SEX EDUCATION WORK WITH YOUNG PEOPLE

THEORY AND PRACTICE

TRAINING AND PRACTICE EXPERIENCE OF MEDICS AT THE SVERDLOVSK OBLAST FAMILY PLANNING CENTRE

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Acknowledgements

In June 1999, I was invited to offer my experience in sex education work with young people in Britain with Russian colleagues at the Sverdlovsk Oblast Family Planning Centre in Ekaterinburg. This post was organised through Voluntary Service Overseas and was to last one year. The progressive view of the centre manager and regional service director enabled me to work with colleagues of other youth services and organisations as their representative. Such training experience and working with young people in Sverdlovsk broadened my scope and understanding of the sex education needs of Russian youth and adults involved in their lives. The experience of developing together with my colleagues a training course for Medics and sharing our ideas resulted in my extending my placement for a further 6 months. This package is the culmination of that work.

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Juliana Slobodian
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SEX EDUCATION WITH YOUNG PEOPLE; THEORY AND PRACTICE

Introduction

This pack results from the training experience of medics and psychology staff at the Sverdlovsk Oblast Family Planning Centre. It is based on concepts of the course "Principles and Practice of Sex Education" delivered by the centre to medics and professionals working with young people across the Sverdlovsk region.

The pack is written from a medical bias concentrating on topics pertinent to the role of a medic. However it is essential that the medical model be placed in the context of the lifestyle requirements of the young person. Hence a **holistic** element is emphasised throughout the material.

Medics are one group of people who may be involved in the lives of young people, if sex education is to be effective, other adults need to contribute to the work, consequently, the pack includes sections on working with teachers and parents.

Sex education work may take place in various settings: formal education classes in schools, informal sessions in youth clubs, and within the medical environment of the clinic. The pack presents various activities and ideas for working in these situations and methods appropriate for both group work and individual consultation.

Using this pack

This pack is intended for the use of medics who currently work in, or propose to embark on teaching sex education to children and young people. It has been devised to provide information and guidance in the theory of sex education work and its delivery in practice with young people. Some concepts and issues are complicated, in these sections the various advantages and disadvantages of particular points and information are highlighted thus allowing the medic to draw their own conclusion and consequences for the work.

Context

Like other areas of Russia the Sverdlovsk region has been affected by a decline in the social and economic conditions associated with a country in transition. The area consists of large industrial towns and small villages that provide various degrees of access (some very limited) to health and social services for the population, and in particular, for young people. The changes in Russian society have impacted upon the relationships and behaviour of young people. The consequences of certain behaviours are evident in the rise of unplanned pregnancies and sexual transmitted infections such as syphilis and chlamydia, which affect both the reproductive and sexual health of this group. The steep increase in HIV and Hepatitis B infections associated with drug use amongst a predominantly young population, may become a significant sexual health issue for their partners. The family planning services are concerned to provide information and education to teenagers and professionals who work with young people in an attempt to address these issues.

International approaches to sex education
Internationally, there is a wide range of sex education available to young people. Sex education ranges from no education to very explicit. Cultural, political and religious considerations affect the type of sex education taught in young people organisations. Many of these beliefs compete and conflict in society.
The six basic types of sex education are:
a. No education = no sex.
The most conservative approach; adolescents are treated as asexual beings

b. Abstinence only.
Conservative approach treats STI prevention and pregnancy as an issue of morality.

c. Abstinence-based.
Practical approach based on medical fact that abstinence prevents pregnancy and STIs.

d. Combination approach.
Promotes abstinence as fact but also acknowledges teen sexuality and discusses most sexual facts about pregnancy and STIs.

e. Reality-based without condom distribution.
More liberal approach talks about sexual activity and promotes postponement, monogamous relationships, and all aspects of 'safer sex', including use of condoms and contraception.

f. Reality-based with condom distribution.
Alternative to unprotected sexual intercourse and distributes condoms on request.

In consultation with Russian medics and teachers, they consider Russia currently promotes approach ©. The majority of these medical professionals would like to achieve an approach in Russia similar to (e).

Why is sex education important?

Without sexual knowledge, unplanned pregnancy and sexual infection transmission is not clearly understood. Sexual secrecy can lead to ignorance and unnecessary risk-taking. Independent research studies show that sex education can prevent risk behaviour and young people have less risky (unprotected) sex after sessions. Sex education does not promote promiscuity; rather, it promotes postponement and 'safer sex' practices. Without sex education programs, adolescents learn glorified sex from the media which promotes entertainment rather than health care.

What is sex education?

Sex education is a term which encompasses the teaching of physical, psychological, emotional, sexual, moral, spiritual, intellectual and social aspects of young people's personal development. It takes into account personal relationships, cultures, beliefs, value systems, attitudes and behaviour.
It involves the exploration of issues, attitudes and skills, and includes:

- Sharing and acquiring knowledge
- Understanding personal sexuality
- Exploring relationships
- Raising awareness of personal attitudes and values
- Practicing skills which promote sexual health and safety
- Building confidence in decision making
- Encouraging respect and empathy for others

What should be taught when?

Sex education is often described by professionals and young people as 'too little too late'. Development of skills and work on attitudes towards family, relationships and lifestyles can be started at a very young age. Work with very young children **does not** contain details of sexual activity but provides a foundation for more sophisticated and sensitive areas during teenage years. In many countries this begins as soon as children enter their school life. The following considerations are vital for any sex education program with children and young people

- The language used is relevant and age appropriate
- Information is prioritised and given in small clear stages; too much information leads to confusion and 'overload'
- The children must be developmentally ready for topics of a personal and sensitive nature; a gradual introduction to intimate subjects is essential

What young people say

Experience of working with Russian young people and carrying out needs assessments with groups from the age of 14 years, highlights their knowledge of the following;

- ❖ basic facts regarding sexual activity
- ❖ some methods of contraception such as the pill and condom
- ❖ how to prevent acquiring a sexual transmitted infection including HIV
- ❖ basic knowledge about anatomy and physical changes at puberty

- ❖ basic information about pregnancy
- ❖ particular values regarding parenthood and family

When asked what they would like to know, young people emphasise the application of the above to their lifestyle and health. They were more concerned about practicalities;

- ♦ Effectiveness and suitability of contraceptive methods for young women "How long can a woman take the pill?"
- ♦ Gender issues "How can a woman make her partner use a condom?"
- ♦ Infections "How does a man or woman know they have an infection and where can you go to get treatment?"
- ♦ Relationships and image "I was first attracted to my girlfriend because she looked sexy. Now I want her to tone down the way she dresses."

The above examples indicate a need for young people to discuss the wider issues related to sex education; often those associated with skills and attitudes although they also identified gaps in their knowledge.

Knowledge, Skills and Attitudes

The aim of sex education is to promote behaviour that prevents transmission of STIs and unwanted pregnancy. Learning the behavioural skills that are needed for prevention forms a major part of the program. If young people are to adopt healthy behaviour what is needed is the motivation to act skills to translate knowledge into practice and positive attitudes. Consequently, an effective sex education program will consider three main areas: knowledge, skills and attitudes.

Knowledge
Information that will help young people decide what behaviours are healthy and responsible includes: ways HIV/STI are transmitted and not transmitted, planned and unwanted pregnancy, anatomy and changes at puberty, contraceptive methods, and local sources of help and advice.

Skill development
The skills relevant to preventive behaviours are: self-awareness, decision making, assertiveness to resist pressure to have sex, negotiation skills to ensure protected sex, and practical skills for effective condom use. These skills are best taught through rehearsal or role-play of real-life situations that might put young people at risk.

Attitudes
Attitudes to sexual relationships, pregnancy and STIs includes: positive attitudes towards delaying sex, personal responsibility, condoms as a means of protection, parenthood, social attitudes such as confronting prejudice, multiple partners, different family systems including single parents, early marriage, divorce, and abusive relationships.

Motivational supports
A well-informed and skilled person needs to be motivated to initiate and maintain safe practices. A realistic perception of the young person's own risk and the benefits of adopting preventive behaviour are closely related to motivation. Discussion with educated peers is effective as well as encouragement from parents who can reinforce the messages of the program.

Assertiveness
Understanding and practicing assertiveness is of particular relevance in sex education. It is basically about valuing and taking responsibility for ourselves, sticking up for our rights, and giving other people the respect that we want for ourselves. The aim is to be able to deal with situations without feeling or being too passive, aggressive or manipulative.

Who teaches sex education?

Significant adults in a young person's life have roles to play in contributing and supporting a sex education program. The personal and intimate nature of this subject creates certain feelings in people and makes discussion difficult. Adults consequently debate who has ultimate responsibility for teaching young people about relationships and sex which may result in young people missing out on vital information altogether.

Parents. They can be regarded as partners in this work by supporting at home a sex education program delivered by a medic or other professional. Further work with parents is outlined on pages…

Teachers. Many areas of the school curriculum provide information and skills development that contributes to a holistic approach:
Literature - discussion about the nature of relationships in books and their comparison with those of contemporary society.
Biology - anatomy and physiology, body changes during puberty, pregnancy and older age.
Moral education - effects of politics, religion, media, and youth culture on the family, society and young people's lifestyles.
Parenthood and family education - many aspects of a sex education program are contained within this subject area.
Further work with teachers is outlined on pages…

Youth workers. Youth workers interact with young people in an informal setting which is conducive to building the kind of relationships that promote a holistic approach to sex education. They tend to work from a young person perspective using opportunities to respond to individual needs as a matter of course during club sessions or on camps. With relevant information, basic training, and knowledge of referral to local medical and support services, youth workers are ideally placed to provide individual and group sex

education programs. Co-working with a medic could provide an ideal combination of skills, knowledge and approaches.

Medics. Medics who have a role in sex education come from a variety of specialisms: gynaecologists, andrologists, paediatricians, venerologists and family doctors. In many countries, trained nurses both in a clinical setting and within young people establishments deliver a significant percentage of sex education work. Medics have the knowledge and information relevant to the physical and medical elements of a sex education program. They have the expertise of contraceptive methods, effects of disease and infection on the body as well as pregnancy and body changes. They specialise in treatment and have access to appropriate medical services. Medics usually see individuals in a clinical setting which relies on clients having the courage to seek support. Those working in the field of family planning are well aware of the consequences of lack of sex education programs with young people and acknowledge the essential role of prevention and health promotion work. As a result, many medics are valuing the role of an 'outreach' specialist that provides vital information to healthy young people in other environments such as schools, camps and youth clubs.

Peers. Trained young people called 'peer sex educators' deliver some sex education programs. The initial barriers to communication often experienced by older professionals may not exist among peers as certain young people relate positively to education from individuals who are similar to them in age and life experience. Peer educators are specialists in education and prevention; they are trained to refer young people to medical specialists for individual consultation and treatment. Medics can provide information on the training courses for peer educators and support the programs by offering specialist consultations for referred young people.

How is sex education taught?

Sex education courses can be categorised into two main types: 'core' programs and 'tailor-made'.
A 'Core' program is a fixed repeated course following the same format with groups having similar characteristics such as age or profession. It will have a limited time lasting as little as one session or up to one full week.
A 'Tailor-made' program is a course designed according to the needs of the group members. It demands prior discussion with members to identify what is important and assess what is required. This course is usually a series of sessions over a period of time.

Sex education programs should be well designed, use a variety of techniques and activities over a consistent period of time, and consist of 6 to 10 sessions.
However, the teaching of sex education programs relies on several factors;

- The environment in which it takes place (clinic, youth club, camp, and school) will impact on the approach, methodology and activities possible.
- The amount of time allocated or negotiated with the establishment for each session and the number of sessions available determines the priority subject areas.

- The skills and comfort level of the medic will determine whether young people are consulted individually or taught in a group. Experience and confidence will determine how the group is taught.
- The size of the group determines the type of approach and activities: workshop (up to 20 people), or seminar (unlimited numbers).
- Sensitive areas of work specific to gender, influences work with single sex groups only. Here, staffing is an issue due to a shortage of trained male specialists in sex education. The reality is that female specialists may have to take on this role with young men's groups.
- Mixed gender groups have advantages and disadvantages. It is often useful for both genders to know how the opposite sex views relationships and associated problems. If activities are well planned young men and women learn together the skills that are important for effective communication and improved relationships. The disadvantages of this arrangement occur when a group is not sophisticated enough to deal with the subject areas, have strong personal feelings that inhibit working, or there is an imbalance of power between the genders.

Working with Staff in Young People Organisations

Young people do not generally attend clinics until they have a personal situation demanding attention or treatment. In order to undertake earlier education and prevention programs, it is vital for medical services to contact establishments and staff that work with young people. This may be happen in several ways

- Schools and youth clubs contact the medic or department and request the work.
- In smaller communities people have personal and professional contacts that make communication easier and general concerns will be shared between them in an informal as well as formal basis.
- In larger towns, networking strategies must be developed to target those organisations that work with young people most at risk. This may involve asking managers and chief doctors to contact the following for information: youth and education services, non-government young people organisations, institutes and colleges.
- The medic requests responsibility from managers to undertake networking as part of the sex education program development.

Meeting with a key staff member

Initial contact is made by telephone and a meeting is arranged with the director or manager of the school or youth club. This meeting has several functions

- Both parties get to know each other.

- To provide a 'contract' in which to negotiate the specifics of the work such as content, amount of sessions etc.
- To discuss resources including whether the work is free or involves any payment.
- To identify a key member of staff who has ultimate responsibility for the program in the establishment, who knows the client group well, and acts as the main contact person for the medic regarding workshops, room allocation and any resources supplied by the establishment.

The following questionnaire highlights useful information and acts as a record of agreement between the two parties.

School/youth club sex education questionnaire

This questionnaire assists the medical service in delivering a program to young people in the school/youth club.

1) Organisation name……...telephone no……
2) Director ……
3) Key member of staff ……...
   Will he/she be attending the sessions? Yes ð No ð
   Year group/age range of young people receiving the program ……..

4) Program details: dates…….no. of sessions……..length per session……..

5) What are the staffs concerns about the young people in the organisation? ……
   …..……
   …….

6) What are the organisation's reasons for wanting a sex education program? ……..
   ……
   ……

7) What resources are available for the work (for example paper, pens, blackboard, large room for workshop)
   ……..

8) What outcome do you hope for from these sessions?
   ……

9) What is the organisation able to contribute financially? ……..

Completing this form can be done as part of the discussion with the staff members with an explanation to explain its purpose.

Policy
A policy provides an outline of the structure and organisation of sex education programs in an establishment. Generally, one lead person takes responsibility for creating a small working party of colleagues and parents who develop and write it. It is then disseminated to a wider audience for further consultation and input to produce the final document.
It is extremely useful because

- Staff and parents know this is a well thought out planned area of work
- It provides a focus that prevents 'anything' from being taught
- Staff, community and parent representatives work together for the benefit of young people
- It supports the establishment should it be questioned about its activities by people external to the organisation.

'Model Framework for a Written Policy Document in Organisations Working with Children and Young People'

Name and type of Organisation
Date of policy
Review date

1. **Description of organisation; (social, environmental details etc)**

2. **Policy Development and Consultation Process.**
   People involved; staff, community leaders, parents
   Statement about the rationale for sex education with children and young people.

3. **Aims and objectives.**
   Overall aim of sex education for children and young people
   What areas are to be taught?
   What children and young people will learn?

4. **Morals and Values Framework.**
   What messages the organisation will encourage it's children and young people to value, promote and respect in each other, society and the organisation community.

5. **Organisation of Sex Education.**
   Name of Co-ordinator responsible for planning and delivery.
   Who will teach it?
   Where and when it will take place.
   Specific arrangements; room, single sex or mixed groups
   Training for staff; meetings or workshops
   Methodology and approaches; HOW it will be taught; activities, discussion, lectures, outside speakers
   Strategies and safeguards; ground rules, confidentiality

6. **Content Headings for the Program.**
   Include a statement about imparting information, developing skills.

7. **Working with Parents.**
   A statement on how the organisation will work with and consult with parents; meetings, workshops or individually

8. **Dissemination of the Policy.**
   Who will receive it?
   How will it be made available?

9. **Monitoring and reviewing the program.**
   What procedures the organisation will use for determing its effectiveness; questionnaires etc

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Rationale for undertaking sex education work:'Why am I doing this?'

From time to time the medic will be asked about the purpose of sex education programs and why she or he is personally involved. This question may be the result of genuine interest on behalf of the inquirer or it may be in the form of criticism. It is extremely useful for the medic to consider their rationale for doing this work prior to such a situation. Inquirers may come from representatives of religious groups, parents, youth and teaching institutions, colleagues, and friends who are often reflecting on information received through the mass media.

Consider information that can be given as responses to questions

- Gather statistics that support there is a problem requiring a structured well planned educational response.
- Use points from the sections 'policy', 'what is sex education?' and 'why do it?'
- Collect information from regional and local strategy to indicate a context for the work.
- Refuse to enter into a personal debate and maintain a calm, professional, work focus.
- Refer persistent enquirers to a manager or appropriate person in authority.

Meetings and workshops with staff

Many staff working with young people feel unskilled and inexperienced when giving advice on personal relationships. Family Planning Centres respond to this by offering core training courses. There is an increasing need to provide basic training to non-medical professionals working in youth clubs schools. In some countries, the main responsibility for delivering sex education work in schools is with trained teachers in partnership with nurses. An initial meeting with a staff member in the establishment provides valuable information about the needs of teachers and youth workers in supporting sex education work.

What staff want to know about sex education can be determined via a questionnaire. It is best distributed and completed prior to the training as medics can pre-plan accordingly. A small response will give a good indication of the needs of the whole group.

Staff workshop questionnaire

Establishment **date**

Please complete the following questions regarding teaching sex education sessions. It will help medics to plan a workshop according to the areas of need in developing or updating the work with young people in your establishment.

Please indicate which of the following is taught in your institution

1. Information and facts

- ❑ Anatomy and physiology
- ❑ STIs and HIV
- ❑ Pregnancy
- ❑ Sexual activity
- ❑ Puberty
- ❑ Contraceptive methods

2. Relationships

- ❑ Different types
- ❑ Marriage and parenthood
- ❑ Assertiveness and dealing with pressure
- ❑ Special relationships and dating
- ❑ Communication skills
- ❑ Delaying sex

3. Attitudes

- ❑ Changes in society and impact on young people's lifestyle
- ❑ Images of relationships and gender roles via media, family, friends
- ❑ Personal and society attitudes towards unplanned pregnancy, abortion, STIs and HIV, different types of family, monogamy and multiple partners, teenagers use of contraception.

4. Which age groups are taught the above?

5. Who teaches it? **How many sessions?**

6. How is it taught-organisation and methods? (individual, mixed or single sex groups, lectures, active learning techniques etc)

7. What areas do you want discussed in the workshop?

- ❑ Information and facts.
- ❑ Skills (how to apply learned facts to risky situations).
- ❑ Attitudes (pressures placed on individuals by media, society etc

8. Is there anything else you would like covered?

Thank you for completing the questionnaire.

The benefits of staff having a workshop or meeting are

- To clarify what sex education is, and is not, and why there is a need for programs with young people.
- To dispel myths and misinformation, and provide information on curriculum areas that is at an appropriate level for non-medical staff.
- To encourage staff to consider their attitudes and experience in the context of changing society and young people's lifestyles.
- To gain support for the programs and provide referral information to medical services.
- To provide a forum for discussion and an opportunity to develop staff confidence.
- To encourage staff to undertake any initial preparation or follow-up work with young people prior to or after sessions with the medic.

The above objectives would be met within a one-day workshop or prioritised for two sessions lasting two hours each. A discussion meeting may be more appropriate if there are time constraints or medics lack experience and skills in training.

The following agenda outlines a meeting with staff. Amendments may be required for certain situations.

Sample agenda for a staff meeting

1. **Introduction** of personnel (medic, staff member responsible for linking with medic, school director etc)

2. **Why have a staff meeting/workshop:**
   Points from the above section, 'rationale for sex education' and 'agenda for parent's meeting.'

3. Description of the program
(If a needs assessment workshop, the following to be determined during the session)

- The aims and objectives.
- The main topics
- The activities
- Materials used
- Total number of sessions and hours.

4. Questions

5. **Where next?**
   What is going to happen as a result of this meeting (for example designing the program or another meeting after the program delivery for feedback)

If funding allows, providing refreshments helps to reduce tension and create a more relaxed atmosphere.

This questionnaire can be used for discussion on defining what is sex education.

SEX EDUCATION

I think sex education is

	Yes	No
Teaching details of the human body		
Teaching young people to enjoy their sexuality		
Preparing young people to have personal relationships		
Reducing the risk of possible exploitation		
Helping young people to gain confidence in communicating with the opposite sex		
Giving young people knowledge of the physical and emotional aspects of relationships		
Teaching young people about responsible sexual behaviour		
Helping young people to build personal relationships in accordance with family values		
Giving knowledge on human reproduction		
Giving fundamentals of healthy family relationships		
Unplanned pregnancy and STIs prevention		
Helping young people to consider ways of expressing their sexuality		
Teaching about HIV and safer sex practices		
Add one more item		

Staff may be resistant to attending training due to the subject raising discomfort or because they believe it is not their job. Occasionally, it is a minor crisis that encourages staff to seek training from medics (for example, a series of unplanned pregnancies among the young women). As with young people and parents, the medic will have to deal with staff defences. The following may help:

- Prior to the session provide basic information about its content. This could be a letter to be read aloud at a staff meeting or a course leaflet. Keep it ‘low key’. This reduces people’s fantasies about what is going to happen.
- In the workshop title use words concerned with relationship and lifestyle issues and avoid direct words associated with sex. Make the wording and title relevant to their profession and client group.
- Provide some indication of what the staff will gain as a result of the workshop.
- Indicate that participants will be discussing professional and not personal issues.

Example of staff leaflet

You are invited to a professional development workshop delivered by (medic's name) of the (medic's clinic).

Are you concerned that young people make healthy choices about relationships?
Do you want to support young people to engage in less risky behaviour?

Relationships and lifestyle issues for young people

Attend this meeting to
Update your information on the aspects and consequences of personal relationships among young people.
Discuss what can be done to improve the situation and how this establishment may contribute.

Venue:
Date:
Time:
Please contact (staff name) for additional details.
This is a professional workshop – staff will not be asked to discuss personal issues.

A Safe Environment

A safe environment is a meeting, workshop or session where leaders enable the participants to feel comfortable about expressing thoughts or admitting to vulnerabilities. This applies not only with staff groups but also with parents and the young people themselves. Certain things can be done to create a safe environment;

- Avoid the need for personal exposure by using the third person and other distancing techniques.
- Use a development approach to increase the safety of sessions; discuss sensitive topics after group introductions and after a few less controversial points have been explored.
- Don't impose your personal agenda – by, for instance, making participants feedback the results of small-group discussions to the whole group if they don't wish to
- Recognise that not everything can be dealt with in these sessions. Provide links to other services or sources of support.

- Create a list of agreements for working together or 'ground rules'.

If two or more sessions are planned, discuss the pros and cons of whether the group will be

- *'Closed'*- a safer group, with a fixed number of known participants regardless of sessional attendance figures.

Or

- *'Open'*- a less safe group, with a fluctuating number and mixture of new and old members each session.

Principles of working together

Ground rules establish a way of group members working together. Sex education arouses strong feelings in people and hence, influences certain behaviours and consequences. The medic at the beginning of the program/session can provide a short list of agreements and ask the group to sanction and add to them, or can do a short brainstorming activity to create a personalised list for each group. It is useful to pose the following:

"If I want to say something in this group, I need to know that members will accept my contribution and behave in a particular manner."

It is then useful to offer an example such as; " Listen to me and not speak as I talk."

This can then be transferred into a general rule about speaking and listening.

It is vital that the group understands what each means and it is essential that the following rules are included

- **Confidentiality (1)** – group members do not divulge personal information about identified other people during the session. This includes clients, other group members, neighbours etc.
- **Confidentiality (2)** – the personal opinions discussed in the session remains the business of the group members only. Information and learning may be used and applied outside the group.
- **Disclosure** – personal experience of a sexual nature is not required for learning in the work. It is also unnecessary to enquire about the personal experience of other group members including that of the medic.

The above are essential for focusing the sessions on educational principles and avoiding sensational and sexual overtones in practise. Should a group member start to personalise matters in the sessions it is essential to remind him/her of these agreements.

The whole list must be manageable and contain a priority of agreements; no more than 6 in total. They can always be reviewed should situations demand something else be added.

Avoid making too many 'don'ts' and try to couch agreements in a positive way.

Language, age and developmental levels must be taken into account when devising agreements with different groups (including staff and parent groups).

The role of staff in the session

The medic may deliver the program alone or with a colleague. However, it is worthwhile considering whether to include a key member of staff from the organisation. This person's role could be as a partner if they have particular experience such as biology

teaching or psychology training. They may have a learning observational role if they lack experience or specific knowledge.

Role	Advantage	Disadvantage
Partner	Multi-disciplinary working. Sharing of different perspective, skills and experience. Ensures a key staff member has relevant training skills and knowledge from medics. Young people have an immediate source of future information in the organisation. Key staff member likely to refer young people to medical services for individual consultation.	Time required pre-planning and preparing sessions. Needs negotiation of who leads which activities. Requires discussion about individual responsibility with the group – who disciplines, which contributes which resources. Demands mutual respect for specific skills and experience.
Observational	Key staff member learns about the subject area and referral possibilities for young people. May learn new information about the lifestyle, behaviour, and attitudes of the client group. May provide useful feedback to medics about the activities and style of the session.	Staff member may be unable to observe without participating and affecting the session. Young people may feel uncomfortable with staff in the room and not contribute. Medics may feel uncomfortable when sensitive issues are discussed.

WORKING WITH PARENTS

Communication between adults and teenagers

Teenage years is a time of life when young people are going through a process of huge physical change which impacts on the individual emotionally and psychologically. As a result, family members are involved in the consequences of such shifts in growth and trauma. This is often experienced as a difficult time for all concerned. The major emphasis for young people is one of leaving childhood behind and struggling to enter the world of adults. It involves risk taking, experimentation, peer group identification, and learning from mistakes. This process is worrying for parents who wish to provide support and protection but experience rejection from their child. Most adults including teachers and medics encounter a struggle with control as young people demand more power for themselves in their relations with them. Anyone who is not part of the peer group and

youth culture may also experience this. Consequently, changes are required in the way adults relate to young people if channels of communication are to remain open.

Participation of Parents and Family Members

The involvement of parents and other family members in programs relating to sexuality benefits both children and parents.

If the program is to make a difference, it needs to receive support from the home. Parents who are involved provide valuable support and motivation for the program and serve as valuable resources for reinforcement of healthy attitudes and behaviours.

A program that involves parents and families:

- Offsets possible resistance in the local area
- Increases knowledge of parents, relatives, and other children in the family.
- Ensures greater acceptance of the program in the community.
- Acknowledged the role of parents and relatives in their child's education and in the development of his or her values.
- Facilitates communication between adults and children in the family.

Although many medics fear opposition by parents, most of them are favourable to sex education programs once they realise the benefits for their children. Many medics are parents themselves and it is useful to consider the issue from this parental experience as well as from the medical perspective. The need for preventive education needs to be explained to them; they need reassurance that sex education does not promote sexual experimentation, but rather protects them from exploitation and makes them aware of the risks involved.

Family units

Delivery of sex education should be in context of family values and positive relationships. Within Russian society, there are different types of family units: single parent families, second or third marriages that brings together children from previous marriages, and unregistered partnerships. Consequently it is vital when working with parent groups and young people to be sensitive to these situations. A percentage of the participants are likely to be living differently from the 'ideal' family unit. Discussing family values without acknowledging these variants in a positive manner may cause offence.

In working with this issue, consider the following;

- Use positive phrases such as 'Most people stay married to the same person all their lives and others chose to do differently'.
- Discuss social and personal attitudes to various family units in a non-biased and sensitive manner.
- Without judgement, consider the advantages and disadvantages of different relationships.

How to involve parents and other family members

Parents concerns about sex education programs can be alleviated with good communication between themselves and the medic delivering the work. Success can be enhanced through considering the following:

- Parents are worried about the welfare of their children. Understand their viewpoint and invite them to discuss issues of protection and reducing risks for their children.
- Be sensitive, use language that will not offend or prohibit them attending a meeting or supporting the work.
- Avoid sexual words or direct reference to sexual activity in written materials.
- Consider alternative titles for the program such as ‘relationships’ or ’personal lives of teenagers’ or ‘becoming adults’.
- Respect them as supportive and contributing partners in this program with their children.
- Accept they may wish the medic to take more responsibility in this ‘specialist’ area.

How can parents be involved?
Contacting parents may require collaboration with other professionals who have already developed good links with them. Consequently the medic may delegate this task to a teacher or youth worker and discuss which of the following may be the best approach

- Parents attend a meeting to discuss the program, look at any materials, and ask questions.
- The medic attends other parent gatherings such as meetings at school and asks for time to talk to them about the program and protection.
- During or following the sessions, parents could be invited to attend a presentation on the work or a short play by young people.
- Parents’ leaflet can be prepared and distributed with information on the issues for young people and advice on how they can best help their children.
- Parents are informed by letter or in a meeting about the program.

Parents and some young people may find it difficult to talk with each other on sexual matters. It is important that they are informed this is a common situation and not made to feel bad about this. Referral services and places of advice and support for young people should be given to parents to suggest to their children.

Sample letter to parents

Dear parent/guardian

We are starting a new educational program on relationships. Your child will learn about aspects of adult relationships and acquire facts and information that will protect him or herself from unwanted behaviours and to keep healthy.

STIs and unplanned pregnancy are a problem in our country, and young people are at risk of these situations. They need information and skills in order to avoid them. Education about these issues does not encourage young people to have intimate relations, rather it makes them realise the risks involved and enables them to make responsible decisions about delaying such behaviour and to protect themselves. Research shows that this kind of education is most effective if given before young people become involved in intimate relationships.

Your interest and support in these activities will be most valuable. If you have any questions about the program do not hesitate to contact me.

Yours sincerely,

(Name of medic and supporting signature of organistion director)

The following agenda outlines a meeting with parents. Amendments may be required for certain situations.

Sample agenda for a parents meeting

1. Introduction of personnel (medic, host of youth organisation, school director etc)

2. The need for a program: 'sex education', 'relationships' or 'becoming an adult'.

Examples of points to use:
- Statistics and sexual health problems amongst young people in the region
- Risks for young people about STIs/HIV, pregnancy.

- Young people have sexual relations despite the recommendations of adults to the contrary.
- Young people need information and skills to avoid infection and unplanned pregnancy.
- Education about sex does not encourage sexual activity rather it makes them realise the risks involved.
- Parents should talk about sex with their children, and the program may make this easier.
- Society has changed and children are exposed early to information whether parents like it or not. It is better they have correct information.
- Sex education for delaying sex and protecting oneself is more effective if given before young people become sexually active.

3. Description of the program

- The aims and objectives.
- The main topics
- The activities
- Materials used
- Total number of sessions and hours.

4. Questions

5. If appropriate, try one young person's activity with the parents

6. Make suggestions how they may interact with their children. If appropriate, do an activity together.

7. Final questions, contact numbers of services and farewells.

The session should be about one and half-hours. It will be necessary to negotiate a break with participants if they request longer. If funding allows, providing refreshments helps to reduce tension and create a more relaxed atmosphere.

Assessment and evaluation of parent meetings

Parent meetings tend to be one session. On-going work may occur where there is a special need and the situation provides the ideal environment; for example, mothers spending time with children in hospital. Most parents cannot dedicate regular time to parents programs on sex education due to other demands and pressures. Consequently

parents needs assessment may have to take place as part of the evaluation process from a previous meeting with another group.
A short questionnaire may be given to early-arrivals at a meeting whilst waiting for others or it could be part of a question and answer section at the end of a meeting.

Examples of assessment-type questions

1. What are parents main concerns about the relationships of teenagers?
2. How can parents, teachers and medics prepare young people for adult relationships?
3. What kind of information and education do young people need?
4. What kind of information do parents need?

Examples of evaluation-type questions

1. What did you find most interesting in the meeting?
2. What will be most useful in your communication with your son/daughter?
3. What would you have liked to know more about?
4. Was there something not particularly useful?
5. Any other comments?

Methods of working with adults

It is feasible to work with parents in the same ways as those with young people and staff groups (see methodologies section). However, consider the following

- Creating an open dialogue and discussion is the main focus.
- The medic is likely to be placed in the expert role and responsibility deferred to her/him.
- Parents may prefer to be passive due to the sensitivity of the subject area. Seminar format is what most will be used to from their school days and institutes.
- Participatory methods may be threatening to them and non-familiar.
- Small group work can reduce embarrassment and be an excellent arena for good ideas and consultation. Splitting the group according to genders or to age may produce good results. Ask first!

Using techniques to create dialogue will more likely result in a two-way discussion. However, all groups respond differently: some will not ask questions whilst others will be keen to participate and demand more than was expected.

Example of a parents' questionnaire

Talking with children about sex

	Yes	Sometimes
I am always frank and honest in answering my children's questions about sex.		
If I feel that my children need information concerning sex or relationships I can always start the conversation with them.		
I always had the opportunity of talking about sex with my own parents.		
I can always think of suitable words for discussing sex with my children.		
Being a parent, I can always discuss and answer my children's questions concerning		
Menstruation		
Contraception		
Abortion		
Sexual activity		
Relationships		
Love		
Sexuality		
HIV		
Rape		
STIs		
Masturbation		
Gay and lesbian relationships		
Anal sex		

At the end of my school life I had enough knowledge about my body.		
I think young people need to know more about sex than I did at their age.		

The following text may be used to create a leaflet for parents.

PARENT'S LEAFLET

It is very difficult for parents and carers to talk to children about the way their bodies work if they're uncomfortable with the subject and vocabulary. It's easy to teach children to wash their hands and face because it's so easy to talk about hands and faces, but not so easy to talk about how babies are made if you can't talk about private parts of the body. The more you talk about these things, the easier it will get.

There are several reasons why we don't talk about these issues with our children:

- We want to preserve their innocence by keeping them ignorant
- We do not recognise them as sexual beings
- We have to deal with our own issues about sex
- We lack knowledge
- We are embarrassed

You may find that some of what follows is not very easy at first. Don't worry. It gets easier as you go along.

DO THE DO'S

DO…

- ✓ **Try** and overcome your own embarrassment about sex.
- ✓ **Offer** opportunities for informal chats – and be supportive.
- ✓ **Compromise** – give and take on both sides makes things much easier.
- ✓ **Negotiate** family ground rules together e.g. coming home at a certain time.
- ✓ **Ensure** your children know about contraception and preventing sexually transmitted infections.
- ✓ **Give** your child the option of someone else to talk to if they do find it difficult to talk to you.
- ✓ **Be sensitive** to unspoken concerns – e.g. the daughter who thinks her breasts are too small or too large.

DON'T THE DON'TS

DON'T

- **Tease** or be sarcastic.
- **Be heavy handed** – it only causes confrontation and makes it much harder to step down.
- **Embarrass or upset** your child by putting them down in front of other people.
- **Hold other young people** up as models of perfection.
- **Be put off** by an initial refusal to discuss things – don't stop offering.
- **Be put off** if cuddles become less frequent or unwanted – Don't stop offering.

As sex educators, we aim to help children to recognise their sexuality, enjoy their relationships as sexual beings, prevent harm from infection and unwanted pregnancy, and provide a positive role model of good parenting.

SEX EDUCATION WORK WITH YOUNG PEOPLE

As discussed in other sections, the medic is ideally placed to deliver sex education programs based on their training and medical experience. However, to be effective in the role as sex educator with young people demands the medic adapt skills associated with their profession. It is essential in a changing society for the medic to 'be in touch' with the client group and learn from them what is an appropriate response to their sex education needs.
One effective way to achieve this is to apply the skills used in individual consultation to the group setting. Therefore a medic not only imparts facts but also facilitates the group members communicating and debating the wider issues associated with relationships and sexual activity.
This section considers the dynamics between medic and client in a clinical setting. Similar processes take place with groups and the same skills are needed to work with them.

Professionals talking to young people in clinical settings

The following is based on experiences of British medics working in clinical settings with young people. It includes the medics perceptions of the ways in which young people communicate, the difficulties encountered and the professional response were probed. In addition to understanding the interaction from the medic perspective, the research sought to identify areas of good practice in communication in clinical settings.

How young people communicate – medic perspective and response

Gender

The vast majority of visitors to family planning clinics are female. Young men who attend come under the guise of accompanying their girlfriend. Young men who do attend regarding their own concerns find it more difficult than women to communicate with medics.

First impressions
The manner in which a young person enters a consultation indicates their level of apprehension. Some attempt to drag in friends, some march in confidently, while others saunter in nonchalantly. Some pull away their chair from the medic while others pull it up close. Expressions range from uncomfortable to distressed, timid and pensive to confident and relaxed. Medics claim they can quickly discern the extent to which a young person is feeling at ease. They constantly observe non-verbal cues, all the while adapting their approach to the perceived level of ease displayed by the young person. Simply by being human and ordinary, a medic can break down initial defences.

Presenting with friends and relatives
Young clients often appear with friends and relatives. Medics report that it is not uncommon for groups of friends to be noisy in the waiting room. The outward display of bravado usually dissipates once inside the consultation room. Medics are careful to deal with this behaviour sensitively since the cause is typically fear and anxiety.

Friends may accompany the young person in the consultation room. They come to provide moral support or listen to the advice, but occasionally may be an enthusiastic mother, keen that her daughter should receive some family planning advice. Medics always ascertain the identity of the supporting person and ensure that the young person is happy for them to stay. Sometimes the presence of a third party hinders the consultation. In this situation, most medics politely ask the supporter to leave.

Showing fear
Young people are often quite anxious, particularly when attending for the first time. This anxiety manifests itself in a number of ways, including both shyness and aggression. Fear is sometimes disguised behind a pseudo-sophisticated, “I know what I want” attitude, or by feigning disinterest.
Medics use several strategies to break down these defences

- Avoid asking probing questions which might push away the young person
- Interpret how the young person might be feeling and reflect this back to them. For instance if a young person looks distressed, you might say “This is difficult for you isn’t it?” If it is inaccurate, the young person can deny it – and the channel of communication is open.
- Gently remind a young person that they can decide what to talk about.
- Where an impending physical examination is the source of anxiety, take care to offer concise explanations and reassure the young person that feeling anxious is common, understandable and acceptable.
- Reassure the young person by reminding them that you have seen and heard about all of problems and are therefore difficult to shock.

Giving false or inconsistent information
It is not uncommon for young people to give inconsistent information. This may stem from a desire to give the ‘right’ answer (e.g.”yes, I use condoms all the time”), in which

case further gentle probing is needed to reveal the truth. However, young people may also be genuinely confused, perhaps due to unfamiliar language. A young person may deliberately withhold the truth, through embarrassment, shame, and fear of being judged or fear of non-confidentiality. Once alerted to inconsistencies, medics have to decide whether to pick up on them. If information is critical to treatment it is unavoidable. Highlighting inconsistencies requires sensitivity if the young person is not to be left feeling humiliated. Sometimes refusal to give information, provision of blatantly false information is not necessarily a sign of non-cooperation. It can be an attempt to remain anonymous. Some medics consider it worth sacrificing the collection of routine data in order to open a channel of communication with a suspicious and anxious young person.

Professional communication skills

Building trust and winning the confidence of young people are important prerequisites to open and honest communication. Several aspects to building trust and rapport are: assurance of confidentiality, avoiding assumptions, acceptance, listening, patience and non-verbal communication (body language).

Assurance of **confidentiality** is considered the most important aspect of working with young people. They need convincing that information will not be passed on to parents or teachers. Asking young people how they think parents might react gives an indication of the degree of parental support.

Accept that young people are having sex and avoid judging them for doing so. It does not necessitate the medic abandon their own value system but it is necessary to confront their own prejudices and judge whether these interfere with consultations.

Unless a young person is convinced that a medic is **listening**, and is genuinely interested, they will ‘switch off’. The ideal is a two-way dialogue in which information and advice is tailored to what the young person wants to know and discuss. This requires patience in providing ample pauses so that the young person can interject with their own thoughts.

The ability to be **patient** is important but must be considered in the light of other things such as queues in the waiting room. However in certain contexts and with certain vulnerable young people there is no substitute for spending time with that young person and slowly encouraging a trusting relationship to develop at a pace dictated by the individual.

Non-verbal communication is important in conveying interest and helping young people feel ‘safe’. Training and experience teaches medics to be aware of the way in which their own non-verbal communication affects the consultation.
Non-verbal communication works both ways: the medic observes the young people, and young people will also be observing the medic. Verbal communication is often less significant than non-verbal. It is the gestures and expressions which are the true

indication of a persons thoughts and feelings. Consequently, any behaviours a medic displays associated with discomfort will be communicated non-verbally to the group or individual. It is worth practicing alone the phrases and language required for the work before undertaking the session with young people!

Features of non-verbal communication

- **Personal distance** – individuals often have a sense of what distance from another person feels comfortable. Should an individual move away, they may be feeling their 'personal space' is being intruded upon, or are uncomfortable about the group situation or the subject being discussed. In a clinical consultation setting, allow the young person to define their own comfortable distance in terms of where they prefer to sit. This will enable better communication possibilities with the medic. In a group situation, if several members appear physically excluded, change the activity to a pairs exercise.

- **Eye contact** – making eye contact with another person indicates the medic is interested in what the young person has to say. Prolonged eye contact may be experienced as intrusive and discomfort will result. Position chairs in a clinical setting such that they are at an angle of about 120 degrees and enable both people to look away when sensitive subjects raise the level of discomfort. Returning to make appropriate eye contact will be easy in this position.

- **Gestures** – are small body movements such as biting nails, wringing hands, playing with hair and fidgeting. They become exaggerated when under stress. When leading a session, it is useful for the medic to be aware of what gestures he or she repeats when nervous and to control them to a degree. Likewise, observing gestures of young people in an individual or group situation will indicate their comfort level with the setting or task. The medic can chose to alter their behaviour or the task accordingly to promote effective communication.
  When people are upset, it is a natural response to physically reach out and touch them. In most situations this is relevant. However, if the subject area triggering the emotion is one associated with physical matters (such as physical or sexual abuse) resist the urge to touch without permission as this may reinforce and not alleviate the painful issue.

- **Expression** – like gestures, expressions present the true picture of how a person thinks or feels about an idea or situation. Should a young person say 'No' to a question but nod their head in agreement, it is the gesture that is likely to be their intention. Similarly, giggling while relating a tragic or painful story is contrary to the words expressed. This may need to be mentioned to the young person. In a group exercise on assertiveness it is vital to point out that a person who smiles while stating 'No' is giving a conflicting message and needs to have the appropriate facial expression to accompany it.

- Closed body positions such as crossing arms and legs often indicate a defensive position presenting a barrier to communication. In a clinical situation it is useful for

the medic to be aware of how they present themselves to the young person as well as noting the position of the young person's limbs. It is not necessary to be over cautious about this as never crossing arms or legs can feel uncomfortable. Relaxed crossing of knees, and feet at the ankles, whilst adopting a natural open position of arms and hands is conducive to good communication.
In a group activity, should the medic notice a person appear physically defended, change their role in it or make a general declaration to the group that the task is optional. The medic may wish to remind them also of optional individual time to talk at the end of sessions.

Verbal communication
Developing skill in the type of questions asked will lead to improved communication and ability to seek out the information required for treatment.

Type of question	Example	Advantage	Disadvantage
Open	Begins with how, when, why, what. 'What kind of relationship do you have with your boyfriend?'	Encourages person to say more than a few words. Useful with non-talkative clients. Builds good client/medic relationship.	Don't use with clients who talk a great deal.
Closed	'You weren't aware of any symptoms until now?'	Clarifies specific information needed by medic and checks out facts given by the client. Useful for talkative clients as it encourages a one-word response.	The question and medic determine information retrieved. Additional vital information can be missed. Does not develop equal communication.
Hypothetical	'How do you imagine a healthy sexual relationship?'	Encourages client to think and talk about an alternative behavioural or sexual scenario to their current one.	
Statements	'You mentioned pain. Tell me more about it.'	Avoids the consultation resembling an interrogation.	
Minimal prompts	'Yes..' 'I see…'	Encourages	Medic must be

		continued talking. Shows the medic is interested.	aware when continued talking is not useful for the consultation.
Praise	'Good idea' 'excellent'	Helps develop trust.	Medic must take care to avoid sounding patronising.

Environment

The environment has an important role in determining the type of methods and activities used. It also impacts on communication between group members and the medic. Often there is no choice of room and the medic works with what is available. However, if a workshop is planned then it is useful to contact the organisation beforehand and negotiate a room with plenty of space and seating to form a circle. The medic may have to adapt the activities should seating turn out to be benches or fixed furniture. Tables and desks need to be moved to provide space for participatory groupwork.

The following table considers implications of the environment on work

Room layout	Advantage	Disadvantage
Desk/table	Provides barrier- improves comfort level. Useful for 'one-off' sessions containing sensitive material and in clinical setting with anxious young person.	Barrier prevents easy and effective two-way communication. Promotes passivity that may result in young people not receiving the information or treatment they need.
Rows of chairs	Allows participants and medic to feel more comfortable because of barriers. Traditional and therefore 'known'.	As above. Can be a significant distance between medic and group. Medic may leave the session feeling members are not interested.
Two chairs, no table	In a clinical setting young person has medic's full attention without physical barrier.	Angle, position and distance of chairs are important. In emotional situations, the medic and young person may feel this is too intimate.

Circle of chairs with central floor space	Medic is part of group-removes sense of 'us and them' leading to open communication. Encourages individual responsibility for participation.	Less known format. Members may feel 'exposed' initially.

Conducting clinical consultations

The shape of the consultation session
There are generally 4 stages to a consultation session

1. **Establishing contact**
   Introductions and expectations from the session

2. **Exploring and discussing the problem**.
   Developing communication and understanding of the issues from a medical and client lifestyle perspective.

3. **Problem-solving**
   Providing information and options for treatment with consequences. Client makes an informed decision in context of facts and personal means.

4. **Exiting from contact**
   Client leaves with understanding of implementing the decision and information regarding any future consultation.

Beginning the consultation
Most medics begin their consultation with a welcoming, friendly smile. They introduce themselves using their first names and give a clear explanation of their professional capacity. At this stage the priority is to ensure that young people understand what is happening and that they are happy with it. Emphasising the confidential nature of the consultation helps to allay initial fears and helps the young person to relax. It is also

useful to acknowledge the embarrassing nature of the subject and to congratulate the young person for having the courage to come to the clinic. The person is now more at ease and the next stage is to determine the problem and the reason for attending. Opening the discussion is a challenge; some ideas to overcome initial anxieties are suggested in the 'showing fear' section.

Taking sexual histories and eliciting other information
Many young people, especially those visiting for the first time, find this an intimidating and embarrassing experience. It is essential to avoid raising the level of anxiety which will make further communication difficult. Good communication during sexual history is therefore essential. Five keys to good communication have been identified.

- **Permission.** Asking permission to take a history. The right to choose is considered to be an important prerequisite to cooperation. More importantly, this demonstrates that the medic respects the autonomy of the young person.
- **Explanation.** Explain the reasons for taking the history and how the information is to be used. Emphasise that the information collected is confidential. Accept that some young people will still give false information because they are concerned about confidentiality.
- **Assumptions.** Try to avoid assumptions about answers likely to be given based on appearance, attitude, family situation, area of the region the person comes from etc. Try to avoid leading questions which will engender biased answers.
- Conversation. Make the procedure as informal and natural as possible. Insensitive questions may lead to a refusal to answer further questions. It is not always necessary to stick rigidly to the history sheet as information is often offered freely during the natural course of discussion. This is gained through experience and confidence.
- **Timing.** Building rapport with a young person before launching into a history decreases the likelihood that the young person will feel alienated during what is regarded by many as a formal and intrusive procedure.

Giving explanations
Young people are eager for information, and those who actually make it through a door of a family planning centre want to use the opportunity to learn as much as they can. Skill is needed by medics in offering information appropriately.

First, the level of detail offered in an explanation to a young person should be tailored to pre-existing levels of knowledge, ability to comprehend and apparent level of distress.

Recognise that a young person may be reticent to ask questions and it is essential to provide a non-threatening environment to encourage questions being asked. Leaflets can back up discussion when young people are shy about asking questions.

Often more intimate questions (e.g. about their own bodies and what is normal) arise only when rapport has been established. Many young clients are concerned about the nature of 'good' sexual activity and quality of their relationships. Medics must treat these questions as equally valid.

Note-taking
Information in clinical settings needs to be recorded. The medic may also need to write notes as part of a group activity. Such activity by the medic may be experienced by the young person or group as an unwillingness to relate with them. Explain to group members why this is required for the work and endeavor to maintain maximum eye contact with people throughout. Reducing the writing to a minimal level and making additional notes after the session allows more time to work with young people in the session. This must be balanced with time constraints for consultations.

Language of the medic
Medics should seek to adapt their language to the level of ease and understanding shown by each individual. Ideally they should aim for a repertoire of language that is accepted and understood by both parties. Both the 'street language' of young people and medical jargon should be avoided, as these risk causing misunderstanding and offence. In establishing this repertoire, medics should be alert to possible misunderstandings and positively encourage requests for clarification of terms. It is easy to talk in vague terms about sexual activity with both parties assuming that they know what the other is talking about and not checking out the reality (some young people will acknowledge the words 'the sex act' but have never had the mechanics explained to them). It is the professional responsibility of the medic to support young people in developing their language and understanding of sexual activity to a level where effective and useful discussion can occur.

Improving treatment outcomes
Consultation sessions require a change in attitudes and behaviour of both people involved; there should be a more equal balance of talk in the session. If medics know more about the young person's situation and concerns, they can identify and clear up client misunderstandings and improve their use and understanding of the treatment methods. For some young people, they may have rare opportunity to attend a family planning clinic due to distance, inaccessibility and the cost involved. It is important to 'get it right' the first time. Young people may have more confidence in a decision that was based on a consideration of their needs and lifestyle and therefore may be committed to following through with their treatment.

4 steps to improvement

- Young people need to consider their options and which best fits their needs.

Medics need to relate information to the young person's individual situation and focus their discussion on what is appropriate and of most interest to the young person.

- Young people need to understand their own needs and priorities

Medics need to encourage young people to make a self-assessment

- Young people need to consider the pros and cons of using and adhering to the method of contraception or treatment

Medics need to provide guidance on the method of use or treatment plan and question the young person's understanding of what is prescribed and its application to their lifestyle.

- Young people need to know when to return and what to do if there are problems.

Medics need to provide complete information including specific details of what problems might occur as a result of the treatment or method.

Additional factors that promote improved clinical consultation sessions
In the waiting area whilst waiting to see a specialist can provide an educational opportunity for young people in the following ways

- Information can be given through leaflets and in a pictorial format for various ages and development levels using posters, cartoons and comics.
- Information about the process of consultation: whom they will see and what will happen- using leaflets, cartoons and diagrams.
- Instructions on how to ask questions of the medic about their health and treatment. How to ask if they don't understand information.
- Display the 'Patient charter of rights'.

These provide information to the young people concerning expectations from the medic, young people, and the style of consultation. It promotes client participation and encourages interactive partnership. These additional considerations help reduce potential tensions and the overall length of time required in the consultation session.

GROUP WORK

Group work may take place with a small number of 3 people to a much larger gathering of 30 or more. For many professionals, talking in a large group setting and working with small groups can be an experience that raises anxiety. The ideas for planning preparation and communication in this pack may help reduce some of the concerns. However, it is practice that will provide confidence and experience!

Confidence with groups
Prior to starting sex education work with young people, it is advisable that the medic identifies their own level of comfort with the subject areas. Completing the form below helps with this. Other ways to reduce discomfort are

- Practice saying aloud the words (for example, terms used by young people to describe private body parts) when alone.
- Record the words into a tape recorder and listen to yourself
- Watch yourself saying them in front of a mirror
- Draw pictures and label them
- Perform all the above with a trusted colleague, friend or partner. Allow yourself to laugh and work through the discomfort.

Comfort with sensitive topics

How comfortable are you in discussing the following topics with young people?

Topic	Very comfortable	Somewhat comfortable	Not comfortable
How HIV is transmitted			
Sexual intercourse			

AIDS			
Condom use			
Delaying sex			
Male sexual organs			
Female sexual organs			
Injecting drug use			
Varieties of sexual behaviour			
Unplanned pregnancy			
Contraceptive methods			
Sexually transmitted infections			

Scoring procedures – comfort level
A high score on each item indicates a high degree of comfort and a low score indicates a low degree of comfort. The following scale should be used to score items (the minimum score is 12, the maximum score is 60).
Very comfortable: **5** *Somewhat* comfortable: **3** *Not* comfortable: **1**

Qualities of the sex educator
Personal attributes and attitude of the medic and the relationship of the medic to young people impact on the enjoyment and effectiveness of sessions. Young people identify those medics who are reluctant sex educators and those who have neither the confidence nor the skill to cope with this topic. The most important attributes are an open, relaxed attitude, a sound knowledge base and a non-shockable demeanor. Young people sometimes prefer 'outside' educators as they can take risks in sessions with people they do not have to see the next day.
Age, gender and position impact on group dynamics and medics must adapt an appropriate role in the group. Older medics face the challenge of showing an appreciation and interest in the culture of young people without compromising their authenticity as adults. Attempting to be fashionable and young may embarrass and patronise young people. Younger educators are likely to become involved in the sexual dynamics of the group, while older medics may adopt a more maternal/paternal role.

Challenges from young people

The classroom atmosphere
Young people may react to sex education sessions in different ways. They may:
- Ask baiting questions (to try to embarrass the educator).
- Remain silent because of embarrassment.
- Shock or try to amuse by describing sexually explicit behaviours.
- Ask very personal questions about your private life.
- Make comment that open themselves to peer ridicule or criticism.
- Dominates the conversation

- Is critical of others; puts other people down, usually to make himself/herself feel superior
- Tells others what to do most of the time
- Often interrupts other people
- Does not participate in group activity
- Chats about things not related to the activity

To deal with these situations it is very important to set group rules. The young people can develop their own or a list could be provided for discussion with young people if they are fair and why they are important. The agreements are better adhered to if written on a large piece of paper (wallpaper) and placed in view during each session.

Suggestions for basic group rules with young people

- No put-downs (negative comments)
- Only one person talks at a time; no interrupting of others
- Everyone has a right to 'pass' (to decline to discuss or disclose a personal issue)
- Keep on the topic; no side discussions on other topics; and
- What you say stays here (information is confidential)

Remember to give full explanations of confidentiality and disclosure.

It is vital that rules apply to both staff as well as participants. Agreeing to prohibit inquiries about personal information protects everyone from disclosure and embarrassment. Young people may be offered the possibility of putting their questions anonymously to the medic. Many young people laugh and giggle about sex. This should be allowed in the beginning, as it lowers the barriers when discussing sexuality.

Ways of dealing with problems in groups

The following strategies may be used to deal with personal questions, explicit language and inappropriate behaviour.

- Respond to statements that put down or reinforce stereotypes (for example, statements that say women are available for sex because of the way they dress) by discussing the implications of such statements.
- Calmly remind young people of the agreed ground rules that apply to all: *"We agreed not to discuss or ask questions about group members personal lives. That includes mine."*
- Be assertive in dealing with difficult situations - for example, "That topic is not appropriate for this session. If you would like to discuss it, I'd be happy to talk to you after the session".
- Avoid being overly critical about answers – so that young people will be able to discuss their opinions openly and honestly.
- Present both sides of a controversial issue. Avoid making value judgements.
- It might be important to have single sex groups for activities that might be embarrassing or where separated groups may function more efficiently.

- If there are disruptions, politely remind the group that there is a task or problem to solve as well as a time limit
- Respond to those who interrupt by saying, "Excuse me. Just a reminder that everyone in the group has a right to speak without being interrupted"
- If the behaviour is so disturbing that it can't be ignored, deal with it in the group. Criticize what is being **said** or **done** (not the person responsible for the disruption or making the disruptive statements). Point out how the behaviour blocks the group from functioning well.
- At the end of the session, lead a discussion on how the group is doing. Try to do this in such a way that feelings are not hurt.
- Complete the activity 'Dealing with behaviour in groups'

Finally, many young people associate a medic wearing a white coat with power and authority. This could create a barrier to effective communication whilst in their school or club environment. The medic must consider the image they wish to portray with young people and the best way to interact with them.

Activity; DEALING WITH BEHAVIOUR IN GROUPS

This activity can be undertaken after discussion on dealing with behaviour in small groups.

1. Place people into groups of 3 or 4. Give each group one of the following situations.

2. The group is to brainstorm solutions for 5 minutes.

3. The group is to decide on the best solution and feed this back to the whole group.

Situation 1
The group has been together for a few sessions now and it is quite clear that Ivan dominates the others. He talks most of the time and when others say something, he does not pay attention.

Situation 2
Katya has been very quiet during the first group meeting. However, suddenly she becomes very critical of the other group members. She made rude remarks to one person in particular but also objected to opinions expressed by the rest of the group.

Situation 3

Michael is a little older than the others in the group because he failed an earlier grade. He tells people in his group what to do and how to do it. No one has objected to what he is doing but you can tell they are not happy about the situation.

Situation 4
Lena is not really interested in the class. When she is in the group she acts 'bored' and seldom makes any suggestions to the group. At other times she tries to talk to someone in the group about something completely off the topic. If others do not join her she becomes disruptive.

Follow-up questions
After each group has fed back, discuss the following questions as a whole group activity:

1. Which 2 of these situations would be the most difficult to deal with? Why?

2. Which of the solutions offered by people here are likely to be the most effective? Why?

3. Discuss ways of reinforcing or supporting someone who is trying to behaviour in a group working on a task.

Helping the anxious young person

- It is helpful for medics to think ahead of how they might respond to young people in the class who believe they may have been exposed to a sexually transmitted infection including HIV or have had unprotected sex. It is important that the medic behaves in such a way that young people who are worried will feel comfortable seeking their advice.
- Responsibility in teaching a sex education program includes learning in advance what help and services are available in the community.
- Medics must listen to the young person without imposing their values, moral judgements or opinions. They must not ask leading or suggestive questions about his or her behaviour.
- They must convey concern for the young person's health and when appropriate, tell the young person that they know of services that can help him/her. The medic can offer to start the process by contacting the one the young person chooses.
- The medic must be aware of the tone in which they speak to the young person and avoid sounding patronising or authoritarian.
- Continue support by being available by telephone during working hours, or if there are more sessions, confidentially *ask* the young person if they need further information or is still concerned about anything related to the conversation.

Giving information and making referrals

Many workers with young people feel they have a particular responsibility to provide accurate information on health issues including the social and psychological aspects. This leads to several pressures:

- A feeling that 'I ought to know' about a whole range of issues
- A need to know that information is correct
- A need constantly to update information

But information is not always available. Views about what is accurate change frequently, as do views about what young people need to know and how they will learn it, which can lead to censorship and confusion.

Specialist health and educational advice sessions and help-lines need to be established locally to support young people learning in these areas.

- Make a checklist of all known contacts likely to be of use
- Make a checklist of books, articles, and leaflets that may be useful and where they can be obtained.
- Practice saying 'I don't have that information today but I will find out for the next session.'
- Create a home task for young people using suggested contacts for discussion at the next session.
- Structure a questionnaire with young people to find out the responses to questions from their peers or family members.
- Invite representatives of outside groups and agencies (STI clinic, health clinic, and so on) to take part in a forum on young people's needs or to speak about their work.
- Use case studies to check participants knowledge, to give practice in finding things out and to illustrate the kind of situations where making a referral is necessary

Case studies: information giving and referall

The following may be used in an adult training session. For example, what is the role of the medic in the following situations, and where else might young people get support? They may also be used for teachers, youth workers and young people themselves to consider where advice and support may be sought.

1. Olga thinks she's pregnant and doesn't know what to do.

2. Lena is going out with Sasha. He used to use drugs a few years ago. Lena is worried that he may have contracted Hepatitis B or HIV when he was sharing needles.

3. Natasha has two small children and finds it hard to make ends meet. She says she can't afford contraception.

Discuss what might happen to standards of confidentiality where more than one agency or a variety of people are involved with a young person. How can confidence be safeguarded?

PLANNING

The process and structures used to pre-plan and organise workshops; meetings and sessions with young people are the same as those with staff and parents groups. The pack highlights differences relevant to each (for example, age, development, experience and lifestyle differences) but the principles are similar. What is suggested in working with these groups can be adapted and transferred to each other.

Terminology of planning programs and delivering sessions

Program

A structured series of sessions that considers all related subject areas and includes all age groups. It sets out theory and practice, overall aims, and time allocated to the various elements.

Session

A well planned lesson focusing on one or more aspects of a particular subject area with one age group.

Plan

A structure of the session that provides activities related to the aim and objective. It considers pace and variety as well as information and teaching points. Facilitators refer to it during the session to maintain focus and good timing.

Aim

A concise summary of what the medic aims to teach.

Objective

A breakdown of the aim into 2 or 3 points focusing on what the young people will learn as a result of the teaching.

Monitoring

Regular consultation with participants to maintain or review the program aim and objectives.

Evaluation

To provide evidence of the program's effectiveness measured against the original and revised aim and objectives.

Method

What types of activities the medic uses to teach the information.

Facilitate

Skills used similar to those in individual consultation that encourage partnership, individual responsibility for learning, promote sensible decision-making and apply facts to individual needs and situations.

Co-facilitate

More than one person is involved in delivering the session. Sharing activities or leading them must be negotiated in the pre-planning stage of a session.

Assessment
As previously stated, assessment is essential for the medic to have a clear understanding of where to begin the work with a particular group of young people. It has a similar function to individual clinical consultation: to find out the problem and provide appropriate treatment, or in this case, educational response.
Purpose of assessment
- Defines group knowledge
- Identifies gaps in learning
- Provides consultation on what young people need to know

Assessment **clarifies**
- Course aims
- Objectives relevant to what young people will learn
- Content of the course and any specific issues for the group

Assessment **creates focus**
- Medic plans what is needed rather than everything or too little
- Medic does not give what the group already knows
- Young peoples experience and skills are utilised for the benefit of the course.

Activity; GROUP REQUIREMENTS AND COURSE PLANNING

Objectives
- To introduce the idea of self-directed learning.
- To gain information from the group for course planning.
- To make the content of the course relevant to as many group members as possible.

Prerequisites Literacy skills

Age group 14 – 16, 16+
This activity could be adapted for 11 – 14 year olds.

Group size Ideally a maximum of 25.

Time needed 30 –45 minutes.

What you need Personal writing materials, paper, pens.

How you do it
- Ask each person to write down privately what she or he would like to learn, know more about or find out during the amount of sessions they have together. Explain to

the group that this might include how the group will operate, ground rules, content or how the group is organised.

- Allow enough time for each person to finish and then move people into small groups of 3 or 4. Have each group nominate a person to act as scribe. The task is now to make a composite set of objectives and to select priorities.

- Have the participants discuss what they would like to set as their own priorities. Emphasise that individuals do not have to read out their private lists unless they choose to do so. The scribe notes all the priorities discussed.

- When the list is complete, ask the group to mark those most mentioned. It is useful to develop a code for topics most mentioned, high priorities, those of lower priority, realistic and unrealistic comments.

- Bring the small groups back together, and ask a volunteer from each group to read out the list. Develop a list of priorities and record them for the whole group. If there seem to be too many put a limit on the amount of priorities.

- Use the lists for planning the rest of the course.

- Keep the lists and refer to them during and at the end of the course as a check that the group is achieving its objectives. Participants keep their own private lists for personal reference during the course.

- At the end of the course have the group and individuals check what has been achieved against their original objectives and priorities.

Monitoring

Monitoring a session provides an indication of how the work is progressing towards the program's main aims and objectives. It is similar to ongoing consultation with a client regarding their treatment plan.

Activity: MONITORING A SESSION

Objectives

- To gain an immediate reaction from participants about a session.
- To check that the unit is meeting the participants' expectations.

- To gain information for further planning.

Prerequisites Participation in the session or unit to be evaluated.

Age group 11 – 14, 14 – 16, 16+

Group size Any size

Time needed 10 –15 minutes.

What you need A copy of *Sentence stems* (see examples below), a pen for each Participant, paper.

How you do it

a. Select four appropriate sentence stems and space them on a sheet.

b. Read out the sentence stems to the participants.

c. Ask each participant to complete the sentences and write them on a sheet of paper. Explain that these sheets will be handed in and they do not have to sign them. Stress that it is important that they be honest with their responses so that a true picture can be gained.

d. Collect the sheets of paper and collate the responses. If the group is having further sessions, they may like to see the collated responses and discuss them.

Examples of Sentence Stems

Right now I feel…
Next session I hope…
The best thing about this session was…
One thing I really liked was…
I wish I could…
I think we could have…
I learnt…
One thing I didn't like was…
I would change…
Next time we…
This unit has been…

Program evaluation
Impact evaluation

By carrying out an impact evaluation study of the program about sex education, the sex educator will be able to:

- Determine whether there have been measurable effects on the young peoples' knowledge, attitudes, skills and behaviour intent as a result of the program.
- Demonstrate to education and health officials, parents and the general public that effective programs can be carried out.
- Make a case for obtaining additional staff, materials or funds.
- Increase the support to the program of teachers, parents and communities.

To measure the impact of the program, the same questionnaire is administered to classes or groups of young people who do not receive the program (control group), before the program starts and after it is completed. A comparison between the experimental and control group will help evaluators decide whether learning is in fact associated with the program or with other outside factors (media, parents, etc). The control group must be similar to the experimental group and close to the numbers of participating in the program. Young people in the control group will receive the program at a later stage. There should be a central collection of the results of questionnaires and reassessment of the program in light of the results.

Results from the pre-questionnaire will give useful indications to the medics about the most common misconceptions or incorrect attitudes, and enable him/her to ensure that these issues are properly covered and given appropriate emphasis.

Session plans for workshops

Workshop sessions demand pre-planning if they are to be successful, lively and professional. A plan takes time and thought and must consider several things:

Focus

- it relates to the overall curriculum topics of the subject
- it has an aim and objectives to keep the session focussed
- a variety of activities and methods to maintain interest and provide different pace
- consideration of skills and attitudinal elements to reinforce important facts and information.

Shape

- an preliminary activity to bind the group and perhaps introduce the topic of the session
- a core section that concentrates on information, skills or attitudes
- an ending activity that closes the session and provides some reflection on its content.

Practicalities

- accessibility to resources and collection of materials
- time allowances for activities
- if co-facilitating, who is leading which activity.

Example of a session plan

Subject Contraceptive methods
Venue School number ()
Date 3rd February 01 **Group** year 9 **Time** 10.00-10.45

Aim: To provide comprehensive information on contraceptive methods relevant for the lifestyle of young people.

Objectives: To introduce all methods of contraception
To consider the pros and cons of consultation versus self medication
To discuss the contraceptive needs of young people in relation to their lifestyle.

Time	Activity	Materials	Facilitator
5 min	Introductory activity; 'contraceptive methods' In pairs write as many small words from the Above in the time allowed. The pair with the most words wins.	Pens, piece of paper	Teacher
10 min	Join with another pair to form 4's. Brainstorm as Many contraceptive methods you know. Feedback from one group. Ask for additions from Other groups. Medic inputs if some missing.	Pen, piece of paper	Medic

5 min	Categorise list. Underline methods that can be Bought in a kiosk/chemist. Circle those that require Medic consultation. Feedback as above.	Pen	Medic
10 min	Whole group-ask why do some methods demand Consultation? Benefits of consultation regarding Certain methods (e.g. pills) and why young people May not do this – cost, access to services etc. Write On board. Discussion – questions/answers.	Blackboard	Medic
10 min	General whole group discussion – what makes Contraceptive methods attractive or unattractive to Young people? What would be their preferred Method? Information regarding methods used by Young people.	Questions to ask group. Leaflets on Condom, pill if available.	Medic
5 min	In circle. Inform next session looking at functions, Use, pros and cons of individual methods. Each person to say; '1 thing learnt in session 'plus 'One thing I would like to know next session'.	None	Teacher

This session outline is confined to one page that allows for focused planning that contains all necessary information. It reduces the amount of written work required.

Session plan outline

Subject……..……

Venue …….

Date ……**Group** (age/adults) ……..**Time** ……..…….
Aim ……

Objectives
…….
…….
…….

Time	**Activity (with instructions)**	**Materials**	**Facilitator**

Curriculum areas

The following guidelines suggest broad topics for inclusion in a sex education program within the age range of 5 to 16. They require the specialist to break down further the finer details of information needed under these headings (an example of this is the topic 'contraceptive methods'). They promote a holistic approach, taking into consideration the social, emotional, psychological and biological factors that affect relationships. Doctors and nurses are likely to use a medical model, and therefore concentrate on the biological aspects; they must take other factors into consideration.

CONTENT AREAS OF A SEX EDUCATION PROGRAM

Ages 5 to 7 years old

- Humans develop at different rates and babies have special needs
- Name parts of the body and understand the concept of male and female

- Personal safety; rights over their body and know the difference between good and bad touch. Develop basic skills to maintain personal safety.
- Communication skills – listening, sharing, discussing
- Different types of family and roles in the family
- Importance of valuing others and self
- Begin to recognise the range of human emotion and ways to deal with these
- Humans move,feed,grow,use their senses and reproduce
- Growth from babies into children and then into adults and that adults can reproduce babies
- Recognise similarities and differences between themselves and their peers

Ages 7 to 11 years old

- Begin to know about and have some understanding of the physical, emotional and social changes that take place at puberty
- Know and understand how changes at puberty affect the body in relation to hygiene
- Know basic biology of human reproduction and understand some of the skills necessary for parenting
- Know there are different patterns of friendship; be able to talk about friends with important adults
- Know that people have different attitudes, values and beliefs that influence their relationship with each other and the environment
- That there are life processes common to all animals
- The main stages of the human life cycle
- How the foetus develops in the uterus

Ages 11 to 14 years old

- Recognise the importance of personal choice in managing relationships so that they do not present risk
- Know HIV is transmitted sexually
- Understand moral values and explore those held by different cultures or groups
- Understand the concept of stereotyping
- Be aware of the range of sexual attitudes and behaviours in present day society
- Understand that people have a right not to be sexually active, know that parenthood is a matter of choice, know in broad outline the biological and social factors that influence sexual behaviour and their consequences
- That living things have structures that enable life processes to take place
- The ways that some cell types, including sperm and ovum, are adapted to their functions
- Human reproduction system, menstrual cycle, fertilisation, and the role of the placenta

Ages 14 to 16

- Understand aspects of the law relating to sexual behaviour
- Understand biological aspects of reproduction
- Consider advantages and disadvantages of various methods of contraception

- Be able to discuss controversial issues – conception, birth, abortion, child-rearing, technological developments; which involve consideration of attitudes, values, beliefs and morality
- Be aware of services that offer support in human relationships
- Be aware that feeling positive about sexuality and sexual activity is important to relationships; understand the changing nature of sexuality over time and its impact on lifestyle- for example the menopause
- Be aware of partnerships, marriage and divorce and the impact of loss, separation and bereavement
- The way in which hormonal control occurs, including the effects of sex hormones
- The medical uses of hormones, including the control and promotion of fertility
- How variation may arise from both genetic and environmental causes; reproduction produces clones
- Basic principles of genetic engineering, cloning and selective breeding

These curriculum areas are guidance indicators for teaching in context of general developmental levels. Medics who know an individual or group well may chose to begin some areas of work earlier or later according to the lifestyle and sophistication levels of the young people. Undertaking some form of initial assessment helps to clarify what is required when.

PRACTICE; DELIVERY OF SEX EDUCATION

Introduction

This section concentrates on the implementation of theory of sex education into practice. Basically, it provides guidance on how to do the work with individuals and groups of young people.
Practice, therefore, can be simply defined as ‘doing’.

The section ‘Content areas on sex education’ provides a holistic view of sex education programs from the age of 5 years old to 16. Medics are most likely to be engaged in delivering certain topics with young people and consequently, the themes highlighted here are; puberty, delaying sexual activity, contraceptive methods and sexual transmitted infections.

Approaches to information giving and teaching

Approaches
There are two main styles in which information is given and learning takes place: **active** and **passive**. Traditional methods of teaching in schools and professional institutes consist of one person facing a group of people in a room or large hall. For example, a conference where a gathering of experts offer their expertise in a field of work to an audience. Similarly, a seminar provides an expert describing an area of personal expertise to a smaller audience. This places the role of an audience member and learner into one of passivity: receiving facts and knowledge from an 'other'. There is minimal interaction apart from, perhaps, questions at the end of the lecture. Many people have experienced this approach of teaching and describe moments of 'switching off' or thinking about personal matters during the lecture.

Another approach used in models of adult learning, has more interactions and described as active. This is based on several principles;

- Adults are experienced in their fields of work and also in life experience.
- The participants on a course have possible areas of excellence that facilitators may not have.
- The combination of this experience and knowledge provides greater awareness, information and opinion than the expertise offered solely by one person.

A **workshop** is the format used to encourage active learning. There are usually one or two facilitators with a group of about 24 members. A circle of chairs replaces desks and rows of seats with a space in the centre to enable participants to communicate with each other. This format may be changed during several activities but the aim of interaction generally remains constant throughout. The role of the group member is to interact via an activity with other group members as part of the process of acquiring knowledge and information. The person contributes to the course with thoughts, ideas and experience and has responsibility for their own learning.
Children and young people are able to participate fully in this approach, developing their skills, thoughts and knowledge through the activities provided by the course or session leaders.

Considerations of approaches

Format	**Active**	**Passive**	**Advantages**	***Disadvantages***
Lecture		✓	Unlimited participants. Easier to prepare and deliver information.	Expertise is with one person
Seminar		✓	Large numbers. More intimate than lecture.	Limited interaction
Workshop	✓		Expertise shared. Learner Responsible for own learning.	Limited number of participants Facilitation skills required. Variety of resources and activities to pre-plan.

Participatory methods (see below)	✓		Fun, interactive, interesting. Acknowledges group expertise and experience.	Medic has to relinquish some power to the experts in the group. As above.
Film/video		✓	Easy to prepare and deliver.	Unless used well, can be entertainment rather than educational.

Disco programs
Many young people enjoy going to discos and clubs. It is a common feature of Russian discos to have a break in the dancing and entertainment is provided via a floorshow. In small towns and young people's camps, this may be replaced with a program of organised party games and competitions whose primary purpose is to entertain but also to present information in a fun way. This approach promotes basic facts to large numbers of young people whilst reducing the embarrassing serious aspect of sex education. Its disadvantage is that there is no dialogue, it provides basic facts without opportunity for clarification, and for some, the information is lost and secondary to the entertainment value. However, it is easily organised, few resources are required (except for imagination and one or two prizes), and all that is needed is a sense of humour and access to a venue.

Teaching methods

Learning about sexual activity, prevention of STIs and unwanted pregnancy cannot be merely the memorisation of new information: the aim of a sex education program is to promote behaviour that prevents unwanted situations with unhealthy consequences and promotes skills and attitudes regarding positive lifestyles.

Participatory methods facilitate the process of discovery and communication between learners. This is important in sex education programs because unless people can be open and honest about their experience, views and fears, it is difficult for them to understand how potential unwanted situations and certain behaviours affects them, and what they can do about it personally. Participatory methods are used to validate the young persons experience and give them confidence, knowledge and skills to question themselves and others, and take action with regard to themselves and others.

Developing the Young Peoples' activities
One of the most important tasks after initial assessment with the young people is to develop activities that suit their needs. Integrate the views of young people, the words they use, and the situations in which they most often find themselves. Some of the activities suggested in this package may be relevant, or they may have to be adapted and rewritten to make them culturally relevant to the day to day life of young people. In particular, the stories and case scenarios must correspond to real risk situations. Consider the following:

Language

- Are words understandable for the reading and developmental level of the children or young people?
- Are sentences short with only one major point?
- Are words used that young people are not familiar with?(it is better to use popular expressions rather than medical terms)
- Could the idea be expressed in simpler terms?
- Are medical terms limited to those that young people need to know?

Scenarios (stories, case studies)

- Are the most common risk scenarios represented, and are they appropriate to the risk situations young people experience (e.g. drinking at parties, sex to prove virility, sex just to please the partner, sex in exchange for small gifts)?
- Will parents and other professionals; teachers, youth workers, approve of the scenarios you have devised?
- Can you include scenarios where condoms are used or discussed?
- Is sexual abuse (unwanted or forced sex) a situation that needs to be presented?
- Are there an equal number of boys and girls in your scenarios?
- Are the young people likely to identify themselves with the characters in the scenarios (this may have negative consequences)?
- Is there urban and rural representation in your scenarios? (if applicable)

Collect resources and materials as part of the planning process before the program begins. It is wise to have a 'toolkit' of additional activities and ideas as back up for when sessions have to be quickly adapted or unexpected needs of the group arise.

The following methods are suggested:

Discussion

Discussions can be held with the whole group but work best when held in small groups. Group discussion stimulates free exchange of ideas, and helps individuals to clarify ideas, feelings and attitudes. Discussion works very well if it follows some kind of "trigger", e.g. a case study, a story.

Questioning

When conducting a group discussion, medics should be aware of the impact of "putting down" a young person's response. By not accepting responses in a positive way, medics may discourage people from answering further questions. Learning points and messages may have to be introduced by the medic if the young people do not raise the issues themselves. Use open-ended questions and be aware of placing your own judgement on the situation through the kind of language chosen. . Avoid closed questions that require a one-word response. Pacing of questions is also important. Young people should be given time to think but questions should be rapid enough to keep the pace of the session lively. Anonymous questions can be written by young people on pieces of paper and placed in a container. Members take these individually for whole or small group discussions.

Brainstorming

Brainstorming is a technique in which every person's response that applies to the subject is acceptable. It is important to not evaluate ideas but to accept everything and record each idea on the blackboard or piece of paper. Young people need to know that they will not have to justify or explain any answer, that it demands freeflowing of thoughts and therefore spelling and grammar are not a priority. After a period of time (which should not be too long), time for reflection or prioritising of the list should be allowed. Brainstorming is effective for:

- Sensitive and controversial issues that need to be explored.
- Encouraging people who are hesitant to enter a discussion.
- Gathering a lot of ideas quickly.

Before the activity it is useful for the group to identify a 'scribe' and if appropriate, someone to feed back verbally to the whole group.

Role-play
Role-play involves presenting a short spontaneous play which describes possible real-life situations. In role-play, we imitate someone else's character. This is often easier than having to express our own ideas and feelings.

Role-play is a very effective technique but also a difficult one to master. The following points may help you make this method more effective:
- Select volunteers who are outgoing and enthusiastic.
- You could involve yourself in one of the roles.
- Give young people a case study, some lines or script to get them started.
- Use 'props'- hats, cards with names on, etc.
- Use humour if possible.
- Pair people in the group and have each one play a role, e.g. a father and a son. This will eliminate embarrassment of being in front of the class.

When watching a role-play, give the audience a task e.g. to comment on the response of a certain character and to offer another option. The task of observing prevents a 'free for all' in other people's role-plays, promotes thinking, and provides an opportunity for discussion of the subject.
It is vital that character names are not associated with someone in the group and that distancing techniques (e.g. unrelated questions or physical movement activities) are used afterwards to encourage a return to reality after the role-plays have been presented.

Case study/situation
A case study is a fictional story that allows people to make decisions about how the person should act or respond and what the consequences of their actions might be. Case studies allow the young people to discuss someone else's behaviour and, therefore to avoid revealing personal experiences that might be embarrassing or inappropriate for them to do so.

The case study can be open-ended; that is, the ending of the story may be missing. It is up to the young people to decide on all possible conclusions and the consequences and to finally decide on what would be the best ending for the situation.

Group work

Many activities can be done in small groups. The following points are useful to consider:

- Start with pairs or groups of three or four. This tends to be less threatening for people. As confidence builds, the medic can make the groups larger.
- Vary the methods of forming groups as much as possible and make sure the young people work with different group members to avoid 'cliques' and potential negative behaviours. It is best not to let young people form their own groups. Those who are not selected will feel unwanted.
- Try giving group responsibilities e.g. scribe, time keeper, keeping the group on their task, presenter of the group's work etc.
- Emphasise that all members must contribute to the assigned task. The group's success depends on the individual contribution of each member.
- It may be important at times to use groups where the genders are separated rather than mixed.

Cards

Cards are made consisting of facts and information. Words can be drawn on larger pieces of paper for whole group activity ('HIV game'), or smaller pieces ('contraceptive methods') for either individual or small group work. Card games are useful for

- Finding out the level of information known and imputing gaps in knowledge.
- To reinforce information recently given on a subject.
- Interaction and fun

Drawing

Young people can be asked to sketch their impressions of a situation or draw a message regarding information or behaviour. Creating cartoons and posters often produces some useful and useable pieces of work. Some people feel comfortable using this medium whilst others are resistant due to an 'inability' to draw. It is useful to initially produce a creation of your own to demonstrate that ability is less significant than the message required!

Physical/active games

These games provide an alternative way of young people making a statement about facts, thoughts and ideas on a subject. In this situation a room with adequate space is needed for the group to move around. An example of this type of activity is 'Change places'.
Games are used as

- **Icebreakers** – activities that enable members of a group to get to know each other. To release tension at the beginning of a session where the topic is sensitive.
- **Energisers** – to increase the level of energy within the group when members are appearing sleepy!
- **Warm-up** – when the session is taking place in a cool room and the temperature affects the work of the group.

Consideration of individual methods

Method	Advantages	Disadvantages	Planning
Discussion	Encourages all members to contribute, exchange of ideas	Some members dominate, others are silent	Medic to ensure different points of view are expressed
Questioning	Encourages thinking from various perspectives	Members may not be forthcoming	Use of variety of types of questions. Medic may have to pre-write some.
Brainstorming	Acknowledges value of individual contribution. Work on facts, attitudes, and moral dilemmas.	Requires prior planning. Medic unable to use material provided by group.	Medic decides what areas is to be a priority before the activity. Resources and group member roles needed.
Role-play	Fun, enjoyable, visual. Practice skills needed for situations and options for consequences. Audience has observational role.	Some may dislike acting. Audience can lose role and become involved in acting. Medic needs to work with 'here and now' of the situation.	Trigger points required. Medic needs to pre -consider teaching points for discussion afterwards.
Case study	Focuses members on particular aspects of situations. Encourages discussion of dilemmas and consequences from 'a distance'.	None	Situations need to be created and written in context of young people's lifestyle.
Pairs work	Useful for introduction activity. Easier to talk with one person.	Feedback from pairs in whole group is time consuming.	Prioritise the task to 2or 3 discussion points maximum.
Small group work	Easier for members to contribute and exchange ideas. Useful where there are specific behavioural difficulties in the group.	Space for groupings needed.	Materials must be prepared beforehand. Organisation of groups and roles for members. Medic will have to circulate amongst groups to maintain task and deal with questions.
Whole group	Development of communication skills in larger setting. Easier to prepare activity.	Members may not all contribute. Turn taking can be time consuming and interest is lost.	Materials used must be larger than small group work. Facilitation skills required to engage all members.
Cards	Practical. Fun. Adaptable. Demands thinking and negotiation skills. Used for assessment, reinforcing previous teaching.	Sufficient materials required.	Designing of cards with purpose in mind. Resources to produce them. Demonstrate and describe the task before giving out materials.
Drawing	Fun, individual or group. Often produces useable materials for peer education.	Members may not feel comfortable with their lack of skills. Resources required.	Collection of adequate resources.
Physical/active games	Energises. Provides experiential learning. Play can be educational.	Space needed. Organisation and maintaining task can be challenging. Some members	Explain task with demonstration prior to organisation of game.

		may not enjoy these.	Resources required.

Variety and pace

Creative use of teaching methods and approaches promotes memorable sessions that are interesting as well as informative. Providing a mixture of activities stimulates a lethargic atmosphere but occasionally, the group may not work due to excessive noise and boisterous behaviour. In this situation individual work is effective in 'de-energising' and redirecting group members to the task. Individual work is

- Brainstorming individually and then discuss in pairs
- A short quiz on facts recently given
- Draw an interpretation of a situation and its consequences.
- Provide a short list of sentence stems to be completed around a current theme of work.

Although a serious subject, sex education sessions do not have to be humourless. Variety of activities and change of pace throughout can provide an invigorating and fun way to learn. It may help remove difficult feelings and promotes more effective communication between the young people and with the medic leading the session. With improved confidence and experience, the medic may chose to use the following different ways of getting group members into pairs and small groups

- Choose someone you have not had a conversation with today

- Number individuals in the circle (repeat 1,2,3,4,5.1,2 etc) ask all number 1's to form a group, then 2's and so on.

- Notice what people are wearing. Ask those wearing black boots to form a group, those with glasses etc

- Ask the individuals to form a straight line according to height, shortest person one end of the room with the tallest at the other. Go along the line and split people into groups.

- Provide each member with a small piece of paper on which is drawn a symbol or a colour. The group is to mingle and meet up with others carrying a similar piece of paper.

Adapting Ideas and Resources

It is possible to use one method for different themes for example 'Find someone who..' can have sentence stems that are applicable for an introductory game with a new group;

Find someone who..
has parents that were married before they were 20 years old

does not have a dacha
has a cat

This method may also be used as a warm-up activity to introduce a new theme for the session. For example, providing sentence stems about World AIDS Day could lead into a session on HIV education and prevention.

Card games are versatile and can be adapted to create variety and a different focus on the same theme. The card activity 'Contraceptive Methods' can be used to in its original format and again to categorise methods according to barrier and non-barrier methods, or those that require consultation and those that can be bought at a chemist or kiosk.

Case studies can be used for small group discussion purposes or as triggers for role-play.

The activities and themes used with young people may also be delivered with parent and staff training groups. It is important however to ensure that the content is relevant to the ages and lifestyles of the group members. Pre-planning is essential to revise language and adapt situations that are appropriate.

An example of an easily adapted activity

Changing places

Objectives

- To introduce a theme of work.
- To practice words that may be 'sensitive' and difficult to say.
- To raise the energy levels and have fun.
- To provide group interaction and responsibility for the activity.

Prerequisites none

Age group all, including adults
Group size up to 24

Time needed 10 minutes

What you need Circle of chairs, space

How you do it

1. Ask people to remove articles from the floor that may cause harm (bags, books etc)

2. Ask the group to brainstorm all the STIs they know. Chose 4.

3. In turn give each person in the circle one of the 4 STIs – gonorrhea, HIV, syphilis, chlamydia Check everyone has heard and remembered their word by saying "All those with chlamydia raise your hand" and so on.

4. The medic asks all those with HIV to stand up and then swap places. This is further demonstrated with a few of the other words. Now introduce a 5th word such as Hepatitis B, on this command, everyone swaps places.

5. The medic removes his/her own chair out of the circle and stands in the centre floor space. Explain
   the person in the middle decides on the word and says "All those with gonorrhea change places". As people swap seats the medic endeavors to sit in one hence leaving someone else in the middle.

Variants
When used as an introductory activity, chose a theme that is general such as: preferences for entertainment, likes and dislikes of food, what is common to group members (clothes, eye colour etc).

This activity is not suitable for a competitive group or one that is already highly energised as accidents may occur.

Specific areas of sex education work

Topic; Contraceptive methods

Ages 11-14 14-16

Objectives
- Young people will recognise that parenthood is a matter of choice
- Young people will understand the medical uses of hormones, including the control and promotion of fertility
- Young people will consider the advantages and disadvantages of various methods of family planning
- Young people will understand moral values in relation to contraception and explore those held by different groups

KNOWLEDGE	SKILLS	ATTITUDES/VALUES
Why have contraception? Definition of contraception	Discussing individual Contraceptive needs – what t Vocabulary. Practice scenarios	Whose responsibility? Gend Issues
Methods – different types, Advantages and disadvantage How they work.	Demonstration of safe condo and when pills are taken etc	Thoughts and feelings about Personal and others preferer
Methods – suitability for your People. How to store and mar Using contraceptives	'the condom moment'- discu its use with a partner; role-pl what to say and when to mer the subject	Perceived image by others o and women who carry a cond
Services – when to get Contraception. Where to go fo Consultation and advice. Med Language that is useful to knc	Practice consultation situatio what questions to ask.	Mass media image of people's relationships and behaviour; its impact on lifes
Practicalities – the physical Examination, Medics questior Confidentiality. Costs	Vocabulary work on 'accepta words required for consultati Practice them.	Society and personal attitude Towards very young people Contraception.
Links with STIs including HI	Condom use	How people view individuals have, or transmit an STI.
Consequences of unprotected Pregnancy, birth, abortion	Assertiveness skills in 'risky social and intimate situations -plays.	Different perceptions on sing young mothers, early marriag abortion. Emotional and psychological consequences.

Contraceptive methods card game:

Objectives

- For young people to assimilate information received on contraceptive methods
- For medic to gain information of the young peoples knowledge
- To provide self-directed learning in variety of ways: individual, pairs, small groups

Prerequisites Literacy skills
If required, previous facts on contraceptive methods

Age group 14-16, 16+
Could be used with younger teenagers as appropriate

Group size Depending on sets of cards, up to 25

Time needed 20-30 minutes

What is needed Sets of cards, table or floor space

What you do

1. Photocopy or make enough sets of cards for the group. Include the categories written down the side of each.

2. Keep an answer sheet for reference and checking purposes.

3. Divide the group into pairs or small groups. Provide each with a set of mixed-up cards.

4. Explain each contraceptive method should have 5 cards describing it fully. They are to categorise and sort the cards according to the contraceptive method. Demonstrate how they may lay out their cards as on the page.

5. The young people are to be encouraged to discuss information with group members as they undertake the activity.

6. Discuss the answers; provide correct and additional information as necessary, plus any issues or questions.

7. This activity may also be used to concentrate on particular issues such as: gender concerns regarding responsibility, appropriateness for young people and their lifestyles, health concerns, cost etc. It can be categorised according to barrier and non-barrier methods.

Cards; Contraceptive Methods

Combined pill		Emergency contraception (pill)	
How reliable is it?	If taken properly, it is over 99% Effective.	How reliable is It?	If taken within 72 hours after Unprotected sex, it is over 95% Effective.
How it works.	Contains 2 hormones oestrogen and Progestogon which stop a woman Releasing an egg each month.	How it works.	The pills stop an egg being released or a fertilised egg settling in the womb.
Advantages	May reduce bleeding, period pain And pre-menstrual tension. Protects against cancer of the ovary Womb and some pelvic infections.	Advantages	Can take the pills on more than one Occasion. Should have a normal period Within 3 weeks.
Disadvantages	Not suitable for all women. May have temporary minor side Effects.	Disadvantages	May feel sick or vomit. Not every woman can use them (if a woman has a blood clot or migraines).
Comments	Some other drugs stop the pill Working. Not reliable if taken over 12 hours late or after vomiting or diarrhea. Condoms must be used in these cases.	Comments	Not an effective form of regular Contraceptive method. Must use Condoms after taking the pills. The pills have not been shown to Affect the pregnancy or harm the Baby if the fail.

Spermicides		Male condom	
How reliable Is it?	More effective if used with a condom. Instructions must be followed properly.	How reliable Is it?	If used properly, it is 98% Effective.
How it works.	Destroys the sperm and prevents fertilisation of the egg.	How it works.	Made of very thin rubber, it is put over the man's penis and stops sperm from entering the woman's vagina.
Advantages	Variety of types; some shared between man and woman. Easily available. May prevent some sexually transmitted infections.	Advantages	Sold widely. Protects from sexually Transmitted infections and HIV Protects against cancer of the Cervix. Men take responsibility.
Disadvantages	Some people are sensitive to spermicide. Can be messy. Must be used each time sex takes place.	Disadvantages	May interrupt sex. May slip off or split if not Used correctly.
Comments	Use a condom for better effectiveness.	Comments	Use a condom each time. Check for expiry date and Electronic testing. Sunlight and oil-based products Will damage them.

The IUD (intrauterine device)		**Contraceptive injection**	
How reliable is It?	98% to over 99% effective depending on type used.	How reliable is It?	It is over 99% effective.
How it works.	Small plastic or copper device put into womb. Stops sperm meeting an egg or an egg settling in the womb.	How it works.	Releases progestogen hormone Very slowly into the body which Stops an egg being released.
Advantages	Works immediately. Can stay in for a minimum of 5 years. Cost effective.	Advantages	Lasts for 12 weeks (Depo-Provera) May protect against cancer of the Womb.
Disadvantages	Heavier or painful periods. No protection against STIs.	Disadvantages	Irregular periods. May take up to 1 year or more for Regular periods and fertility to Return. May have weight gain. Cost.
Comments	Needs to be inserted by a specialist Woman is taught how to check the device in the vagina. Can be fitted after giving birth or abortion.	Comments	Unwanted side effects continue During 12 weeks. No protection against STIs Including HIV.

Topic: Sexually transmitted infections

One main aim of sex education is to reduce the level of sexually transmitted infections among the young people population. This topic requires much factual information but it must go hand in hand with the skills needed to put the information into practice and affect change.

Age group 14-16, 16+
may be adapted with young people in 11-14 age group

Objectives

- Know that HIV and other infections are transmitted sexually.
- Be aware of the range of sexual attitudes and behaviours in present day society.
- Understand that people have a right not to be sexually active, know in broad outline the biological and social factors that influence sexual behaviour and their consequences.

KNOWLEDGE	SKILLS	ATTITUDES
What is an STI-Definition	Vocabulary- practice saying it	Society's attitudes towards STIs
Signs and symptoms; m/w, both. Consequences	Language of intimate private body parts-practice saying, drawing etc	Myths – how to tell someone has an STI.
Transmission (also oral/anal) – penetrative and non-penetrative	Assertiveness skills: responses to wanted and unwanted behaviour. What to say/do: role-play.	Personal and society's attitude to monogamy and multiple partners
Prevention of STIs. Safer sex practices.	Discussion of safer sex with partner-what to say and when. Case studies. Role-play.	Why is sex a taboo subject? Is Russian youth different or the same from its parents? Response to various sexual activity and notion of individual choice.
Condom use and some contraceptive methods that prevent STIs.	Demonstration of condom use	Attitudes towards men and women who carry/buy condoms. Whose responsibility?
Non-sexual infections-thrush, cystitis etc. Toxic shock syndrome	Ideal health and personal hygiene practices. Diagrams of self-examination of breasts, testicles. Discussion of women's sanitary protection.	Social and psychological aspects of health. Consequences on self-esteem, partner
HIV-facts, sexual transmission, prevention.	Case studies on social situations involving alcohol, drugs and sexual activity. Role-play.	Discussion of terms; discrimination, prejudice and stereotype. Which groups in society are targeted? Why?
Treatment of	Difficulties of adhering to	Society, personal, religion and

HIV and STIs.	treatments. Case studies and practice of questions to ask medics about condition and treatment.	media attitudes towards people living with HIV.
Local services- where, what tests and treatments available.	Process of appointments, examinations and consultation. What to expect and ask of the medics involved.	Personal and society attitude to using sexual health services.

HIV card game: assessing risky behaviour and activity

Objectives

- To follow-up information given on transmission of HIV
- To personalise risk behaviour rather than attribute HIV to certain societal groups
- To clarify facts from myths
- To trigger whole group discussion and debate

Prerequisites Information on HIV and transmission
Literacy skills

Age group 14-16, 16+ (adaptations for younger teenagers)

Group size Ideally a maximum of 20

Time needed 45 minutes

What you need Set of large cards for whole group activity

How you do it

i. The group sits in a circle leaving a large area of floor space in the middle. The 2 large cards: low risk, high risk are placed either end of the central floor space.

ii. Each person takes one of the smaller cards and decides whether it is low or high risk in terms of behaviour that transmits the virus. They can discuss the reasons for their decision with their neighbour before the whole group activity begins.

iii. Whole group activity-one person reads out the activity statement on their card and states why they are placing it at the chosen point. The medic asks the group for any additional information and whether they agree with the placement. The card may be moved according to revised discussion or additional and factual information.

iv. Only when the final decision has been made with the card, can the next person read out theirs and so on.

v. The group may decide that some behaviours are neither low or high risk and want to place cards in a line continuum that stretches along the floor between the two large cards.

Variations

1. Remove or add certain behaviour cards that are specific to the needs of the group. For example, the cards on drug use may be left for another time, and younger age groups may not need to know about certain types of sexual activity.
2. Instead of a line continuum, categorise the cards according to the two large cards, or add another labeled 'medium risk'.
3. Use the method for work on transmission of sexually transmitted infections or include it as part of the activity. For example stating "You may not get HIV via this activity but could some other infection be transmitted?"

The following suggestions can be used for cards

Low risk	Sex with several partners	**High risk**
Penetrative sex using a Condom	Mopping blood spillage	Sharing needles and syringes
Wet kissing	Penetrative sex without a Condom	Massage
Oral sex	Masturbation	Mosquito bites
Body rubbing	Sharing drugs equipment – Spoons, filters, water	Cleaning up vomit
Sharing a shower or bath	Tattoos	Body piercing
Activities involving 'sex toys'	Sharing toothbrushes and Razors	Non-penetrative sex without a condom
Activities involving biting And licking	Holding hands	Using public toilets

Find someone who…

Objectives
- To provide an opportunity for people to talk each other
- To introduce the subject area of sexually transmitted infections
- To determine group knowledge and gaps in information
- To create energy and have fun

Pre-requisites	group members have already worked together literacy skills
Group size	6 or more
Age group	14-16, 16+ including adults
Time needed	10 – 15 minutes
What you need	paper and pen for each individual

How you do it

1. Ask the group members to get a clean sheet of paper and pen. The paper must have room to write down a list on the left-hand side and space to write an answer next to it on the right. Demonstrate this to them with a sheet of paper as you speak.

2. First tell them to write the following words at the top of the paper; find someone who…

3. Now read out the following sentence endings as a list:

   Can name 3 STIs
   Knows what the letters HIV mean
   Knows a way of preventing STIs
   Knows where a person can get treatment
   Can name a symptom of an STI

4. Everyone is to mingle with each other and ask one person at a time one question only. If the person cannot answer, move onto a second person.

5. Write the name of the person next to the sentence ending. A different person/name must follow each one. When all the sentence endings are completed, sit down on a chair.

6. When everyone is seated, ask for the findings from the group members first before correcting or adding to the facts as appropriate.

Variations

- Change the sentence endings and use as an introductory exercise with a new group, or according to the subject of any session.
- Add more sentence endings and provide a time limit rather than wait for people to finish.

An example of a young people's questionnaire

Sexually transmitted infections

STI QUIZ

Put a tick in the correct box

	Right	Wrong
You can have an STI more than once even though you've previously been treated for it.		
STI symptoms may disappear without treatment.		
All STIs can be cured.		
Men have STI symptoms earlier than women.		
If you are under 16 and have treatment for an STI, your parents must be informed.		
STIs are not transmitted via a toilet seat or dirty cup.		
A condom is an effective protection against STIs.		
You can only be infected with STIs through sex.		
Women who take hormone contraceptive pills can't be infected with an STI.		
You can have several STIs at the same time.		
Women can have an STI and not know it.		
If you have an STI all your previous partners must be		

informed.		
Very often STI symptoms are very much like symptoms of other diseases.		

Topic; Puberty

Ages 7-11

Objectives

- To begin to know about and have some understanding of the physical, emotional and social changes that take place at puberty.
- Know and understand how changes at puberty affect the body in relation to hygiene.

KNOWLEDGE	SKILLS	ATTITUDES/VALUES
Puberty – what this means; process of child developing into adult.	Discussions and practice of Communication skills in a single sex or mixed group situation.	Exploration of feelings about leaving childhood and entering teenager-world.
Body changes – female anatomy and physiology.	Finding an appropriate vocabulary For private body parts-practice activities for 'comfort' level	How society and close family View teenagers and their behaviour changes towards young women.
Body changes – male anatomy and Physiology.	As above	As above in relation to young men.
Hygiene	Access at home to daily washing of specific and private body part areas. Practice scenarios/case studies on negotiating with family members.	Society and personal attitudes Towards tidiness and cleanliness.
Periods – basic biological facts, their significance and practicalities. Types of sanitary protection and usage.	Case study-coping with protection In various daily and social situations. Vocabulary practice for buying and using protection. Creating a menstrual calendar.	Challenging myths regarding hygiene, health and lifestyle activities.Psychological effects on yo women.

	Vocabulary	
Wet dreams and involuntary Erections. What happens and why.	Case study- consequences and Coping strategies for home and social situations. Vocabulary for body functions.	Challenging myths. Psychological effects of lack of body control on young men.
Self-pleasure; masturbation. Male/ female. Basic facts as relevant.	Developing a comfortable Language.	Neutral information. Discuss why it a taboo subject. Present as optional and common activity. Challenge myths.
Voice breaking-male. What happens and why.	Case scenarios on dealing People's reactions. Assertiveness.	Acknowledging psychological effect on young men's self-esteem.
Breast development-female. What happens and why.	Assertiveness skills and case Studies on dealing with unwanted comments/looks.	As above in relation to young women.

Topic: Responsible behaviour-delaying sex

Participation in a structured sex education program from an early age prevents teenagers engaging in sexual activity. Very young teenagers should be encouraged not to have sex. Delaying sexual activity to an older age usually results in more mature decisions about contraception and protected sex. Young people need to discuss the reasons for delaying sexual activity and learn how to resist pressures for unwanted sex. Assertive communication skills should be learnt through role-play of real-life situations that young people may encounter. They may also learn that affection can be shown in ways other than sexual activity.

Delaying sexual activity mostly involves skills development and attitudinal work and places much less emphasis on facts and information.

KNOWLEDGE	SKILLS	ATTITUDES
Abstinence – wh This means	Create a vocabulary of terminology a Practical everyday words	Exploration of how society and fr view abstinence.

Delaying sex – Define sexual Activity	Case scenarios and vocabulary that de Confidence in discussing sexual activ	Acknowledge feelings of discomf This area. Discuss society and oth Reasons for sex being a taboo.
Reasons to say n to sex	Create a priority list with teenagers. F Play using these as responses	Explore how individuals feel abou Saying no to sex. Discuss why so young people choose to have sex
Lifestyle pressur Of teenagers- de	Create typical sayings used by indivi Have sex. Practice responding to ther	Discuss peer pressure and difficul Being different from the friendshi Group
Affection withou Sex- what is this	Suggestions for alternative ways of sl Affection: advantages and disadvanta	Discuss how friends, media, socie Family value these
Physical affectio	Rank physical behaviours from least Sexually arousing. Establish personal	Explore limits according to situati Length of relationship, age, others Of view
Assertiveness – Define verbal an Non-verbal Behaviours	Practice recognition and demonstrati These behaviours through role-play, Magazine pictures, drawings.	Discuss personal and society's vie On expressions of certain emotion Why some may be more difficult Show. Gender issues

Activity

Delaying sex: what's next?

Objectives

- To consider personal limits regarding physical and sexual activity
- To consider personal limits with a partner in context of a relationship

Prerequisites literacy skills

Age group 11-14, 14-16,16+

Group size up to 25

Time needed 20-30 minutes

What you need personal writing materials

How you do it

1. Explain the activity via the objectives. This is an individual activity with discussion in pairs afterwards.
2. List the following physical activities on the blackboard. Place them in any order. The medic may chose to read them out if the group is 'sophisticated'

Hugging - Touching breasts and/or genitals on top of clothes - Dry kissing – Holding hands – Touching breasts and/or genitals under clothes – Deep (wet) kissing – Body rubbing with no clothes

3. Place each of the sexual behaviours from the list of physical activities in the appropriate level, from the one that is least physical (1) to the one that is most physical next to the sex act (7).

4. Chose a partner and discuss the lists.

5. If appropriate, involve the whole group in a discussion on the following

- Why is it difficult to stop as you get closer physically?
- Would it be easy to go back to a safer activity? Why or why not?
- Where do you think the limit is?
- Who should decide where the limit is? When should it be decided?

Variations

1.Write the behaviours on cards and individuals place their card in a line continuum according to the level of least/most physical activity. Do it as a small or whole group activity.
2. Ask the young people to brainstorm or create a list of physical/sexual activities. Use these for this activity.

Activity

Delaying sex: showing affection without sex

Objectives

- To consider ways of showing affection without sexual activity
- To discuss ways of avoiding unwanted physical behaviours and the consequences

Prerequisites	Literacy skills
Age group	7-11, 11-14+ as appropriate
Group size	maximum 25
Time needed	15-30 minutes
What you need	personal writing materials, blackboard

How you do it

1. Ask the group to define affection and what it means. Discuss who shows affection to whom and why.

2. Write an incomplete list on the board of ways of showing affection in context of a special friendship with a person.

Giving a flower	Holding hands
Kissing	Writing a note
Touching	Saying "I like you"

3. In pairs discuss what makes a special friendship. Feedback to the whole group.

4. Remaining in pairs discuss other ways of showing affection without sexual activity. Write them down. After 5 minutes, one at a time, invite individuals to add them to the list on the blackboard. Discuss the merit of each one before the next person adds theirs to the list.

Variations

1. Ask the young people to draw a poster depicting the message and words associated with showing affection without sex.

SUPPORTING THE NEEDS OF BOYS AND YOUNG MEN IN SEX EDUCATION

Why do we need to focus on boys?

There is an emerging realisation that we may not be meeting the sex education needs of boys. This is a problem for a number of reasons:

- A failure to address boys needs has serious implications for their emotional and sexual health such as an inability or reluctance to seek help and advice
- Approaches which do not engage boys leave them bored and sometimes disruptive
- A focus on reproductive aspects of sex education engages girls but not boys. This can reinforce the message that sex education is nothing to do with boys.

There are many good reasons for focusing on boy's needs:

- To increase their ability to take responsibility for their sexual behaviour and to make informed sexual choices – there is an increase in sexual transmitted infections such as chlamydia, there continues to be unplanned pregnancies
- To increase their confidence in talking about sexual and emotional matters – research highlights that fathers are less comfortable talking to their children about sexual matters than their mothers. An early start in their own education may make the task easier.

- To improve their self-esteem and confidence, increasing their enthusiasm for schooling and in some cases to reducing behavioural problems.

Issues for boys and young men

Boys tend to get less sex education than girls within the family. This is partly because mothers provide so much more sex education than fathers and may not know enough about boy's development. It may also be because boys aren't seen as having an obvious stage of development equivalent to girls' menstruation and so are left to learn about sex and sexuality on their own. Also the motivation for parents to provide sex education may be in response to fears. As parents tend to have more fears in relation to their daughters – for example, the possibility of their becoming pregnant – they may be more motivated to provide sex education for their daughters.

Boys are also less likely than girls to learn about sex from other informed sources such as health professionals. Only a small proportion of young men have discussed sexual matters with a doctor because they are unlikely to attend a clinic. Young men are unlikely to seek out information or advice on sex. They are expected to 'know' and will hide their ignorance.

Boys tend to learn much of what they know about sex from male friends. Learning in this way within the peer group can be complicated, as it may be acceptable for them to show ignorance. Discussion of sex within the peer group often takes place through the telling of 'performance' stories of sexual conquests, real or imagined, in a highly competitive environment. Discussion in groups also limits the opportunities about fears, emotions and feelings.

Boys experience a high level of peer pressure to lose their virginity at an early age. In the absence of other forms of rites of passage for boys, sexual intercourse may be seen as the best way to 'become a man'. Many young men increasingly learn about sex through pornography.

Behind the mask

Comments from teachers and youth workers about boys; 'they act macho', 'they don't take it seriously', depicts sex education as going on almost in spite of boys. Those working with them highlight how vital it is to 'look behind the mask', to consider the vulnerabilities that hide behind such behaviour. The idealised conception of the 'real man' places pressure on young men to differentiate themselves from women and 'failures'. The goal of achieving successful masculinity puts them under pressure not to reveal the extent of their vulnerability by concealing displays of caring, dependency, loving and other forms of nurturing or supposed effeminacy.

It is clear that sex education can raise deep anxieties for boys – fear of ridicule or bullying can be the reason for macho posturing and disruptiveness. To understand the motivations for certain behaviours medics may need to examine their negative perceptions and expectations of boys.

Our agenda or theirs?
If medics are to gain boy's interest they must ensure that sex education is not based on adult perceptions of what they need. Boys report that sex education is almost entirely negative –'Don't do this or this will happen.' What they actually wanted was opportunities to talk about relationships.

To be successful medics must work with *boy's* agenda. To do this boys must be actively involved in developing sex education programs and have a real influence over the content and delivery of their sex education. Medics need to ask them what they want and need, how they want it covered and by whom, listen and then feedback what they will do to accommodate these needs.
Educators need to look behind behaviour and attitudes to see what fears might be there; a reluctance to consider using condoms may be due to fears of looking stupid if you get it wrong. Skills-based lessons – for example, practicing putting condoms on a model or similar, are essential.

Showing respect for boys
It is essential to give boys opportunities to talk about things that reflect their interests and concerns. It is important to acknowledge their opinions and respect the reasons why they hold them. Many of the behaviours seen in adolescent boys and young men result from the experiences they have in early socialisation and gender role modeling. It is important to realise that their opinions aren't simply 'wrong ideas' that can be shifted by superior logic or replaced by new skills, but have an active function for boys negotiating and making sense of the world they live in. It is important to provide positive role models of a range of ways of being male which include the caring side of their natures and fathering.
Activity

Young men's work: Messages men receive about 'being a man'

Objectives
- To explore the messages that boys receive when they are growing up
- To discuss the impact of these messages on the behaviour, sexual health and relationships of young men

Prerequisites	group has spent time together
Age group	11-14, 14-16, 16+
Group size	up to 20
Time needed	20-40 minutes
What you need	large paper (wallpaper), pens

How you do it
1. Introduce the activity using the above objectives to the whole group.

1. Divide group into small groups of 4 or 5 people.

2. Explain brainstorming. Inform the groups they have 5 minutes to brainstorm each of the following two categories:

- Firstly; Messages boys receive about being a boy as they grow up.
  For example
  – 'big boys don't cry'
  – 'tough boys don't feel pain'

- Secondly; Messages concerning what it is to be a man and be sexual
  For example
  - 'men sow wild oats'
  - men aren't interested in contraception'

3. Ask representative to feedback from each group. Discuss the following
- Where do these messages come from?
- What are the effects of these messages on the behaviour of boys and young men?
- What are the advantages and disadvantages of such messages and behaviour for men?
- How do they affect attitudes and relationships with women, family, and work?
- What are the affects of these messages on men and their attitudes to sexual health, sexual relationships and accessing health services?

4. How would the group like things to be different for men in terms of messages received about what it is to be a man?

Activity

Young men's work: sexual health

Objectives

- To consider how attitudes and gaps in information influences sexual behaviour of young men.
- To clarify facts and misinformation on sexual transmitted infections and contraception.

Prerequisites information on STI's, contraceptive methods

Age group 14-16, 16+. May be adapted for younger age groups

Group size maximum 20

Time needed 30-45 minutes

What you need copies of case scenarios

How you do it

1. Introduce the activity. Divide the group into pairs or small groups of 3 and 4.

2. Explain each group has a card and they have 5 minutes to discuss the main issues on it. Provide each group with a case scenario.

3. In turn, a group representative reads out the situation and tells the whole group what they have discussed.

4. The medic first asks other group members if they have anything to contribute, if they agree with the facts or if they have other suggestions.

5. Should the whole group have misinformation or gaps in their knowledge, the medic provides updated correct information and advice.

6. After all case scenarios have been discussed; the medic provides information on local services.

Variations

This activity can be done with mixed and young women's groups making adaptations to the gender of characters in the situations.

Sexual health case scenarios

1

A young man sometimes uses condoms and sometimes doesn't. He's very confident that he can tell if someone is 'risky'. He says he knows which women are 'slags' and which are clean

2

A young man claims he has been using withdrawal method successfully for years, but his partner now has persuaded him to try something 'more effective'. He has never used any form of contraception and is not sure what is expected.

3

A young man has several sexual partners. He is confident that he is clean because none of his partners are experiencing any symptoms of infections.

4

A young man informs his friends that he is unable to drink alcohol at the moment due to medical reasons. His friends wonder what the problem is.

5

His girlfriend telephones a young man the morning after a party with friends. They had drunk lots of beer and vodka and she thinks they had sex. She wants to know if they used protection or not. She does not want to get pregnant.

6

Several weeks after a sexual encounter with someone other than his girlfriend, a young man notices discomfort when passing urine. He wonders what to do next.

7

A young man used to use drugs. He has a serious relationship with a young woman. Recently she told him she wants to stop using condoms and start using another form of contraception. He does not know what to do, as he is concerned about their health.

8

A young man has had a painful throat infection for over a month that has not responded to treatment suggested by the pharmacist. He wonders if he ought to see a specialist.

9

A young man frequently complains about the quality of condoms. He insists that each time he uses a condom it either splits or slips off. He asks his friends for advice.

10

A woman friend tells a young man that she is being treated for chlamydia and suggests he may be infected. He tells her he is fine because he has no symptoms.

References

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'School health education to prevent AIDS and STD', (1994), World Health Organisation and UNESCO- available AIDS Infoshare, Moscow.

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Date November 2000

'Sex Education with young people: theory and practice' context and additional notes

This package was devised as a means to providing context for a 2-day course delivered by a Gynaecologist, Psychologist and Andrologue employed at the Sverdlovsk Oblast Family Planning Centre. The specialist from Voluntary Service Overseas in Britain was requested by the centre to develop the training skills of the staff to enable more effective working with young people under 18 years old.
Prior to the departure of the volunteer, the centre staff requested written materials that encapsulated the specific work undertaken by the specialist and could be used for reference.

Consequently the package is in context of the training course and the needs of the staff at the Sverdlovsk Centre. Some of the points and chapters may appear somewhat original and not necessarily what one would expect to find in a package about sex education!

The following highlights certain areas

- The staff had already received basic training on sex education theory and were delivering a 1 day course on this subject but required further more in-depth work
- Centre staff believed medics who attended the training course already had the medical information and background so these aspects are not included in the package
- Colleagues delivering the course had minimal experience of work practice with young people and wanted to improve in this area
- The newly introduced areas of patient rights and the consultation process became a focus of training on consultation skills for medics attending the course
- During the development of the course, colleagues saw the need to include work with young men
- Course participants had received little or no training on psychology and acknowledged the benefits for their work with clients. Therefore some aspects have a psychological bias

As stated, the package is targeted at medical staff. It does contain valuable information about practice that is of use to any professional working with young people in the field of sex education such as teachers and youth workers. The author has provided training courses and used the materials with these groups. Biological and basic medical facts could be obtained from medics at local polyclinics or family planning departments.

Errata

The package is formatted for easy photocopying and making of transparencies for work with young people or training purposes.
Due to the difficulties with translation, access to technological resources and inability to meet with colleagues, the package contains mistakes and fewer references to Russian culture, educational and medical systems than the author ideally aimed for.

Specifically

- Elena Borisovna Nikolaevna is Chief Doctor and not Director
- Pages 62 –64 Contraceptive methods card game should be tabulated with cards of equal size for photo-copying purposes
- Page 67 – HIV low/high risk card game: the page layout should be tabulated as cards for photo-copying purposes and not as a small table

The package contains a variety of translated materials from the referenced articles on page 79. The author has adapted most of these for the situation in Russia. The majority of the text is the

author’s own work and permission is given for specialists in Russia to add, alter and improve upon the work as it currently exists in order for it to be appropriate for individual needs and client groups.

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November 2000