be harmful if abused.
4. Drug use can be problematic for young people's sexual and reproductive health as substances can cloud decision–making and enhance feelings of invincibility, which can lead to risky sexual behaviors. Sharing needles to consume drugs also puts young people at risk of HIV and other serious infections and disease.
5. Split teachers into two teams and explain that we will be playing a game to test knowledge about drugs. Ask each team to come together at opposite sides of the room and to pick a team name.
6. Explain that each team will take turns drawing a statement about drugs from a container (you may want to pick the statements most relevant to the local context and/or add others to address prevalent myths and commonly used drugs in your country). Some of the statements are true and others are false. After reading the statement, the team member should consult with the entire team on the best answer and provide their answer. Teams get a point for each correct answer and an extra point for sharing accurate supporting information.
7. After teams are named, have a member from one team draw a statement, read it out loud and then confer with team members for an answer. If the answer is correct, give the team a point. Additional information about why the statement is a myth or a fact gets an additional point.
8. When teams do not know the correct answer, provide additional information from the Leader's Resource on Myths and Facts about Drugs and Their Use Answers.

Activity 11: Drug Use and Sexual Risk

INSTRUCTIONS (CONTINUED)

9. Ask members of the other team to draw a statement and repeat the process. Alternate statements until there are no more.
10. Keep the activity moving—do not allow too much time for answers but encourage some discussion of the statements.
11. Ask participants:

- ✔ What was it like to test your knowledge about drugs in this way?
- ✔ What did you notice about the facts and myths—which statements were more difficult to identify as a fact or myth?
- ✔ Which myths or facts can impact the health of learners? How can these impact sexual decision-making?
- ✔ Why do you think it is important for learners to know about drugs? How might you use this activity with learners and does drug use impact you as a teacher?

12. Conclude by noting that it's important for learners to know about drugs so that they can better understand how drug use can cause harm and affect decision-making abilities that can put them at greater risk of violence, unintended pregnancy, and STIs.

Leader's Resource on Myths and Facts about Drugs and Their Use Statements

1. Alcohol is an addictive substance, not a drug.	2. Coffee, tea, and many sodas contain drugs.
3. Cigarette smoking can be addictive.	4. Inhalants are basically harmless.
5. A cup of coffee and a cold shower can make you sober.	6. Alcohol affects some people more than others.
7. Using un-prescribed steroids is not that dangerous.	8. Alcohol is a sexual stimulant.
9. Anyone using oral contraceptives (the birth control pill) has to be careful about taking prescription medication.	10. When people stop smoking cigarettes, they can reverse some of the damage to the body.
11. Cigarette smoking will hurt a pregnant woman but not hurt her baby.	12. Drinking only beer will prevent problems with alcohol.
13. Alcoholism tends to run in families.	14. Smoking cigarettes every now and then is not harmful.
15. Marijuana is not harmful.	16. Cocaine is addictive
17. Larger amounts of alcohol help women to achieve orgasm.	18. In men, long-term abuse of alcohol may cause enlarged testicles.
19. Women become more sexually aroused with increasing amounts of alcohol.	20. Alcohol gives you energy.
21. The use of alcohol and drugs may place a person at risk for sexual violence.	22. Young people who use drugs and alcohol are less likely to use condoms.
23. Young people's decisions are not impacted while under the influence of drugs or alcohol.	24. Marijuana is not harmful.
25. Driving after using marijuana is much safer than driving after drinking.	26. The only drugs that increase the risk of HIV infection are those that are injected with a needle and syringe

Leader's Resource on Myths and Facts about Drugs and Their Use Answers

1. Alcohol is an addictive substance, not a drug.

   Myth. Alcohol is a drug as is any substance that affects the mind or body.

2. Coffee, tea, and many sodas contain drugs.

   Fact. Coffee, tea, and many sodas and diet sodas contain caffeine, which is a stimulant. Caffeine is addictive; headaches are a common sign of withdrawal.

3. Cigarette smoking can be addictive.

   Fact. Nicotine is an addictive substance found in cigarettes and therefore cigarette smoking is a very difficult habit to break.

4. Inhalants are basically harmless.

   Myth. Using inhalants such as gasoline, hairspray, cleaning fluids, glue, or polish remover can be extremely dangerous. Unlike most drugs, inhalants can cause permanent damage to organs like the liver, brain, or nervous system. They are also extremely flammable and can cause serious injury if matches are lit nearby.

5. A cup of coffee and a cold shower can make you sober.

   Myth. Only time will cause a person to become sober. It takes one hour for the liver to process one–half ounce of pure alcohol.

6. Alcohol affects some people more than others.

   Fact. Factors that influence how alcohol affects the individual include: body weight, amount of alcohol consumed, the presence of other drugs in the system, the general health of the individual at the time, and how recently she or he has eaten.

7. Using un–prescribed steroids is not only illegal, it is dangerous.

   Fact. Steroids (synthetic male hormones) have very serious health consequences, such as liver disease, heart disease, sexual dysfunction, and mood swings leading to aggressive or depressive behavior. Sharing needles for steroid use can transmit HIV, the virus that causes HIV.

8. Alcohol is a sexual stimulant.

   Myth. Alcohol, like cocaine and other drugs, can actually depress a person's sexual response. The drug may lessen inhibition with a sexual partner, but it causes problems such as lack of erection, loss of sexual feeling, or inability to have an orgasm. In addition, alcohol or drugs may cause a person to do something sexually that he or she would not do while not under the influence of alcohol or drugs, such as having sex when they really don't want to or forcing someone to have sex.

9. Anyone using oral contraceptives (the birth control pill) has to be careful about taking prescription medication.

   Fact. Girls and women who are using oral contraceptives to prevent pregnancy need to alert their doctor if they prescribe antibiotics as these may render oral contraceptives less effective in preventing pregnancy.

Leader's Resource on Myths and Facts Answers

10. When people stop smoking cigarettes, they can reverse some of the damage to the body.

Fact. If there is no permanent heart or lung damage, the body begins to heal itself when a person stops smoking.

11. Cigarette smoking or using drugs will hurt a pregnant woman, but not her baby.

Myth. Smoking and drug use during pregnancy can affect how the baby's heart, lungs, and brain work and leads to premature birth and low-birth weight. It can also cause lifelong learning, emotional, and physical problems for the child.

12. Drinking only beer will prevent problems with alcohol.

Myth. Ethyl alcohol affects drinkers, and ethyl alcohol is present in beer, as well as in wine and liquor.

13. Alcoholism tends to run in families.

Fact. Children of alcoholics are much more likely to be alcoholics than children of non-alcoholic parents. Some theories state that alcoholics have a different chemical make up that might be passed from one generation to the next.

14. Smoking cigarettes every now and then is not harmful.

Myth. As soon as people start smoking, they experience yellow staining of teeth, bad breath, and a shortness of breath that may affect their physical performance. Addiction to nicotine is quick. People who smoke for any period of time have a greater risk of lung cancer and other lung diseases, cancer of the tongue and throat, and heart diseases.

15. Marijuana is not harmful.

Myth. Although research is ongoing, many experts believe that long-term use of marijuana is potentially dangerous and may lead to: a decrease in motivation, memory loss, damage to coordination, impaired judgment, damage to the reproductive system, and throat and lung irritation.

16. Cocaine is addictive.

Fact. Cocaine is psychologically addictive. Crack cocaine is especially addictive, sometimes developing dependence after only a few uses.

17. Larger amounts of alcohol help women to achieve orgasm.

Myth. Alcohol is a depressant that actually slows down the nervous system and impairs reflexes and muscle coordination making it difficult to maintain sexual arousal for both men and women.

18. In men, long-term abuse of alcohol may cause enlarged testicles.

Myth. In men, chronic abuse of alcohol may cause shrinking of the testicles, as well as lower levels of testosterone, lower sperm count, and the inability to obtain or maintain an erection.

19. Women become more sexually aroused with increasing amounts of alcohol.

Myth. Alcohol is a depressant that slows down the nervous system and impairs reflexes and muscle coordination making it difficult to maintain sexual arousal for both men and women.

Leader's Resource on Myths and Facts Answers

20. Alcohol gives you energy.

Myth. Alcohol is often thought of as a stimulant because it lowers inhibitions, which means you may take chances that you would otherwise not take. Alcohol actually acts as a depressant on your nervous system, though, slowing down your brain function.

21. The use of alcohol and drugs may place a person at risk for sexual violence.

Fact. Both drugs and alcohol can affect a person's ability to assess risk and can thereby put them at risk of sexual violence as they cannot consent to sexual activity.

22. Young people who use drugs and alcohol are less likely to use condoms.

Fact. Research indicates that the use of alcohol and drugs increases the likelihood of having unprotected sex.

23. Young people's decisions are not impacted while under the influence of drugs or alcohol.

Myth. Alcohol and drugs can impact how you assess and make choices, making it difficult to keep to decisions about sexual activity.

24. Marijuana is not harmful.

Myth. Although research is ongoing, many experts believe that long–term use of marijuana is potentially dangerous and may lead to: a decrease in motivation, memory loss, damage to coordination, impaired judgment, damage to the reproductive system, and throat and lung irritation.

25. Driving after using marijuana is much safer than driving after drinking.

Myth. Like alcohol, marijuana affects motor coordination, slows reflexes, and affects perception (the way we see and interpret events around us). Any of these changes increases the likelihood of an accident while driving.

26. The only drugs that increase the risk of HIV infection are those that are injected with a needle and syringe.

Myth. Sharing needles with other people increases a person's chances of getting infected with HIV. In addition, however, use of any drugs, including alcohol, increases the likelihood that a person will be uninhibited enough to take sexual risks, like having intercourse without a condom, or having sex with several partners. Unprotected intercourse always puts a person at risk of HIV infection as well as unintended pregnancy.

Activity 12: Communicating Assertively

TOTAL TIME REQUIRED

1 hour

MATERIALS NEEDED

- ✔ Flip chart
- ✔ Markers
- ✔ Pens/pencils
- ✔ Scrap paper

RESOURCES NEEDED

- ✔ Communicating Assertively Handout
- ✔ One pre-written flip chart with the following questions:
    1. How will Alice feel?
    2. How will the two girls feel?
    3. What is the worst possible outcome?
- ✔ Pre-written flip charts each with one of the following at the top: Passive, Assertive, Aggressive

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Identify and compare passive, assertive, and aggressive responses and possible consequences to a situation.

INSTRUCTIONS

1. Explain that the purpose of this session is to learn the difference between assertive, aggressive, and passive behavior.

2. Explain that when we teach learners to be assertive, we need to also teach them to assess situations and to consider their personal safety. In some situations, speaking up and communicating assertively can be dangerous (if someone has a weapon, has been drinking or taking drugs, is extremely angry, and so on).

    - Keep in mind that communicating assertively, especially for young people and young women in particular, is often not considered the norm. You are not suggesting to teachers that they encourage learners to behave in a way that could have unpleasant consequences for them in their cultural or family circles. It is important, however, that teachers help learners understand that there are certain situations in which assertive behavior will often yield positive results. (Examples include resisting pressure from romantic partners or peers to have unwanted sex, engaging in an activity that could put a young person at risk of violence, using drugs, or doing poorly in school).

3. Tell teachers that one way to make communication more effective is to choose the appropriate kind of communication in difficult situations. Read the following scenario aloud:

Alice has been standing in line for over two hours to buy a concert ticket. The rule is, one person, one ticket. Her feet are hurting and she knows she is in trouble with her mom, who expected her home by now. But there are only five people left in front of her and she is sure she will get a ticket. Out of nowhere, two girls from school walk up and join their friend who just happens to be standing in front of Alice, taking places in line in front of her.

4. Ask teachers to write one sentence describing what Alice should do in this situation.

Activity 12: Communicating Assertively

INSTRUCTIONS (CONTINUED)

Allow about 3 minutes, then ask participants to form three groups based on the following criteria, indicating a different area in the room for each group:

Group 1: All who wrote that she should stand there but not say anything

Group 2: All who wrote that she should raise her voice and threaten them if they did not go to the end of the line

Group 3: All who wrote that she should speak up and tell them to go to the back of the line

5. Once the three groups have formed, ask each group to take 5 minutes to discuss the questions you have posted on the flip chart.
    - How would Alice feel after making the response you chose?
    - How do you think the two girls who got in line will feel if Alice responds like you?
    - What is the worst thing that could happen if Alice were to give the same response you did? *(Note: If there is only one person standing in either position, join that person to form a group and discuss the questions with her or him.)*
6. Call time and ask for one participant from each group to share group responses to the questions. Record the major points on the three pre-written flip chart papers titled “assertive," “aggressive," and “passive, asking teachers where each response should be placed.
7. Review Alice’s choices for action one more time and illustrate why assertiveness is usually the best choice in a situation like this.
8. Conclude by reviewing definitions of the different kind of responses:

Passive Response: Behaving passively means not expressing your own needs and feelings, or expressing them so weakly that they will not be addressed. A passive response is not usually in your best interest, because it allows other people to violate your rights. Yet there are times when being passive is the most appropriate response. It is important to assess whether a situation is dangerous and choose the response most likely to keep you safe.

Activity 12: Communicating Assertively

INSTRUCTIONS (CONTINUED)

Aggressive Response: Behaving aggressively is asking for what you want or saying how you feel in a threatening, sarcastic, or humiliating way that may offend the other person(s). An aggressive response is never in your best interest, because it almost always leads to increased conflict.

Assertive Response: Behaving assertively means asking for what you want or saying how you feel in an honest and respectful way that does not infringe on another person's rights or put the individual down. An assertive response is almost always in your best interest, since it is your best chance of getting what you want without offending the other person(s). At times, however, being assertive can be inappropriate. If tempers are high, if people have been using alcohol or other drugs, if people have weapons, or if you are in an unsafe place, being assertive may not be the safest choice.

9. Ask participants:

- ✔ How did it feel to decide what you think Alice should do?
- ✔ Was there anything surprising to you as everyone chose their responses and discussed possible consequences?
- ✔ What are some things you would consider when deciding how to react to a situation?
- ✔ How might you approach situations like this in the future?
- ✔ How could you use an exercise like this in your class?

10. Conclude by noting that thinking critically about how to respond to difficult situations is an important life skill. Understanding the difference between assertive, passive, and aggressive communication and the potential harmful outcomes or benefits to these can help equip learners with the skills they need to foster their own self–respect and confidence while also minimizing sexual risk.

Communicating Assertively Handout: Definitions of Passive, Aggressive, and Assertive Responses

Passive Response: Behaving passively means not expressing your own needs and feelings, or expressing them so weakly that they will not be addressed. A passive response is not usually in your best interest, because it allows other people to violate your rights. Yet there are times when being passive is the most appropriate response. It is important to assess whether a situation is dangerous and choose the response most likely to keep you safe.

Aggressive Response: Behaving aggressively is asking for what you want or saying how you feel in a threatening, sarcastic, or humiliating way that may offend the other person(s). An aggressive response is never in your best interest, because it almost always leads to increased conflict

Assertive Response: Behaving assertively means asking for what you want or saying how you feel in an honest and respectful way that does not infringe on another person's rights or put the individual down. An assertive response is almost always in your best interest, since it is your best chance of getting what you want without offending the other person(s). At times, however, being assertive can be inappropriate. If tempers are high, if people have been using alcohol or other drugs, if people have weapons, or if you are in an unsafe place, being assertive may not be the safest choice.

Source: Adapted by Advocates for Youth, 2014, from Life Planning Education Resource, by Advocates for Youth.

SESSION SEVEN:
Classroom Management

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Describe the professional and personal boundaries that determine when they disclose information about themselves.
2. Identify potential consequences of disclosing personal information in an educational setting.
3. Explain possible rationales for disclosing personal information.
4. List at least three tips for how and when to disclose personal information to learners.
5. Identify various types of challenges they may face in answering questions by reflecting upon their own experience and participating in a large group discussion.
6. Identify strategies for overcoming barriers related to each type of challenge.
7. Demonstrate their ability to respond effectively to questions by practicing in small groups, answering questions that are typically asked by learners.

ACTIVITIES

Activity 1 Self–Disclosure

Activity 2 Answering Difficult Questions

Activity 1: Self-Disclosure

TOTAL TIME REQUIRED

1 hour

MATERIALS NEEDED

- ✔ Flip chart
- ✔ Markers
- ✔ Tape
- ✔ Pens/pencils
- ✔ 1, 2, 3, 4 signs

RESOURCES NEEDED

- ✔ Self-Disclosure Assessment Handout
- ✔ Guidelines for Self-Disclosure Handout
- ✔ Pre-written flip charts on:
  1. Disclosure Scenario Discussion Questions
     - What was the rationale for your choice?
     - What could be some positive consequences of your choice?
     - What could some of the negative consequences be?

RESOURCES NEEDED (CONTINUED)

2. Tips on Boundaries/Self-Disclosure Regarding:
   - Your clothing and workspace décor
   - Sharing information about your current personal or professional life
   - Sharing information about your own adolescence
   - Your choice of language OR Social Media

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Describe the professional and personal boundaries that determine when they disclose information about themselves.
2. Identify potential consequences of disclosing personal information in an educational setting.
3. Explain possible rationales for disclosing personal information.
4. List at least three tips for how and when to disclose personal information to learners

Activity 1: Self-Disclosure

INSTRUCTIONS

1. Introduce the activity and its purpose, which is to discuss when and how it is appropriate to share personal information in an educational setting, or self-disclosure.

Note that disclosure can be:

- One-to-one
- Could be in a group
- Could be non-verbal (wedding ring, photos, buttons, etc.)
- Could be on-line (Facebook: even pages that you like)

2. Distribute the Self-Disclosure Assessment handout. Tell participants that there may be some statements or situations that do not apply to them; if they do not, ask them to imagine who they WOULD tell **if this situation did apply to them.** Also, if they HAVE experienced the statement, they don't need to write down who they actually told—they should record who they WOULD tell today.

3. Assure them that they will not be expected to share the content on their forms with the entire group—but that they will be discussing the **process** of doing this with at least one other person, and will be encouraged to discuss what **patterns** they observed in their decision-making.

4. Ask participants to complete the assessment individually. After about 5-10 minutes, give each person a moment to reflect on their individual worksheet. Ask them to find a partner.

5. Reveal the flip chart with the guiding questions they should use to process the activity with their partner.

6. Emphasize again that they do NOT need to share anything that's on their worksheet unless they wish to, but simply reflect on the process.

Activity 1: Self–Disclosure

INSTRUCTIONS (CONTINUED)

7. After a few moments of discussion among the pairs, call the groups attention back and ask the following questions:
    - What was it like to do this? What was _____ about it?
    - What did you notice about who you disclosed to?
    - How did you decide who you would disclose to?
    - What's something you learned about yourself (or were reminded of) by doing this?
8. Ask everyone to turn the worksheet over and to complete this sentence: "One way this activity could potentially impact how I do my work is…."
9. Ask for volunteers to share responses in the large group.
10. Now ask participants to think about any experiences they have had in an educational setting where the educator/trainer disclosed personal information. This can be from when they were a student in school or when they attended training as a participant.
11. Ask for a volunteer or two to briefly share their experience by asking the following guiding questions:
    - What was the experience?
    - Did the disclosure help or hinder the learning?
    - Did the disclosure seem strategic/planned or spontaneous?
12. Ask teachers, "So from what we've seen in this activity, what are some of the potential positive consequences of self–disclosure?" Record responses on a flip chart. Supplement participants' responses as needed with the following:
    - Increase student participation, sharing, comfort, and motivation
    - Decrease power difference between educator and students
    - Develop rapport between students and educator

Activity 1: Self–Disclosure

INSTRUCTIONS (CONTINUED)

13. Ask, "What are some of the potential negative consequences of self–disclosure?" Record responses on a flip chart. Supplement participants' responses as needed with the following:

    - Interferes with students' learning
    - Enhances power of educator beliefs
    - Focus shifted to educator, not students
    - Questions educator professionalism
    - Creates role confusion

14. Note that as it relates to social media and self–disclosure, there are similar issues and pros and cons. That said, there are also some issues that are unique to social media that teachers should be aware of, such as the viral nature of social media (that messages can be forwarded instantly to many people at once).

Review these tips with teachers:

- Avoid putting information about politics on your pages
- Limit the personal information you share
- Be aware that what others comment on your page can be seen by students
- Refrain from using social media to spy or gossip about learners
- Don't lecture learners about information you may have seen on their page.

15. Next provide each teacher with a copy of the handout, Guidelines for Self–Disclosure and review this in a large group, asking teachers to share their thoughts or examples as you walk through them.

Activity 1: Self–Disclosure

INSTRUCTIONS (CONTINUED)

16. End the activity by asking the following questions:

- ✔ What was it like to spend time discussing the issue of self–disclosure?
- ✔ Why is it important to think through when and how much information to share with learners?
- ✔ What is an important lesson that you have taken from these activities?
- ✔ How might this discussion impact how you approach information sharing in the classroom?

17. Conclude by underscoring the importance of reflecting on when and what to disclose to learners in a classroom setting, noting that oftentimes one may not realize the negative impacts of self–disclosure, which is why it is so important to be selective and intentional about what and when to share.

Adapted by Advocates for Youth, 2014, from Answer's Training Institute in Sexual Health Education (TISHE), Lesson Plan by Allyson Sandak

Self-Disclosure Assessment Handout

For each of the items below, place a check mark under each type of person with whom you would disclose that piece of information (or note if you would choose not to disclose). Please answer honestly. You will not need to share anything that's on this worksheet unless you wish to, but you will be asked to reflect on the process.

With Whom Would You Disclose If You...?

	CO-WORKER(S)	SUPERVISOR	PARENTS OF LEARNERS	LEARNERS	WOULD NOT DISCLOSE
1. Were married/in a committed relationship					
2. Had children					
3. Had ever been arrested					
4. Ever used birth control and which type					
5. Were ever in a sexual relationship with someone of the same gender					
6. Were ever in a sexual relationship with someone of a different gender					
7. Ever had a Sexually Transmitted Infection					
8. Ever had an affair					
9. Had sex as a young person					
10. Or your partner were pregnant					
11. Or your partner had ever had an abortion					
12. Had strong feelings about the next election					
13. Ever found a young person you teach sexually attractive					
14. Have strong religious beliefs and what they are					

Adapted by Advocates for Youth, 2014 from Rutgers Training Institute in Sexual Health Education, based on an adapted work developed by Elizabeth Schroeder Ed.D., M.S.W.

Guidelines for Self-Disclosure Handout

answer
sex ed, honestly

41 Gordon Road, Suite C
Piscataway, NJ 08854-8067
(T) 732-445-7929 (F) 732-445-5333
answer.rutgers.edu
sexetc.org

We disclose information about ourselves every day, often without thinking about it. When it comes to answering questions about sexuality—especially when working with young people—there is a bit more of a slippery slope to consider.

While some people believe that disclosing personal information will help to build a sense of trust with young people, others are able to make very strong connections with teens without doing so—or, by maintaining very clear boundaries about what topics are and are not off limits.

Every professional must make the decision of whether to disclose personal information—and how much to disclose—for her or himself. The following are some issues professionals may wish to consider when making these important decisions:

When you might choose to disclose:

- Only with an established individual or group with lots of trust.
- Only when it enhances learning and the example makes a good point.

When NOT to disclose:

- For ego-enhancement, to get a laugh, or to make others like you.
- When it is about your personal sex life.
- When it is something that you would not want someone else sharing about themselves.
- When it could jeopardize the future education or safety of group members.

Six Tips on Self-Disclosure:

1. **Know the organization's policy**. As long as you work within a particular school or youth-serving organization, your professional responsibility is to that organization and its policies.
2. **Notice what things you already disclose** about yourself every day without thinking about them—symbols of relationship status, religion, or political affiliations, and other things that give messages about who we are—both accurate and inaccurate!
3. Once you disclose something or cross a boundary, **you can't undo it**.
4. **Ask yourself** *why* you would disclose the information?
   If it is to make yourself feel better, then don't disclose.

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5. **Think about the secondary message** that disclosing can give: i.e., about abortion: i.e., "I have never had an abortion, but" or about sexual orientation: i.e., "I'm not gay, but …"
6. It is possible to connect with young people without sharing too much personal information. Use your own experiences **in the third person**. For example, "I know someone who…"

Keep in mind that once a piece of information has been disclosed…

- You can't take it back.
- You have no control over what that person will do with the information. Young people in particular are at a developmental level where they may use personal information inappropriately.
- It often carries more weight than general information. The nature of a professional/student relationship has an inherent power differential. Therefore, if a young person asks you what type of condoms or other birth control you use and you share that information, the young person is not making her or his own decision. Your brand/type will carry more weight for them just because they know and trust you. However, what is right for you is not necessarily right for your students or anyone else.

Adapted by Advocates for Youth, 2014, from the Rutgers University Training Institute in Sexual Health Education adaptation on the work of Dr. Eva S. Goldfarb, Ph.D., Montclair State University, NJ

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Activity 2: Answering Difficult Questions

TOTAL TIME REQUIRED

1 hour 30 minutes

MATERIALS NEEDED

- ✔ Flip chart
- ✔ Markers
- ✔ Note cards

RESOURCES NEEDED

- ✔ The Meaning Behind a Question Handout
- ✔ Beyond the Lesson Plan: Tips for Responding to Challenging Questions and Comments Handout
- ✔ Leader's Resource of 20 Sample Questions
- ✔ 20 sample questions prepared in advance on half-sheets
- ✔ 2 pre-written flip charts each with one of the following questions:
    1. When did you have sex for the first time?
    2. What happens when a person has sex with an animal?

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Identify various types of challenges they may face in answering questions by reflecting upon their own experience and participating in a large group discussion.
2. Identify strategies for overcoming barriers related to each type of challenge, by listening to discussion led by a facilitator.
3. Demonstrate their ability to respond effectively to questions by practicing in small groups, answering questions that are typically asked by participants.

INSTRUCTIONS

1. Introduce the activity and its purpose, which is to discuss the types of questions that sexuality education teachers can encounter and how to effectively respond to them.
2. Remind teachers that as part of healthy adolescent development, learners are curious, can worry about whether they are normal or not, and care about peers and how they are perceived by them. They will therefore ask questions because they want to understand the world around them and it is important to treat questions with respect and without judgment.
3. Distribute note cards and ask teachers the following: "Visualize a time when you asked someone a difficult question and felt you heard an effective response."
4. Write this question down on your note card and what the other person did to make the response effective.
5. Ask teachers to put the note card aside for later use.

Activity 2: Answering Difficult Questions

INSTRUCTIONS (CONTINUED)

6. Review the five types of questions that educators are typically asked when teaching sexuality education:
    1. Information seeking
    2. Am I normal?
    3. Permission seeking/advice
    4. Personal beliefs or experiences
    5. Shockers
7. Refer to the handout, The Meaning Behind a Question, to go over the types of questions and provide one example for each.
8. Next, ask teachers under what circumstances such questions could be asked and jot down answers on flip chart paper.

If teachers have not mentioned the following, complete the list with these:

- During a group education session
- One–on–one outside the session
- Anonymous question box
- On–line via e-mail, text, or other social media

9. Note that the focus of this activity will be more on how to manage in–person interactions.
10. Ask teachers, "Why can some questions feel challenging? What other barriers are there to responding effectively?"
11. Solicit ideas and jot on flip chart. (Possible examples could include: teacher discomfort, agency policy restricts what can be said, distractions in the room, curriculum requires fidelity).
12. Direct teachers to form pairs. Hand each pair ONE sample question. Say, "Practice identifying the type of question you have—there may be more than one type that applies. If you and your partner disagree about the type, discuss why. You have 5 minutes."
13. Lead a brainstorm of some strategies to successfully respond to challenging questions or situations and write examples on a flip chart.

Activity 2: Answering Difficult Questions

INSTRUCTIONS (CONTINUED)

14. Distribute the Beyond the Lesson Plan: Tips for Responding to Challenging Questions and Comments handout. Allow people time to read it. Invite suggestions for additional tips missing from this and the flip chart.

15. Direct teachers to form new pairs, and swap questions with another pair so that every pair has a fresh question.

16. Ask pairs to role-play (2 minutes per person) as teacher and learner. It is okay for both to see the question as written—no surprises required. Explain that the learner can add details on context such as their age, gender, etc. to help the teacher. Advise the teacher to try to apply some of the tips that were just reviewed. If they finish before 2 minutes they can step out of their roles and discuss what worked about the interaction (or what could have improved it).

17. Direct teachers to form new pairs and to swap their question out for a new one. At the signal, they can role-play the new question. Advise them to stop after 2 minutes.

Ask teachers:

- ✔ How did it feel to learners to ask the question? How did it feel to teachers to respond?
- ✔ What tips did teachers use to respond effectively?
- ✔ Have you experienced something similar in your work?
- ✔ What might you do as a result next time you encounter a similar type question in the classroom?

** If you see that teachers may be unclear on factual information, ask if they need clarification and provide it. If you aren't sure yourself about the answer, find out and provide it later in the day before closing or the next morning before beginning. **

Activity 2: Answering Difficult Questions

INSTRUCTIONS (CONTINUED)

18. Direct teachers to form new pairs. Explain that all pairs will work on the same question, noted on the flip chart paper as follows:

When did you have sex for the first time?

Pairs can determine who will start as teacher and learner. Explain that there will be a second question so that they will have the chance to reverse roles.

19. Note that the key for this role-play pairing is to tailor the response as if it were to the learners that you actually serve in real life.

20. After 2 minutes, ask pairs to switch and to role-play using the question noted on the flip chart paper as follows:

What happens when a person has sex with an animal?

Ask teachers:

- ✔ How did it feel to learners to ask the question? How did it feel to teachers to respond?
- ✔ What tips did teachers use to respond effectively?
- ✔ What was important to understand about your real-life learners when crafting a response? (e.g. your agency policy, learners' developmental level, etc.)
- ✔ What might you do differently next time you encounter a similar type question in the classroom?

21. Ask teachers to take out the note cards they completed at the start of the plenary and invite a few examples for sharing with the large group—what did the other person do or say to make an effective response to your difficult question? How is that similar to the tips discussed during this exercise?

22. Close with concluding remarks:

    - Learners will inevitably ask you tough questions and this is part of healthy adolescent development.
    - Being aware of the types of questions you can encounter when teaching sexuality education and tips for addressing these can equip you to better respond to learners' inquiries and to do so respectfully and without judgment.

Adapted by Advocates for Youth, 2014, from Answer's Training Institute in Sexual Health Education (TISHE), Lesson Plan by Jenny Palmer and Kurt Conklin

The Meaning Behind a Question Handout

answer
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1. INFORMATION-SEEKING

These are basically very straightforward questions that have specific, factual answers.

Examples:

- How does a condom work?
- What does oral sex mean?
- Can you get an STI from a toilet seat?

SAMPLE RESPONSE—Since most STIs are caused by germs and bacteria that are very fragile, it is not possible to get a disease from a toilet seat, because the bacteria or virus could not stay alive there.

2. AM-I-NORMAL

These questions are often about something a person worries about and needs reassurance about. So while there may be a factual response, the person needs to know that wanting to know the answer is normal.

Examples:

- Is it possible to masturbate too much?
- What is the average size of a penis?
- Why are boys horny all the time?

SAMPLE RESPONSE—It really does seem as though all boys are horny all the time, but we know that not only are some boys not at all interested in sex, but girls can be very interested in sex and we don't often hear about that. It is really normal for teens to think about sex a lot, be curious and even masturbate a lot. It is also normal for those feelings not to be very strong at all. People develop at different times and so a person's interest in sex is a really individual thing. Why do you think we have this stereotype that all guys are horny?

3. PERMISSION-SEEKING/ADVICE

These questions are really about something that a teen is trying to make a decision about and needs permission to make a decision. Sometimes they are looking to be talked out of something, and sometimes they really want to know the steps to figuring out the answer for themselves.

Examples:

- What is the correct age to have sex?
- How do you give a blow job?
- What are the consequences of dating someone who is older than you?

The Meaning Behind a Question Handout

answer
sex ed, honestly
41 Gordon Road, Suite C
Piscataway, NJ 08854-8067
(T) 732-445-7929 (F) 732-445-5333
answer.rutgers.edu
sexetc.org

SAMPLE RESPONSE—Dating an older person can be wonderful, but there are certainly some cautions to keep in mind. In some situations, an older person will try to control a younger person, or may keep the younger person from doing things that someone his or her age might wish to do. An older person may expect sex when a younger person may not be ready. Depending on the age differences, sex between the older and younger person might be considered illegal.

4. PERSONAL BELIEFS OR EXPERIENCES QUESTIONS

These questions are again a test of how much you are willing to share about yourself. Most of the time, sharing personal information is not appropriate, but generally explaining that your experiences happened at a time very different from today, and therefore are not relevant to them, is a safe way to avoid answering those questions.

Examples:

- How old were you when you had sex for the first time?
- Do you think abortion is wrong?
- If you were me, what would you do?

SAMPLE RESPONSE—Since I am NOT you, and I do not have to live with the consequences of the choice, it does not make sense for me to give you an answer. We can talk together about the choice you have to make, and then maybe it will be easier for you to make a decision that is right for you.

5. SHOCK QUESTIONS

These questions are asked to test the facilitator. This is a check of your sense of humor, your ability to think on your feet, and your ability to not get flustered or upset by a question. Sometimes it is best to ignore the question, but other times, it helps to give a serious answer.

Examples:

- I want to f—k you.
- If I have sex with 300 guys does that make me a slut?
- My girlfriend smells like dead stinky fish, what should I do?

SAMPLE RESPONSE—This question has two parts to it. In one part, it is asking about something we often hear—that a girl's vagina smells dirty or bad, but the way it is asked is part of the problem. It is true that all girls and women's vaginas have a scent and that some scents are stronger and more noticeable than others, this is very normal. It is not right to make a girl or woman feel bad about her body since the scent is normal and natural. A strong scent could be a sign of infection.

Beyond the Lesson Plan: Tips for Responding to Challenging Questions and Comments Handout

For many sexuality educators, preparing a lesson plan and leading activities is the easy part of the job. It's those spur-of-the-moment comments or questions that can cause the most anxiety. Below are several types of challenges, and some suggestions for dealing with them.

1. Knowledge or Skills

Usually, these questions are very straightforward questions that have specific, factual answers. How does a condom work? What does oral sex mean? Can you get an STI from a toilet seat? How can you get an appointment to see about contraception? However, sometimes a question will challenge the limits of our own knowledge or skills.

Tips:

- It's OK not to know something, and to be honest about it.
- This moment is an educational opportunity to "model" that no one should be embarrassed at not knowing everything.
- Ask the group if anyone knows more.
- If the question contains slang that you don't know, ask to be educated (this will help build rapport between you and the learners).
- Promise to get the answer. (And follow through!)
- When a topic is difficult to explain, check in to be sure the audience understood your answer.

2. Comfort

Most educators will become embarrassed at one time or another. Of course, being calm and matter-of-fact is the overall goal. Being calm helps normalize talking about sexuality and helps "absorb" the natural discomfort of learners (discomfort which can distract from the learning process). However, a moment in which the educator is clearly embarrassed is an opportunity for him/her to model, "What should we do when we're embarrassed by the topic?" (The answer: Keep discussing anyway!)

Tips:

In the moment:

- Breathe. Literally. Breathing helps relax us.
- If you can remain outwardly calm, do so. Try not to send the message that the question warrants embarrassment.
- Stall for time, so you can gain composure—nod your head, use a general phrase, like "You know, I'm really glad this question came up."
- If it's too late (your face is flushed, your voice shakes, you've begun laughing), acknowledge it. It immediately puts you with the crowd that may be laughing at you. *(Note: If you do acknowledge being embarrassed, if appropriate be sure to underscore that the question is valid, and an important one to ask.)*
- Then, answer the question if it's appropriate.

Beyond the Lesson Plan: Tips for Responding to Challenging Questions and Comments Handout

Does it seem that the purpose of the question is to shock you or entertain the class?

- Not all shocking questions are asked for shock value. In other words, it may be an honest question. If so, it deserves a calm, honest answer.
- If you're "unshockable," any purposeful behavior on the part of the questioner will become unsatisfying.
- Option one: Answer the question at face value, as if it were sincerely asked.
- Option two: Say, "Here's a question dealing with xx, but I'm not sure the person really wants an answer—it may be just for a laugh. For now, I'm going to move on. If I've misunderstood your question, feel free to see me afterward, and I'll be happy to answer it."

Addressing Discomfort On Your Own Time:

- Examine your discomfort. Your feelings have presented an opportunity for increased self-understanding and growth, which helps you become a better sexuality educator.
- If it's just the "Get-over-it" type of discomfort, practice can help—as you teach, in discussions with co-workers, or repeating words/phrases in a private setting.
- If you experience deep-seated discomfort, it may mean you have some healing to do regarding past experiences. If that's the case, you deserve a chance to get assistance from a reliable resource. (It's not fair to the educator or learners for an educator to be forced to teach sexuality when it causes him/her emotional distress.)

3. Values Issues

When discussing values related to sexuality, the goals of the educator are to:

- Increase awareness among participants of their personal values.
- Promote the value of respect for differing opinions.
- Model and teach how to engage in respectful discussion.
- Promote universal values.

Tips:

- Do not impose your personal values. (If you make a rare exception and share a personal opinion, surround it with comments that validate alternative viewpoints.)
- Explore a range of values.
- Use the "reporter technique." Give the facts, "report" examples of views on both sides of the issue. (Then turn it to the group for discussion.)
- When a strong opinion is stated, ask for responses from the group.
- If the group seems to be discussing one point of view, make sure other possibilities are explored. Ask the group if there are alternative points of view, or state them yourself.

Beyond the Lesson Plan on Tips for Responding to Challenging Questions and Comments

- Be careful about putting people on the spot for their personal opinions. It might be less threatening to ask "Why might some people choose to…?" rather than "What do you believe…?"
- Encourage discussing such matters with the moral authorities in the learners' lives—Parents, clergy, and other trusted adults.
- Know what can get you upset or uncomfortable ahead of time so that you can be ready to react calmly. When the topics arise, pause, and breathe!

4. Your Role (Personal Questions, Permission, Advice)

Sometimes educators are asked to disclose their values (Do you think it's wrong to…?); their experiences (Have you ever…?); or something about their personal identities or lives (Are you straight? Do you have kids?). They may be asked to give advice (What do you think I should do?); or permission (Is it OK. for a 16 year-old to…?).

Our responses to these questions have implications about the professional's role in the lives of his/her students. There is no "one size fits all"—In some settings, the professional is a guest speaker. In others, the professional is a live-in counselor, taking a quasi-parental role. In others, it is something in-between. Whatever his or her setting and role, the professional should carefully deliberate beforehand how she/he will approach requests to share personal information or advice. In the moment, she/he should take extreme care, choosing non-disclosure (i.e. not sharing personal information) over possibly inappropriate disclosure.

Tips:

- It is usually preferable to not answer personal questions.
- You always have the right to not answer a personal question.
- Never discuss personal sexual behavior.
- If you make the exception and share personal information, it should always be done for a specific, positive reason—to demonstrate empathy, to model appropriate sharing, etc.
- You should never share personal information to meet your own needs.
- Consider setting a ground-rule ahead of time—in which you announce that you won't answer personal questions (just as we'll respect anyone's right not to share personal information).
- When asked to "grant permission" or share advice, generalize the issue—explore a range of options; discuss pros/cons; share a variety of viewpoints.

Beyond the Lesson Plan on Tips for Responding to Challenging Questions and Comments

5. Crisis, Legal Matters, or Disclosures of Trouble

Occasionally, a question or comment will reveal a personal crisis that a group member is facing. In these situations, the educator is juggling several needs and interests—attending to a participant's very important personal situation (perhaps involving protecting his/her safety); protecting the privacy of that individual; sharing pertinent information; maintaining calm in the group; and advancing the original learning goals of the session.

Tips

- If possible (anonymous written question), generalize the issue, so as to not draw attention to an individual.
- Encourage anyone who is facing that type of situation to talk to you or another group leader afterward.
- If a person discloses a personal trauma to the group, respond empathetically (I'm sorry to hear that you had to go through that), then switch to general comments and information about the topic (When a person has been a victim of rape, it's usually very helpful for them to talk about it with people they trust. Often, a counselor who is specially trained can offer the most help…)
- If a group member seems interested in "processing" his/her situation in front of the group, politely seek buy–in to move on. (It's very important that you have a chance to ask questions about your situation. Because we're here as a group to hear about a range of other things, I'd like to move on. If you'd like to talk with me after the class is over, I'm more than happy to stick around. Would that be OK?)
- Be familiar with, and comply with, mandatory reporting laws in your state.
- When discussing a situation with an individual that triggers mandatory reporting, it is usually best to let him/her know that you will need to report what he/she is sharing.

6. "The Heart" and Other Complicated Topics

How do you know when you're in love? Why are boys always touching their private parts? Some questions are asked as "factual," but there just may not be a straightforward answer. A helpful approach here is to facilitate a discussion rather than give an answer.

Tips:

- Bounce the question back: "What do you all think?"
- Explore various possibilities: "What do you think would happen if…?" "How might a person feel if their partner…?"
- If you offer up an answer, give a few possibilities and note that they are educated guesses.
- Check in to see if there are other thoughts on the matter.
- Check in to see if the questioner feels the question was answered adequately.

Beyond the Lesson Plan on Tips for Responding to Challenging Questions and Comments

Some General Guidelines

1. Remember that in addition to imparting information and skills, the educator's job is also to:
    - Normalize and de-mystify.
    - Absorb discomfort.
    - Affirm learners.

This means that the emotional content of your answer is as important as the informational content. How you say something is as important as what you say.

2. Convey gratitude for the questions and comments that arise. Use the exercise to underscore the idea that discussing these topics is a good thing.

3. Be aware of the "question behind the question." Often, the real question is underneath the surface.

Examples are:

- "Am I normal?" question (What is the average age that a girl's breasts start to show?)

Proper response: Calmly normalize, or calmly suggest a person get attention from an expert.

- "Permission" question (Is it OK for a 16 year-old to...?)

Proper response: Explore a variety of possibilities, opinions, possible outcomes, etc.

- "Crisis/trouble" question (Is it incest if a girl's step-father asks her to have sex?).

Proper response: Be as general in your answer as you can; if appropriate encourage people in those situations to seek assistance; offer to be available to talk to any student individually.

4. Be aware that nonverbal communication can speak volumes. Work to avoid nonverbal cues such as wrinkled brows or frowns that may imply judgment, disapproval, etc.

5. Use third person (a girl's...a boy's..., two people...) rather than the pronoun "you" when answering very personalized questions in a group setting.

6. Use gender-neutral and orientation-neutral language when describing behavior and people.

Originally compiled by Mark Huffman, M.T.S., with adaptations from material by Nora Gelperin, Eva Goldfarb, Wayne Pawlowski, and Pam Wilson. Further adapted by Advocates for Youth, 2014.

Leader's Resource of 20 Sample Questions

Use any of the following sample questions for the activity and/or use questions that teachers may have already come across and/or are especially common in your country.

1. How does a condom prevent HIV?

2. What does oral sex mean?

3. Can you get an STI from a toilet seat?

4. How can you get an appointment to see about contraception?

5. What is an erection?

6. Should you worry if you're 14 and you haven't gotten your period?

7. How do you know when you're in love?

8. Is it okay to masturbate?

9. What causes menstrual cramps?

10. How old were you when you first had sex?

11. What is the average age that a girl's breasts start to show?

12. Is it okay for a 16 year–old have had sex?

13. Is it incest if a girl's step–father asks her to have sex?

14. Can you get pregnant the first time you have sex?

15. What is a normal penis size?

16. Can you get HIV from oral sex?

17. Have you ever had an STI?

18. Do you think having sex before marriage okay?

19. How much sperm is normal when you ejaculate?

20. Is it okay if one breast is bigger than the other?

SESSION EIGHT:
Application, Practice, and Resources

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Review, prepare and deliver a sexuality education lesson.
2. Provide constructive feedback to colleagues' delivery of lesson plans.
3. Identify two professional development needs and locate resources to support their teaching of sexuality education.

ACTIVITIES

Activity 1 Teach Backs with Peer Review

Activity 2 Professional Development Needs and Resources

Activity 1: Teach Backs with Peer Review

TOTAL TIME REQUIRED

3 hours 30 minutes

MATERIALS NEEDED

- ✔ Materials to facilitate teachers' delivery of the lesson plans, as noted in the plans themselves (for example, tape, markers, flip charts, etc.) Trainers will need to review the lesson plans prior to this session to ensure that teachers have the materials they need, which will depend on the number of teachers and number of times any given lesson is being delivered.

RESOURCES NEEDED

- ✔ Multiple copies of the following lesson plans so that each teacher receives one lesson and so that all lessons are used:
    1. Increasing Awareness of Child Marriage
    2. Correct and Consistent Condom Use
    3. Managing Peer Pressure
    4. Sexual Choices and Relationships
    5. Deciding Whether to Have Sex
    6. Healthy Relationships

RESOURCES NEEDED (CONTINUED)

7. Navigating Relationships
8. Taking Care of Your Sexual Health

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Review, prepare, and deliver a sexuality education lesson.
2. Provide constructive feedback to colleagues' delivery of lesson plans.

INSTRUCTIONS

1. Explain that the next step in the training will be to apply what everyone has been learning and observing by reviewing, preparing, and delivering a sexuality education lesson that will be provided to them.
2. Remind teachers about core competencies gained thus far and distribute lesson plans so that each teacher receives one lesson.
3. Indicate that the lesson plans cover additional core sexuality education topics and so not only will they be practicing teaching sexuality education but also learning from each other. List out the lesson plans as follows:
    1. Increasing Awareness of Child Marriage
    2. Correct and Consistent Condom Use
    3. Managing Peer Pressure
    4. Sexual Choices and Relationships
    5. Deciding Whether to Have Sex
    6. Healthy Relationships
    7. Navigating Relationships
    8. Taking Care of Your Sexual Health

Activity 1: Teach Backs with Peer Review

INSTRUCTIONS (CONTINUED)

4. Divide teachers into groups of four and distribute the lesson plans. Depending on the number of teachers you have, the same lessons might be taught in multiple groups.

5. Note that teachers will each have 30 minutes to review and prepare their lesson and 30 minutes to deliver it within their group of four by taking turns in a round robin fashion. After each lesson is delivered, fellow teachers are to take 5 minutes to provide feedback to their colleague, using the Stepping Out questions as a guide, before moving onto the next lesson.

6. Let teachers know that as the lessons would normally take longer to deliver than 30 minutes and would likely be done with more than four people, they will need to make adjustments accordingly to stay within the time frame.

7. Once all groups have completed their lessons, ask teachers:

- ✔ How did it feel to prepare and deliver your lesson? How did it feel to participate as a learner?
- ✔ What were some activities or techniques that you applied that we have discussed so far?
- ✔ What worked well and not so well either in your lesson or the other lessons?
- ✔ How might this practice impact your lesson planning and delivery in the classroom?

8. Conclude by noting that purposefully designing your lesson, applying new techniques to strengthen delivery of the lesson, and benefiting from peer review and support do not have to end here with the training but should continue as you work to effectively deliver sexuality education.

Lesson Plan – Increasing Awareness of Child Marriage

TOPIC: Increasing Awareness of Child Marriage	**TARGET-AGE RANGE:** 12–15	**TIME:** 45 minutes
SUBJECT: Life Skills		
IDEAL NUMBER OF LEARNERS: 40		

WHAT ADVANCE PREPARATION, IF ANY, IS REQUIRED OF THE TEACHER FOR THIS LESSON?

- If possible, review Ending Child Marriage in Africa—A Brief by Girls Not Brides to make sure you are familiar with the latest facts about child marriage. If you have access to your country's statistics about child marriage you can add in that information when discussing the answers to the quiz.
- Review your country's legal frameworks for information about the legal age of marriage." Be prepared to share this information with the learners.
- Hang the True and False signs on opposing walls in your classroom.

LEARNING OUTCOMES:

By the end of this lesson learners will be able to:

1) State at least three facts about child marriage. [knowledge]

2) Convey a core message about the impact of child marriage. [attitude]

LIFE SKILLS DEMONSTRATED IN THIS LESSON:

1) Think critically about the issue of child marriage.

RESOURCE MATERIALS FOR TEACHER:

- Ending Child Marriage in Africa—A Brief by Girls Not Brides, accessible here: *http://www.girlsnotbrides.org/wp-content/uploads/2015/02/Child-marriage-in-Africa-A-brief-by-Girls-Not-Brides.pdf*
- True or False Quiz about Child Marriage – Teacher Guide
- Two signs on 8.5 x 11 paper—One piece with "True" written on it and one with "False" written on it

MATERIALS FOR LEARNER:

- None

Lesson Plan – Increasing Awareness of Child Marriage

This lesson is enhanced when learners have the following background knowledge: Content from the International Technical Guidance on Sexuality Education—Key Concept 1 – Relationships, Learning Objective 1.4 – Long-term Commitments, Marriage, and Parenting

PROCEDURE:

Step 1)

Introduce the concept of child marriage by asking the learners, "Can anyone share with the group what you know about child marriage?" Take a few responses from volunteers and make sure to add the following if the learners did not offer it. "Child marriage is when adolescents under the age of 18, and sometimes as young as 8 or 9, are married to adults, generally without their consent. Child marriage can happen to both boys and girls, but often it impacts girls much more than boys. Child marriage happens all over the world, including many countries here in sub-Saharan Africa. Today's lesson will help us understand the issue of child marriage more and then use our new knowledge to help raise awareness among others in our families and communities." Next explain that forced marriage is a little bit different and is defined as, "Forced marriage is when a marriage takes place without the consent of the individuals getting married, where pressure or abuse is used to 'force' one or both people to marry against their will. A forced marriage can happen to anyone; of any gender, of any age and is a form of violence."

Step 2) 5 minutes for Steps 1 & 2

Explain to students, "Now we'll take a short quiz to figure out what you already know about child marriage and add in some new information. I will be reading some statements and I want to you decide for yourself whether you think that statement is True or False. If you believe the statement is true, you move to the side of the room where the "True" sign is hanging. Or if you think the statement is false, you move to the other side of the room where the "False" sign is hanging. It is okay to guess since a lot of this information may be new to you or may have changed in the last few years. Are there any questions?" If there are no questions, instruct students to stand up and begin by reading the first statement on the True or False Quiz about Child Marriage – Teacher Guide.

Step 3) 20 minutes

Once students have moved to the sign that represents their belief, have students talk quickly with others who are on the same side about why they believe that statement is either True or False. Then gather the class's attention and ask the following questions:

- Why do you think that statement is true?
- Why do you think that statement is false?
- The correct answer is (and fill in the answer and key facts from the Teacher Guide).

Continue with the same process using statements 2–5 as time allows. Then have learners return to their seats.

Step 4) 5 minutes

Once learners have settled back in their seats, ask the following processing questions:

- What did you learn about child marriage from that activity?
- How do you feel about child marriage now knowing this new information?
- Do others in your family and community know about child marriage? Why or why not?

Lesson Plan – Increasing Awareness of Child Marriage

PROCEDURE (CONTINUED):

Step 5) 10 minutes

Explain by stating the following, "Child marriage is an issue that more people need to know about given the impact on adolescents and their children. Next you are going to turn to the person next to you and share what you would say if you were to tell others in your community about child marriage. Make sure you share some correct facts about child marriage and communicate these facts in a way that will grab the attention of others."

Ask the learners to pair up with someone else and give them 5–10 minutes to each share their message with each other.

Step 6) 5 minutes

Close the lesson by asking the following questions:

- What was it like to share a message with someone else about child marriage?
- What did you notice about what you said and what your partner said?
- What information about child marriage do you find most easy to remember?
- Now that you know more about child marriage, who do you think you might share this information with and why?
- What could someone do if they were worried about this happening to them?

KEY MESSAGES OF LESSON:

1) Child marriage has damaging impacts on girls' health and well–being.

2) Child marriage is more common in sub–Saharan Africa than most think.

ASSESSMENT OF LEARNING OBJECTIVES AT CONCLUSION OF LESSON:

- Teachers can have learners write down the core message that they shared about child marriage and submit them for assessment of the learning objectives.

HOMEWORK WITH FOCUS ON FAMILY INVOLVEMENT ACTIVITIES:

- None

POSSIBLE ADAPTATIONS:

1) Large class size—If the class size is too large to allow moving around the classroom during the True/False activity, the teacher can have learners raise their hands for True and keep their hands in their laps to indicate False. This still allows the learners to guess the answers but does not require movement.

2) Limited materials/technology—None

SOURCE: Nora Gelperin, M.Ed., Director of Sexuality Education and Training, Advocates for Youth, 2014 and Child Marriage in Africa – A Brief by Girls Not Brides, 2014

True or False Quiz About Child Marriage – Teacher Guide

Directions: Teachers should read each statement aloud to their learners. Ask learners to decide whether they believe the statement is true or false. Then the teacher should share the correct answer and the following key messages about each statement written below.

1) In sub-Saharan Africa, 40% of women are married as children. TRUE

Key Points:

- All African countries are faced with child marriage.
- In East and Southern Africa, child marriage affects 37% of girls.
- Some girls as young as 8–9 are forced to marry adult men by their family.

2) Child marriage occurs when a girl falls in love very young. FALSE

Key Points:

- Families in extreme poverty feel that child marriage will reduce their expenses and/or provide them some income from a bride price.
- For some families, they are following tradition.
- Sometimes marriage for young girls is perceived by the family as a way to ensure their safety from physical or sexual assault.

3) Girls who are forced to marry young often have children very young and most can not continue with their schooling as a result. TRUE

Key Points:

- Many girls become pregnant soon after they are married, even though their bodies are not mature enough to have a baby safely.
- Many girls drop out of school to care for children or do household chores.
- Some girls who are married young never get the opportunity to attend school even before they are married.

4) Girls who give birth before the age of 15 generally don't have problems during childbirth. FALSE

Key Points:

- Girls' bodies are not mature enough to have a safe pregnancy and delivery and there are often very serious consequences.
- Girls who give birth under the age of 15 are five times more likely to die in childbirth than girls who give birth in their 20s.

5) Girls who are forced to marry young often have an equal say in the relationship. FALSE

Key Points:

- Girls who marry very young are more likely to be beaten and forced to have sex by their husbands than girls who marry later in life.
- Girls who marry young are not able to insist their husbands use protection, like condoms, and are therefore at greater risk for getting HIV and other STIs, in addition to pregnancy.

Lesson Plan – Correct and Consistent Condom Use

TOPIC: Correct and Consistent Condom Use	**TARGET-AGE RANGE:** 12–18	**TIME:** 45 minutes
SUBJECT: Life Skills		
IDEAL NUMBER OF LEARNERS: 40		

WHAT ADVANCE PREPARATION, IF ANY, IS REQUIRED OF THE TEACHER FOR THIS LESSON?

- Find out if the female condom is available locally and where. Review the information about male and female condoms from a reliable source.
- Review the Correct Steps in External or Male Condom Use – Teacher Answer Key.
- Review the Teacher's Resource about Condoms.
- Prepare one set of 10 pieces of paper for steps on external or male condom use (see "Correct Steps in Condom Use – Teacher Answer Key").

LEARNING OUTCOMES:

By the end of this lesson learners will be able to:

1) Describe at least three obstacles to condom use and how these obstacles can be addressed. [knowledge]

2) Describe correct steps for the use of a male, latex condom. [knowledge]

LIFE SKILLS DEMONSTRATED IN THIS LESSON:

1) Critical thinking skills

2) Decision–making skills

3) Negotiation skills

4) Communication skills

RESOURCE MATERIALS FOR TEACHER:

- Chalkboard and chalk
- Correct Steps in External or Male Condom Use – Teacher Answer Key
- Teacher's Resource about Condoms
- 10 prepared pieces of paper for steps for the use of the male condom
- If appropriate, sample male and female condoms for demonstration purposes

MATERIALS FOR LEARNER:

- None

Lesson Plan – Correct and Consistent Condom Use

This lesson is enhanced when learners have the following background knowledge: Content from the International Technical Guidance on Sexuality Education—Key Concept 6 – Sexual and Reproductive Health; 6.1 – Pregnancy Prevention

PROCEDURE:

Step 1)

Introduce the concept by explaining the following, "Today we will be discussing condom use and how to use condoms consistently and correctly." Ask the following questions and write down learners' responses on the chalkboard:

"What do you know about condoms?"

"Why is it important to know about condoms?"

Step 2) 5 minutes for Steps 1 & 2

Introduce the topic by explaining, "One of the reasons that people don't use a condom is that they do not know how to use one. That is not a good reason to end up with a serious health problem, so we are now going to learn the proper way to use a male condom. Being old enough to learn how to use a condom does NOT mean you are ready to have sex, but it is better to know how to use a condom BEFORE you need it, not after you have sex, when it's too late. When using condoms, you can take some steps well ahead of time, that is, before you are in an intimate situation. Some steps you can take when you are already in an intimate situation but immediately before sex actually takes place. You should know what to do regarding condom use before, during, and after sex." *[**Teacher's Note:** On the board, create four columns and write "well ahead of time," "immediately before," "during sex," and "after sex," at the top of each column.]*

Step 3) 5 minutes

Explain the activity by saying, "I have broken down all the steps involved in correct use of a male condom and put each step on 10 separate pieces of paper. I will hand out these papers to some volunteers. Each volunteer should work with one or two learners seated near them to figure out which column the step goes in." Point out the four columns on the board. Go on to explain, "The first column will include steps that should be carried out well ahead of time. The next column will show the steps to be carried out immediately before sex. The third column will include steps that may be involved during sex. The fourth column will display steps to be taken after sex. Within the columns, try to put each step in order as well. You have five minutes."

Step 4) 10 minutes

Stop the process after five minutes and bring the whole group together. Review each of the four columns together with the learners ensuring the steps are in the correct order as indicated on the Correct Steps in External or Male Condom Use – Teacher Answer Key. Make sure to rearrange any steps that were in the wrong column or within a column, in the wrong sequence.

Once each of the 10 steps is in the correct column, go on to tell students about the female condom by saying, "In addition to a condom worn on a penis, there is also a condom that can be worn inside the vagina. *[**Teacher's Note:** If you are able to show a female condom, this is a great time to display it for your students to see.]* This condom is inserted into the vagina before sex with a partner and captures the semen inside the condom so it does not get into the body. The condom should be removed after sex and thrown away. The female condom, like the male condom, should only be used one time and can be obtained from some of the same places where male condoms are available."

Lesson Plan – Correct and Consistent Condom Use

PROCEDURE (CONTINUED):

Step 5) 5 minutes

Next brainstorm with learners five reasons why some young people don't use condoms each time they have sex. Ask whether these reasons are different if you are male or female and why. Write these reasons or barriers on the chalkboard as your learners brainstorm the first five that come to mind. The list might include barriers such as:

- Embarrassed to talk about or buys condoms
- Believe it is boys' responsibility to bring condoms or that "good girls" don't carry condoms
- Can't afford to buy condoms
- Don't think they are at risk for pregnancy or STIs
- Don't think sex will feel as good with a condom

*[**Teacher's Note:** If you are doing this lesson with very young learners, you will need to help them brainstorm these responses since they are likely to be too young to know why young people may not to use condoms.]*

Step 6) 10 minutes

Have learners form pairs with someone seated near them and have each pair select one of the five barriers from the chalkboard to work with. Explain the directions by saying, "You and your partner will come up with one way that young people could overcome that barrier to using condoms. For example, if you select "can't afford condoms" as your barrier, you and your partner might suggest that a young person could either borrow money or find a youth center that gives away condoms for free. So first select the barrier you want to work with from the list on the chalkboard and then come up with a way that a young person could overcome that barrier." Give learners a few minutes to complete the task. *[**Teacher's Note:** If learners come up with a lot of myths about condom use instead of barriers to their use, use the Teacher's Resource about Condoms to refute those myths as needed.]*

Step 7)

When most pairs seem to be done, gather the attention of learners and ask for three volunteers to share the barrier they chose and what ideas they had for ways young people could overcome those barriers. Write the suggestions on the chalkboard. The suggestions for overcoming common barriers might include:

- Good communication between partners
- Knowing how to use a condom and where to get them
- Understanding the risks of unprotected sex (how you get pregnant and how you can acquire STIs, including HIV)

Step 8) 10 minutes for Steps 7 & 8

As a closure to this lesson, ask the following question and try to bring in gender perspectives:

- Who is responsible for condom use?

End the lesson by saying, "It is critical and in fact it is your right as young people to know how to use condoms consistently and correctly and how to anticipate potential barriers to condom use and ways to overcome those barriers. This information protects health and saves lives."

Lesson Plan – Correct and Consistent Condom Use

KEY MESSAGES OF LESSON:

1) The consistent and correct use of condoms is an important strategy to protect oneself and one's partner from unintended pregnancy and STIs, including HIV. Male and female condoms are currently the only method that provides dual protection (protection against pregnancy and STIs, including HIV). It is also possible to use a male or female condom with another method of contraception to maximize protection, such as the pill or injectables.

2) There are many steps to using condoms correctly.

3) While there are challenges to using condoms, it's possible to anticipate these and identify solutions.

ASSESSMENT OF LEARNING OBJECTIVES AT CONCLUSION OF LESSON

- Teachers can ask learners to write down one barrier and one solution to using condoms correctly and consistently and submit for assessment of the learning objectives.

HOMEWORK WITH FOCUS ON FAMILY INVOLVEMENT ACTIVITIES:

- None

POSSIBLE ADAPTATIONS:

1) Large class size—Teachers can conduct the activity on identifying solutions to barriers in small groups instead of pairs or as a whole class.

2) Limited materials/technology—None

Adapted from: It's All One, Activity 47 – Gender and Condom Use, pages 150–155, Copyright © 2009 The Population Council, Inc. Revised first edition, printed 2011 and Source: NHS Choices - http://www.nhs.uk/Livewell/teenboys/Pages/Condoms.aspx

Correct Steps in External or Male Condom Use – Teacher Answer Key

Note to Teachers: Prepare 10 pieces of paper and write one step from the list below on each piece. DO NOT INCLUDE THE STEP NUMBER, as those are shown just for your reference in the answer key guide and will make the activity too easy for learners. Remember that steps 1–3 in the "Well Ahead of Time" column are all flexible in terms of sequence.

Well Ahead of Time Column

1. Buy condoms (and lubricant) or find a health center or community-based organization that gives them away for free.
2. Check the expiration date of the condom and be sure the date has not passed.
3. Practice putting on a condom—on the penis, or your hand, or if available, a banana—so that you are comfortable using one later.

Immediately Before Sex Column

4. Open the condom gently, being careful not to rip it (don't use teeth!)
5. When the penis is erect, squeeze the tip of the condom and place it over the head of the penis with one hand while you unroll the condom over the length of the penis with the other hand. Make sure penis is covered completely.
6. If having vaginal sex, ensure that the vagina is lubricated or if having anal sex, that the anus is lubricated so that the condom will not break or tear. Use additional lubricant as needed, but never use oil-based lubricant, as it will cause the condom to break.

During Sex Column

7. If the condom breaks during sex, the male should pull out immediately and the couple should consider using emergency contraception to prevent pregnancy.
8. After ejaculation, while the penis is still erect, hold onto the condom at the base of the penis and pull out of partner's body.

Immediately After Sex Column

9. Turn away from partner's body and carefully remove condom from the penis without spilling any semen that may be inside the condom.
10. Dispose of the condom as you would do for other trash (do not flush down a toilet). Never re-use a condom.

Teacher's Resource About Condoms

Below is a list of common myths about condoms and the factual information to dispel the myth. The following publication from UNFPA might also be helpful:

https://www.unfpa.org/sites/default/files/pub-pdf/myths_condoms.pdf

MYTH: It's safer if you use two condoms.

TRUTH: Whether it's two male condoms or a male and female condom, using two condoms is not better than one as they are more likely to break. Only use one condom at a time.

MYTH: **Condoms break easily.**

TRUTH: No they don't. To avoid a condom breaking, you need to put it on carefully and make sure there's no air bubble at the end. Be careful of sharp nails, jewelry or teeth. If the condom won't roll down, it's the wrong way round. Throw this condom away and start again with a new one as there could be semen on the tip of the previous condom.

If a condom breaks and you're not using any other contraception, go to a health center as soon as possible and ask about emergency contraception. You may also need to get tested for sexually transmitted infections (STIs), including HIV.

MYTH: Condoms are the only type of contraception I need to think about.

TRUTH: No they're not. Condoms can provide protection from STIs and unplanned pregnancy. But to get the best protection, it's better if you and your partner use a condom and another form of contraception. There are lots of different types of contraception, including the implant, injectables, the copper IUD coil, or the pill. It's worth exploring all options.

MYTH: You need extra lube. Vaseline is good.

TRUTH: No it's not. A bit of extra lubrication is good but don't use anything with oil in it as it can dissolve the condom. That includes baby oil, Vaseline and hand cream. Lipstick has oil in it too. Use a water–based lubricant, such as KY jelly from a pharmacy or supermarket.

MYTH: Condoms make me less sensitive.

TRUTH: Using a condom doesn't have to spoil the moment. They can make some men last longer before they come, which is good news for both partners. There are lots of different sizes, shapes, colors, textures and flavors of condoms, so enjoy finding the one that suits you both best.

MYTH: Condoms cut off my circulation.

TRUTH: No they don't. A condom can stretch to 18 inches round. There are many different shapes and sizes that you can try.

MYTH: My girlfriend is on the pill, so we don't need condoms.

TRUTH: Yes you do. The pill does not protect you or your partner from STIs, including HIV. Also, if your girlfriend forgets to take a pill, has been sick or has been using antibiotics, the effectiveness of the pill is lower and she could still get pregnant.

Teacher's Resource About Condoms

MYTH: If I ask to use a condom, my partner will think less of me.

TRUTH: Insisting that you use a condom suggests that you know how to take care of yourself and shows that you know what you want, which can be very sexy.

MYTH: You don't need a condom if you're having oral sex.

TRUTH: Actually, HPV, gonorrhea, chlamydia, herpes, and HIV can be passed on by oral sex. You can protect yourself with a condom (worn on the penis for a male receiving oral sex or cut into a sheet for a female receiving oral sex).

MYTH: As a young person, you aren't allowed to get condoms.

TRUTH: Young people can usually get condoms from peer educators, community health workers, health centers, pharmacies, stores, or community–based organizations.

MYTH: I don't need a condom because my partner seems healthy.

TRUTH: The way someone looks is no indicator of whether they have an STI, including HIV. A person may look healthy and still have an STI, including HIV. Lots of STIs don't have any symptoms, so you could infect each other without even knowing it.

MYTH: All condoms provide the same level of safety.

TRUTH: Not necessarily—while most condoms are very effective, it's important to use them correctly and consistently. Condoms need to be stored properly and not be expired to be used correctly. Also, there are some novelty condoms for sale that are made for fun, such as glow in the dark condoms, that don't provide protection from pregnancy and STIs. Choose condoms that are from a well–known brand or source and check the expiration date before use.

Source: NHS Choices - http://www.nhs.uk/Livewell/teenboys/Pages/Condoms.asp

Lesson Plan – Managing Peer Pressure

TOPIC: Managing Peer Pressure	**TARGET-AGE RANGE:** 9–15	**TIME:** 45 minutes
SUBJECT: Life Skills		
IDEAL NUMBER OF LEARNERS: 40		

WHAT ADVANCE PREPARATION, IF ANY, IS REQUIRED OF THE TEACHER FOR THIS LESSON?

- Prepare two pieces of flip chart paper with "Advantages" and "Disadvantages" written at the top of each, respectively.

LEARNING OUTCOMES:

By the end of this lesson learners will be able to:

1) To discuss the importance of belonging to a group. [knowledge]

2) To look at the benefits and disadvantages of belonging to a group. [knowledge]

3) To identify and rank peer pressure coping strategies. [knowledge]

LIFE SKILLS DEMONSTRATED IN THIS LESSON:

1) Critical thinking about the need to belong to a group or not.

2) Critical thinking about strategies to manage peer pressure.

RESOURCE MATERIALS FOR TEACHER:

- Two sheets of prepared flip chart paper

MATERIALS FOR LEARNER:

- None

Lesson Plan – Managing Peer Pressure

This lesson is enhanced when learners have the following background knowledge: Content from the International Technical Guidance on Sexuality Education—Key Concept 2 – Values, Attitudes, and Skills, Learning Objective 2.2 – Norms and Peer Influence on Sexual Behavior

PROCEDURE :

Step 1) 5 minutes

Ask learners to talk about what makes friends/friendships important. Encourage learners to share how they feel about having friends and different kinds of friendships.

Step 2) 5 minutes

Use the following notes to explain the importance of friends and to define peer pressure.

Friends and Peer Pressure

- The peer group is important during adolescence. There is a great need to belong to a group that is a natural part of adolescent development. Sometimes this can create a need to act like others in the group, which may lead to your own individuality being 'swallowed' up by the group. The group's behavior may not be good for your own health and well being such as use of alcohol or drugs, and you may find yourself under pressure to take part in activities that you do not or would not normally do. This is called peer pressure and often results in young people joining in on group behavior rather than risk being made fun of or rejected by the group.

Step 3) 10 minutes

Refer to the two prepared sheets of flip chart paper on the wall or write it on a chalkboard. Lead a brainstorm asking learners to list some advantages of belonging to a group and some disadvantages of belonging to a group. Write down their responses on the flip chart papers.

Once learners have shared a number of advantages and disadvantages, guide a discussion using the following questions:

- What do you notice about the items written on the Advantages list?
- What do you notice about the items written on the Disadvantages list?
- Are there any important items that are missing from either list? (If so, feel free to add others that learners may come up with to each list.)
- Looking now at both lists, what did you learn about belonging to groups?

Step 4) 20 minutes

Next, divide learners into groups of five and ask them to come up with a list of ways young people could cope with peer pressure. Have learners write their list on a piece of paper along with the names of each person in the group. Give learners five minutes to complete this task. When time has passed, ask each group to look at the list they created and take a couple of minutes to rank the top three coping strategies on their list in order of which would be most effective for young people to use. Then, have groups share their one of their top three ideas with the whole class as you write them on a piece of flip chart paper. Continue hearing one from each group as time permits. Ask groups to turn in their lists.

Lesson Plan – Managing Peer Pressure

PROCEDURE (CONTINUED):

Step 5) 5 minutes

Summarize the lesson by highlighting the following key points:

- It is healthy and normal to want to belong to a peer group.
- Many young people find themselves bullied or taken advantage of by a peer group.
- We must first and always be true to our values and ourselves and make decisions that are good for us.
- Friends are important but we should not be led astray or pressured into doing things that we do not want to do.

KEY MESSAGES OF LESSON:

1) It is healthy and normal to want to belong to a peer group.

2) Friends are important but we should not be led astray or pressured into doing things that we do not want to do.

ASSESSMENT OF LEARNING OBJECTIVES AT CONCLUSION OF LESSON:

- Teachers can have learners write down the advantages and disadvantages of belonging to a group from Step #3 or coping strategies from Step #4 and submit for assessment of learning objectives.

HOMEWORK WITH FOCUS ON FAMILY INVOLVEMENT ACTIVITIES:

- None

POSSIBLE ADAPTATIONS:

1) Large class size: The teacher can make slightly larger groups for Step #4, use pairs and then write ideas and rank them as a whole class, or limit report outs to a few groups but share back a consolidated written list of the top ways to cope with peer pressure identified by all groups.

2) Limited materials/technology—None

Lesson Plan – Sexual Choices in Relationships

TOPIC: Sexual Choices in Relationships	**TARGET-AGE RANGE:** 12–18	**TIME:** 45 minutes
SUBJECT: Life Skills		
IDEAL NUMBER OF LEARNERS: 40		

WHAT ADVANCE PREPARATION, IF ANY, IS REQUIRED OF THE TEACHER FOR THIS LESSON?

- Attach the string horizontally across the room. At one end attach the pre-labeled index card that says, "Completely forced, not desired" and at the other end attach the other pre-labeled index card that says, "Fully voluntary, desired."Modify the handout "Case Studies in Sexual Choice and Coercion" as indicated in the Case Studies in Sexual Choice and Coercion Activity Sheet.
- Make four copies of the set of case studies you select to use with learners.
- Review local sexual health services resources in your community so you can refer any student seeking help to appropriate sources of support.

LEARNING OUTCOMES:

By the end of this lesson learners will be able to:

1) Be aware of the sexual choices they have in a relationship. [knowledge]

2) Recognize situations where sex is voluntary but not wanted. [knowledge]

3) Clearly understand the right to say no to sex. [knowledge]

LIFE SKILLS DEMONSTRATED IN THIS LESSON:

1) Critical thinking skills

2) Assertiveness skills

3) Decision-making skills

RESOURCE MATERIALS FOR TEACHER:

- Chalkboard and chalk
- One or more copies of each of the selected case studies (depending on the number of groups you have and number of case studies desired per group) taken from the Case Studies in Sexual Choice and Coercion Activity Sheet
- A piece of rope or sturdy string long enough to stretch across the length of the classroom
- Two index cards, with one of each of the following written on them—Index Card #1 – Completely forced, not desired; Index Card #2 – Fully voluntary, desired
- Paper clips (or tape)
- Colored markers, if available

MATERIALS FOR LEARNER:

- None

Lesson Plan – Sexual Choices in Relationships

This lesson is enhanced when learners have the following background knowledge: Content from the International Technical Guidance on Sexuality Education—Key Concept 6 – Sexual and Reproductive Health; 6.1 – Pregnancy Prevention

PROCEDURE:

Step 1) 5 minutes

Introduce the topic by explaining the continuum. Say, "There is a continuum between sex that is forced and completely undesired and sex that is fully voluntary and desired. Explain that the continuum range from 0 to 10. 0 stands for voluntary and desired sex and 10 completely forced and not desired. So, what do we call sex that is forced?" After learners respond, write the word "rape" on the card that says "Completely forced, not desired". Go on to ask learners, "If a person agrees to have sex, does that always mean that he or she actually wants to have sex?" After they respond, ask: "When sex is voluntary but not really wanted, would that be at one end of the string or somewhere between the two ends?" Process some responses from your learners and probe for their different reasoning by using any of the following prompts:

- "Tell me more about what you're thinking…"
- "Help me understand where you're coming from…"
- "What do others think about that same situation?"

Step 2) 10 minutes

Divide the learners into six groups. Give each group one set of two case studies and two paper clips. Explain the activity by stating, "Read over each case study in your group. Then talk about it together and decide where on the string continuum you think the case study falls from completely forced to fully voluntary. Write your names on each case study so we'll know which group did which case study. Then attach the case study with a paper clip at the place on the continuum where you have decided it fits. You will have 10 minutes to complete this activity in your groups." Circulate among the groups and offer help. Allow them to spend extra time discussing their views even if they do not complete all the case studies.

Step 3) 15 minutes

After 10 minutes, ask someone from the group to read the first case study and explain where on the 0–10 continuum their group put it and why. Allow two to three minutes for the other groups to indicate where they put it on the continuum and why and encourage them to discuss any differences of opinion. Repeat this process for each case study.

Lesson Plan – Sexual Choices in Relationships

PROCEDURE (CONTINUED):

Step 4) 10 minutes

Reserve ten minutes at the end to discuss the following questions:

- Forcing someone to have unwanted sex is a violation of that person's human rights. By a show of hands, who believes that forced sex is common among young people?
- Who thinks it is rare?
- We discussed that a person who does not want to have sex and is not forced into it may still voluntarily engage in sex. Who believes this is a fairly common experience among young people?
- Who thinks it is rare? *[Note whether boys respond to this question similarly to how girls respond.]*
- Are girls and boys equally likely to have sex in a situation that is not forced but also not desired? *[Probe: Do you think girls and boys usually share equal power in sexual relationships? What about adult men and women?] [Note: Emphasize that even if a situation does not fall at the extreme "forced" end of the spectrum it may nonetheless, be unacceptable.]*
- Does a person always know whether his or her partner really wants to have sex? What are some ways to be sure? *[Probe for: Ask the person! Talking it over together beforehand is best. What if you ask and your partner is not sure what he or she wants?]*

Step 5) 5 minutes

Close the lesson by explaining, "Far too many people are survivors of forced sex, either while they are children, adolescents or adults. It happens more often than we would like to think and if it should happen to you or someone you know, it's crucial to know it's never your fault. People who have survived forced sex need our help and support." Instruct learners to get out a piece of paper and anonymously write down two kinds of trusted adults (such as a grandmother, a religious leader, an older sister or brother, or an aunt) that they could talk to if they or someone they knew was ever forced to have sex. Collect papers from learners at the end of the lesson and after reviewing for appropriateness, post the papers in a spot in the classroom where learners can see them and know about all the kinds of adults who can help if a student ever needed support. *[Note: Please make sure to screen the papers before you post them to make sure there is no identifying information listed and that all of the adults listed are appropriate.]*

Lesson Plan – Sexual Choices in Relationships

KEY MESSAGES OF LESSON:

1) It is never okay to force someone to have sex they don't consent to.

2) You have the right to say no to sex if you don't want to, without feeling guilty.

3) Forced sex is a sign of unhealthy relationship.

ASSESSMENT OF LEARNING OBJECTIVES AT CONCLUSION OF LESSON:

- Teachers can collect the case studies completed by each group for assessment of learning objectives based on where the case studies were placed on the continuum.

HOMEWORK WITH FOCUS ON FAMILY INVOLVEMENT ACTIVITIES:

- None

POSSIBLE ADAPTATIONS:

- Large class size—The teacher can carry out the case study activity in more or less groups if need be. If using more groups, limit the number of case studies, even to one per group if necessary, in order to limit the activity processing time. If using less groups, increase the number of case studies reviewed by each group.
- Limited materials/technology—None

Case Studies in Sexual Choice and Coercion Activity Sheet

INSTRUCTIONS FOR THE TEACHER: Select four of the following case studies or write your own case studies. Be sure that your final selection includes at least one case in which a boy feels pressured to have sex. Modify them to be suitable and meaningful for your students, including using names that are relatable.

EDWARD and ALICE: Edward wants to have sex but his wife Alice does not feel like it tonight. She has been taught that it is a wife's duty to have sex whenever her husband wants to unless she feels sick or is menstruating, so she has sex with Edward.

MIREMBE and AKELLO: Mirembe, age 22, has been going out with Akello for about six months. He has told her several times that he really wants to have sex with her, but only if she wants to. Mirembe feels unsure but she thinks she should do what her boyfriend wants. She knows other young women have sex with their boyfriends and is concerned that he might leave her if she doesn't, although Akello has never threatened to do so. The next time they are intimate, they have sex.

SYDNEY and GRACE: Sydney and Grace are alone at one of their houses. Sydney is drunk and slurring words and then lies down on the floor. Grace, who also had a bit to drink, lies down too. Feeling uninhibited, she takes the initiative and performs oral sex. Sydney feels confused and is not sure what to say. Sydney is not sure what to think since they didn't talk about it before Grace did that.

HENRY and ROSETTE: Henry and Rosette have been kissing passionately. When Henry starts to undress Rosette, she tries to stop him and says, "No". Henry thinks she wants more but that she is worried about seeming too "easy". So he keeps trying. After trying to push Henry away and saying "no" for five minutes, she eventually stops struggling and just lies there. Henry goes ahead and has intercourse with her.

MAKENA and AZIZI: Makena and Azizi have met only a couple times, always with supervision. Azizi seems like a good person so Makena agrees when her parents tell her that Azizi wants to marry her. Both Makena and Azizi have been taught that everything related to sex is shameful. Makena has heard that it hurts the first time and will make her bleed. She is really scared. They hardly know each other and both feel ashamed at the thought of having sex. Neither of them really wants to have sex but they know that when you get married, you must have sex on the wedding night and so they do, even though they were not ready to.

Case Studies in Sexual Choice and Coercion Activity Sheet

SELAH and JAMES: The last time Selah refused her husband James, he threatened her and beat her badly, giving her a black eye. She doesn't want to have sex with James today but he might beat her again, so she doesn't refuse.

SAMSON and ELIZABETH: Samson and Elizabeth are classmates at university. They have been dating for a few months and are very attracted to each other. They are deeply in love and agree that they want to have sex. After agreeing to use a condom, they have sexual intercourse and both enjoy it.

GINA and BRIAN: Gina comes from a poor family. She works in a shop for Brian and her salary is her family's main income. One day Brian starts touching her after the shop closes and pulls her in the storeroom in the back and lifts up her dress. Gina is confused, and frightened about losing her job. She starts to resist but when Brian says, "What? You don't like working here?" She gives in.

PATRICIA and OSCAR: Oscar is not sure if he really wants to have sex with Patricia, but Patricia suggested it and he is afraid that his friends will find out and tease him if he says no. He goes ahead but later regrets doing it and wishes he had waited.

PETER and VICTORIA: Peter often buys Victoria gifts and other things she needs. Tonight they went out for dinner and he paid. Even though Victoria doesn't feel ready to have sex, she feels she owes it to Peter. She doesn't refuse him.

MARIE and WILLIAM: Marie and William have had sex once before. Tonight, William tells Marie that he has wanted her all day. Marie would rather just hang out and talk, but she think since they did it once, there is no going back. When William starts to take off his clothes, Marie says nothing to him and they have sex again.

EMMA and SYMON: One evening Emma drank a lot. Symon finds her lying on the bed passed out. He takes off her clothes and has sex with her. She doesn't wake up.

Lesson Plan – Deciding Whether to Have Sex

TOPIC: Deciding Whether to Have Sex	**TARGET-AGE RANGE:** 12–15	**TIME:** 45 minutes
SUBJECT: Life Skills		
IDEAL NUMBER OF LEARNERS: 40		

WHAT ADVANCE PREPARATION, IF ANY, IS REQUIRED OF THE TEACHER FOR THIS LESSON?

- Review the list of conditions in the handout and ensure that you feel prepared to facilitate any questions that may arise.
- Review the age of consent for your country as per the legal frameworks and be prepared to explain it to your learners if appropriate.

LEARNING OUTCOMES:

By the end of this lesson learners will be able to:

1) Identify the skills they will need to be able to negotiate a safe and comfortable sexual relationship. [Knowledge]

2) Strengthen critical thinking skills. [Skills]

LIFE SKILLS DEMONSTRATED IN THIS LESSON:

1) Critical thinking skills

2) Decision-making skills

RESOURCE MATERIALS FOR TEACHER:

- Chalkboard and chalk

MATERIALS FOR LEARNER:

- Student worksheet – Am I Ready? How Do I Decide?—One copy per learner

Lesson Plan – Deciding Whether to Have Sex

This lesson is enhanced when learners have the following background knowledge: Content from the International Technical Guidance on Sexuality Education—Key Concept 2 – Values, Attitudes, and Skills; 2.3 – Decision–Making

PROCEDURE:

Step 1) 2 minutes

Explain to learners by saying, "Young people around the world have many different reasons for deciding whether and when to become sexually active. Some young people wait until a certain age, until they meet someone that they feel ready to start an intimate relationship with, or until they are engaged or married. Others might start having sex because they feel pressured into doing so by peers, a partner, or even the family.

Determining if and when to become sexually active can be difficult for many young people. Many young people consider how they feel about their relationship only when they weigh the decision about whether to become sexually intimate with their partner. Some people want to make sure they have reached the legal age of consent, which is (INSERT AGE HERE) for our country. This activity will help you to think about how maturity, self–awareness, and communication skills can affect your sense of readiness to become sexually active. It will also help you identify what is most important to you."

Step 2) 3 minutes

Ask the learners to form pairs and give each pair one copy of the worksheet. Explain, "Look at the list on this worksheet. These are some pieces of advice that can be important to consider when deciding about whether or not to become sexually active."

Step 3) 15 minutes

Read aloud the instructions for the worksheet. Ensure that everyone understands the activity. Within the pair, they should try to reach agreement about their responses, but if they cannot, they can check off additional items. Allow 10 to 15 minutes for them to discuss the questions and record their answers.

Step 4) 10 minutes

Reassemble the group. Review the worksheet and ask for some responses on the different pieces of advice listed. Ask whether learners tended to agree or disagree with their partners. Ask learners if there were any additional pieces of advice that they identified as important and would like to share with the bigger group.

Step 5) 10 minutes

Use the following questions to guide a discussion on how boys and girls might react differently to advice:

- In general, which advice do boys seem to prioritize?
- In general, which advice is more important to girls?
- How do you explain, and feel about, any differences between boys' and girls' priorities?

Lesson Plan – Deciding Whether to Have Sex

PROCEDURE (CONTINUED):

Step 6)

Close by discussing the following questions:

- How did it feel to complete this worksheet?
- What did you notice upon filling it out?
- Would some of the pieces of advice be easier to follow than others? Why?
- How might hearing these pieces of advice impact decisions about whether to become sexually active?

Step 7) 5 minutes for steps 6 and 7

- Conclude the lesson by explaining, "No matter when you decide whether and when to become sexually active or even if already sexually active, thinking about conditions that matter to you is important to being safe and healthy."

KEY MESSAGES OF LESSON:

1) There are important criteria to consider when deciding whether and with whom to be sexually active.

2) There are many perspectives to consider when making an important decision, like whether or not to be sexually active.

ASSESSMENT OF LEARNING OBJECTIVES AT CONCLUSION OF LESSON:

- The teacher can instruct students to write their names on the worksheet and collect them for assessment of the learning objectives. It would be important not to assess the worksheets for correctness, since the activity is based on personal values, but rather to assess whether the learners completed the activity as instructed.

HOMEWORK WITH FOCUS ON FAMILY INVOLVEMENT ACTIVITIES:

- None

POSSIBLE ADAPTATIONS:

1) Large class size—Teachers can conduct the activity that was in pairs in small groups and instead of processing it together as a large group, gather two or three groups together to share their answers.

2) Limited materials/technology—None

Am I Ready? How do I Decide? Worksheet

Directions: Please review the following advice for helping decide if and when to become sexually active. Think about what a friend and a parent or trusted adult would say. First, draw a smiley face next to the two feelings or conditions that you think the best friend would say are most important. Then, draw a check mark next to the two feelings or conditions that you think the parent or trusted adult would say are most important.

IN DECIDING WHETHER TO BECOME SEXUALLY ACTIVE, MY ADVICE TO YOU IS THAT IT WOULD BE IMPORTANT TO...	FRIEND	PARENT/ TRUSTED ADULT
Feel that you are honoring your own values and those of your partner		
Feel close to the other person		
Feel that you and the other person respect each other		
Feel that you and the other person have made the decision together and that both of you want to have sex		
Have condoms (and/or other contraceptives) and know how to use them		
Feel comfortable talking with the other person about condom use		
Know your HIV status		
Feel safe for either of you to say at any time you want to stop		
Feel sexually attracted to the other person		
Other?		
Other?		

LEGEND: ☺ = FRIEND ✓ = PARENT OR TRUSTED ADULT

UNFPA Advocates for Youth Rights. Respect. Responsibility. UNESCO United Nations Educational, Scientific and Cultural Organization

Lesson Plan – Healthy Relationships

TOPIC: Healthy Relationships	**TARGET-AGE RANGE:** 9–15	**TIME:** 45 minutes
SUBJECT: Life Skills		
IDEAL NUMBER OF LEARNERS: 40		

WHAT ADVANCE PREPARATION, IF ANY, IS REQUIRED OF THE TEACHER FOR THIS LESSON?

- Make copies of materials needed
- Make signs

LEARNING OUTCOMES:

By the end of this lesson learners will be able to:

1) Identify at least four ways that he or she would like to be treated in a romantic relationship. [knowledge]

2) Identify at least three warning signs that a relationship is potentially unhealthy or abusive. [knowledge]

3) Identify at least two effective communication practices. [knowledge]

LIFE SKILLS DEMONSTRATED IN THIS LESSON:

1) Critical thinking about qualities of healthy and unhealthy relationships.

2) Communication skills

RESOURCE MATERIALS FOR TEACHER:

- 12 pieces of paper with one way to be treated taken from the How I Would Want to Be Treated by My Partner in a Relationship handout written on each piece of paper
- Tape to hang signs

MATERIALS FOR LEARNER:

- How I Would Want to be Treated by My Partner in a Relationship Handout—One copy per learner
- Relationship Scenarios Handout—One copy per learner
- Healthy, Unhealthy, and Warning Signs of Abuse Handout
- Effective Communication Tips Handout—One copy per learner
- Individual Homework – Thinking about Healthy Relationships—One copy per learner (if assigning the homework)
- Family Homework – Talking about Healthy Relationships—One copy per learner (if assigning the homework activity)

Lesson Plan – Healthy Relationships

This lesson is enhanced when learners have the following background knowledge: Content from the International Technical Guidance on Sexuality Education—Key Concept 1 – Relationships; 1.2 – Friendship, Love, and Romantic Relationships

PROCEDURE:

Step 1)

Introduce the lesson by saying, "Today we are going to talk about relationships and how to have healthy and happy relationships. We will discuss how someone might recognize if they are in an unhealthy relationship and what kinds of communication skills can help us have the relationships we want."

Step 2) 5 minutes for Steps 1 & 2

Distribute the handout "How I Would Want to be Treated by My Partner in a Relationship" to each learner. Explain to students, "This worksheet has a list of ways you perhaps would want to be treated by a romantic partner, whether now or in the future. Looking at this list, think about which ones are most important to you. Circle three that you think are most important Then, choose your top item, and write a brief explanation about it on the bottom of your worksheet. Once you are finished, you will have a chance to share some of your thinking." If a student asks if they can add any qualities to the list, you can let them know that they can add a quality, but for the sake of this activity, they cannot choose it as their "#1 Quality."

Step 3) 15 minutes

While students are working, hang the 12 previously made signs around the classroom. Once learners are done instruct them to find the three qualities that they chose on their worksheet and put their initials on each of those pieces of paper with that quality hanging around the room. Then, have students stand by the quality they rated at #1.

Once the learners have initialed the three signs and are standing next to their #1 quality, debrief several of the top–scoring items, including why people chose them and what that quality would look like in a relationship.

Sample discussion questions (these assume that "respect" had been a popular choice among learners but it would be whatever leaners chose most) might include:

- Why did you all choose respect? Direct the question to the group standing by the sign.
- Did anyone else choose respect for a different reason? Directed to the rest of the class.
- How could someone show their romantic partner that they respect them?
- What are some disrespectful things a romantic partner might do?

Lesson Plan – Healthy Relationships

PROCEDURE (CONTINUED):

Step 4)

Pass out the Healthy, Unhealthy, and Warning Signs of Abuse Handout.

Tell learners, "It sounds like you all know how you would like to be treated in your relationships, which is so important. In fact, sometimes people don't actually know what they want in a partner and that makes it hard to have a happy and healthy relationship. I am really glad to see that so many of you are already thinking about what would be important to you. I have just handed out a sheet that lists many of the qualities we have just been discussing, as well as some qualities of an unhealthy relationship because while it's important to know what you would be looking for in a relationship, it's also important to be able to recognize when a relationship is unhealthy. Let's take a look at a couple of real-life scenarios. We can use the qualities on this sheet to help us examine their relationships."

Step 5) 15 minutes for Steps 4 & 5

Pass out the Relationship Scenarios Handout. Have a volunteer from the class read Scenario 1, Marcus and Lillian, first. Debrief with questions listed below. Repeat with Scenario 2, Tasneem and Kato.

- Do you think this is a healthy or unhealthy relationship? Why?
- What characteristics **from your handout** do you see in their relationship? (If they simply list a quality from the handout, prompt them to describe the specific behavior from the scenario that illustrates that quality.)

Marcus and Lillian debrief:

The class should identify this scenario as having several qualities of an unhealthy or abusive relationship, including:

- Trying to limit or control what the other person does
- Is often jealous
- Throws or breaks things during a fight

However, they may also see some qualities from the healthy relationship list, such as that Marcus states he trusts Lillian and that he loves her.

It is important to emphasize that while Marcus may love and trust Lillian, **his actions are unacceptable** and make for an unhealthy relationship. If he can learn to control his anger, perhaps they could have a healthy relationship. However, Lillian does not deserve to be treated in this way and it would be **unsafe for her to stay in the relationship** at this point.

Lesson Plan – Healthy Relationships

PROCEDURE (CONTINUED):

Tasneem and Kato debrief:

The class should identify this scenario as having several qualities from the healthy relationship list, including:

- Being supported and encouraged
- Being treated as an equal
- Being honest

Tasneem and Kato have different interests, but still support one another in the things that are important to them. Neither of them feels the need to give up their individual interest or feels forced to join the interest of the other person. They are honest with each other and were able to negotiate a compromise that they were both happy with.

*[**Teacher's Note:** If you are able to explore same–sex relationships, it can be a great teaching opportunity to make the names of the two characters in either scenario the same gender.]* This can normalize relationships between gay, lesbian and bisexual people and reinforce that everyone, no matter their sexual orientation, deserves to be in a healthy relationship. If your leaners express the opinion that two people of the same gender being in a romantic relationship with each other is never a healthy choice, it's important to point out that, although people have differing beliefs about the rightness or wrongness of gay and lesbian relationships, any two people's relationship can have healthy or unhealthy characteristics, such as those listed on the handout. Some gay and lesbian relationships are healthy and some are not, just like some heterosexual relationships are healthy and some are not. Redirect the conversation by explaining that the point of the lesson is to give learners tools to evaluate the health of their own relationships.

Step 6) 10 minutes

Explain to students, "I want to thank you for really taking the time to think about what would be important to you in a relationship, and what might be some signs that a relationship is unhealthy. Now let's think about how communication fits into a healthy relationship, as good communication is fundamental to a healthy relationship." Hand out Effective Communication Tips Handout to each learner and review together with the group by asking any of the following questions:

- What do you think about the communication tips on this handout?
- Which ones do you already use?
- Which ones do you think are more difficult to use and why?
- Why do you think these tips lead to more effective communication?

Close the lesson by saying, "Relationships are at the heart of being human and everyone deserves happy and healthy relationships. Hopefully some of the information we discussed today will help you have healthy relationships in the future."

Lesson Plan – Healthy Relationships

KEY MESSAGES OF LESSON:

1) Healthy relationships are very important and take work.

2) It's important to know the warning signs of unhealthy relationships and how to get help.

3) Knowing the qualities you would like in a partner is important to being safe and healthy.

4) Communication is a key part of a healthy relationship and practicing these skills can help you build and keep a healthy relationship.

ASSESSMENT OF LEARNING OBJECTIVES AT CONCLUSION OF LESSON:

- Teachers can collect the How I Would Want to be Treated by My Partner in a Relationship Handout for assessment of the learning objectives. Additionally, assigning either the individual or family homework activity could be another way to assess learning.

HOMEWORK WITH FOCUS ON FAMILY INVOLVEMENT ACTIVITIES:

- Use the Talking about Healthy Relationships worksheet and a clean copy of the How I Would Want to be Treated by My Partner in a Relationship Handout. See each worksheet for detailed directions.

POSSIBLE ADAPTATIONS:

1) Large class size—None

2) Limited materials/technology—None

Adapted from: Family Life and Sexual Health – High School Lesson 5: Healthy Relationships Seattle-King County Department of Public Health www.kingcounty.gov/health/flash

How I Would Want to Be Treated by My Partner in a Relationship Handout

Directions: Please review the following list and circle 3 ways you would want to be treated in a relationship that are most important to you. You may see many qualities here that you like, but try to pick your top three. Follow the directions at the bottom of the page after you have picked your top three.

I want my partner to...

Treat me with respect

Be trustworthy

Need me

Treat me fairly

Support me

Be honest with me

Treat me as an equal

Make me laugh

Encourage me

Protect me

Trust me

Love me

Looking at the three you chose, please list the number one most important way you would like to be treated by a romantic partner and write a brief explanation of why that quality is so important.

#1 Quality: _____

Explanation: _____

_____

_____

Relationship Scenarios Handout

1. Marcus and Lillian

Marcus really likes Lillian – she is pretty and smart. Marcus often feels nervous that he might lose her to another boy. He doesn't think she would ever cheat on him, but he does see her talking with other boys sometimes. It makes him feel so jealous he doesn't know what to do. He told her that she needed to stop talking with those other boys, especially right in front of him! Lillian got upset with him, and they had a huge fight. As they were arguing, Marcus felt so mad that he grabbed her by the arms to get her to listen to him and then threw his book bag across the room. Marcus promised Lillian it would never happen again. He says it was an accident, and he didn't mean to hurt anyone. He just couldn't control himself when he was feeling so angry.

2. Tasneem and Kato

Tasneem and Kato really like each other. Kato loves to play soccer and has hopes of joining a league someday. He has just started to play with a group after many hours of practice over the past few months. He excitedly calls Tasneem to tell her about the first game that he will be playing in. Tasneem is not so sure that she can go but still talks and listens throughout the entire conversation, showing Kato how excited she is for him. Tasneem knows how much the team means to Kato, and wants to support him but Tasneem tells him that she can't come because she has a meeting that night. Kato is disappointed, and wishes that Tasneem would just forget about her meeting and come to the game anyway. But, he knows that the meeting is as important to Tasneem as soccer is to him. Kato tells Tasneem that it would really mean a lot to him if she came to the game, and Tasneem agrees to come to the second half, after her meeting is over. Kato is happy that she can come to the 2nd half and understand that Tasneem also has an important commitment on that same day.

Healthy, Unhealthy, and Warning Signs of Abuse Handout

In a healthy relationship people…

- Treat their partner with respect and fairness
- Support and encourage each other
- Treat each other as equals
- Are honest
- Earn their partner's trust
- Have shared interests
- Also have separate interests and identities
- Try hard to have honest and clear communication
- Enjoy being with each other
- Never hurt their partner physically or sexually

In an unhealthy relationship people…

- Treat their partner disrespectfully and unfairly
- Frequently argue or fight
- Have no shared interests
- Or they do things ONLY with each other – they have no separate friends or interests
- Cheat on their partner
- Don't care about their partner's feelings
- Don't enjoy spending time together

Warning signs of an abusive relationship include…

- One person throws or breaks things during an argument
- One person tries to control what the other person does, who they see, what they wear, or what they say
- One person is often jealous or is overly jealous
- One person hurts the other person physically or sexually
- One person puts the other person down, calls them names or humiliates them
- "Crazy-Making" behavior—this is when one person lies or changes their story, or when they deny or minimize the other person's experience. This behavior often makes the other person feel like they are "going crazy."

Effective Communication Tips Handout

Voice

Make sure the tone of your voice and the volume of your voice are right for what you are saying.

Intent

Know what you want if you are asking for something. What outcomes would be okay with you?

Body Language

Think about what you are saying with your body. Are your arms folded? Are you looking somewhere else? Are you turned towards the person or away from them? It is best when your body language is saying the same thing your words are saying.

Timing

Think about when you are going to ask for something or bring up a difficult topic. Does the other person have the time and energy to devote at that moment?

Approach

Think about how you bring something up. Are you defensive, attacking or angry? Or are you calm and open to hearing the other person's thoughts?

Being Clear

Know what it is you want to say or bring up. Pay attention to word choice, tone of voice, and body language

Effective communication often includes:

- "I" statements ("I think …", "I want …")
- Expressing opinions ("I believe …")
- Saying "No" firmly but respectfully
- Asking for what you want
- Initiating conversations
- Expressing positive feelings
- Expressing appreciation
- Stating your strengths and abilities ("I can …")

Individual Homework – Thinking about Healthy Relationships

1. List 3 things you might say or do if a friend told you that they were feeling scared of their partner.

A) _____

_____

B) _____

_____

C) _____

_____

2. Briefly describe why you chose one of the three qualities from the How I Would Want to be Treated by My Partner in a Relationship worksheet.

_____

_____

_____

_____

_____

_____

3. Describe how you would use one of the Effective Communication Tips listed on your worksheet to bring up a difficult topic with your parents.

_____

_____

_____

Family Homework – Talking about Healthy Relationships (Optional)

PURPOSE: This is a chance to ask someone in your family about relationships and to share beliefs related to sexuality and relationships with each other. It will also give you a chance to get to know one another a little better.

DIRECTIONS: Find a place where you and a trusted adult (parent, guardian, grandmother, aunt or uncle, or adult friend of the family, etc.)—can talk. Set aside about 10 minutes. You will be sharing some questions with the trusted adult that you will both discuss together. During this time, please give full attention to one another.

Before starting the discussion, explain that:

- Both of you are each welcome to say, "That question is too private. Let's skip it."
- What you discuss will not be shared with anyone else, even within the family, unless you give one another permission to share it.
- It's okay to feel silly or awkward and it's important to try to do the homework together anyway.

SHARE AND EXPLAIN the handout "How I Would Want to be Treated by My Partner in a Relationship."

DISCUSS the following questions, by taking turns asking each other the questions. When it is your turn to listen, really try to understand the other person's response.

- Which qualities listed on the worksheet are most important to you in your relationships?
- Which qualities listed do you hope that I would have in a romantic relationship?
- Are there other qualities you think are important that are not listed here? What are they?
- What is one piece of advice you would give someone about how to have a happy and healthy relationship?

Lesson Plan – Navigating Relationships

TOPIC: Navigating Relationships	**TARGET-AGE RANGE:** 9–15	**TIME:** 45 minutes
SUBJECT: Life Skills		
IDEAL NUMBER OF LEARNERS: 40		

WHAT ADVANCE PREPARATION, IF ANY, IS REQUIRED OF THE TEACHER FOR THIS LESSON?

Prepare three pieces of flip chart paper with one of each written on the top:

- Peer/Friend
- Sexual/Romantic
- Family

LEARNING OUTCOMES:

By the end of this lesson learners will be able to:

1) Identify positive and negative factors that influence relationships and how to deal with these. [knowledge]
2) Discuss common elements of positive relationships. [knowledge]

LIFE SKILLS DEMONSTRATED IN THIS LESSON:

1) Critical thinking about the elements of a good friendship.

RESOURCE MATERIALS FOR TEACHER:

- Large picture of a locally popular plant or flower (either hand-drawn on flip chart paper or the chalkboard) showing soil, roots, stem, leaves, petals, sun, rain, etc.
- Flip chart paper—Three pieces prepared as noted above
- Flip chart paper—Two sheets to write brainstorm lists on during introduction
- Markers
- Tape to hang flip chart paper on classroom walls

MATERIALS FOR LEARNER:

- None

Lesson Plan – Navigating Relationships

This lesson is enhanced when learners have the following background knowledge: Content from the International Technical Guidance on Sexuality Education—Key Concept 1 – Relationships; 1.2 – Friendship, Love, and Romantic Relationships

PROCEDURE:

Step 1) 5 minutes

Introduce the lesson by asking learners the following questions:

- Why do people get into relationships?
- What are the different types of relationships that young people find themselves in?

Write responses from learners on flip chart paper.

Step 2) 5 minutes

Display the picture of the locally popular plant or flower. Explain to learners by saying, "Just as there are certain things that keep a plant or flower healthy (sun, water, nutrients from the soil), there are certain things needed to keep a relationship healthy and strong." Ask for an example of something that is necessary for a strong or healthy relationship (e.g. respect) and write it in the picture—such as in the soil, near the roots of the plant/flower, in the sun's rays, or rain drops.

Next explain that there are certain things that can ruin a relationship, just as lack of water or sun can hurt a plant or flower. Ask for an example (e.g. dishonesty) and write it in the picture as well.

Step 3) 15 minutes

Divide the learners into three large groups and give each group a sheet of prepared flip chart paper with one of the headings written at the top. Explain to learners the following directions:

a) Each group gets a piece of flip chart paper with a particular type of relationship noted at the top.

b) Each group should draw a picture of a plant or flower of their choosing on their paper.

c) Next, identify at least 3 things that help make their particular type of relationship successful and write these on the picture.

d) Then, identify at least 3 things that could damage or destroy that relationship and write these on the picture.

e) Lastly, hang the flip chart on the wall when they are finished.

Give learners 10 minutes to complete this activity and use the Teacher's Note further below for reference if you need to share examples of positive factors for healthy relationships.

Step 4) 15 minutes

When all the groups are finished allow some time for learners to move around and look at each other's plants or flowers. Have learners return to their seats and ask them the following questions to process the activity:

- How did it feel to do this activity?
- What did you notice about what the different groups put down as things that keep that relationship healthy?

Lesson Plan – Navigating Relationships

PROCEDURE (CONTINUED):

- Why do you think these things (mention or ask specifically about what the groups identified, such as respect, communication, empathy) are important to healthy relationships?
- How might thinking about relationships in this way affect the relationships you might have or are seeking to build?

*[**Teacher's Note:** You can use any of the following notes to elaborate if needed:*

Positive Factors that Support Healthy Relationships

Respect

- *This is shown through attitudes and behaviour.*
- *The other person must feel valued, worthwhile and important.*
- *Negative criticism, name-calling and ridiculing is destructive.*
- *Useful tools include:*
  - *Being there when needed*
  - *Listening carefully to what is said*
  - *Responding appropriately*

Empathy

- *This means trying to understand another person's position—trying to see situations from the other person's point of view.*
- *This shows a deeper understanding, particularly if communicated back to the other person using different words.*
- *Empathy is different from sympathy.*

Genuineness

- *Being genuine involves being yourself and having positive self-esteem.*
- *Genuineness is shown if verbal and non-verbal behaviour gives the same message.*

Values and attitudes

- *Successful friendships/relationships are often based on the individuals having similar values. Two people will continuously be in conflict if their values about most things differ.*
- *Values can change over time, owing to changing circumstances, etc. This may have an effect on a relationship.*
- *Pressure to change values may jeopardize a relationship. If virginity before marriage is valued, for example, then pressure to become sexually active will harm the relationship.*

Lesson Plan – Navigating Relationships

PROCEDURE (CONTINUED):

Communication

- *Humans communicate verbally and non-verbally. Verbal communication is talking; non-verbal communication is known as body language and shown by listening, smiling, frowning, nodding, body posture, etc.*
- *Communication reveals how one individual feels about another.*
- *Most people tend to spend more time talking than listening.*
- *Listening is a skill that takes time to develop and needs to be practiced.]*

Step 5) 5 minutes

Summarize the lesson by highlighting the following key points:

- No two people are the same. We therefore need to compromise and understand each other's differences for relationships to be successful.
- Many people practice negative behaviors in their relationships.
- Respect, empathy, genuineness, values and communication are all important factors needed to build a good relationship.
- We have to be honest with ourselves and those with whom we have a relationship—say when things are going right and when we are unhappy about something.
- We need to assess our relationships and decide whether they are good or bad for us.

KEY MESSAGES OF LESSON:

1) Respect, empathy, genuineness, values and communication are all important factors needed to build a good relationship.

2) There are many factors that contribute to a relationship being healthy or unhealthy.

ASSESSMENT OF LEARNING OBJECTIVES AT CONCLUSION OF LESSON:

- Teachers can have learners write their names on their picture and collect it for assessment of learning objectives.

HOMEWORK WITH FOCUS ON FAMILY INVOLVEMENT ACTIVITIES:

- None

POSSIBLE ADAPTATIONS:

- Large class size—The teacher can create six groups instead of three groups so that there are two groups focusing on each type of relationship.
- Limited materials/technology—The teacher can use a chalkboard instead of flip chart paper but there would need to be enough room for all groups to draw their pictures.

Source: Life Planning Skills: A Curriculum For Young People in Africa, Botswana Version 2002, Activity 6.2 – Building Healthy Relationships, pages 180–183

Lesson Plan – Taking Care of Your Sexual Health

TOPIC: Taking Care of Your Sexual Health	**TARGET-AGE RANGE:** 9–15	**TIME:** 45 minutes
SUBJECT: Life Skills		
IDEAL NUMBER OF LEARNERS: 40		

WHAT ADVANCE PREPARATION, IF ANY, IS REQUIRED OF THE TEACHER FOR THIS LESSON?

- Identify a health care provider from a local health center or hospital who can speak about the family planning and reproductive health care services available to young people in your country. Use the Guidelines for Teachers in Preparing a Guest Speaker to guide your selection and preparation of this health care provider before they present to your learners. Ideally the speaker can bring samples of birth control methods to show students during class.
- A day prior to the guest speaker's visit, ask learners to write down a question, which will be anonymous, that they have about reproductive health care for the speaker. Collect these questions to use in case the learners are too timid to ask questions directly during the presentation. This is helpful when learners are hesitant to ask questions in front of each other, including for example, if girls are hesitant to do so in front of boys or vice versa.
- If the gender dynamic is such that more is needed to ensure full engagement of both girls and boys, consider separating learners by gender and have the guest speaker address the groups separately.

LEARNING OUTCOMES:

By the end of this lesson learners will be able to:

1) Describe at least three reproductive health care services provided by a local health care provider. [knowledge]

2) Identify at least three reasons why a young person would seek reproductive health care. [knowledge]

LIFE SKILLS DEMONSTRATED IN THIS LESSON:

1) Think critically about reproductive health care available to young people.

RESOURCE MATERIALS FOR TEACHER:

- Guidelines for Teachers in Preparing a Guest Speaker
- Any available information about the reproductive health care services that your guest speaker will be presenting about. This will allow you to respond to questions from your learners after the presentation is over.

MATERIALS FOR LEARNER:

- Taking Care of Your Sexual Health—A Homework Assignment

Lesson Plan – Taking Care of Your Sexual Health

This lesson is enhanced when learners have the following background knowledge: Content from the International Technical Guidance on Sexuality Education—Key Concept 6: Sexual and Reproductive Health – All Topics

PROCEDURE:

Step 1)

The teacher should introduce the topic and reason for this lesson by saying, "Today we will be learning about reproductive health care, which is how to care of our bodies and specifically the parts of our bodies involved with reproduction and sexual behaviors." Ask the learners, "Who can tell me one reason why a young person might need reproductive health care?" Ask for volunteers to share their responses, which may include any of the following:

- They think they might be pregnant and want to take a pregnancy test
- They think they might have an STI and want to get tested for STIs
- They are planning to have sexual intercourse and want to get contraception
- They are planning to have sexual intercourse and want to be tested for STIs
- They want to get tested for HIV
- They want to get contraception for other health reasons.

Step 2) 5 minutes for Steps 1 & 2

Tell learners that you have invited a very special guest to speak to the class today. Introduce your guest speaker; explain what their role is at the health care facility and the name of the health care facility. Explain to your learners that the guest speaker will present for 15 minutes and then there will be time for learners to ask questions Encourage learners to write down any additional questions they may have as the guest speaker is presenting.

Step 3) 15 minutes

Have the guest speaker present about their health care facility and the reproductive health care they provide young people for 15 minutes. If speaker was able to obtain samples, have them display and/or pass around samples of birth control methods as appropriate during their presentation.

Step 4) 15 minutes

When the guest speaker has concluded, ask learners if they have any questions and facilitate a question and answer session for an additional 15 minutes. If learners do not initially have questions, you can start with any of the following questions, if this information has not already been covered in the guest speakers' presentation. Additionally, if you had learners write down questions the day before, use some of those questions now to get the conversation started and to get their questions answered.

Lesson Plan – Taking Care of Your Sexual Health

PROCEDURE (CONTINUED):

Sample Questions for the Guest Speaker:

- At what age can young people access services on their own?
- What are the different types of reproductive health care services you offer and what do these consist of?
- Where is your clinic located? How can a young person get to your clinic location? Is there transportation available?
- What are the costs associated with the services you provide?
- Is everything confidential, meaning no one else can know about it? If not, what is not confidential and why?

Step 5) 5 minutes

Once time has elapsed, ask the learners to thank the guest speaker for their time and sharing their expertise. Ask learners to think of one new thing they learned from the presentation and raise their hands once they have something in mind. Ask for five volunteers to share one new thing they learned with the whole group as a result of the guest speaker's presentation, making sure not to repeat any comments already shared.

Step 6) 5 minutes

Distribute copies of the homework activity and explain the directions and expectations for the assignment with your learners. Explain how the learners should accomplish the task and when it is due to you for credit.

KEY MESSAGES OF LESSON:

1) Taking care of one's sexual health is important for overall well–being.

2) There are community resources that can provide reproductive health care for young people.

ASSESSMENT OF LEARNING OBJECTIVES AT CONCLUSION OF LESSON:

- The homework assignment can be used for assessment of learning objectives.

HOMEWORK WITH FOCUS ON FAMILY INVOLVEMENT ACTIVITIES:

- See Step #6 above for homework assignment.

POSSIBLE ADAPTATIONS:

- Large class size—None
- Limited materials/technology—None

Source: Nicole Cheetham, MHS, Director of International Youth Health and Rights & Nora Gelperin, M.Ed., Director of Sexuality Education & Training, Advocates for Youth, 2015

Guidelines for Teachers in Preparing a Guest Speaker

Here are some questions to consider when both selecting a guest speaker and preparing the guest speaker to present to your class.

1. Is the speaker's information medically accurate?

2. Is the presentation (including method and materials) inclusive of all students' needs?

3. Is there certainty that the speaker does not use fear-based educational techniques?

4. Is the philosophy of the health care facility aligned with your curriculum?

5. Is the material appropriate for use with learners of all races, genders, sexual orientations, ethnic and cultural backgrounds, and learners with disabilities?

6. Are the instruction and materials used in the classroom free from the teaching or promotion of religious doctrine?

7. Is the material free from promoting bias against any person?

Adapted from: New Jersey Department of Education and California Department of Education, USA

Taking Care of Your Sexual Health – Homework Assignment

Your Name: _____ Date: _____

Directions: Complete the following four sections with information about the guest speaker and their organization's sexual and reproductive health services.

Today's speaker represented this organization:

_____

A: List three reproductive health care services that young people can get from this organization:

1) _____

2) _____

3) _____

B: Identify one place where young people can get condoms in your community:

C: Identify one place where young people can get a pregnancy test in your community:

D: Identify one place where young people can get tested for STIs/HIV in your community:

Activity 2: Professional Development Needs and Resources

TOTAL TIME REQUIRED

30 minutes

MATERIALS NEEDED

- ✔ Note cards

RESOURCES NEEDED

- ✔ Professional Development Resources Handout

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Identify two professional development needs and locate resources to support their teaching of sexuality education.

INSTRUCTIONS

1. Explain that now that everyone has had a chance to teach back and that the training is coming to a close, we will take a few minutes to think about needs that you may have and resources that you could use to continue to inform yourselves about sexuality education and reinforce the skills that you have learned during this training.
2. Distribute note cards and ask everyone to reflect on their knowledge and skills related to teaching sexuality education and to write down the top one or two areas that they would like to continue to gain further information/skills.
3. Ask for a few volunteers to share what they wrote.
4. Distribute and review the Professional Development Resources Handout. Briefly review what each resource provides.
5. Ask teachers to turn their cards over and take about 5 minutes to write down at least 3 time bound steps that they will take to gain further information/skills in support of the areas that they identified on the card.
6. Thank teachers and conclude by saying that it is important to reflect on your needs as a teacher and to seek out additional information and support to continue to build confidence and skills for teaching sexuality education. These resources are a first step to providing information and tools for continued learning. You can also find ways to stay in touch and support each other in the future as you work to implement sexuality education in your schools.

Professional Development Resources Handout

Resources:

1. **Advocates for Youth Sex Education Resource Center for Professionals,** located here: *http://www.advocatesforyouth.org/for-professionals/sex-education-resource-center*

   Advocates' Sex Education Resource Center for Professionals provides information and resources for sexuality educators focused on two key areas: lesson plans, curricula and other resources and advocacy facts and tools for helping make the case for sexuality education. While developed for a U.S. audience, many of these materials can be adapted to a country's context and are free and available to all.

2. **Planned Parenthood Federation of America, Inc.,** located here: *http://www.plannedparenthood.org/educators/implementing-sex-education/*

   This website provides tool for teachers in support of implementing sexuality education, program evaluation tools, and additional resources. It provides information on what sexuality education is, why it is important, and how it is effectively implemented.

3. **Rutgers Answer** website, located here: *http://answer.rutgers.edu/page/resources*

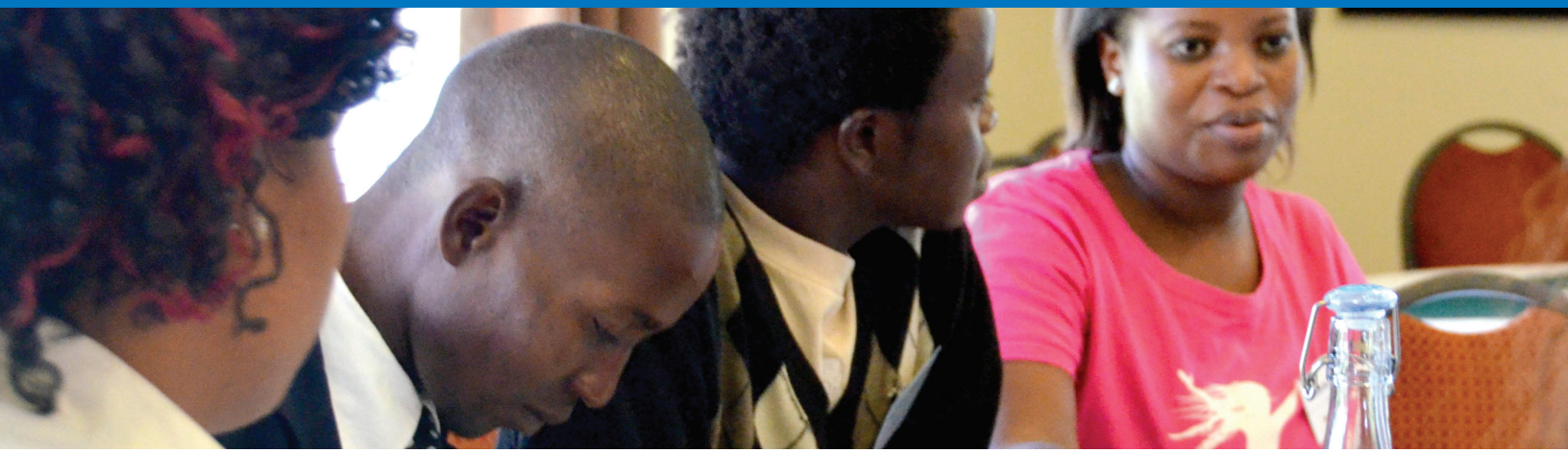
   This website offers resources for purchase for sexuality educators, including online workshops, webinars, lesson plans, and other resources. Geared to a U.S. audience, much of the materials can be adapted to other country contexts.

4. **The Sex Ed Library by SEICUS**, located here: *http://www.sexedlibrary.org/*

   This website serves as a clearinghouse of sexuality education resources, providing links to lesson plans available online from multiple sources. Topics include human development, sexual health, relationships, society and culture, personal skills, sexual behavior, and other resources.

SESSION NINE:

Understanding Human Rights Agreements, Legal, and Professional Ethics



LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Discuss why respect for human rights is essential in CSE and SRH interventions
2. Explore the legal environments in their countries and implications to sexuality education.
3. Acknowledge the importance of being aware of relevant state/provincial and school district reporting laws and procedures relating to student confidentiality and disclosure of sexual abuse, incest, violence, and other associated sexual health issues.
4. Identify where to seek out such laws and procedures.
5. Describe when and from whom to seek guidance on sexuality–related ethical/legal matters when there are no such laws and procedures.
    - Identify potential areas for legal reform and advocacy to support young people access sexuality education
    - Explore the different outcomes for young people as a result of legal frameworks and their impact to CSE and SRH services for young people

ACTIVITIES

Activity 1 International Agreements in Support of Sexual and Reproductive Health and Rights and the ESA Commitment

Activity 2 Know the Law, Policies, and Procedures

Activity 1: International Agreements in Support of Sexual and Reproductive Health and Rights and the ESA Commitment

TOTAL TIME REQUIRED

1 hour

MATERIALS

- Note cards
- Scissors
- Tape
- Flip chart
- Laptop computer
- Projector

RESOURCES

- Leader's Resource on the Agreements
- Note cards with content from the Leader's Resource on the Agreements Activity Sheet cut and pasted on the cards (one piece of information per card) and mixed together in no particular order
- Seven half sheets of flip chart paper each with one of the seven agreements (described in the PowerPoint and in the Leader's resource) written in large letters and hung around the room
- PowerPoint on International Agreements and the ESA Commitment
- Universal Declaration of Human Rights Handout
- Convention on the Rights of the Child Handout

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Describe and differentiate between a core set of international agreements supportive of youth sexual and reproductive health and rights and the ESA Commitment.

INSTRUCTIONS

1. Congratulate teachers on all of their hard work in preparing and delivering sexuality education lessons during the teach back sessions. Thank them also for the attention and feedback shared with their colleagues.
2. Explain that having the strategies and content to teach sexuality education as well as a good sense of how to explain its benefits to others are all critical to being able to deliver sexuality education well in a school setting but that there is one more area that is key and that we have yet to address—policy frameworks and understanding legal and professional ethics.
3. Note that we will start out by taking a quick look at international and regional agreements that provide policy framework that are supportive of sexuality education. It's important to be aware of these instruments grounded in human rights that call for and support the sexual and reproductive health and rights of young people.
4. Take no more than 30 minutes to present the PowerPoint slides on International Agreements and the ESA Commitment.
5. After the PowerPoint, split teachers into groups of anywhere from 5–10 people and provide each group with a set of note cards, split as evenly as possible across the groups, with anywhere from 5–8 note cards per group (there are a total of 50 note cards).
6. Ask teachers to take a look around the room and see the titles of the different agreements noted on flip chart paper. Give them 10 minutes to review their cards and decide under which agreement they should go. Ask them to tape their cards under the appropriate agreement.

Activity 1: International Agreements in Support of Sexual and Reproductive Health and Rights and the ESA Commitment

INSTRUCTIONS (CONTINUED)

7. Call time and ask teachers to take their seats. Begin with the first agreement (preferably in the order in which they were presented on the PowerPoint) and review the content taped under the carton/paper. If there is a card that seems misplaced, ask teachers if there is anything that appears out of place. If someone suggests the misplaced card, ask them to explain why and to relocate it to where they think it belongs. If someone suggests moving a card that is well–placed, that's okay too, but respond as to why the card remains where it is.

8. Continue this process until all the agreements have been reviewed so that the note cards are all placed where they belong.

9. Ask teachers:

- ✔ What was it like to learn about these agreements and to have to identify components of each?
- ✔ Were some agreements more familiar than others?
- ✔ Were any particularly interesting and why?
- ✔ How might these agreements be useful to you in your work to teach sexuality education at school?

10. Distribute handouts of the Universal Declaration of Human Rights and the Convention on the Rights of the Child for teachers to be able to have on hand and refer to, in addition to the ESA Commitment, distributed in Session 3.

11. Conclude by noting that there are many frameworks and agreements and multiple levels that put forward principles and commitments that are grounded in human rights and that call for or support prioritizing youth sexual and reproductive health and rights and sexuality education. Note that it's important to be aware of these agreements as they help make the case for sexuality education and serve to reaffirm the importance of efforts grounded in human rights. The ESA Commitment is particularly timely and relevant as it calls for the delivery of sexuality education in the region.

Leader's Resource on the Agreements

The Universal Declaration of Human Rights (7)

- Adopted by the UN General Assembly on 10 December 1948.
- Emerged as a result of the experience of WWII.
- Considered the foundation of international human rights law.
- Represents the universal recognition that human rights are *inalienable, indivisible, interdependent, and interrelated.*
- Consists of 30 articles.
- First article states, "All human beings are born free and equal in dignity and rights."
- Articles include rights to life, liberty and security, education, to decide to marry, participation, and many more.

Convention on the Elimination of all Forms of Discrimination Against Women (6)

- States that countries shall take all appropriate measures to eliminate discrimination…in particular to ensure, on a basis of equality of men and women…the reduction of female student drop–out rates and the organization of programmes for girls and women who have left school prematurely.
- States that women are entitled to "Access to specific educational information to help ensure the health and well–being of families, including information and advice on family planning."
- States that women have…"the same right to freely choose a spouse and to enter into marriage only with their free and full consent."
- States that women have…"the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."
- Took place in 1979.
- Also known as CEDAW.

Convention on the Rights of the Child (6)

- States that children have the right to get information that is important to their health and well–being.
- States that children have the right to good quality health care—the best health care possible, to safe drinking water, nutritious food, a clean and safe environment, and information to help them stay healthy…
- Took place in 1989.
- It's the **most widely** supported human rights treaty in history.
- The **first** international instrument to include the **full range** of human rights—civil, political, as well as economic, social, and cultural.
- Applies to everyone under the age of 18.

Leader's Resource on the Agreements

International Conference on Population and Development (11)

- Adopted in 1994 in Cairo.
- Member states negotiated the **20-year action plan** to develop a new era of population by 2015.
- The ICPD Programme of Action (also known as the Cairo Consensus) placed the individual needs of men and, especially, women as the single most important factor for governments in determining population and development of policies and strategies.
- Calls for elimination of child marriage and FGM.
- Commits to eliminate adverse effects of poverty on children and youth.
- Pledges to provide equal education opportunities for girls and boys.
- Calls for active youth involvement in the planning, implementation, and evaluation of development activities, including those concerning reproductive and sexual health, including the prevention of early pregnancies, sex education, and the prevention of HIV/AIDS and other sexually transmitted infections.
- Also known as the Cairo Consensus or ICPD.
- In 1999 at the review meeting, governments committed to the protection and promotion of the rights of adolescents, including married adolescent girls, to reproductive health education, information and care.
- In the 1999 review meeting, governments said they should enact legislation and adopt measures to ensure non-discrimination against people living with HIV/AIDS and vulnerable populations, including women and young people, so that they are not denied the information needed to prevent further transmission and are able to access treatment and care services without fear of stigmatization, discrimination, or violence.
- Governments identified provision of, access to, and use of safe and effective family planning and contraception; obstetric care by skilled attendants; and prevention and management of reproductive tract infections, including sexually transmitted infections (STIs) and HIV as especially important for young people.

The Fourth World Conference on Women (6)

- Took place in 1995.
- Otherwise known as the Beijing Conference.
- Ensure equal access to and equal treatment of women and men in education and health care and enhance women's sexual and reproductive health as well as education.
- Include in their activities women with diverse needs and recognize that youth organizations are increasingly becoming effective partners in development programmes.
- Strengthen and reorient health education and health services, particularly primary health care programmes, including sexual and reproductive health, and design quality health programmes that meet the physical and mental needs of girls and that attend to the needs of young, expectant, and nursing mothers.
- The 12th objective in the Platform addresses the girl child.

Leader's Resource on the Agreements

The 2030 Agenda for Sustainable Development (6)

- Adopted in 2015 at the United Nations General Assembly meeting.
- Is the follow-up to the Millennium Development Goals (MDGs), which expired in 2015.
- Contains 17 goals, which will drive development priorities through 2030.
- Goal 3 is Good Health and Well-Being.
- Goal 4 is Quality Education.
- Goal 5 is Gender Equality.

Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African (8)

- Otherwise known as the ESA Commitment on comprehensive sexuality education.
- Adopted in 2013 by the Ministries of Education of 20 countries from East and Southern Africa.
- Seeks to realize a vision of young Africans who are global citizens and who are educated, healthy, resilient, socially responsible, and informed decision-makers.
- Countries committed to ensure access to good quality, comprehensive, life skills—HIV and sexuality education and youth-friendly sexual and reproductive health services for all adolescents and young people, recognizing each country's socio-cultural context.
- Countries committed to initiate and scale up age-appropriate comprehensive sexuality education during primary **school** education to reach most adolescents before puberty, before most become sexually active, and before the risk of HIV transmission or unintended pregnancy increases.
- Countries committed to use agreed international standards, ensure that comprehensive sexuality education is age, gender and culturally appropriate, rights-based and includes core elements of knowledge, skills, and values as preparation for adulthood—decisions about sexuality, relationships, gender equality, sexual and reproductive health, and citizenship.
- Countries committed to wherever possible, make in-school comprehensive sexuality education programmes intra-curricular and examinable,
- Includes targets for 2015 and 2020 related to comprehensive sexuality education implementation and pre and in-service sexual and reproductive health and comprehensive sexuality education training for teachers.

Leader's Resource on the Agreements Activity Sheet

Adopted by the UN General Assembly on 10 December 1948.	Emerged as a result of the experience of WWII.
Considered the foundation of international human rights law.	Represents the universal recognition that human rights are *inalienable, indivisible, interdependent, and interrelated.*
Consists of 30 articles.	First article states, "All human beings are born free and equal in dignity and rights."
Articles include rights to life, liberty, and security, education, to decide to marry, participation and many more.	States that countries shall take all appropriate measures to eliminate discrimination…in particular to ensure, on a basis of equality of men and women…the reduction of female student drop–out rates and the organization of programmes for girls and women who have left school prematurely.
States that women are entitled to "Access to specific educational information to help ensure the health and well–being of families, including information and advice on family planning."	States that women have…"the same right to freely choose a spouse and to enter into marriage only with their free and full consent."
States that women have…"the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."	Took place in 1979.

Leader's Resource on the Agreements Activity Sheet

Also known as CEDAW.	States that children have the right to get information that is important to their health and well-being.
States that children have the right to good quality health care—the best health care possible, to safe drinking water, nutritious food, a clean and safe environment, and information to help them stay healthy...	Took place in 1989.
It's the **most widely** supported human rights treaty in history.	The **first** international instrument to include the **full range** of human rights—civil, political, as well as economic, social, and cultural.
Applies to everyone under the age of 18.	Adopted in 1994 in Cairo.
Member states negotiated the **20-year action plan** to develop a new era of population by 2015.	The ICPD Programme of Action (also known as the Cairo Consensus) placed the individual needs of men and, especially, women as the single most important factor for governments in determining population and development of policies and strategies.
Calls for elimination of child marriage and FGM.	Commits to eliminate adverse effects of poverty on children and youth.

Leader's Resource on the Agreements Activity Sheet

Pledges to provide equal education opportunities for girls and boys.	Calls for active youth involvement in the planning, implementation, and evaluation of development activities, including those concerning reproductive and sexual health, including the prevention of early pregnancies, sex education, and the prevention of HIV/AIDS and other sexually transmitted infections.
Also known as the Cairo Consensus or ICPD.	In 1999 at the review meeting, governments committed to the protection and promotion of the rights of adolescents, including married adolescent girls, to reproductive health education, information, and care.
In the 1999 review meeting, governments said they should enact legislation and adopt measures to ensure non-discrimination against people living with HIV/AIDS and vulnerable populations, including women and young people, so that they are not denied the information needed to prevent further transmission and are able to access treatment and care services without fear of stigmatization, discrimination, or violence.	Governments identified provision of, access to, and use of safe and effective family planning and contraception; obstetric care by skilled attendants; and prevention and management of reproductive tract infections, including sexually transmitted infections (STIs) and HIV as especially important for young people.
Took place in 1995.	Otherwise known as the Beijing Conference.
Ensure equal access to and equal treatment of women and men in education and health care and enhance women's sexual and reproductive health as well as education.	Include in their activities women with diverse needs and recognize that youth organizations are increasingly becoming effective partners in development programmes.
Strengthen and reorient health education and health services, particularly primary health care programmes, including sexual and reproductive health, and design quality health programmes that meet the physical and mental needs of girls and that attend to the needs of young, expectant, and nursing mothers.	The 12th objective in the Platform addresses the girl child.

Leader's Resource on the Agreements Activity Sheet

Adopted in 2015 at the United Nations General Assembly meeting.	Is the follow-up to the Millennium Development Goals (MDGs), which expired in 2015.
Contains 17 goals, which will drive development priorities through 2030.	Goal 3 is Good Health and Well-Being.
Goal 4 is Quality Education.	Goal 5 is Gender Equality.
Otherwise known as the ESA Commitment on comprehensive sexuality education.	Adopted in 2013 by the Ministries of Education of 20 countries from Eastern and Southern Africa.
Seeks to realize a vision of young Africans who are global citizens and who are educated, healthy, resilient, socially responsible, and informed decision-makers.	Countries committed to ensure access to good quality, comprehensive, life skills—HIV and sexuality education and youth-friendly sexual and reproductive health services for all adolescents and young people, recognizing each country's socio-cultural context.
Countries committed to initiate and scale up age-appropriate comprehensive sexuality education during primary **school** education to reach most adolescents before puberty, before most become sexually active, and before the risk of HIV transmission or unintended pregnancy increases.	Countries committed to use agreed international standards, ensure that comprehensive sexuality education is age, gender and culturally appropriate, rights-based, and includes core elements of knowledge, skills, and values as preparation for adulthood—decisions about sexuality, relationships, gender equality, sexual and reproductive health, and citizenship.
Countries committed to wherever possible, make in-school comprehensive sexuality education programmes intra-curricular and examinable.	Includes targets for 2015 and 2020 related to comprehensive sexuality education implementation and Pre and in-service sexual and reproductive health and comprehensive sexuality education training for teachers.

International Agreements and the ESA Commitment

Review of select agreements supportive of youth sexual and reproductive health and rights

Global and Regional Agreements

- The United Nations periodically convenes world summits and conferences as do governments at the regional and national levels
- Such summits and conferences can be catalysts for mobilization
- These meetings also allow leaders to agree on goals and commit to acting to achieve those goals.

How Are International and Regional Agreements Significant?

- While seldom binding, international and regional agreements can set **global and regional expectations** that everyone will work towards certain common goals.
- After a country has signed the agreement, it may face internal and external pressure to make progress on the commitments it has made.
- At the international level, sometimes the UN General Assembly holds special sessions (usually at five-year intervals) to follow-up on UN summits to assess worldwide progress.

Some Key International Agreements and the ESA Commitment

- The Universal Declaration of Human Rights (1948)
- Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW, 1979)
- Convention on the Rights of the Child (CRC, 1989)
- International Conference on Population and Development (ICPD, 1994)
- The Fourth World Conference on Women (Beijing Conference, 1995)
- Transforming Our World - the 2030 Agenda for Sustainable Development (2015)
- Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African (ESA Commitment, 2013)

The Universal Declaration of Human Rights

- Adopted by the UN General Assembly on 10 December 1948
- Emerged as a result of the experience of WWII
- Complements the UN Charter with a road map to guarantee the rights of every individual everywhere
- Considered the foundation of international human rights law
- Represents the universal recognition that human rights are ***inalienable, indivisible, interdependent, and interrelated.***

The Universal Declaration of Human Rights

- Consists of 30 articles
- First article states, "All human beings are born free and equal in dignity and rights."
- Articles include rights to life, liberty, and security, education, to decide to marry, participation and many more.

Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)

- Adopted in 1979
- The **first** international document to address women's rights comprehensively --politically, culturally, economically, and socially as well as within the family.
- The Convention defines discrimination against women as: "any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."
- Although CEDAW does not specifically address youth, several of its articles address the health and educational concerns of young women, including early marriage, too early childbearing, education, and access to reproductive health services.

CEDAW

Includes articles that specifically address:

- Elimination of discrimination, i.e. reduction of female drop-out rates and organization of programs for women and girls whom have left school early
- Access to education for women
- Right to choose a spouse and enter into marriage with free and full consent
- Right to decide freely and responsibly on number and spacing of births with access to information and education to enable women these rights

Convention on the Rights of the Child

- Adopted in in 1989
- The most widely supported human rights treaty in history
- The first international instrument to include the full range of human rights—civil, political, as well as economic, social, and cultural
- In recent years, ratifying nations added two optional protocols--one on children in armed conflict and the other on child prostitution and pornography.
- Applies to everyone under the age of 18, except in countries that legally define adulthood as beginning at an age younger than 18.

Rights of Children

Includes articles that specifically address:

- Right to protection from harm
- Right to quality education
- Right to information for health and well-being
- Right to health care, safe water, food and a clean and safe environment

International Conference on Population and Development (ICPD)

- Adopted in 1994 in Cairo
- Member states negotiated the 20-year action plan to develop a new era of population by 2015
- The ICPD Programme of Action (also known as the Cairo Consensus) placed the individual needs of men and, especially, women as the single most important factor for governments in determining population and development policies and strategies.

ICPD

ICPD pledges the following commitments that are focused on young people:

- Eliminate child marriage and FGM
- Eliminate adverse effects of poverty on children and youth
- Provide equal education opportunities for girls and boys
- Youth participation in all spheres of society including the political process
- Active youth involvement in the planning, implementation and evaluation of development activities, including those concerning sexual and reproductive health

ICPD+5

- In 1999, five years after ICPD, the United Nations General Assembly convened a special session (ICPD+5) to review world progress towards meeting the goals agreed upon at ICPD.
- The Special Assembly reaffirmed the Programme of Action, identified key actions to take, and emphasized commitments to youth.
- Governments committed to the protection and promotion of the rights of adolescents, including married adolescent girls, to reproductive health education, information and care.
- Governments said they should enact legislation and adopt measures to ensure non-discrimination against people living with HIV/AIDS and vulnerable populations, including women and young people.
- Governments identified provision of, access to, and use of safe and effective family planning and contraception; obstetric care by skilled attendants; and prevention and management of reproductive tract infections, including sexually transmitted infections (STIs) and HIV as especially important for young people.

Fourth World Conference on Women (Beijing Summit)

- Adopted in Beijing in 1995
- Focused on increasing opportunities for women and on advancing goals of equality, development, and peace for women.
- Member states put forth a Platform of Action. It outlined strategic objectives to advance the roles of women.
- The 12th objective in the Platform addresses the girl child.

Platform of Action at Beijing

Beijing addresses the following commitments of importance to youth sexual and reproductive health:

- Government partnership with youth organizations and programs focused on women
- Equal access and treatment for women and men in education and health care
- Enhanced women's sexual and reproductive health and and education

Transforming Our World - the 2030 Agenda for Sustainable Development (2015)

- Adopted at the UN General Assembly in 2015.
- Is the follow-up to the Millennium Development Goals, which expired in 2015.
- Contains 17 goals and 169 targets, which will drive development priorities through 2030.
- Is a universal agenda that calls for promoting peaceful societies and global partnerships.

Transforming Our World - the 2030 Agenda for Sustainable Development (2015)

- The preamble references human rights and gender equality.
- Goal 3: Good health and well-being.
- Goal 4: Quality education
- Goal 5: Gender equality

Transforming Our World - the 2030 Agenda for Sustainable Development (2015)

The health and well-being goal (3) includes targets to:

- reduce maternal mortality
- end AIDS
- ensure universal access to sexual and reproductive health-care services, including for family planning, information and education

Transforming Our World - the 2030 Agenda for Sustainable Development (2015)

The gender equality goal (5) includes targets to:

- End all forms of discrimination against all women and girls everywhere
- Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation
- Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African (ESA)

- Otherwise known as the ESA Commitment on comprehensive sexuality education.
- Adopted in 2013 by the Ministries of Education of 20 countries from Eastern and Southern Africa.
- Seeks to realize a vision of young Africans who are global citizens and who are educated, healthy, resilient, socially responsible, and informed decision-makers.

The ESA Commitment on comprehensive sexuality education

- Commits countries to:
  - ***ensure access to good quality, comprehensive, life skills-based HIV and sexuality education (CSE)*** and youth-friendly sexual and reproductive health services for all adolescents and young people, recognizing each country's socio-cultural context.
  - ***Initiate and scale up age-appropriate CSE during primary school*** education to reach most adolescents before puberty, before most become sexually active, and before the risk of HIV transmission or unintended pregnancy increases.
  - ***Use agreed international standards,*** ensure that CSE is age, gender and culturally appropriate, rights-based and includes core elements of knowledge, skills and values as preparation for adulthood: decisions about sexuality, relationships, gender equality, sexual and reproductive health and citizenship.
  - Wherever possible, ***make in-school CSE programmes intra-curricular and examinable.***

The ESA Commitment on comprehensive sexuality education

Includes the following targets:

- **By the end of 2015:**
  - *4.1 A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries*
  - *4.2 Pre and in-service SRH and CSE training for teachers, health and social workers are in place and being implemented in all 20 countries*
- **By the end of 2020:**
  - *4.9 Increase the number of all schools and teacher training institutions that provide CSE to 75%.*

Resources

For more resources on these international agreements and the ESA Commitment, see below:

Advocates for Youth's Brief on International Agreements:
http://www.advocatesforyouth.org/storage/advfy/documents/un_affirming%20_2011_11.pdf
Advocates for Youth's
http://www.advocatesforyouth.org/storage/advfy/documents/policybrief_africanregionalagreements.pdf
Brief on African Regional Agreements: The Universal Declaration of Human Rights:
http://www.un.org/en/documents/udhr/

The Convention on the Rights of the Child:
http://www.ohchr.org/en/professionalinterest/pages/crc.aspx

The Cairo Programme of Action:
http://www.un.org/popin/icpd/conference/offeng/poa.html

The Beijing Platform of Action:
http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf
The ESA Commitment:
http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/HIV-AIDS/pdf/ESACommitmentFINALAffirmedon7thDecember.pdf

Universal Declaration of Human Rights Handout

Universal Declaration of Human Rights

Preamble

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,
Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,
Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,
Whereas it is essential to promote the development of friendly relations between nations,
Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,
Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,
Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,
Now, therefore,
The General Assembly,
Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by

Universal Declaration of Human Rights Handout

teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article I

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3

Everyone has the right to life, liberty and security of person.

Article 4

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Universal Declaration of Human Rights Handout

Article 6

Everyone has the right to recognition everywhere as a person before the law.

Article 7

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9

No one shall be subjected to arbitrary arrest, detention or exile.

Article 10

Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11

1. Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.
2. No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier

Universal Declaration of Human Rights Handout

penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13

1. Everyone has the right to freedom of movement and residence within the borders of each State.
2. Everyone has the right to leave any country, including his own, and to return to his country.

Article 14

1. Everyone has the right to seek and to enjoy in other countries asylum from persecution.
2. This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15

1. Everyone has the right to a nationality.
2. No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16

Universal Declaration of Human Rights Handout

1. Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.
2. Marriage shall be entered into only with the free and full consent of the intending spouses.
3. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17

1. Everyone has the right to own property alone as well as in association with others.
2. No one shall be arbitrarily deprived of his property.

Article 18

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20

1. Everyone has the right to freedom of peaceful assembly and association.
2. No one may be compelled to belong to an association.

Article 21

Universal Declaration of Human Rights Handout

1. Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.
2. Everyone has the right to equal access to public service in his country.
3. The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23

1. Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.
2. Everyone, without any discrimination, has the right to equal pay for equal work.
3. Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.
4. Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Universal Declaration of Human Rights Handout

Article 25

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26

1. Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.
2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.
3. Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

Universal Declaration of Human Rights Handout

2. Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29

1. Everyone has duties to the community in which alone the free and full development of his personality is possible.
2. In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.
3. These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

Convention on the Rights of the Child Handout

UN Convention on the Rights of the Child

In Child Friendly Language

unicef

"Rights" are things every child should have or be able to do. All children have the same rights. These rights are listed in the UN Convention on the Rights of the Child. Almost every country has agreed to these rights. All the rights are connected to each other, and all are equally important. Sometimes, we have to think about rights in terms of what is the best for children in a situation, and what is critical to life and protection from harm. As you grow, you have more responsibility to make choices and exercise your rights.

Article 1
Everyone under 18 has these rights.

Article 2
All children have these rights, no matter who they are, where they live, what their parents do, what language they speak, what their religion is, whether they are a boy or girl, what their culture is, whether they have a disability, whether they are rich or poor. No child should be treated unfairly on any basis.

Article 3
All adults should do what is best for you. When adults make decisions, they should think about how their decisions will affect children.

Article 4
The government has a responsibility to make sure your rights are protected. They must help your family to protect your rights and create an environment where you can grow and reach your potential.

Article 5
Your family has the responsibility to help you learn to exercise your rights, and to ensure that your rights are protected.

Article 6
You have the right to be alive.

Article 7
You have the right to a name, and this should be officially recognized by the government. You have the right to a nationality (to belong to a country).

Article 8
You have the right to an identity – an official record of who you are. No one should take this away from you.

Article 9
You have the right to live with your parent(s), unless it is bad for you. You have the right to live with a family who cares for you.

Article 10
If you live in a different country than your parents do, you have the right to be together in the same place.

Article 11
You have the right to be protected from kidnapping.

Article 12
You have the right to give your opinion, and for adults to listen and take it seriously.

Article 13
You have the right to find out things and share what you think with others, by talking, drawing, writing or in any other way unless it harms or offends other people.

Article 14
You have the right to choose your own religion and beliefs. Your parents should help you decide what is right and wrong, and what is best for you.

Article 15
You have the right to choose your own friends and join or set up groups, as long as it isn't harmful to others.

Article 16
You have the right to privacy.

Article 17
You have the right to get information that is important to your well-being, from radio, newspaper, books, computers and other sources. Adults should make sure that the information you are getting is not harmful, and help you find and understand the information you need.

Article 18
You have the right to be raised by your parent(s) if possible.

Article 19
You have the right to be protected from being hurt and mistreated, in body or mind.

Article 20
You have the right to special care and help if you cannot live with your parents.

Article 21
You have the right to care and protection if you are adopted or in foster care.

Article 22
You have the right to special protection and help if you are a refugee (if you have been forced to leave your home and live in another country), as well as all the rights in this Convention.

Article 23
You have the right to special education and care if you have a disability, as well as all the rights in this Convention, so that you can live a full life.

Article 24
You have the right to the best health care possible, safe water to drink, nutritious food, a clean and safe environment, and information to help you stay well.

Article 25
If you live in care or in other situations away from home, you have the right to have these living arrangements looked at regularly to see if they are the most appropriate.

Article 26
You have the right to help from the government if you are poor or in need.

Article 27
You have the right to food, clothing, a safe place to live and to have your basic needs met. You should not be disadvantaged so that you can't do many of the things other kids can do.

Article 28
You have the right to a good quality education. You should be encouraged to go to school to the highest level you can.

Article 29
Your education should help you use and develop your talents and abilities. It should also help you learn to live peacefully, protect the environment and respect other people.

Article 30
You have the right to practice your own culture, language and religion - or any you choose. Minority and indigenous groups need special protection of this right.

Article 31
You have the right to play and rest.

Article 32
You have the right to protection from work that harms you, and is bad for your health and education. If you work, you have the right to be safe and paid fairly.

Article 33
You have the right to protection from harmful drugs and from the drug trade.

Article 34
You have the right to be free from sexual abuse.Article 35No one is allowed to kidnap or sell you.

Article 36
You have the right to protection from any kind of exploitation (being taken advantage of).

Article 37
No one is allowed to punish you in a cruel or harmful way.

Article 38
You have the right to protection and freedom from war. Children under 15 cannot be forced to go into the army or take part in war.

Article 39
You have the right to help if you've been hurt, neglected or badly treated.

Article 40
You have the right to legal help and fair treatment in the justice system that respects your rights.

Article 41
If the laws of your country provide better protection of your rights than the articles in this Convention, those laws should apply.

Article 42
You have the right to know your rights! Adults should know about these rights and help you learn about them, too.

Articles 43 to 54
These articles explain how governments and international organizations like UNICEF will work to ensure children are protected with their rights.

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QUEEN ALEXANDRA FOUNDATION FOR CHILDREN

Canadian Heritage Patrimoine canadien

Activity 2: Know the Law, Policies, and Procedures

TOTAL TIME REQUIRED

1 hour

MATERIALS

- ✔ To be determined by guest speaker

RESOURCES

- ✔ To be determined by guest speaker, but should include national, state/provincial, and/or school–level policies and procedures of relevance to their presentation and the teaching of sexuality education

LEARNING OBJECTIVES

By the end of this session, teachers will be able to:

1. Discuss why respect for human rights is essential in sexuality education and sexual and reproductive health interventions.

INSTRUCTIONS

1. In advance of the session, invite a resource person to come give a 30 minute presentation to the class on laws and policies that impact the delivery of sexuality education. Ask them to come prepared to share information that would address the following questions:
   - Are there national, state/province, and local/school–level laws and policies regarding what can and cannot be taught in sexuality education? If so, what do they say?
   - Are there national, state, or local sexuality education standards? Where can you find them?
   - Is there a national, state/province, or local curriculum that must be followed?
   - Are there laws or policies about parental involvement in sexuality education that must be followed? Must parents be notified about what will be taught as part of sexuality education?
   - When teaching sexuality education, what are the national, state/province, local/school–level laws/policies related to teacher–student confidentiality? Under what circumstances must a teacher report to law enforcement or a supervisor something a student discloses?
   - Describe a situation in which it might be ethical to report something a student discloses even if no laws/policies exist.
   - Describe a situation in which it might it be ethical to keep a student's confidentiality if no laws or policies exist.
   - When teaching sexuality education what are the national, state/province, local/school–level laws/policies relating to referrals? Can a teacher refer students for sexual health services such as family planning or pre–natal care? HIV/STI testing? Mental health counseling?

Activity 2: Know the Law, Policies, and Procedures

INSTRUCTIONS (CONTINUED)

- When teaching sexuality education, what are the national, state/province, local/school–level laws/policies a teacher must know in order to inform his/her students about their rights and responsibilities related to sexual relationships? Are there age of consent laws? Are there laws relating to the age or marital status a person must meet before they can obtain contraception or have sexual relations? Are there laws about rape, sexual violence, or sexual abuse? And if so what are they? Are there laws about HIV disclosure?
- Are there laws/policies or a code of ethics about how a teacher must or must not behave with students? For example, is it acceptable to flirt or approach a student sexually? Is it acceptable to socialize with students outside of the classroom or on the internet/social media?

2. Explain to teachers that it is important for every teacher to be able to identify, understand and apply laws, policies, standards, and codes of ethics related to the teaching of sexuality education.
3. Introduce the guest speaker.
4. Facilitate a 30 minute question and answer period.
5. Conclude by noting that teaching sexuality education can pose unique ethical and legal challenges for a teacher. This includes, but is not limited to, student disclosure or teacher suspicion of sexual abuse, incest, relationship abuse, or other behaviors that threaten learners' health and well–being. Learners may also disclose sexual activity, pregnancy status, HIV status, sexual abuse, and more. In all instances, it is important for teachers to understand their professional obligations and adhere to national, state/province, and school–level policies that pertain to confidentiality and reporting these types of disclosures.

Teachers may also be presented with situations in which the laws, policies and/or regulations are unclear or lacking. In this case, it is important to have an ethical framework for decision–making to help determine the best course of action where laws or policies are lacking and be aware of any resources that are available to them.

Appendix I: Sample Agenda

The following is a sample 5-day agenda covering core elements of the module. Trainers can use the module to tailor trainings according to the number of days/hours available for training teachers.

Pre-Service Teacher Training on Sexuality Education

Date and Place

Goal

1. To build the capacity of teachers to deliver school-based sexuality education.

Specific Training Objectives:

At the end of this training, teachers will be able to:

1. Describe youth sexual and reproductive health trends and data within the region and country.
2. Define sexuality education, describe its benefits, and counter myths.
3. Locate at least four age-appropriate learning objectives by age range and topic recommended in the International Sexuality Education Guidelines across a range of topics.
4. Contrast and arrange the stages of adolescent development and acknowledge characteristics of healthy adolescent development.
5. Identify the five circles of sexuality and describe at least one component of each circle.
6. Demonstrate awareness of personal values, beliefs, biases, and experiences related to sexuality and acknowledge the importance of not asserting one's beliefs and biases onto learners.
7. Identify and apply at least three principles for effective learning and describe strategies for assessing learning.
8. Develop and apply questions that take learners through the stages of the experiential learning cycle.
9. Characterize commonly used activities and describe at least three techniques for assessment.
10. Identify and demonstrate at least three characteristics of an effective facilitator.
11. Assess potential consequences of disclosing personal information in an educational setting.
12. Practice responding to difficult questions.
13. Assess and reflect on application of modeled sexuality education activities.
14. Acquire an understanding of core content areas of sexuality education, including reproductive anatomy and physiology, adolescent development, puberty, pregnancy, contraception, sexually transmitted infections (STIs), including HIV, supporting people living with HIV/AIDS, gender, harmful traditional practices, relationships, communication, decision-making, and health services.
15. Review and deliver a lesson on sexuality education for learners.
16. Reflect on professional development needs and identify resources for continuing education.
17. Describe laws and policies that impact sexuality education, reflect on why it is important to be aware of these, and identify potential sources for getting more information.

Appendix I: Sample Agenda

Day One

8:30–10:30	**Session One: Introductions and Launch of the Training**
8:30–9:00	Find Someone Who
9:00–10:15	Expectations and Review of Training Goal, Objectives, and Agenda
10:15–10:30	Ground Rules
10:30–1:00	Break
11:00–12:15	**Session Two: Adolescent Sexual and Reproductive Health in East and Southern Africa**
11:00–11:30	Overview of Adolescent Sexual and Reproductive Health in East and Southern Africa
11:30–12:00	Overview of Adolescent Sexual and Reproductive Health in the Country
12:00–12:15	*Stepping Out*
12:15–5:30	**Session Three: Talking about Sexuality Education**
12:15–1:15	Defining Sexuality Education and its Benefits
1:15–1:30	*Stepping Out*
1:30–2:30	Lunch
2:30–3:30	International Technical Guidance on Sexuality Education
3:30–3:45	*Stepping Out*
3:45–4:00	Break
4:00–5:00	Review of Sexuality Education Country Curriculum and Framework
5:00–5:15	*Stepping Out*
5:15–5:30	Daily wrap–up

Day Two

8:30–8:45	Review of first day and today's agenda
8:45–10:45	**Session Three: Talking About Sexuality Education (continued)**
8:45–9:45	Discussion on Social, Cultural, and Contextual Realities and Their Impact on Sexuality Education
9:45–10:45	Debunking Myths About Sexuality Education
10:45–11:00	Break
11:00–4:30	**Session Four: Getting Ready to Teach Sexuality Education**
11:00–11:15	Taking a Trip into Adolescence
11:15–11:30	*Stepping Out*

Appendix I: Sample Agenda

11:30–12:30	Stages of Adolescent Development
12:30–12:45	*Stepping Out*
12:45–1:45	Lunch
1:45–3:15	Circles of Human Sexuality
3:15–3:30	*Stepping Out*
3:30–3:45	Break
3:45–4:45	Values Clarification
4:45–4:30	*Stepping Out*
4:30–4:45	Daily wrap-up

Day Three

8:30–8:45	Review of second day and today's agenda
8:45–12:45	**Session Five: Applying Effective Teaching Methodologies for Sexuality Education**
8:45–10:45	Experiential Learning
10:45–11:00	Break
11:00–12:30	Review of Types of Activities and Assessment
12:30–1:00	*Stepping out*
1:00–2:00	Lunch
2:00–3:00	Facilitation Techniques
3:00–5:30	**Session Six: Knowing Your Content**
3:00–4:00	Reproductive Anatomy and Physiology
4:00–4:15	Break
4:15–5:15	Puberty, Physical Changes
5:15–5:45	*Stepping Out*
5:45–6:00	Daily wrap-up

Day Four

8:30–8:45	Review of the third day and today's agenda
8:45–11:30	**Session Six: Knowing Your Content (continued)**
8:45–9:45	Pregnancy
9:45–10:45	Contraceptive Adverts

Appendix I: Sample Agenda

10:45–11:00	Break
11:00–11:30	Contraceptive Adverts (continued)
11:30–1:00	Sexually Transmitted Infections
1:00–2:00	Lunch
2:00–2:30	*Stepping Out*
2:30–3:00	HIV/STI Transmission
3:00–3:45	Supporting People Affected by and Living with HIV or AIDS
3:45–4:00	Break
4:00–5:00	Gender
5:00–5:30	*Stepping Out*
5:30–5:45	Daily wrap–up

Day Five

8:30–8:45	Review of the fourth day and today's agenda
8:45–12:00	**Session Seven: Classroom Management**
8:45–9:45	Self–Disclosure
9:45–10:45	Answering Difficult Questions
10:45–11:00	Break
11:00–11:30	Answering Difficult Questions (continued)
11:30–12:00	*Stepping Out*
12:00–1:00	Lunch
1:00–4:30	**Session Eight: Application, Practice, and Resources**
1:00–4:30	Teach Backs with Peer Review (with unscheduled break)
4:30–5:30	**Session Nine: Understanding Human Rights Agreements, Legal, and Professional Ethics**
4:30–5:30	Know the Law, Policies, and Procedures
5:30–6:00	Wrap–up and closing

Appendix II: Sexuality Education for Physically, Emotionally, and Developmentally Disabled Youth

INTRODUCTION

In recent years, important changes in public policies and attitudes have resulted in improved opportunities for people with physical and mental disabilities. More and more, people living with disabilities assume their rightful place in society as the equals of non-disabled people. Unfortunately, societal attitudes have changed less in regard to *sexuality* and disability. Even today, many people fail to acknowledge that all people have sexual feelings, needs, and desires, regardless of their physical and/or mental abilities. As a result, many young people who live with disabilities do not receive sexuality education, either in school or at home.

This summary addresses sexuality education for youth who live with physical and/or mental disabilities—including, but not limited to hearing, sight, and motor function impairments; Down syndrome; cerebral palsy; paraplegia and quadriplegia; developmental disorders; and mental health issues. Beginning with a few statistics on disability among youth and an overview of common myths and facts about the sexuality of people living with disabilities, the document also provides general guidelines for sexuality educators working with physically or mentally challenged children and youth.

ARE DISABILITIES COMMON AMONG CHILDREN AND YOUTH?

- Youth with disabilities are amongst the most marginalized and poorest of all of the world's youth.
- UNESCO estimates that 98% of children with disabilities in developing countries do not attend school and 99% of girls with disabilities are illiterate.
- Estimates suggest that there are between 180 and 220 million youth with disabilities worldwide.
- UNESCO estimates 500,000 children every year lose some part of their vision due to vitamin A deficiency.
- 41 million babies are born each year at risk of mental impairment due to insufficient iodine in their mothers' diets.
- For every child killed in armed conflict, three are injured and permanently disabled. 40% out of 26,000 persons killed and injured by landmines every year are children. Over 10 million children are psychologically traumatized by armed conflicts.
- Youth with disabilities face dual disadvantages as individuals with disabilities are more likely to live in poverty.

MYTHS AND FACTS ABOUT SEXUALITY AND DISABILITY[10]

Many people believe myths about the sexuality of people who live with disabilities. Common myths:

- People with disabilities do not feel the desire to have sex.
- People with developmental and physical abilities are child-like and dependent.
- People with disabilities are oversexed and unable to control their sexual urges.[7]

Myth 1: People with disabilities are not sexual. All people—including young people—are sexual beings, regardless of whether or not they live with physical, mental, or emotional disabilities. And, *all* people need affection, love and intimacy, acceptance, and companionship. [6,7] At the same time, children and youth who live with disabilities may have some unique needs related to sexuality education. For example, children with developmental disabilities may learn at a slower rate than do their non-disabled peers; yet their physical maturation usually occurs at the same rate. As a result of normal physical maturation and slowed emotional and cognitive development, they may need sexuality education that builds skills for appropriate language and behavior in public. In another example, paraplegic youth may need reassurance that they can have

Appendix II: Sexuality Education for Physically, Emotionally, and Developmentally Disabled Youth

satisfying sexual relationships and practical guidance on how to do so.[6,7,8,9]

Myth 2: People with disabilities are childlike and dependent. This idea may arise from a belief that a disabled person is somehow unable to participate equally in an intimate relationship. Societal discomfort—both with sexuality and also with the sexuality of people who live with disabilities—may mean that it is easier to view anyone who lives with disabilities as an 'eternal child.' This demeaning view ignores the need to acknowledge the young person's sexuality and also denies her/his full humanity.[6,7,8,9]

Myth 3: People with disabilities cannot control their sexuality. This myth spins off the other two—if people with disabilities are neither asexual nor child-like, then they perhaps they are 'oversexed' and have 'uncontrollable urges'. Belief in this myth can result in a reluctance to provide sexuality education for youth with disabilities. The reality is that education and training are key to promoting healthy and mutually respectful behavior, regardless of the young person's abilities.[6,7,8,9]

GENERAL GUIDELINES FOR PROFESSIONAL SEXUALITY EDUCATORS

Sexuality education materials and programs exist that are designed to meet the needs of youth who live with physical, emotional, and/or mental disabilities. Whether these young people go to public or special school, live at home or in an institution, they need appropriate sexuality education and creative teaching methods. Although these general guidelines will be helpful, content and teaching methods must be particularized to meet the individual's need.

1. Remember that, regardless of the physical, mental, or emotional challenges they face, young people have feelings, sexual desire, and a need for intimacy and closeness. In order to behave in a sexually responsible manner, each needs skills, knowledge, and support.
2. Understand that youth with disabilities are far more vulnerable to sexual abuse than are their peers. Youth who live with developmental disabilities are especially vulnerable. Sexuality education must, therefore, encompass skills to prevent sex abuse and encouragement to report and seek treatment for unwanted sexual activity.
3. Remember that youth who confront disabilities feel the same discomfort and suffer the same lack of information that hampers many of their peers regarding sexuality and sexual health.
4. Learn as much as you can about the disabilities of the populations with whom you work.
5. Be sure that the material addresses boundaries and limits—both setting boundaries and respecting others' boundaries. Rely on role-plays and interactive exercises. Use concrete teaching strategies.
6. Be creative. Develop specialized teaching tools and resources for the youth with whom you work. For example, in working with youth who have developmental disabilities, you may need to use visuals like models, dolls and pictures. For youth with physical disabilities, it may be useful to use stories and examples of others with similar disabilities who have loving, satisfying intimate relationships.

Remember, each young person is unique and may require a specialized program or resources—that is, each adolescent living with a disability is also an individual with individual reactions and needs regarding sexuality education. Thus, this document offers general guidance and should be used with care. It may or may not offer adequate resources to meet the particular needs of an individual.

Appendix II: Sexuality Education for Physically, Emotionally, and Developmentally Disabled Youth

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Appendix III: Additional Resources

Session One:

FoSE. **National Teacher Preparation Standards for Sexuality Education.** *http://www.futureofsexed.org/documents/teacher-standards.pdf*

Session Two: Adolescent Sexual and Reproductive Health in East and Southern Africa

United Nations Educational, Scientific and Cultural Organization (UNESCO) **Young People Today. Time to Act Now.** *http://unesdoc.unesco.org/images/0022/002234/223447E.pdf*

UNFPA. **The Power of 1.8 Billion. Adolescents, Youth and the Transformation of the Future. Sate of the World Population 2014.** *https://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP14-Report_FINAL-web.pdf*

Session Three: Talking About Sexuality Education

Kirby et al. **Reducing Sexual Risk: A Theoretical Guide for Developing and Adapting Curriculum–Based Programs.** *http://pub.etr.org/upfiles/reducing_adolescent_sexual_risk.pdf*

United Nations Educational, Scientific and Cultural Organization (UNESCO), UNFPA, et al. **International Technical Guidance on Sexuality Education, Volumes I and II.** *http://unesdoc.unesco.org/images/0018/001832/183281e.pdf*

Session Six: Knowing Your Content

Advocates for Youth. **Gender Inequality and Violence Against Women and Girls Around the World.** *http://www.advocatesforyouth.org/storage/advfy/documents/gender_bias_fact_sheet_2010.pdf*

Advocates for Youth. **Young People Living with HIV Around the World.** *http://www.advocatesforyouth.org/storage/advfy/documents/young2.pdf*

Family Life And Sexual Health (F.L.A.S.H.) Curriculum of King County. *http://www.kingcounty.gov/healthservices/health/personal/famplan/educators/FLASH.aspx*

UNAIDS. **Getting to Zero in Eastern and Southern Africa.** *http://www.unicef.org/esaro/Getting-to-Zero-2013.pdf*

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Session 8: Application, Practice, and Resources

Advocates for Youth. **Rights, Respect, Responsibility: A K–12 Sexuality Education Curriculum.** *http://advocatesforyouth.org/3rs-curriculum*

Session 9: Understanding Human Rights Agreements, Legal, and Professional Ethics

Advocates for Youth. **Affirming the Rights of Young People at United Nations World Summits and Conferences A Guide for Youth Advocates.** *http://www.advocatesforyouth.org/storage/advfy/documents/un_affirming%20_2011_11.pdf*

Advocates for Youth. **Affirming the Rights of Young People. African Regional Agreements at Summits and Conferences.** *http://www.advocatesforyouth.org/storage/advfy/documents/policybrief_africanregionalagreements.pdf*

International Planned Parenthood Federation. **Exclaim! Young People's Guide to Sexual Rights: An IPPF Declaration.** *http://www.ippf.org/resource/Exclaim-Young-Peoples-Guide-Sexual-Rights-IPPF-declaration*

The Universal Declaration of Human Rights. *http://www.un.org/en/documents/udhr/*

The Convention on the Rights of the Child. *http://www.ohchr.org/en/professionalinterest/pages/crc.aspx*

Appendix III: Additional Resources

The Cairo Programme of Action. *http://www.un.org/popin/icpd/conference/offeng/poa.html*

The Beijing Platform of Action. *http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf*

The ESA Commitment. *http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/HIV-AIDS/pdf/*

Transforming Our World-The 2030 Sustainable Development Agenda. *https://sustainabledevelopment.un.org/post2015/transformingourworld*