



Life Skills



HIV/AIDS (Education)

Revised for compliance with the National Curriculum Statement

Resource Guide



education

Department:
Education
REPUBLIC OF SOUTH AFRICA

Resource Guide

HIV and AIDS Lifeskills and Sexuality Education Primary School Programme

HIV and AIDS Lifeskills and Sexuality Education Primary School Programme

Resource Guide

THIRD EDITION

Revised for compliance with the National Curriculum Statement (2002)
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Teacher's Resource Guide, Teacher's Manuals for Grades 1–7, and
Learner's Activity Books for Grades 1–7, are available in English only.

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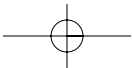
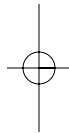
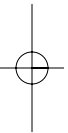
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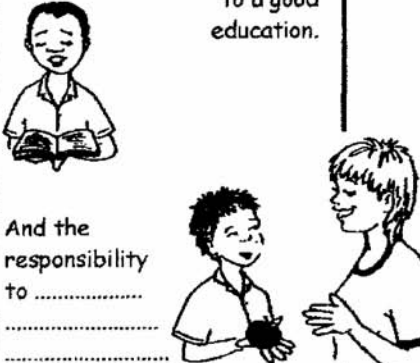
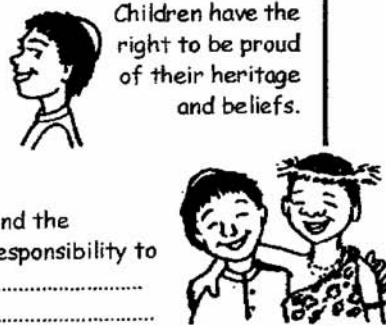
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Introduction

CHILDREN'S BILL OF RIGHTS AND RESPONSIBILITIES

Children have the right to be taken seriously.  And the responsibility to	Children have the right to quality medical care.  And the responsibility to	Children have the right to a good education.  And the responsibility to
Children have the right to be loved and protected from harm  And the responsibility to	Children have the right to get special care for special needs  And the responsibility to	Children have the right to make mistakes  And the responsibility to
Children have the right to be well fed.  And the responsibility to	Children have the right to a safe and comfortable home.  And the responsibility to	Children have the right to be proud of their heritage and beliefs.  And the responsibility to

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Introduction

MESSAGE

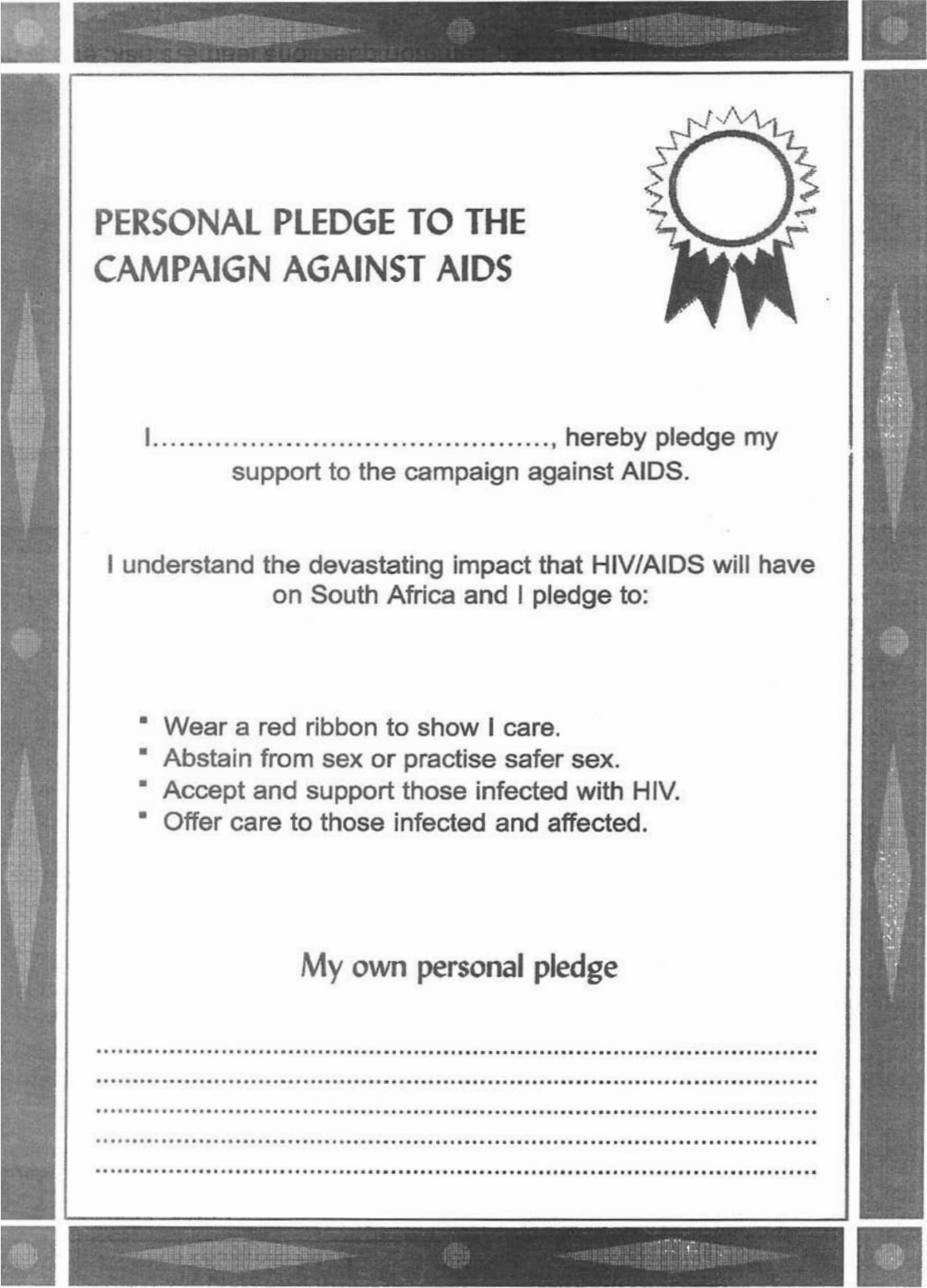
HIV and AIDS is among us, it is real. It is spreading. We can only win against HIV and AIDS if we join hands to save our nation. For too long we have closed our eyes as a nation, hoping the truth is not so real. For many years, we have allowed HIV to spread, and at a rate in our country which is one of the fastest in the world. Every single day a further 1 500 people in South Africa become infected. More than three million people have been infected.

- As partners against HIV and AIDS, together we pledge to pool our resources and to commit our brain power!
- There is still no cure for HIV and AIDS. Nothing can prevent infection except our own behaviour.
- We shall work together to support medical institutions to search for a vaccine and a cure.
- We shall mobilise all possible resources to spread the message of prevention, to offer support to those infected and affected, and to destigmatise HIV and AIDS and to continue our search for a medical solution.
- And so today we join hands in the partnership, fully aware that our unity is our strength. The simple but practical action that we take today is tomorrow's insurance for our nation.
- Together, as partners against HIV and AIDS, we can and shall win.

(Deputy President Thabo Mbeki: 1999)

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Introduction



**PERSONAL PLEDGE TO THE
CAMPAIGN AGAINST AIDS**



I....., hereby pledge my
support to the campaign against AIDS.

I understand the devastating impact that HIV/AIDS will have
on South Africa and I pledge to:

- Wear a red ribbon to show I care.
- Abstain from sex or practise safer sex.
- Accept and support those infected with HIV.
- Offer care to those infected and affected.

My own personal pledge

.....

.....

.....

.....

.....

HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Introduction

FOREWORD

The HIV and AIDS pandemic in our country compels us all to become involved. Research indicates that in order to prevent the spread of HIV and AIDS, it is crucial to reach children before they become sexually active. The increasing incidence of sexual abuse also stresses the urgency to work with children from a very young age. This initiative could not have been more timely.

Because HIV and AIDS is mainly spread through sexual contact, HIV and AIDS education should always be presented in the context of sexuality education.

Presenting sexuality education at school has not been part of the teacher's task in all schools of South Africa. Many teachers may feel that it is not their responsibility, but that of the parents. Some teachers may avoid sexuality education because it is such a sensitive topic and they do not really have the courage or training to present it. They may argue that talking about sex at school will make parents angry, will cause learners to become sexually active at an early age or will increase teenage pregnancies and HIV infection.

However, ignorance does not guarantee innocence and teachers are feeling a growing sense of responsibility regarding sexuality education, as problems like rape, sexual abuse, teenage pregnancies and AIDS escalate in the community. Teachers realise that sexuality education, if it is responsibly presented, is one of the most effective ways to prevent these problems.

Although children are exposed to sexual messages in their daily lives, their knowledge about human sexuality is incomplete and riddled with myths and superstitions. Their main source of knowledge is other children who talk about sex in vulgar and scary ways. The lack of positive adult role models and the influence of the mass media, have left children confused about moral and ethical issues surrounding sexual behaviour.

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Resource Guide for Teachers

This Resource Guide
serves as an information guide
for teachers participating
in this project

This Guide consists of four units, namely:

UNIT 1: Outcomes-based Education

UNIT 2: Sexuality Education

UNIT 3: Management of HIV and AIDS in schools

UNIT 4: The Lesson Plan

APPENDICES

HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Introduction

Training and Learning Programme Outcomes

After working through the material and participating in the training, teachers should be able to demonstrate:

- Knowledge and understanding of Outcomes-based Education.
- A critical awareness of Sexuality Education.
- Knowledge and comprehension of HIV and AIDS-related issues.
- An awareness of the management of HIV and AIDS in schools.
- The ability to present the Lesson Plan on HIV and AIDS at schools.
- Insight into relevant concepts, common questions learners ask, effective programmes and issues related to child abuse.

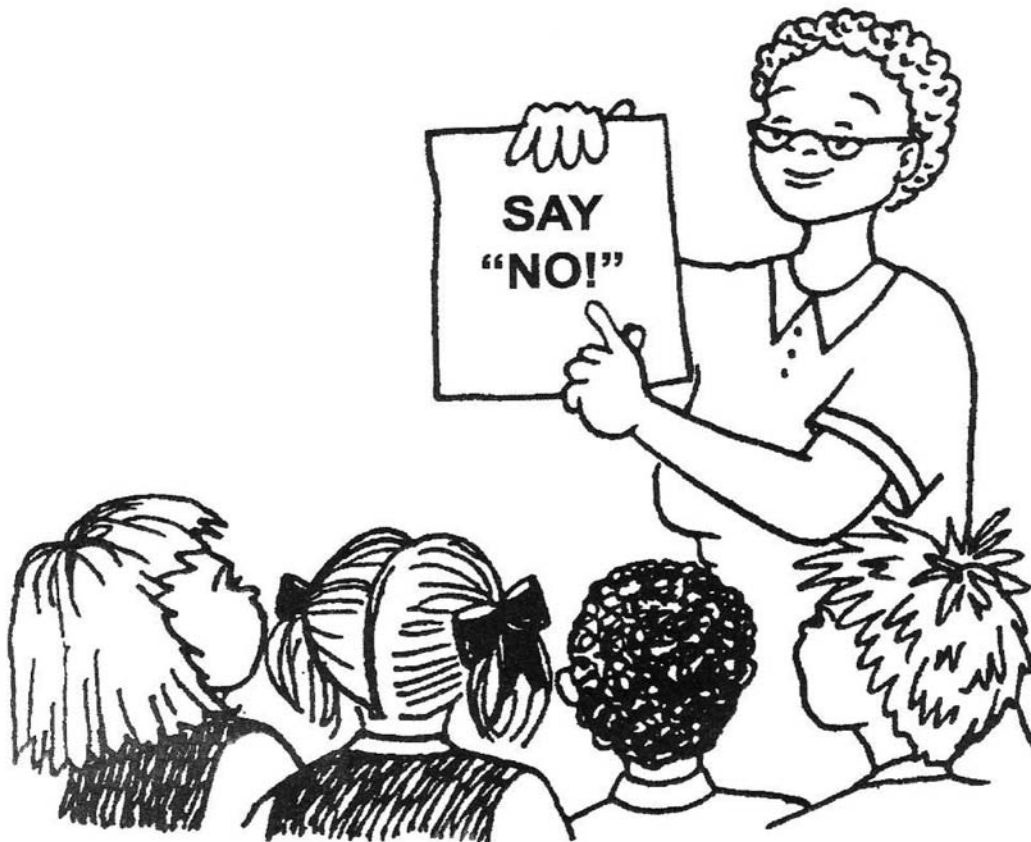


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Introduction

Moreover, the various activities in which teachers are expected to participate will help develop the power of young people

to say No



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Introduction

To all teachers
and others involved in this crisis,
thank you for your
involvement and commitment.
We commend you.

May your participation
and involvement in this project
be an enriching and
meaningful experience.

"The next generation needs the treasure and richness of your potential, your
knowledge, skills and experience."



*This project is dedicated to
all the children and youth
of South Africa who are
affected by HIV and AIDS
in any way.*

Unit 1

Outcomes-based Education



*Tell me, and I'll forget.
Show me, and I may remember.
Involve me, and I'll understand.*

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Unit 1: Outcomes-based Education

UNIT OUTCOMES

After working through this section, teachers should be able to:

- Demonstrate an understanding of outcomes-based education;
- Explain the main concepts related to an outcomes-based approach;
- Demonstrate an understanding of the principles underlying an outcomes-based approach and the National Curriculum Statement Grades R–9 (Schools)
- Incorporate principles underlying the National Curriculum Statement Grades R–9 (Schools) into the Lesson Plan for the Life Skills Learning Programme for the Foundation Phase or the Life Orientation Learning Area for Grades 4–7.



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Unit 1: Outcomes-based Education

OUTCOMES

There is so much talk about an outcomes-based approach, but what does it really mean?

It means a learner-centred approach instead of a teacher-centred approach.

What are outcomes?

The focus is on outcomes and not on content.

Learners have to achieve certain outcomes at the end of a learning process.

An outcome is what the learner can do at the end of a learning process.

Remember in the past the emphasis was on knowledge and content. Now there needs to be a balance between knowledge, skills, values and attitudes.

Learners have to acquire certain knowledge, skills, values and attitudes during the learning process – these are outcomes.

All learners can learn and must be helped to realise their full potential.

This approach is also based on the belief that success leads to more success. Learners should be provided with the possibility of experiencing success.

The teacher and the learners work together to create situations for success through co-operative and collaborative learning experiences in an inviting, challenging, creative and fun-filled classroom

Effective learning is the responsibility of all stakeholders: you, the community and the government.

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Unit 1: Outcomes-based Education

Outcomes are the results of learning processes and refer to:



- Knowledge and understanding



- Skills



- Attitudes and values

***Learners should demonstrate the above after
being through a learning process.***

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Unit 1: Outcomes-based Education

What does the learner know and understand?

- What skills can the learner apply?



- In new situations?
 - Do
 - Apply
 - Transfer
 - Use
 - Demonstrate
 - Participate

- What are the learner's attitudes and values?



There are two kinds of outcomes, namely:

- **Critical and Developmental Outcomes.**
- **Learning Outcomes.**

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Unit 1: Outcomes-based Education

CRITICAL AND DEVELOPMENTAL OUTCOMES

Critical and Developmental Outcomes are generic, cross-field outcomes.
They refer to adult life roles and should therefore
direct all teaching and learning.

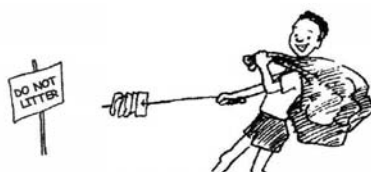
Effective Communicator

**SELF-REGULATED
LEARNER**

Learner



**RESPONSIBLE CITIZEN/
COMMUNITY CONTRIBUTOR**



INFORMATION PROCESSOR

**PROBLEM SOLVER
AND
CRITICAL THINKER**

**Co-operative team**

WORKER



**Contextualist
(UNDERSTAND RELATEDNESS)**

HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Unit 1: Outcomes-based Education

Broad, generic, cross-curricular outcomes. These outcomes will ensure that learners gain the skills, knowledge and values that will enable them to contribute to their own success as well as to the success of their family, community and the nation as a whole. There are seven critical outcomes proposed by the South African Qualifications Authority (SAQA) with an additional five outcomes that support development.

Learners will:

- 1 Identify and solve problems and make decisions using critical and creative thinking.
- 2 Work effectively with others as members of a team, group, organisation and community.
- 3 Organise and manage themselves and their activities responsibly and effectively.
- 4 Collect, analyse, organise and critically evaluate information.
- 5 Communicate effectively using visual, symbolic and/or language skills in various modes.
- 6 Use science and technology effectively and critically. Show responsibility for the environment and the health of others.
- 7 Demonstrate an understanding of the world as a set of related systems by recognising that problem-solving contexts do not exist in isolation.



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Unit 1: Outcomes-based Education



It should be the intention underlying any programme of learning to make an individual aware of the importance of:

- 1 Reflecting on and exploring a variety of strategies to learn more effectively.
- 2 Participating as a responsible citizen in the life of local, national and global communities.
- 3 Being culturally and aesthetically sensitive across a range of social contexts.
- 4 Exploring education and career opportunities.
- 5 Developing entrepreneurial opportunities.

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Unit 1: Outcomes-based Education

Learning Area Learning Outcomes

Each learning area has its own learning outcomes. These learning outcomes refer to the knowledge, skills and values that should be displayed in a particular context.

	Language (HL) (Home Language level)	Language (FAL) (First Additional Language level)	Language (SAL) (First Additional Language level)	Mathematics (M)	Natural Sciences (NS)	Social Sciences (History SS:H & Geography SS:G)	Economic and Management Sciences (EMS)	Arts and Culture (AC)	Technology (T)	Life Orientation (LO)	Total number of LOs
Number of Learning Outcomes (LOs)	6	6	5	5	3	6	4	4	3	5	36
Foundation Phase	HL#LO1 HL#LO2 HL#LO3 HL#LO4 HL#LO5 HL#LO6	FAL#LO1 FAL#LO2 FAL#LO3 FAL#LO4 FAL#LO5 FAL#LO6		M#LO1 M#LO2 M#LO3 M#LO4 M#LO5	NS#LO1	SS:H#LO1 SS:H#LO2 SS:H#LO3 SS:G#LO1 SS:G#LO2 SS:G#LO3	EMS#LO1 EMS#LO2	AC#LO1 AC#LO2 AC#LO3 AC#LO4	T#LO1	LO#LO1 LO#LO2 LO#LO3 LO#LO4	29
Intermediate Phase	HL#LO1 HL#LO2 HL#LO3 HL#LO4 HL#LO5 HL#LO6	FAL#LO1 FAL#LO2 FAL#LO3 FAL#LO4 FAL#LO5 FAL#LO6	SAL#LO1 SAL#LO2 SAL#LO3 SAL#LO4 SAL#LO5	M#LO1 M#LO2 M#LO3 M#LO4 M#LO5	NS#LO1 NS#LO2 NS#LO3	SS:H#LO1 SS:H#LO2 SS:H#LO3 SS:G#LO1 SS:G#LO2 SS:G#LO3	EMS#LO1 EMS#LO2 EMS#LO3 EMS#LO4	AC#LO1 AC#LO2 AC#LO3 AC#LO4	T#LO1 T#LO2 T#LO3	LO#LO1 LO#LO2 LO#LO3 LO#LO4	35
Senior Phase	HL#LO1 HL#LO2 HL#LO3 HL#LO4 HL#LO5 HL#LO6	FAL#LO1 FAL#LO2 FAL#LO3 FAL#LO4 FAL#LO5 FAL#LO6	SAL#LO1 SAL#LO2 SAL#LO3 SAL#LO4 SAL#LO5	M#LO1 M#LO2 M#LO3 M#LO4 M#LO5	NS#LO1 NS#LO2 NS#LO3	SS:H#LO1 SS:H#LO2 SS:H#LO3 SS:G#LO1 SS:G#LO2 SS:G#LO3	EMS#LO1 EMS#LO2 EMS#LO3 EMS#LO4	AC#LO1 AC#LO2 AC#LO3 AC#LO4	T#LO1 T#LO2 T#LO3	LO#LO1 LO#LO2 LO#LO3 LO#LO4 LO#LO5	36

* HL/FAL/SAL 1: Listening. HL/FAL/SAL 2: Speaking. HL/FAL/SAL 3: Reading & Viewing. HL/FAL/SAL 4: Writing. HL/FAL/SAL 5: Thinking & Reasoning. HL/FAL/SAL 6: Language Structure & Use.

** The Language in Education Policy (1997) determines how many languages should be offered at the different phases.

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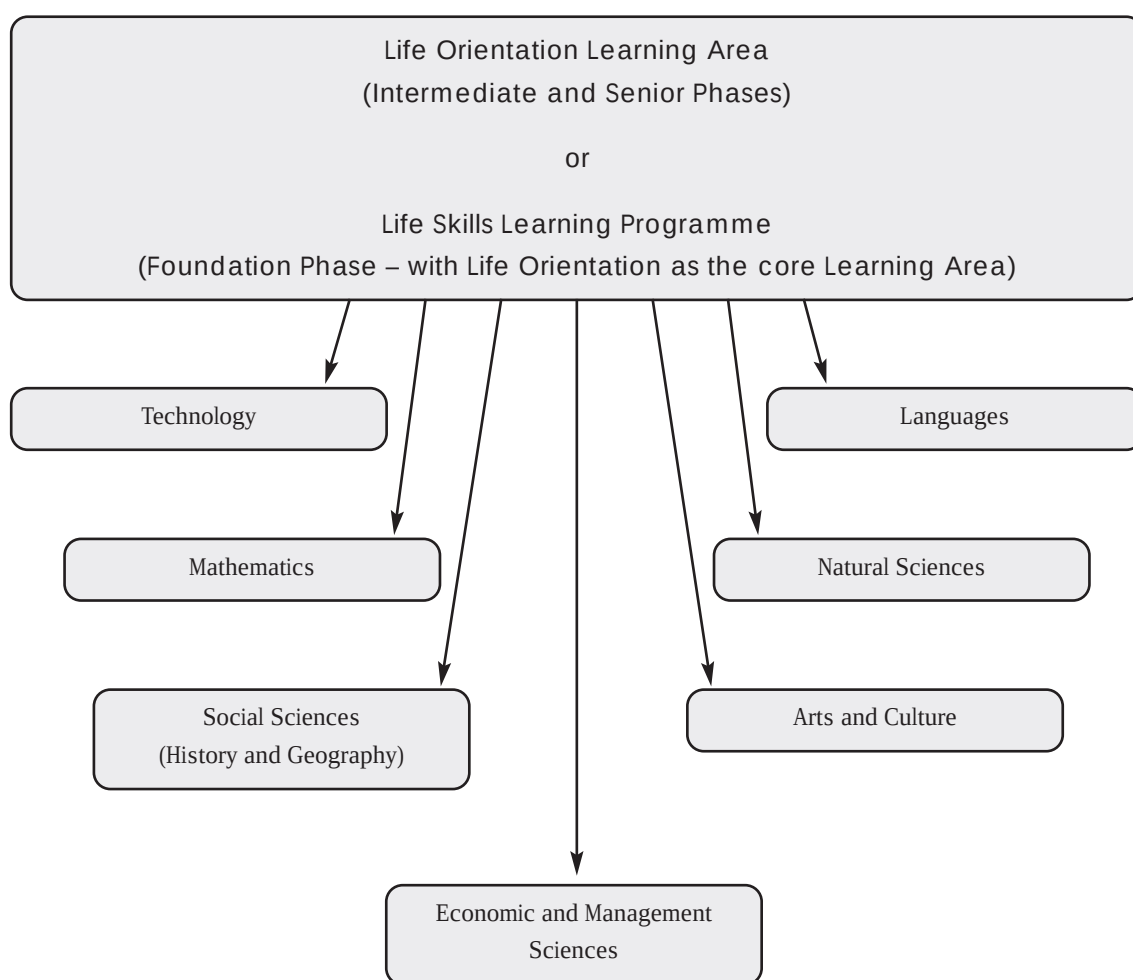
Unit 1: Outcomes-based Education

INTEGRATION OF LEARNING AREAS

Integrated learning is central to outcomes-based education. The historically fragmented nature of knowledge can be overcome if attention is paid to relevant integration both within Learning Areas, and across Learning Areas.

Teachers need to have a clear understanding of the role of integration within their Learning Programmes. The key, however, is the balance to be struck between integration and conceptual progression. That is, integration must support conceptual development instead of being introduced for its own sake. Teachers must therefore be aware of and look for opportunities for integration both within and across Learning Areas.

In developing a Work Schedule, teachers will have to consider in greater detail, matters of integration. In the case of integration across Learning Areas, this may include meeting with teachers from the other Learning Area(s) to ensure that the anticipated integration is workable in terms of their respective Work Schedules.



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Unit 1: Outcomes-based Education

LEARNING AREAS

Vehicles that will be used to attain these outcomes are the Learning Areas. Learning Areas represent eight groups of related knowledge, skills and values.

Life Orientation



Language



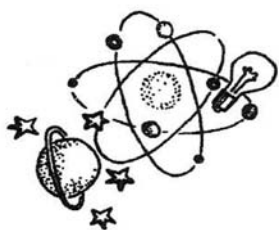
Arts and Culture



Economic and Management Sciences



Technology



Mathematics



Natural Sciences



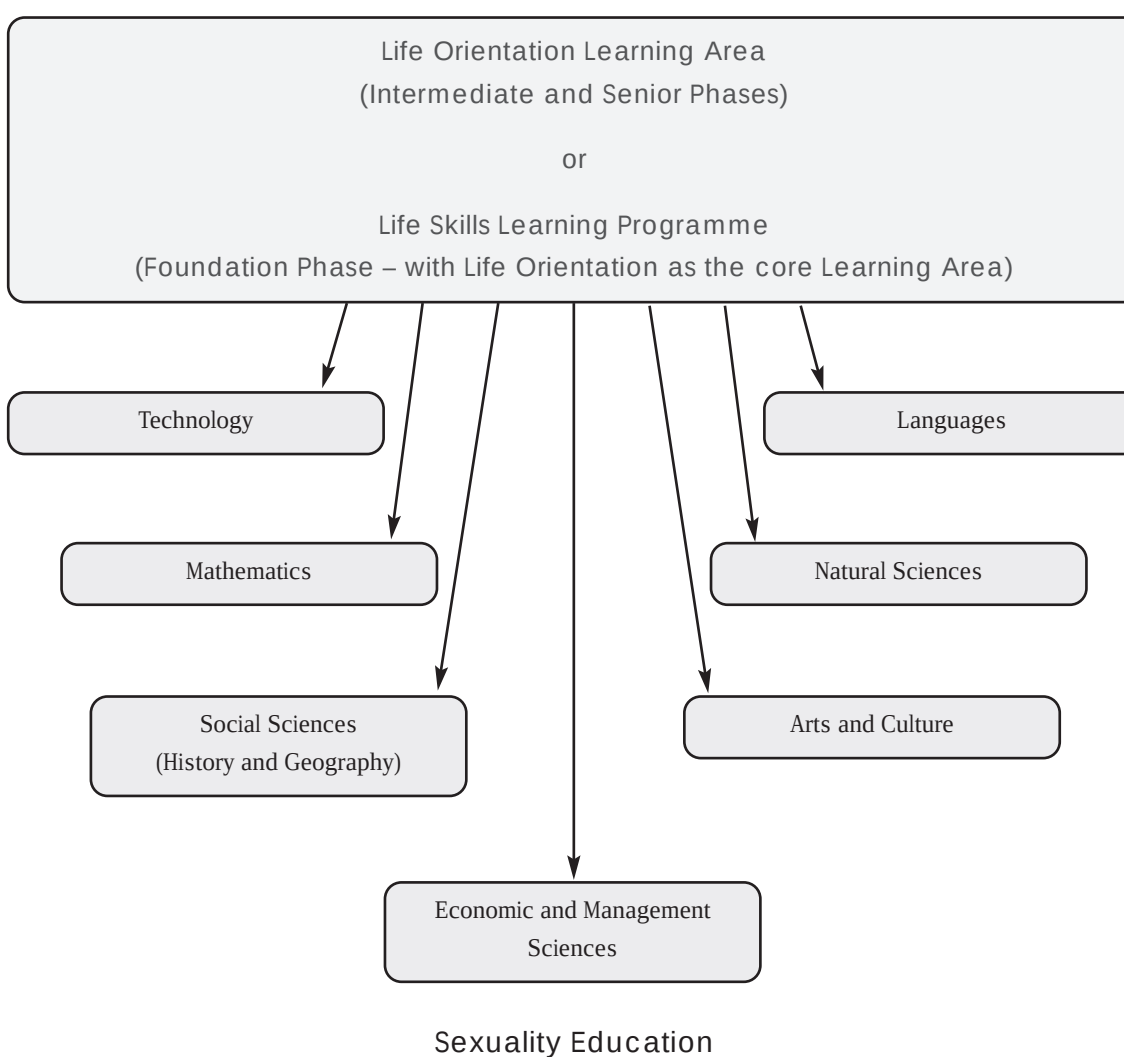
Social Sciences

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Unit 1: Outcomes-based Education

LIFE ORIENTATION

Although Sexuality Education will be integrated into all the Learning Areas, it will find its core in Life Orientation. The unique features and scope and the Learning Outcomes for Life Orientation will therefore be relevant to such education.



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Unit 1: Outcomes-based Education

Introducing the Life Orientation Learning Area

*(Department of Education:
National Curriculum Statement
Grades R–9 (Schools) 2002)*

Definition

The concept of life orientation captures the essence of what this Learning Area aims to achieve. It guides and prepares learners for life and its possibilities. Specifically, the Life Orientation Learning Area equips learners for meaningful and successful living in a rapidly changing and transforming society.

The Life Orientation Learning Area is central to the holistic development of learners. It is concerned with social, personal, intellectual, emotional and physical growth of learners, and with the way in which these facets are interrelated. The focus is the development of self-in-society. The Learning Area's vision of individual growth is part of an effort to create a democratic society, a productive economy and an improved quality of life.

The Life Orientation Learning Area develops skills, knowledge, values and attitudes that empower learners to make informed decisions and take appropriate actions regarding:

- health promotion;
- social development;
- personal development;
- physical development and movement; and
- orientation to the world of work.

These five focus areas of Life Orientation Learning Area Statement all address the human and environmental rights outlined in the South African Constitution.

Purpose

The Life Orientation Learning Area aims to empower learners to use their talents to achieve their full physical, intellectual, personal, emotional and social potential. Learners will develop the skills to relate positively and make a contribution to family, community and society, while practising the values embedded in the Constitution. They will learn to exercise their constitutional rights and responsibilities, to respect the rights of others and to show tolerance for cultural and religious diversity in order to build a democratic society.

The Life Orientation Learning Area will enable learners to make informed, morally responsible and accountable decisions about their health and the environment. Learners will be encouraged to acquire and practise life skills that will assist them to respond to challenges and to play an active and responsible role in the economy and in society.

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Unit 1: Outcomes-based Education

Unique features and scope

Focusing on the holistic development of learners, the Life Orientation Learning Area Statement makes a unique contribution to the General Education and Training Band. It:

- enables learners to make informed decisions about personal, community and environmental *health promotion*;
- enables learners to form positive *social relationships*, and to know and exercise their constitutional rights and responsibilities;
- empowers learners to achieve and extend their *personal* potential to contribute positively to society;
- enables learners to cope with and respond to the challenges in their world;
- promotes *physical development* as an integral part of social, cognitive and emotional development from early childhood through the General Education and Training Band;
- develops a positive *orientation to study and work*, and the ability to make informed decisions regarding further study and careers.

Self-in-society

The Learning Outcomes of the Life Orientation Learning Area equip learners to live productive and meaningful lives in a transforming society. Their focus is the development of self-in-society. The features of contemporary South Africa, and the nature of the personal challenges learners encounter in this society, guide the choice of the content of this Learning Area Statement.

South African society is characterised by socio-political change. Prejudice, often in the form of racism, is still present in post-apartheid South Africa. These prejudices must be acknowledged and challenged if they are to be overcome. In addition, the country faces the challenges of socio-economic development, which include an increasingly global economy, unemployment and environmental degradation. It is necessary to develop ways of living together in an emerging democracy, and of enjoying hard-won civil, political, social and economic rights.

Learners must find a place for themselves in a world increasingly different from that in which their parents lived. Despite political change, learners live in a complex and challenging environment. Crime and violence affect virtually every school, community and individual learner. Environmental issues affect the health and well-being of many communities. Within this context, it is imperative for learners to develop a sense of confidence and competence in order to live well and contribute productively to the shaping of a new society.

The following five focus areas shape the Learning Outcomes that address the developmental needs of the learner in the society:

Health promotion

Many social and personal problems are associated with lifestyle choices and high-risk behaviours. Sound health practices, and an understanding of the relationship between health and environment,

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Unit 1: Outcomes-based Education

can improve the quality of life and well-being of learners. The Life Orientation Learning Area Statement addresses issues relating to nutrition, diseases including HIV and AIDS and STDs, safety, violence, abuse and environmental health.

Social development

In a transforming and democratic society, personal development needs to be placed in a social context in order to encourage the acceptance of diversity and commitment to democratic values. Discrimination on the basis of race, origin and gender remains a challenge for learners in the post-apartheid era. So as to address these issues, this Learning Area Statement deals with human rights as contained in the South African constitution, social relationships and diverse cultures and religions.

The term 'religion' in this Life Orientation Learning Area Statement is used to include belief systems and worldviews. Religion Education in the Revised National Curriculum Statement for Grades R–9 (Schools) rests on a division of responsibilities between the state on the one hand and religious bodies and parental homes on the other. Religion Education, therefore, has a civic rather than a religious function, and promotes civic rights and responsibilities. In the context of the South African Constitution, Religion Education contributes to the wider framework of education by developing in every learner the knowledge, values, attitudes and skills necessary for diverse religions to co-exist in a multi-religious society. Individuals will realise that they are part of the broader community, and will learn to recognise their own identities in harmony with those of others.

Personal development

Personal development is central to learning, and equips learners to contribute effectively to community and society. This area focuses on life skills development, emotional development, self-concept formation and self-empowerment.

Physical development and movement

Physical and motor development is integral to the holistic development of learners. It contributes significantly to learners' social, personal and emotional development. Play, movement, games and sport contribute to developing positive attitudes and values. This area focuses on perceptual motor development, games and sport, physical growth and development, and recreation and play.

Orientation to the world of work

Work is an essential aspect of meaningful living. All learners in the General Education and Training Band require a general orientation to work and /or further study, whether they intend to enter employment or further their studies.

At the end of the General Education and Training Band, learners must make career and study choices that will affect their future. In order to make such choices, learners need career information from a range of Learning Areas. These areas focus on career information-gathering and planning skills, self-knowledge, general work, further study, and work ethics.

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Unit 1: Outcomes-based Education

Life Orientation Learning Outcomes

The five Learning Outcomes for the Life Orientation Learning Area are:

Learning Outcome 1: Health Promotion

The learner will be able to make informed decisions regarding personal, community and environmental health.

Learning Outcome 2: Social Development

The learner will be able to demonstrate an understanding of and commitment to constitutional rights and responsibilities, and to show an understanding of diverse cultures and religions.

Learning Outcome 3: Personal Development

The learner will be able to use acquired life skills to achieve and extend personal potential to respond effectively to challenges in his or her world.

Learning Outcome 4: Physical Development and Movement

The learner will be able to demonstrate an understanding of, and participate in, activities that promote movement and physical development.

Learning Outcome 5: Orientation to the World of Work

The learner will be able to make informed decisions about further study and career choices.

The Foundation and Intermediate Phases cover only the first four Learning Outcomes, while the Senior Phase includes all five Learning Outcomes.



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Unit 1: Outcomes-based Education

ACHIEVEMENT OF LEARNING OUTCOMES

Outcomes are statements about knowledge,
understanding, skills, and values.

The question now is:

How does the learner achieve such knowledge,
understanding, life skills and values:

- By exposing/facilitating the learner to a learning process, *knowledge* and *understanding* are achieved;
- Values are established and cemented, and the learner is motivated to practise and acquire *life skills*.
- Activities are designed for the learner (see next page).
- The learner is exposed to a variety of educational resources (see next page).
- The learner is assessed continuously throughout the learning process to establish whether the outcomes have been achieved (see next page).

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Unit 1: Outcomes-based Education

EDUCATIONAL ACTIVITIES

Examples of educational activities

Graphic

- Puppets
- Costumes
- Games
- Puzzles
- Cards
- Collages
- Comic strips
- Scrapbooks
- Sketches
- Illustrations
- Cartoons
- Maps
- Charts
- Photographs
- Slides
- Transparencies
- Posters
- Stamps
- Labels

Audio-Visual

- Slides with commentary or story on tape
- Slide-sound programmes
- Transparencies with commentary
- Pictures or photos with commentary
- Filmstrips with commentary
- Video excerpts
- Sound recordings

Oral

- Panel discussions
- Short plays
- Role plays
- Dialogues
- Debates
- Reports
- Zones
- Talks
- Interviews

Written

- Press releases
- Essays
- Articles
- Letters
- TV programmes
- Reviews
- Books
- Plays
- Songs
- Dialogues
- Opinion surveys
- Diary entries
- Poems
- Interviews



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Unit 1: Outcomes-based Education

EDUCATIONAL RESOURCES

Examples of educational resources that the learner can refer to:

Education supplementsNewspapers
and magazines**Fiction and non-fiction
books**

Museums



Workbooks

Charts

Field tripsBulletin board/
Display area

Video recordings

Non-governmental
organisationsReference books,
e.g. dictionaries, atlases**Learners****Community resource
persons****Directory of learning
materials**Audio tapes
Multimedia packs

Television/radio

Published textbooks

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Unit 1: Outcomes-based Education

Educational resources (continued)

Resource	Use	Where can I get more information?
Newspapers and magazines	To develop language and communication skills; equally useful for all other learning areas.	Courses on using print media in education run by: MiE (KwaZulu-Natal) Tel: (031) 303 4206 MiE: (Gauteng) Tel: (011) 836 6040 MiE: (E Cape) Tel: (0431) 20349
Bulletin board/ Display area	To display materials on a theme or concept. Learners can also display their own work.	Use newspapers, magazines, your own posters and learners' work.
Charts	To explain, illustrate, clarify and reinforce different aspects of learning.	Use cardboard and kokis to make your own charts.
Workbooks	As assignments for learners. Find activities that encourage thinking and problem solving.	Provincial education department or local non-government education organisations.
Published textbooks	As a reference; for content; hand out any activity sheets to learners.	Educational publishers and non-government organisations.
Audio tapes, multimedia packs	To reinforce learning by running programmes on the eight learning areas.	Local teacher resource centres and some local libraries.
Fiction and non-fiction books	To develop a culture and love of reading.	Local library.
Reference books, e.g. dictionaries, atlases	For assignments and projects being done by learners/groups.	Local library.
Field trips	Visits to places of interest that relate to the different learning areas.	Tourist information centres can advise on landmarks or places to visit.
Museums	Arrange visits for learners and plan follow-up activities.	Local municipality.
Community resource persons	Health workers to talk about sexuality; AIDS, etc; professionals could be invited to talk to learners about specific careers.	Ask your local civic organisation, or your colleagues and learners in your school.

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FACILITATION



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Facilitation methods



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A brief Explanation of certain methods

1	Buzz groups	After a short presentation members are asked to turn to their neighbours (partners, or small group) and share their views or opinions (buzz) for a few minutes before asking questions.
2	Collage	A collage is a form of art using a variety of materials that are glued on a sheet of paper. The materials can consist of pictures cut out from magazines or newspapers, photographs, drawings, objects like match-sticks, leaves or pieces of material. The purpose of a collage is to illustrate or describe significant characteristics such as values and beliefs that need to be highlighted.
3	Fishbowl	One group works while another sits around them and observes how they work. Feedback is given. The group can then change around.
4	Jigsaw	Participants put pictures together to form an integrated "picture". Parts are assembled to form a system.
5	Simulations	You are all members of...? "You are the charman of...?"
6	Skit	The precise dialogue is provided and learners read the roles.
7	Panels	Useful when the group is large and time is limited. Learners form a panel of not more than ten who are given the opportunity to present their views on a particular topic. The rest of the class listens and are given the chance to ask questions at the end. Can be prepared or unprepared. Example: "What can we do to make sure that we stay healthy?"

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8

Rounds

Learners sit in a circle and each learner is asked to comment. If learners do not wish to comment they can PASS. A useful method to share and consolidate learning. Rounds can be done on particular themes or questions, e.g. What do you think of pre-marital sex?

9

Movement

Not all learners are good at speaking or writing. Movement is an ideal alternative to express one's feelings in written form: fly like a bird; game; do this, do that.

10

Critical incident

A brief introduction to an incident is given and the group discusses questions about it.

11

Input

Teacher input is an essential part of life skills facilitation. More often, it is best to give learners additional information at the end of the activity after they have given their own ideas.

12

Junk-heap

Keep junk, e.g. empty cartons, newspapers, wool, orange bags, empty toilet rolls. When learners need to make something they use things from the junk pile. It stimulates creativity.

13

Props

Collect odds and ends around the house and store in a bag for use during role plays, e.g. old telephones, broken radios, old shoes, socks, hats, walking-sticks.

14

Brainstorming

Brainstorming is a technique in which we gather all our ideas in an attempt to solve problems in new and creative ways.

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Rules for brainstorming sessions

- Generate as many ideas as possible.
- Expand on the ideas of others – combine and improve ideas.
- Have someone record all ideas in a way for all to see.
- Free-wheeling is important, in other words, the wilder and zanier your idea, the better.
- Quantity is essential – the more ideas, the better the odds on finding solutions.
- Delay all evaluation till the end.
- Criticism is not allowed.

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EXPERIMENTAL LEARNING

Experiential learning is participatory – it is a shared activity in which every learner has something to teach and something to learn.

It is a basic learning tool for acquiring skills,
and essentially means the following:

1 Learning from experience

2 Involvement

3 Reflection

4 Active learning

5 Discovering knowledge

6 Shared knowledge

7 Learner participation

8 Shared competence

9 Whole person is involved
(body, mind, feelings, etc.)



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Promotion of experimental learning

You promote Experimental Learning when you:

- Get learners to become actively involved in lessons.
- Give opportunities for learning by doing.
- Give learners the opportunity to use their experience.
- Allow learners to add new knowledge to their own experiences.
- Encourage learners to explore and expand on what they know.
- Encourage learners to think, talk, discuss, relate and tell.
- Give learners opportunities to express themselves.
- Recognise that feelings are an important part of learning.
- Allow learners to experiment, risk and try.
- Enable learners to become committed to making changes.
- Create the space for learners to reflect on their experiences and knowledge.
- Give learners opportunities to practise skills.
- Allow learners to make mistakes.
- Allow learners to use lateral thinking and learning.
- Encourage group work.
- Encourage creativity.
- Use new methods to ensure learner participation.

CLASSROOM MANAGEMENT

Through effective classroom management the teacher attempts to make the environment as friendly and relaxed but also as safe, secure and comfortable as possible. Firstly, classroom management, rules and discipline are aimed at creating an open, friendly and learning-oriented environment without allowing learners to get out of hand to the detriment of the learning process. Secondly, classroom management aims to help learners understand and accept self-control and accountability as part of the process of discipline.

The facilitator should try through his/her management style to:

- Create a friendly learning environment.
- Enable learners to be on-task with their learning.
- Enhance self-concept.
- Encourage accountability for behaviour.
- Encourage learners to recognise and respect the rights of others and, ultimately.
- Develop self-discipline and self-control.

(Source: Kruger 1998)

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Learner characteristics

Learners at different grade levels usually interpret and respond to rules and procedures in different ways.

Grade and learner characteristics

Learners ...

0–3:

- Are compliant, eager to please facilitators.
- Have a short attention span, tire easily.
- Are restless, wander around the room.
- Require close supervision.
- Often break rules only because they forget to adhere to them.
- Need rules and procedures to be explicitly taught, practised and reinforced.

4–6:

- Are increasingly independent.
- Respond well to concrete incentives (e.g. stickers, free time).
- Understand the need for rules and accept consequences.
- Enjoy participating in the rule-making process.
- Know how far they can push and will push as far as they can.
- Need rules to be consistently and impartially enforced and reviewed often.

7–8:

- Are continually testing independence.
- Are sometimes rebellious and capricious.
- Need a firm foundation of stability, explicit boundaries and predictable outcomes.
- Are critical.
- Need rules that are clearly stated and administered.
- Desperately want to be part of the rule-making process.

9–Further Education and Training (FET):

- Do not accept information unconditionally.
- Like to argue and debate.
- Are more critical in their judgments.
- Experience intense emotions, but are capable of controlling emotions.
- Show increasing reasoning powers.
- Want to be part of the decision-making process;
- Take increasing responsibility for themselves.

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Classroom management during OBE

Traditional

Teacher solely responsible for management and discipline.

Co-operative (OBE) classroom:

- Learner and facilitator jointly involved in setting classroom rules and regulations.
- Learners regulate their own behaviour.
- Most effective approach: create a group-based positive reward system.
- Successful classroom management hinges on clear expectations.

Management techniques:

- the zero-noise signal
- group praise
- special – recognition bulletin
- special – recognition ceremony
- class or team fun time

(Source: Kruger 1998)

Classroom management guidelines

Establishing procedures and rules

When preparing group rules, the following guidelines may be helpful:

- Enlist the help of learners when preparing rules and encourage their continual input.
- Keep the group rules consistent – explain changes when necessary.
- State the rules clearly and put them on a bulletin board as a constant reminder of agreed-upon behaviour.
- Explain why rules are necessary and important.
- State rules positively, for example "Treat the facilitator and all other learners with respect" instead of "Do not be disrespectful".
- Keep the list as short as possible.
- The golden rule: 'do unto others as you would want them to do unto you'.

Preventing and addressing misbehaviour

Corrective measures may include:

- Exclusion from the group.
- Withholding of privileges.
- Referral to the principal.

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- Individual meetings with the learner and his/her parents or caregivers.
- Detention, referral to other school procedures such as "time-out" rooms or "in-school suspension".

Thinking differently about classroom management and power:

- Facilitator
- Boss
- Authoritative (democratic)
- Authoritarian (dictatorial)
- Learning oriented
- Work oriented
- Learner centred
- Facilitator centred

(Source: Kruger 1998)

ASSESSMENT

Assessment should take place in the context of a caring, non-judgmental environment. It should serve as a positive affirmation of the learner.

Assessment should be broad enough to include processes and skills as well as knowledge and concepts.

Refer to The National Protocol on Assessment for Schools in the General and Further Education and Training band (Grades R–12), October 2005 and the Assessment Policy (1998) for more detail.

Unit 2

Sexuality Education



***"I learned about sex from the street. Believe me,
that is not a good place to learn it. Talk to me early and
often and tell me what I need to know."
(Teens speak out)***

Unit 2: Sexuality Education

UNIT OUTCOMES

After working through this unit teachers should be able to:

- Distinguish between certain concepts, namely sex and sexuality, sex information and sexuality education.
- Formulate outcomes for sexuality education.
- Indicate the relationship between knowledge, skill, values and attitudes in sexuality education.
- Identify the skills, values and attitudes that are basic to sexuality education.
- List the qualities of an effective sexuality educator.
- Describe sexuality education during the developmental phases of children.
- Create a conducive environment for sexuality education.
- Describe the methodology for presenting sexuality education.
- Present sexuality education by using outcomes-based principles.



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Unit 2: Sexuality Education

CONCEPTUALISATION

Sexuality

In order to understand the concept sexuality, one needs to differentiate between "sex" and "sexuality".

Sex

Sex indicates whether a person is male or female, based on their physical differences. Sex also refers to the act of intercourse.

Sexuality

Sexuality is the total of a person's inherited characteristics, knowledge, attitudes, experience and behaviour as they relate to being a man or a woman. Sexuality affects all areas of our lives. It includes our physical bodies, sexual intercourse, feelings and attitudes, our beliefs and values, the way we walk, dress, behave, the decisions we make, inherited characteristics, relationships between people, social and spiritual aspects of persons' lives. All these aspects determine our sexuality, i.e. the way we perceive ourselves as men and women.

Factors influencing sexuality

Many factors interact to influence one's sexuality, for example:

Parents

- Parents are the initial educators in a child's life.
- Parents are the first contact the child has with modelled behaviours.
- Parents are influential in setting their children's patterns of life by their attitudes towards males and females.
- Children's perception of acceptable behaviour for males and females is largely based on their observation of their parents.
- Parents instill values and beliefs with regard to male and female roles.

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- Friends
- The media
- Teachers
- Religious institutions
- Culture
- Society



The difference between sexuality education and sex information



This is not sexuality education:

Sexuality education entails much more than sexual relationship

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Sex information



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SEXUALITY EDUCATION

In order to understand the term sexuality education one has to distinguish between sexuality education and sex information.

Sexuality education

Sexuality education is mainly a matter of education (guiding the child to responsible adulthood) and is always accompanied by values and norms. Education and moulding are the primary aims.

Sex information

Sex information on the other hand is transmitted for the sake of imparting information without having education and moulding as an aim – values and norms are absent. Sex information can be dangerous and can lead to permissiveness and promiscuity.

Sexuality Education is a lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles. (SIECUS 1991)

From this definition it is clear that sexuality education involves much more than teaching about sex. The aim of sexuality education is to:

- help learners develop a positive view of sexuality and of their bodies, provide them with the necessary **information**,
- assist them to clarify their **values**,
- teach them values and assist them to attain the **skills** needed to develop caring and considerate relationships,
- make responsible, wise and informed choices.
- sexuality education is an ongoing process. It starts at birth and should ideally start at home and be complemented by sexuality education at school.

Learners therefore need to be taught **information**, **values** and **skills**. These three elements should form the core of an effective sexuality education programme.

Information

Values

Skills

(Source: Vergnani & Palmer 1998)

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Sexuality education takes place continuously in every person's life through verbal and non-verbal messages from everyone around him/her including relatives, friends and the media. Withholding factual information from children in an attempt to preserve innocence may prove harmful. It could force children to seek answers from friends who usually do not provide correct, factual answers. Children are inquisitive. Withholding information encourages them to want to know more anyway.

In essence, the function of sexuality education is to encourage the development of pride in every adolescent and his/her chosen lifestyle. This education includes:

- P** Preparing the individual for the physical changes of adolescence; protecting him/her against guilt and exploitation by providing the necessary information and skills.
- R** Removing fears and misconceptions regarding sexuality.
- I** Informing and providing insight into one's sexuality, attitudes, beliefs and values.
- D** Developing positive self-esteem.
- E** Education about responsible sexual relationships, sexual decisions and the choices available

(PPASA: 1998).
(Source: PPASA: 1998)

Aims of sexuality education

Sexuality education should aim to:

- Make young people like and respect themselves, i.e. to enhance their self-esteem and self-awareness.
- Help learners regard sexuality as a natural and positive part of life.
- Provide accurate information.
- Teach the skills needed to make informed and responsible decisions, including decisions regarding sexual relationships.
- Explore different values and attitudes in order to help each learner develop his/her own moral framework.
- Help learners act in accordance with their values.
- Teach understanding, tolerance and respect for different sexual needs, orientations and values.
- Teach learners to behave responsibly and in a caring, respectful way in all relationships.
- Teach learners how to protect themselves from exploitation and how not to exploit others.
- Teach learners how to communicate and express their needs and feelings.
- Teach learners how to use health services and how to find the information they need.

(Source: Vergani & Palmer 1998)

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Sexuality education therefore aims to help young people develop a positive view of their own sexuality and sexual relationships.

It should provide the necessary information



Clarify and teach values



Teach skills



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These elements are needed to make wise, informed decisions and choices about all sexual matters.

Knowledge, Skills, Values

A balance between knowledge, skills and values is important in the sexuality education programme.

Information

What kind of information should be given?

Information should be appropriate to the learners' age and phase of development and should be presented in a language they can understand. Learners can identify their own needs and interests. Information should be meaningful and relate to everyday experiences and to the life world of learners.

Life skills

What skills are relevant to sexuality education?

Life skills are essential for successful living and learning. Life skills are a large range of coping abilities people need to be able to function effectively in their everyday lives. As we develop skills, we should be able to deal with challenges and problems better and even prevent some problems from occurring. Life skills make life easier. The more we practise these skills the greater our abilities become to live successfully and do the best we can. When life skills are achieved, capacity building (the growth and development of people) becomes a reality. Through life skills people also become empowered. According to Rooth (1999) we are empowered when we:

- Believe in ourselves.
- Take control of our lives.
- Can cope with life.
- Feel in charge of what is happening to us and around us.
- Feel motivated.
- Feel confident to face the challenges of life.
- Achieve the best that we are able to.

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You taught me
You taught me the names of the cities in the world
BUT
I don't know how to survive in the streets in my own city
You taught me about the minerals that are in the earth
BUT
I do not know what to do to prevent my world's destruction
You taught me to speak and write in three languages
BUT
I do not know how to say what I feel in my heart
You taught me all about reproduction in rats
BUT
I do not know how to avoid pregnancy
You taught me how to solve maths problems
BUT
I still can't solve my own problems
Yes, you taught me many facts, and thank you,
I am now quite clever
BUT
Why is it that I feel I know nothing?
Why do I feel I have to leave school to learn about coping with life?

(Rooth 1999)



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Life skills could include abilities such as being able to communicate effectively, handle your emotions and to find personal meaning in life. General or generic life skills are those skills that are relevant to most areas of life and therefore to all learning areas in the school. Interestingly, general life skills are being taught in such a wide variety of countries that they appear to have relevance across cultures as well.

Life skills are a key component of sexuality education. Even if learners have the necessary information and values to make responsible decisions, they still need the skills to implement decisions, e.g. if the decision is not to have sex before marriage then communication, assertiveness, refusal, skills will be needed to convey the decision to a partner and to stick to the decision.

A number of skills that are central to sexuality education have been identified. This list is by no means complete and you will most probably be able to add other skills to your list as you gain more experience in sexuality education:

Communication (including listening skills)	Building self-esteem
Self-awareness	Goal setting
Finding information (resources and help)	Critical thinking
Creative thinking	Decision making
Conflict resolution	Handling emotions
Safety awareness	Assertiveness
Refusal skills	Negotiation
Value clarification	Identifying one's emotional needs
Identifying one's values	Delaying gratification (in order to meet long-term objectives)

Once these skills have been acquired by learners they can also apply them to other areas of life, e.g. deciding on a career.

Everybody has potential, abilities, talents and strengths that need to be developed. Pickworth (Baloyi 1998) says it was once assumed that every individual acquired skills as part of growing up and that such skills could not be taught. We all know today this is incorrect. Skills should be **taught** (and practised in class and applied to everyday situations) rather than be left for incidental learning.

Values

Why do we need to include values in sexuality education?

Sexuality education cannot be neutral or value-free. Neutral or value-free teaching is not true education because education is always accompanied by moulding and guiding learners towards responsible adulthood. Responsibility goes hand in hand with being able to distinguish between right and wrong, and should be accompanied by particular values and norms. What people

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believe in will affect the decisions and choices they make. Adolescents are in a period of change. They are highly critical and question many issues. They are often confused about their values with regard to sexuality because they receive so many confusing messages – for example their parents and the church oppose pre-marital sex, but the media and their friends often say the opposite. Adolescents need help to clarify their values. This can take time, even several years. Adolescents need to discover the origin of their beliefs and values regarding sexuality, and to distinguish between these and their emotional needs. Learners should ideally be helped to arrive at a set of attitudes and values with which they feel comfortable and which are not only in their own best interests but also in the interest of those around them.

Inclusion of values during the phases

Foundation Phase

Learners in the Foundation Phase are still discovering and learning about beliefs and values. They are impressionable and easily influenced. They are subjected to many confusing messages about what is wrong and what is right from their family, society and the media. It is therefore critical that learners should be guided to develop a sense of what is right and wrong. Although this process starts when learners are very young it is a process that should continue throughout their school years.

You will not be dealing with issues such as attitudes towards pre-marital sex, contraception, etc, but you will take the age, level of cognitive and moral development of learners into account. Matters such as family relationships; issues regarding friends; liking, respecting, caring for and protecting their bodies; preventing child abuse; and treating people who are "different" from themselves with respect and those equal to themselves, will be focused upon.

Intermediate Phase

As has been stated above, learners receive so many confusing messages regarding sexual issues that it becomes difficult for them to make decisions. It is easier to make decisions when the decisions relate to what one believes in.

The aim of sexuality education is also to teach values and to assist learners to understand and to clarify in what they believe. It should encourage them to critically evaluate and judge their own thinking and judgement. One's behaviour should be in accordance with that in which one believes. Ideally teachers should assist learners to arrive at a set of values with which they feel comfortable - values that take other people's interests and needs into consideration. Clarifying values should be done over a number of years.

During the Intermediate Phase the process of clarifying values should be repeated as often as possible, and should be related to concrete situations. Children during this phase are concerned about issues of justice and fairness, good/bad/wrong and right. They also fear being rejected by

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their friends – the peer group plays a major role in their lives. They need opportunities look critically at different issues and behaviour involving what is right and what is wrong. Case studies can be used meaningfully in this regard.

Senior Phase

Adolescents find themselves in a transitional period during which they question and criticise many issues.

(Source: Vergani & Palmer 1998).

Three broad views – the teaching of values

Three broad views regarding the teaching of values in sexuality education can be identified:

- Persons who believe that sexuality education should be value-free. They present facts in a unbiased, neutral manner and generally do not take a stand on issues. For example: "People with AIDS deserve to die" "Homosexuals should be removed from society" "All women are inferior to men". Think about the consequences of such beliefs for learners and society.
- Persons who have a **moralistic and judgmental view**. Learners are not really permitted to say how they feel and to form their own opinions. For example: "Contraception is wrong" "Having a child outside of marriage is wrong". Think about the consequences of such viewpoints.
- Persons who believe that teachers **should teach values**. Learners need guidance with regard to wrong and right. Teachers should not impose their values and views on learners, but should guide them to develop their own attitudes and values with regard to what is right and wrong. Certain matters are non-negotiable, such as hurting or exploiting others or discriminating against others. However, teachers should never attempt to take the place of parents and the community. Rather, they should assist learners to interpret, discuss and understand the messages, values and attitudes that they have brought from their home, culture and communities.

(Louw 1994; Vergnani & Frank 1998).

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Core/common values and attitudes

Certain core/common values and attitudes have been identified that are important for the survival of people and societies. Once again you will find that you can add to the list as you gain more experience.

Commitment	Accountability
Responsibility	Loyalty
Honesty	Tolerance
Non-discrimination	Health and hygiene
Privacy	Respect for myself
Respect for others	Empathy
Self-control	Helpfulness
Friendliness	Caring
Kindness	Respect for life
Sensitivity	Compassion
Trustworthiness	Self-discipline
Forgiveness	

Teachers' values

At this point we need to ask teachers the following questions:

What about your own values regarding sexuality? Are you comfortable with your own sexuality? Are your own values about sexuality clear? What is your opinion about termination of pregnancy? How do you feel about homosexuality?

In order to teach sexuality education, teachers should know their own values as this will influence the way they present information and ideas to learners. We all have beliefs that will influence our teaching – it's no use pretending that one can remain absolutely neutral. Look at your own values briefly in the Activity for teachers (bookmark). An important guideline to adhere to is the South African Bill of Rights (see Unit 3).

Messages teachers should convey about sex and sexuality

- Sexuality is a natural and positive part of every person.
- The human body, no matter what it looks like, is special, good and acceptable.
- The genitals are a natural, good part of the body.
- Everybody needs to be touched in a caring and non-exploitative way.
- All people (adults and children) have the right to say who may touch them, especially on the sexual parts of their bodies.
- Sexual behaviour is more than just reproduction. It is also a way of showing love, experiencing pleasure and having fun.

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- Differences between people should be recognised.
- It is wrong to exploit or to take unfair advantage of other people.
- Sexuality is a topic that children can and should discuss with parents, teachers, relatives and friends.

(Source: Verganani & Palmer 1998)

THE SEXUALITY EDUCATION TEACHER

The success of Sexuality Education will depend on the kind of teacher presenting it and the way in which the teacher talks about sexuality. As the entire issue of sexuality education is often sensitive and controversial it should be dealt with by a teacher with special qualities who:

- Feels there is a need to teach about sexuality issues.
- Has the necessary knowledge to present sexuality education.
- Is comfortable with his/her own sexuality.
- Has high self-esteem.
- Gets on well with most learners.
- Can work well with parents and members of the community.
- Can deal with situations in which there are not clear-cut answers.
- Uses interactive methods of teaching.
- Is tolerant of different viewpoints.
- Is a positive role model.
- Is trusted and respected by the learners.
- Is trusted and respected by the parents.
- Can speak openly about sexual matters without being embarrassed.
- Has a sense of humour, without being vulgar.
- Can guide learners in groups and individually towards making morally responsible choices about their sexual behaviour.
- Is willing to read and learn more about sexuality – is prepared to be trained for the task of sexuality education.
- Is an experienced teacher and able to use audio-visual media.
- Can empathise.
- Has a healthy heterosexual orientation.
- Can accept the sexuality of others.
- Is strict but not rigid in his/her approach.
- Is willing to answer sensitive questions.
- Does not preach or talk down to children.

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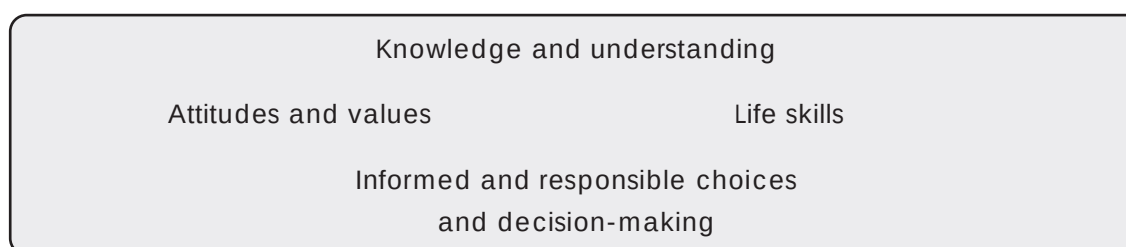
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METHODOLOGY

The following questions are often asked:

How one should guide children to make informed and responsible decisions about their sexual behaviour?

How one should establish core/common values without forcing one's own values on them? How does an educator motivate children to practise the necessary skills when making decisions?



The solution to this lies in the planning of activities for the learning unit. Learners are guided through knowledge to understand and internalise core/common values in order to make responsible decisions about sexuality. Skills have to be practised in order to implement these decisions. The aim therefore, should be to inspire the learner to gather information and also to guide him/her to experience a sense of depth, meaning and destiny in terms of which decisions about sexual behaviour can be made and implemented. This is the difference between sex information and sexuality education. If there is an imbalance between knowledge, skills and attitudes or values (i.e. if one is over-accentuated at the cost of the others) learners will be harmed.

The teacher, as facilitator, should therefore ensure that learners have internalised the essence of learning units and understand its *meaning* in their lives. The learner should be able to achieve the outcomes.

We as educators should realise that the content of sexuality education is different from any other content presented at school. It must be *age-appropriate* and dealt with the greatest care and sensitivity. We often make the mistake of talking about sexuality as if it were something like brushing our teeth or climbing a mountain. As soon as one moves into the area of sexuality education, one is touching the learner personally, because the content is *highly* personal and *sensitive*.

Feelings such as:

- shock,
- fear,
- revulsion (disgust),
- uncertainty,

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- anxiety,
- guilt,
- appreciation,
- wonder,
- gratitude,

may be experienced by learners during the discussion of a particular topic/theme. They should be given the opportunity to talk about personal problems with the teacher alone. They should be assured of the confidential nature of the discussion and that their secrets will be safe with the teacher.

Sexuality education in the different phases

Foundation Phase (age: ± 6–8 years)

Although the skills and values regarded as important for Sexuality Education should already be part of the curriculum in the Junior Primary Phase of development, **no formal Sexuality Education lessons should be taught at such an early age. The only exception should be lessons** on the prevention of child **sexual abuse**. Questions about AIDS and other aspects of human sexuality should be answered by the teacher in a responsible manner as they arise. Teachers should also be aware that even though this is regarded as the "latent" phase of sexual development, children in the junior primary phase are extremely interested in their own bodies and genital organs and curious about the bodies of the opposite sex. There is a certain amount of experimentation (games like "doctor-doctor"), peeping, use of foul language and masturbation.

Teachers should **never overreact** to things like these, but **should set limits to unacceptable behaviour**. Discussions with children about problems should take place in private. Extreme problem behaviour should be discussed with a professional.

Intermediate Phase (age: ± 9–11 years)

There are great individual differences in the tempo of growth and sexual development among children. Girls usually show signs of development before boys do; some even start menstruating at nine or ten years of age. However, on the whole, children in this age group are still in the pre-puberty phase of development and although they are aware of the differences between the sexes, there is little obvious sexual development. However, because some girls do start menstruating early, it would be **wise to have a discussion concerning menstruation with the girls in this age group**. Other lessons that could be included at this age are the lessons on **stages of development** (so that the learners will understand "growing up as a total human being"), **sexual abuse** and AIDS (mainly to comfort and allay fears, but also to warn against certain risky behaviour), and **relationships** with members of their own and the opposite sex.

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Unit 2: Sexuality Education

Senior Phase and Further Education and Training Band (age: $\pm 12-18$ years)

All the themes on Sexuality Education should be discussed with learners in this phase. It is recommended that instead of spreading the discussion of themes over a long period of time, themes should be grouped together and discussed as Sexuality Education units. For example: the themes on **puberty and adolescence** (growing up, marriage, conception, birth) could form one unit that is discussed during a specially allotted time on the timetable ($\pm 2\frac{1}{2}$ hours). The themes on **meaningful relationships** (heterosexual, homosexual, dealing with sexual abuse, rape, STDs and AIDS) could form another separate unit, and **family planning, teenage pregnancy** and **abortion** yet another (each $\pm 1\frac{1}{2}$ hours).

When presented in this manner, the learners have enough time to ask questions, a relationship of trust is established between the teacher and the learners, fears are allayed and myths dispelled. The learning content is so sensitive it should not be presented in smaller units (i.e. during one period only). Special time must be allocated on the timetable for the presentation of these three units.

It is recommended that **boys and girls be separated** for this kind of sensitive discussion, as they will then have more courage to ask questions. It also seems that same-sex teachers are preferable, although boys do not seem to mind discussions of this type with a female teacher (mother figure). Groups should be small ($\pm 40-50$) in order to facilitate discussion.

Choose a suitable venue where there will be little or no disturbance. This will promote open discussion.

Sexuality Education is often not accepted by parents and religious institutions. However, if parents and representatives of all interest groups are familiarised with the content of the lessons and the audio-visual material at the school, and if parents are asked to give written permission for their children to attend Sexuality Education lessons, there is usually much more mutual trust and co-operation. In various countries, Sexuality Education was stopped by angry parents and religious representatives because it seemed as though it had been forced on children without prior consultation with all concerned groups.

The atmosphere in the sexuality education classroom

Because of the sensitive nature of the learning content, the teacher should take special care to establish a relationship of trust with learners in the class (boys and girls separately). The learners should feel welcome and should be reassured that they can ask questions and will be given the opportunity to talk about personal problems with the teacher alone. They should be assured of the confidential nature of the discussion and that their secrets will be safe with the teacher.

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Unit 2: Sexuality Education

Dealing with sensitive questions and situations

The same kind of skills that a teacher uses in discussions with learners will be useful when sensitive questions arise. Here follow some recommendations based on the school policy or community values:

- Answer all questions (acknowledge limitations – if you do not know an answer. Offer to do research on the question).
- Be reliable about follow-up (do this quickly/swiftly).
- Consider the reason behind the question (the learner may be seeking information, expressing anxiety or wanting a solution to a problem).
- Be relaxed (establish trust and put the learner at ease).
- Pay attention to your own body language, conduct and attitude (be a role model, show genuine interest – let learners know you are listening to them).
- Inspire confidentiality (appreciate the confidence placed in you, and do nothing to damage that trust).
- Answer questions honestly and provide the facts (make sure of the facts and use the correct terminology).
- Keep the developmental phase and age of the learner in mind (avoid complex information).
- Handle disclosures and discoveries appropriately (remain calm and reassure the learner as far as possible: set ground rules in this regard. Private matters should be discussed with parents or in individual discussions with you; do not tease learners about the questions they ask).
- Provide appropriate reassurance, particularly concerning HIV and AIDS.
- Refer to parents or other sources when necessary.
- Avoid answers that may cause learners to feel badly about family members (alcohol abuse, divorce – phrase questions in a non-judgmental way).
- Try not to show embarrassment.
- Be honest and open.
- Use the correct biological terminology.
- Use humour to relieve tension, but the humour should never be vulgar.
- Never preach/admonish or judge the actions of parents or learners – rather guide learners through knowledge to understand what behaviour is acceptable and what is not, and consequently to make responsible choices.
- Ask learners to give their opinions on sexual issues – encourage open discussion.
- React calmly to the use of street words or other coarse remarks by replacing them with the correct biological or medical terms and explaining what they mean.
- Speak with sensitivity (soften the content) in order to prevent vulgar interpretations and to promote respect for human sexuality.
- Maintain discipline (not too rigid) so that meaningful discussions can take place.
- Avoid teaching sex techniques (i.e. details of certain sexual activities) as this could lead to a Sex Information lesson, instead of a Sexuality Education lesson.

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Unit 2: Sexuality Education

Examples of how to handle sensitive Topics

Philosophical or moral questions

Teacher asks:

"Are people who have sex without being married bad?"

"This is a question that can be answered in many different ways. Different people have different beliefs about sex, including what they believe about having sex without being married. This is a good question to talk over with your parents and other people in your family. You can think about how you feel about this question when you understand more about the things they believe".

Questions too sophisticated for the class

Sometimes learners ask questions that are above the knowledge, or developmental level of the rest of the class. Affirm the importance of the question, but redirect the learner to a private discussion after class.

"What is a boy supposed to do if he cannot use a condom because he cannot keep his penis hard?"

"You have asked a good question, but it is also a complicated one. I think this is something I could explain more easily if we talk privately after class. You could also ask your parents, a nurse or doctor about it."

Questions using explicit or slang terms

When learners use slang terms, and if they are offensive, rephrase the question using the correct terminology or normal language. Do this in a matter-of-fact way, without appearing to judge or correct the learner.

"Why is my 'ntoto' not as big as Mpho's?"

"This question why your 'ntoto's is not as big as Mpho's is a good question. We can also talk about 'ntoto' as a penis. Remember everyone's body develops at its own pace. We are unique and special. So when you are as old as Mpho your penis will also become larger."

Fears about having AIDS

Even if a learner's fear about AIDS is unfounded do not dismiss it, because his/her fear is real to him/her.

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"I have a friend who thinks she has AIDS, but she is afraid to tell anyone about it."

"Children who are afraid they may have AIDS should tell an adult, especially one they trust – their parents or caregiver – about their fears. Something as important as this is hard even for grown-ups to handle themselves. If any of you ever have such fears and you do not feel comfortable telling your parents or caregiver, I hope you will tell me so I can help you"

(Schonfeld et al. 1996).

Rape

What is rape?

Rape is forcing a person to have sex against their will. Date rape occurs when someone takes you out on a date and forces you to have sex with him against your will. Gang rape is when a person is raped by more than one person. Rape is a violent, traumatic and life changing experience. Any woman or man can be raped.

What should I do if I am raped?

If you are raped it is your choice whether or not you want to report it to the police. You do not have to report it and no one can force you to report the rape if you do not want to.

If you decide to report the rape you should do so immediately after it has happened. You should not wash yourself or change your clothes because this can be used as evidence against the rapist in court.

If you report the rape you must be prepared to go to court if the police catch the rapist.

Whether you report the rape or not, the most important things to do are:

- To get medical treatment,
- To talk to someone about what has happened to you.

Where should I go for medical treatment?

If you report the rape to the police, you will get medical treatment from a state doctor called a District Surgeon.

If you do not report the rape, go to the nearest clinic, your doctor or a hospital and ask them to help you. The medical treatment will involve treating any injuries you have on your body as well as an internal examination to check that your internal organs have not been damaged. If you report the rape the District Surgeon will scrape under your finger nails and comb your pubic hair because there may be evidence of the rapist in these parts of your body, for example his sperm.

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Can I get pregnant as a result of the rape?

Yes. For this reason it is vital to get medical treatment. The nurse or doctor must give you emergency contraception to prevent you from falling pregnant. If you do not receive an emergency contraceptive in time and you do become pregnant as a result of the rape, you can have an abortion.

Can I get HIV and AIDS from being raped?

Yes. Anyone who is raped can get HIV and AIDS. The risk of getting HIV and AIDS is higher if you are gang-raped. As part of your medical treatment you should ask to have an HIV test three months after the rape.

Can I get Sexually Transmitted Diseases (STDs) from being raped?

Yes, but if you receive medical treatment after being raped the nurse or doctor must give you medicine to prevent you from getting a sexually transmitted disease.

Whom can I talk to if I have been raped?

It is important to talk to someone you trust, who will listen to you and who will believe your story. This could be a member of your family, a friend, a social worker, your teacher or a professional counsellor or psychologist.

Talking about the rape is not always easy but it is a crucial part of overcoming this traumatic experience.

There are organisations that offer counselling for people who have been raped and that provide information on rape, such as Rape Crisis in Cape Town (tel. 021 479762) and POWA in Johannesburg (tel. 011 642 4345).

When will I feel better?

Recovering from rape is different for every person. It may be weeks, months or years before you can put this experience behind you.

Be patient with yourself. With good medical care, emotional support and time you will feel better.

Effect and consequences of rape for the victim

Rape is a highly traumatic, violent and life-threatening experience. The effects of rape can be very serious, depending on the person who is raped.

Every person reacts differently and copes differently. There are however some common feelings and behaviour changes that occur in someone who has been raped.

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These are just some of the common ones:

- Not being able to eat or sleep properly.
- Feeling dirty and wanting to wash all the time.
- Not wanting to go out alone and always feeling scared and frightened.
- Blaming themselves for what happened.
- Not being able to concentrate and crying a lot.
- Feeling angry, helpless and worthless.

In addition to the above a woman can fall pregnant as a result of rape and she can contract a sexually transmitted disease such as HIV and AIDS.

Consequently it is vital for rape victims to receive medical care immediately. A nurse or doctor must give a woman who has been raped emergency contraception to prevent her from falling pregnant, and medicine to treat any sexually transmitted diseases she may have been infected with.

Someone who has been raped should also talk to someone they trust about what has happened to them.

Consequences of rape for the rapist

If the rapist is caught, he will go to court and if he is found guilty he will go to jail. In some cases community members may take the law into their own hands and kill him. They may also march and protest about the rape. If the rapist is still at school he will be expelled. In some cultures a rapist who makes a woman pregnant is forced to marry her and look after the child.

Any man who has sex with a woman under 16 is automatically guilty of rape. This is called statutory rape.

How others can help someone who has been raped

If someone close to you has been raped you should:

- Believe what they tell you and don't be judgmental;
- Not blame them for what has happened – the only person to blame is the rapist;
- Listen to them and offer support;
- Be understanding regarding any behavioural or emotional changes they may show;
- Allow them to make their own decisions so that they have a sense of being in control of their lives;
- Be patient, as it may take a long time for them to recover;
- Not expect them to want to have sex with you, if the victim was your wife or girlfriend. Wait until she says she is ready to have sex again.

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Cultural factors contributing to rape

- Cultures where men are thought to be macho and aggressive and women are thought to be submissive.
- Media that portray women as sex objects, as a man's property, or as weak, pathetic people who always need protection.
- Cultural beliefs that hold that a "real" man must have sex with many women but that "nice" women should be virgins.
- The idea that there are "good" girls and "bad" girls. These labels can suggest that it is all right to force sex on "bad" girls.
- Communities where men are thought to be the more powerful, dominant sex.

Rape in South Africa

South Africa has one of the highest incidences of rape in the world. One out of every three women in South Africa will be raped at one time or another.

Whether a woman reports the rape or not, she should always receive medical treatment and talk to someone she can trust about what has happened to her.

As a life skills teacher you may have learners who have been raped and who come to you for help. It is important that you believe what they tell you and that you encourage them to talk to a social worker or a counsellor.

Myths and facts about rape

1. Myth:

Rape is sex.

Fact:

Rape is a life-threatening and violent experience.

2. Myth:

Women ask to be raped.

Fact:

No one asks to be raped. Most rapes are planned so that the rape happens when the woman is in a vulnerable situation.

3. Myth:

Women secretly enjoy being raped.

Fact:

No one, – man, woman or child – enjoys being raped. It is a terrible experience that has life-long consequences.

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4. Myth:

Women "cry rape" to get men in trouble.

Fact:

Reporting a rape can result in secondary victimisation, as the police may not believe the woman or they may treat her badly when she comes to report the rape. It is unlikely that a woman will put herself through the trauma of reporting a rape if it did not happen.

5. Myth:

If a woman did not fight back she was not really raped.

Fact:

Rapists often use a weapon such as a gun or a knife. Even if the woman would have wanted to fight back, in most cases she is too scared to because she may be killed.

6. Myth:

There is a "right" way to respond to a rape situation.

Fact:

There is no "right" way to respond to being raped. Every person will react differently but in most cases a woman will do what she has to – to stay alive.

7. Myth:

A victim who doesn't report a rape to the police is responsible for any other rapes that happen to her.

Fact:

No one but the rapist is responsible for a rape.

8. Myth:

Rape trauma syndrome is a temporary problem. Most people return to their normal state of functioning within a year.

Fact:

Rape is a life-changing experience. People cope differently after being raped. There is no time limit to recovery. It usually depends on how good the person's support structure is.

9. Myth:

A victim should be discouraged from dwelling on the rape. She should "put it behind her and forget it".

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Fact:

This advice often comes from people who are more concerned with their own feelings than the victim's. All victims should be offered the opportunity to talk about what happened to them with people they are close to and/or with a counsellor. Victims who are not allowed to talk about the rape have a much more difficult time recovering from it.

10. Myth:

Someone who is raped more than once must be asking for it.

Fact:

That is not true. Women can be raped more than once by their husbands or boyfriends. In some communities gangs of men rape the same woman more than once.

11. Myth:

Women never get pregnant as a result of being raped.

Fact:

Women frequently get pregnant as a result of rape.

12. Myth:

Rapists never rape the same woman twice, so women who live in fear of this are stupid.

Fact:

Many cases of rapists returning have been reported. Especially if the rapist knows where the woman lives and works.

13. Myth:

Prostitutes can't be raped.

Fact:

Prostitutes are often easy targets for rape because they are unlikely to report it. The police do not recognise that prostitutes can be raped because of the nature of their work.

14. Myth:

Rapists are non-white, lower class, "criminal types".

Fact:

Rapists who fit this myth are far more likely to be jailed. But a rapist can be anyone: a doctor, a policeman, a clergyman, a social worker or a financial manager, amongst other high profile persons.

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15. Myth:

Incest isn't harmful to a child, because the child is learning about sex at home and being loved.

Fact:

Incest is extremely damaging to a child. The adult is using an innocent and vulnerable child to fulfil his sexual needs. Incest survivors suffer many psychological problems as a result of this form of abuse.

16. Myth:

Rape doesn't happen that often. I don't know of anyone who has been raped.

Fact:

South Africa has one of the highest incidences of rape in the world – a woman is raped every 83 seconds in this country. You may think that you do not know anyone who has been raped, but you may well – they just haven't told you.

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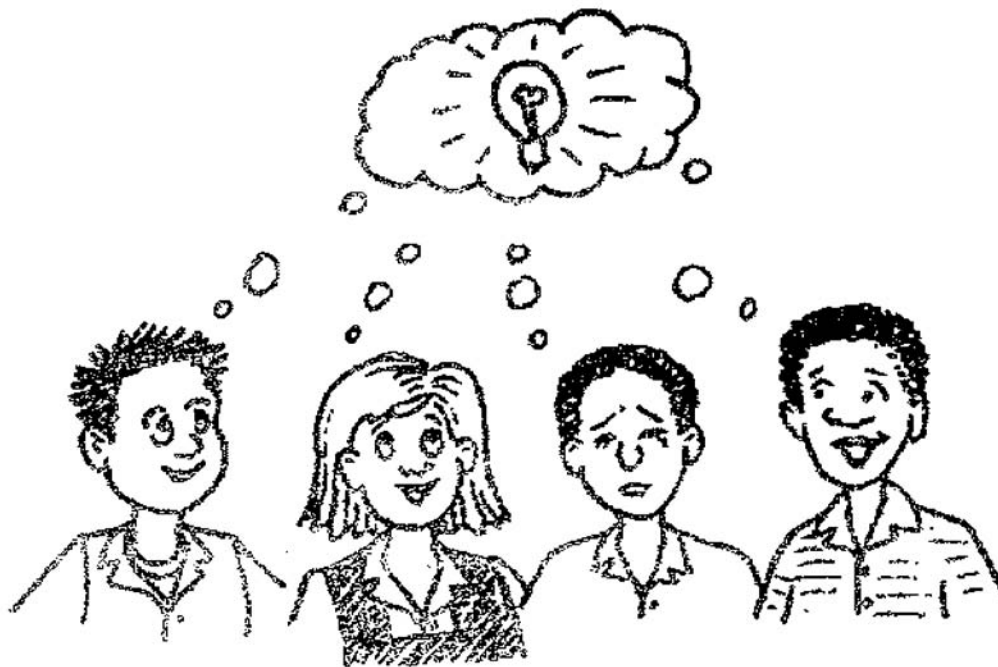
Unit 2: Sexuality Education

OUTCOMES-BASED SEXUALITY EDUCATION

Sexuality education should be based on an outcomes-based approach. Please refer to the sections in Unit 1 on the main principles underlying an outcomes-based approach for the methodology.

When the essential principles of an outcomes-based approach are incorporated into sexuality education we can speak about outcomes-based sexuality education. The life skills/HIV and AIDS learning programme is based on this approach.

(Louw 1994; Louw et al. ?.; Edwards & Louw 1998; Vergnani & Frank 1998; Rooth 1999; Schonfeld et al. 1996).



HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Unit 2: Sexuality Education**TEACHER ACTIVITY**

Sex versus sexuality: explain your understanding of sex and sexuality

Sex

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Sexuality

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Sexuality education versus sex information

Your principal asks you to address the staff on the urgent need to implement sexuality education at your school. Some teachers feel uncomfortable about the idea because they say it can lead to permissiveness among learners.

Design two transparencies that can be used during the meeting.

Transparency 1: Point out the main differences between sexuality education and sex information as you understand the terms.

Transparency 2: Indicate the aims of sexuality education.

The sexuality educator

Many people think that sexuality education should be presented by a teacher with special qualities.

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Why do you think this teacher should possess special qualities?

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Mention ten of these qualities and briefly explain why you think each one is important.

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Sexuality education during the phases

Sexuality education should be presented according to a learner's age and developmental phase. Why do you think this is important.

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Unit 2: Sexuality Education

Information, life skills and values

Do you think that providing information only will be effective in changing learners sexual behaviour? Give reasons for your answer.

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Give your own definition of life skills.

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What skills do you feel you personally are lacking and would like to acquire?

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Make a poster and on it indicate the kind of life skills that will be taught during the sexuality programme at school. Try to add to the list other skills that you regard as important. Illustrate with drawings or pictures from magazines.



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Unit 2: Sexuality Education

Answer the following questions concerning your own values with regard to sexuality as honestly as you can:

I see sexuality as:

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Relationships would be better if:

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Sexual relationships should:

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In sexuality education teachers should be very careful that they do not:

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Teaching about topics like erections and menstruation is the responsibility of:

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I think sex before marriage is:

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Abortion is:

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There are three broad views regarding the teaching of values. Which view do you prefer and why?

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Make a poster indicating the values and attitudes that should always be part of sexuality education and display it in the corridors of the school. Illustrate with drawings/pictures from magazines/comic strips. Add values of your own to the list.

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Unit 2: Sexuality Education

Methodology

What is meant by the following statements? Provide examples.

"Learners should understand the meaning of learning in their lives."

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"As soon as one moves into the area of sexuality education one is touching the learner personally."

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"Learners can experience different emotions, e.g. anxiety, guilt, uncertainty."

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Handling sensitive questions and situations

Explain how you would handle a situation where a boy/girl uses bad language during a sexuality education class. Can you provide an example?

Outcomes-based sexuality education

Draw a poster with a "potjie" displaying all the ingredients (essentials) of outcomes-based sexuality education. Explain it to your colleagues.

Unit 3

The Management of HIV and Aids in Schools



***"It is not the HIV virus which is killing me or making my life not worth living, but the bad attitudes of people towards me and their rejection of me."
(A person with HIV infection: Evians1995)***

HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Unit 3: The Management of HIV and Aids in Schools

UNIT OUTCOMES

After working through this unit the teacher should be able to:

- recognise his/her own attitude towards persons with HIV and AIDS;
- display understanding, empathy and compassion;
- demonstrate knowledge and understanding of the basic HIV and AIDS facts;
- manage issues related to HIV and AIDS in schools;
- apply universal precautions.

Attitudes

Before we focus on the management of HIV and AIDS in school, we should turn the spotlight on our own attitude towards HIV-infected persons and persons with AIDS. Attitude encompasses perceptions such as prejudice, stigma associated with HIV and AIDS, as well as discriminatory factors.

Definitions

Attitude

A relatively stable and enduring tendency to behave and react in a certain way towards a person, object, institution or issue.

Prejudice

A one-sided unreasonable opinion of something/someone.

Stigma

A distinguishing mark of disgrace.

Discrimination

Treating someone unjustly/unfavourably because of certain factors, e.g. because of his/her race, religion, sexual orientation, or because he/she has a certain illness.

Unit 3: The Management of HIV and Aids in Schools

COMMON FEELINGS AND ATTITUDES OF HIV-INFECTED PERSONS OR PWAs (PERSONS WITH AIDS)

Often feelings and attitudes of denial, shock, anger, fear, bargaining, loneliness, self-consciousness, guilt and depression are experienced.

Attitudes towards HIV-infected persons or PWAs

Often the following feelings, attitudes and behaviour towards such persons can be identified:

Self-righteousness, anger, fear, rejection, judgement, marginalisation, isolation/avoidance, labelling, disgust, hate, pity, alienation, discrimination, amongst others.

Discrimination

Why do people discriminate?

- they learn discrimination from parents, adults and peers
- lack of accurate information
- fear of certain kinds of people
- dislike of anyone who is different

Why is it important not to discriminate?

- it hurts other people
- it is not fair
- we would not want to be discriminated against
- equality is a fundamental human right

What can you do if you hear discriminatory remarks about a person with HIV infection or AIDS?

- inform the person that he/she is wrong and tell him/her why. Be assertive and tell the person you do not want to hear his/her comments
- explain why it is important to be compassionate towards and supportive of someone with HIV infection or AIDS



HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Unit 3: The Management of HIV and Aids in Schools

ESSENTIAL ATTITUDES OF TEACHERS

Respect, genuineness, empathy, acceptance, compassion, tolerance, willingness to support.

Compassion

We need to develop compassion and be role models in respect of our attitude to illness.

Why should we show compassion?

- we have a moral duty to care about sick people
- HIV and AIDS sufferers are in the minority and are therefore discriminated against
- they are often rejected by those who look after the sick
- they are often very young to be dying
- they are often rejected by relatives and friends
- it feels nice to help or care for someone
- it will help you to overcome your fears of death and AIDS

Why is it difficult for some people to show compassion?

- they have experienced a lot of pain themselves and can only look after themselves
- they only care about and look after themselves
- they do not know how to be compassionate
- they are afraid to be compassionate

BASIC HIV AND AIDS FACTS REVIEW

Conceptualisation

AIDS is an acronym made up of the letters of the following words:

A Acquired:	become infected from others
I Immune:	the body's way of protecting itself against infection
D Deficiency:	lack
S Syndrome:	collection of symptoms and diseases

AIDS is a disease that breaks down a part of the body's immune system, leaving the person defenceless against a variety of illnesses that are normally not life threatening to people without AIDS.

AIDS is caused by the human immunodeficiency virus (HIV). People can be infected with HIV for many years before they develop signs or symptoms of any illness.

HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Unit 3: The Management of HIV and Aids in Schools

What is the difference between HIV infection and AIDS?

A person infected with HIV may display no physical symptoms, mild physical symptoms or severe physical symptoms.

An AIDS diagnosis is made when an individual infected with HIV shows signs or symptoms of severe weakening of the immune system. Usually this is at an advanced stage of HIV infection.

Transmission

HIV enters the body in the following ways:

- Sexual intercourse: vaginal, oral (mouth) or anal, from male to female, female to male, male to male, female to female.
- An infected mother to her baby, in the uterus or at birth.
- Blood transfusion with infected blood or infected blood products.
- Infected tissue and organ transplants.
- A contaminated needle or cutting object.
- Close physical contact with an infected person's blood (e.g. if such blood comes into contact with an open wound or cut on a "healthy" person's body).

Which body fluids carry HIV?

These include:

- Blood
- Any body fluid containing visible blood
- Semen and pre-ejaculate fluid
- Vaginal fluids (vaginal or cervical secretions)
- Menstrual blood
- Human breast milk

HIV and AIDS cannot be transmitted in the following ways:

- airborne routes such as coughing, sneezing, laughing, talking
- simple skin contact such as handshaking, hugging, touching or dry kissing
- sharing food, water, plates, cups, spoons, toilet seats, baths, swimming pools and showers with an infected person
- sharing towels, bed linen, clothes
- insects (e.g. mosquitoes, and bedbugs) and pets are not known to spread HIV
- the virus is not present in high enough quantities in the urine to cause infection, unless blood is also present
- the virus cannot penetrate normal, intact skin and does not readily enter through a healthy mouth or eye

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Unit 3: The Management of HIV and Aids in Schools

Note: Saliva and tears contain minute amounts of the virus but not enough to cause infection unless these body fluids also contain blood.

Who is at risk?

Anyone can become infected with HIV if he/she has unprotected sexual intercourse or shares needles/instruments with someone else who is infected.

Avoiding HIV infection

How can people protect themselves from HIV?

Safe sex

Abstinence, – no sex at all, – is the only real 100% safe method. It is your choice to say NO. The purpose of sexuality education in primary school will be to guide learners to abstain from or postpone sexual activity.

Safer sex

Means:

- having a long-term relationship with a faithful, uninfected partner
- having sex only while using a condom and using it correctly
- merely touching, hugging and cuddling
- avoiding body fluids (see body fluids that carry HIV)

Transmission of HIV at schools

HIV transmission takes place only when a person comes into contact with body fluids as mentioned previously. Children are not likely to have this kind of contact with or exposure to others in the school setting.

People are often concerned about an HIV-infected child with open sores fighting with other children or becoming injured, e.g. during sports activities. Children should be taught not to touch anyone else's blood but rather to call an adult for help. Teachers and others should be familiar with universal precautions and also train children in this regard.

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Unit 3: The Management of HIV and Aids in Schools

Management of HIV and AIDS in schools

Children's rights

Excerpt

Neither the state nor any person may (unfairly) discriminate directly or indirectly against anyone on one or more grounds, including (but not limited to) race, gender, sex, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

(South African Bill of Rights)

International Declaration of Children's Rights

- Regardless of race, colour, sex, language or religion, all children are entitled to these rights.
- Children have a right to special protection, and opportunities and facilities so that they can develop in a normal and healthy way, in freedom and dignity.
- Children have a right to a name and a nationality from birth.
- Children have a right to be given enough to eat, to have a decent place to live as well as to play, and to receive good medical care when they are ill.
- Children have a right to grow up with love, affection and security. Babies should not be separated from their mothers. Children should be brought up by their parents wherever possible. Children without parents should be cared for by the state.
- Children have a right to free education.
- Children have a right to be among the first to be protected in times of disaster.
- Children have a right to be protected from all forms of neglect, cruelty and exploitation.
- Children should not be made to work before a certain age or do work that endangers their health or prejudices their education or physical or moral development.
- Children should be protected from anything that causes racial, religious or other forms of discrimination. They should be brought up in a spirit of understanding, friendship, peace and universal brotherhood.

Why are children's rights so important?

Children's rights are human rights, and the rights of children are very important in the worldwide struggle for human rights. Throughout the world children are discriminated against on the basis of their age, their race, their sex and sexual orientation, their indigenous or minority status, or their disability.

In South Africa, there are over ten million people under the age of 15. Under the new Constitution, a child is any person under the age of 18. The rights of children are explained and protected in the Bill of Rights. South Africa has also ratified (signed and agreed to) the United Nations (UN) Convention on the Rights of the Child.

HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Unit 3: The Management of HIV and Aids in Schools

Many children are living with HIV and AIDS. Many babies are born with HIV. Also, many sexually active young people are being infected with HIV. They face numerous forms of discrimination. Babies are abandoned or refused access to crèches. School children are victimised or marginalised by teachers and other children. Learners are refused bursaries.

This section aims to show what legal rights children have, and what forms of discrimination we will have to fight against when children are infected with HIV and AIDS.

Access to education

Can a child with HIV be excluded from a school?

The new Constitution says that everyone has the right to basic education.

The South African Schools Act says that every public (government) school "must admit learners and serve their educational requirements without unfairly discriminating in any way". It also adds that in private and public schools, it is unlawful to make admission to any learner dependent on "any test".

- A child cannot be excluded from a private or government school because of his/her HIV status.
- Private schools sometimes include an exclusion clause (a shut-out clause) in their application and entry requirements as a way of preventing children with HIV from going to those schools. The Constitution can be used to challenge this in court.
- The Bill of Rights also says that everyone has the right to a basic education. If a child is stopped from going to school because of his/her HIV status, this is unlawful and can also be challenged in court.
- HIV is never transmitted through casual contact. This is why it is very difficult for children of any age to get HIV from everyday social contact at school. Therefore the risk of infecting other children cannot be used as a reason to exclude children with HIV from a school.

If a child has HIV and attends school, who do you think would be more at risk?

- The child with HIV who can catch various diseases from other children, or the other children?
- If a child has HIV and is prevented from attending school, what social, psychological and emotional effect do you think this will have on the child?

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RIGHT TO SEXUALITY EDUCATION

What is sexuality education?

Sexuality education includes teaching about safer sexual practices to prevent HIV and other STDs. Children can be taught about safer sex only if they have some understanding of matters such as:

- What sex is
- Their physical anatomy (their body parts and their uses)
- How they can respond to feelings for another person
- Why and how to use condoms and other contraceptives

Do children have a right to sexuality education?

In 1995 South Africa ratified the UN Convention on the Rights of the Child. This means that South Africa agreed to implement the Articles (clauses) in the Convention. Article 18 says that a child should have access to information that will help the child promote his/her physical and emotional well-being. Sexuality education and information on HIV and AIDS will certainly help a child in this regard. So, South Africa has agreed to ensure that children have access to this type of education.

South African education departments have indicated their support for this type of education. The Children's Charter of South Africa contains an Article that states that children have the right to education on issues such as sexuality and AIDS. South African children therefore have a right to sexuality education.

What age group should sexuality education be aimed at?
How much detail should each age group receive?
What should sexuality education include?

There are many ideas about what should be included in a sexuality education programme.

Sexuality education is only one part of a broad life skills programme aimed at helping people cope with the many challenges of life.

Sexuality education should include:

- Attitudes to sex in different cultures, religions and beliefs
- Discussion about different sexual orientations (heterosexual, homosexual or bisexual)

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Think and talk about these issues:

- A young girl says she will not have sex until she is married because of her religious beliefs.
- A teacher teaches sexuality education and talks only about heterosexual (sex between a male and a female) family values.
- A rural school has an excellent sexuality education programme, but the nearest clinic where condoms can be obtained is 40 km away.
- Sexuality education is optional at a school, but no one chooses the course because of the fear of being teased about sex.

Medical treatment of children

The Child Care Act protects the rights of children, including the medical treatment of children (Section 39 of the Act.)

The Child Care Act states:

- If a doctor believes that it is necessary to treat or operate on a child, but his/her parents or guardian either refuse to give permission or cannot be found, then the doctor can apply to the Minister of Health for permission to treat or operate on the child.
- In an emergency situation where there is no time to apply for the Minister of Health's permission, the hospital superintendent can approve the treatment or operation.
- Any person who is 18 or older can consent to an operation without the consent of his/her parents or guardian.
- Any person who is 14 or older can consent to medical treatment (for an illness, getting medicine, having blood tests or X-rays) but not to having an operation.
- Children who are 14 or older can consent to treatment on their own, but until they are 18 they need the consent of their parents or guardian for an operation.
- However young women under 18 can consent to an operation if it is for an abortion.

Who should know the HIV test results of a child who is 14 years or older?

At the age of 14 a child can legally consent to an HIV test for him/herself. If a child is 14 or older, the child has the same rights to confidentiality as an adult. This means that a child of 14 or older who consents to an HIV test has the right to keep the result private (to him/herself).

Nobody is allowed to disclose the HIV status of someone who is 14 or older without the consent of that person.

Many parents feel that they have a right to know the HIV status of their child if that child is younger than 18 and dependent on them.

Do you think parents should be able to demand that a doctor disclose their 15-year-old child's status to them? Do you think that a child of 14 can make wise decisions about whom to disclose confidential medical information to?

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Who should know the HIV test results of a child younger than 14?

When a child is younger than 14 the child cannot consent to an HIV test alone. The consent of a parent or guardian is necessary.

Under our Constitution any decisions made about a child must be made in the best interests of the child. So, if a child younger than 14 is to have an HIV test, it must be clear that this is in the child's best interests, for example: will the child receive adequate care and treatment if his/her HIV status is known?

The test results should be given to the parent or guardian who at their discretion can decide whether to disclose the child's status to the child. A lot depends on whether the child is old enough to understand the results. There are no legal obligations forcing a parent or guardian to tell a child younger than 14 his/her status.

Does a school have to be told about a child's HIV status?

Confidentiality is a common law right of children.

Disclosure of a child's HIV status to a school is not a legal requirement.

If the child is under 14 and a parent or guardian believes that it is in the child's best interests for the school to have the information on the child's HIV status, then this can be allowed. It is therefore the responsibility of the parent or guardian to determine whether or not a school should know.

If a child is 14 or older, then the child can decide whether or not to tell the school about his/her HIV status.

What if a child has been ill for some time, and the school requests information on the child's HIV status before making a decision on whether to allow the child to write exams that year or not?

Think about confidentiality. Consider whether the child's HIV status is important in making this decision.

Should a children's home or place of safety have information on a child's HIV status?

A children's home or place of safety can be informed about a child's HIV status if

- The child is under 14.
- The status of the child is already known, and it is in the child's best interests for the information to be passed on.
- The person to whom the information is disclosed is legally responsible for the child.

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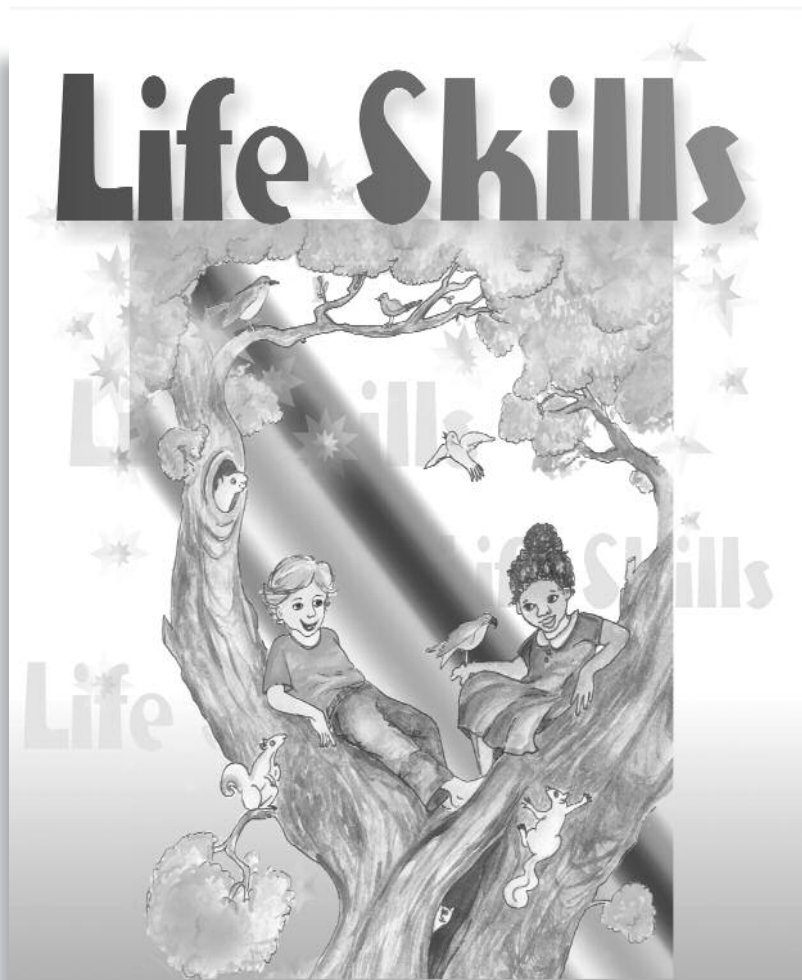
- The person who is given information respects the principle of confidentiality and does not disclose the information to anyone else.
- The information will not lead to the segregation of the child or any other form of discrimination.

Universal precautions should be followed by all staff members at places of safety and children's homes. This is why knowledge of the HIV status of a child is not necessary for the protection of the staff.

House-parents at a children's home need only be informed about a child's HIV status if this is in the best interests of the child.

Resource Guide

The Programme



HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Unit 4: The Programme

UNIT OUTCOMES

After working through this unit and after being trained to present the learning programme, teachers should be able to:

Define different concepts,

Understand the components of the HIV and AIDS programme,

Understand their role as facilitators of activities,

Facilitate group activities effectively,

Avoid common facilitation mistakes,

Plan co-operative and participative learning experiences,

Motivate learners to participate in activities,

Lead group discussions effectively,

Make a commitment to present the programme.

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Unit 4: The Programme

CONCEPTUALISATION

Structure of the National Curriculum Statement Grades R–9 (Schools)

There are eight Learning Areas in the National Curriculum Statement.

- Languages
- Mathematics
- Natural Sciences
- Technology
- Social Sciences
- Arts and Culture
- Life Orientation
- Economic and Management Sciences

Principles of the National Curriculum Statement

The Revised National Curriculum Statement Grades R–9 (Schools) builds on the vision and values of the Constitution and Curriculum 2005. These principles include:

Social Justice, a Healthy Environment, Human Rights and Inclusivity

The curriculum attempts to be sensitive to issues of poverty, inequality, race, gender, age, disability, and such challenges as HIV and AIDS.

Outcomes-based education

The critical and developmental outcomes are a list of outcomes that are derived from the Constitution and are contained in the South African Qualifications Act (1995). They are generic, cross-curricular outcomes crucial to all learning areas that indicate the knowledge, skills and values that learners should have acquired by the end of a learning process.

A High Level of Skills and Knowledge for All

The Revised National Curriculum Statement aims to provide for a stronger base from which to enable the development of a high level of skills and knowledge by all.

Clarity and accessibility

Two design features – learning outcomes and assessment standards – clearly define for all learners the goals and outcomes necessary to proceed to each successive level of the system.

Progression and integration

The achievement of an optimal relationship between integration across learning areas and conceptual progression from grade to grade are central to this curriculum.

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Unit 4: The Programme

Learning Outcomes and Assessment Standards

Learning Outcomes and Assessment Standards express the requirements and expectations of learners by grade at the Foundation (Grades R-3), Intermediate (Grades 4-6) and Senior (Grades 7-9) Phases.

A Learning Outcome is derived from the Critical and Developmental Outcomes. It is a description of what (knowledge, skills and values) learners should know, demonstrate and be able to do at the end of the General Education and Training band.

Assessment Standards describe the level at which learners should demonstrate their achievement of the learning outcome(s) and the ways (depth and breadth) of demonstrating their achievement. They are grade specific and show how conceptual progression will occur in a Learning Area. They embody the knowledge, skills and values required to achieve learning outcomes. They do not prescribe method.

Learning Programmes

Learning Programmes are structured and systematic arrangements of activities that promote the attainment of learning outcomes and assessment standards for the phase.

Learning Programmes must ensure that all learning outcomes and assessment standards are effectively pursued and that each learning area is allocated its prescribed time and emphasis. Learning Programmes will be based on relationships amongst learning outcomes and assessment standards, without compromising the integrity of Learning Areas. Learning Programmes specify the scope of learning and assessment activities per phase and contain **work schedules** that provide the pace and the sequencing of these activities each year as well as exemplars of **lesson plans** to be implemented in any given period.

Planning Learning Programmes requires teachers to pay attention to the **content of learning**, the **process of learning**, **progression of learning** and providing learners with an **integrated** learning experience.

Planning Learning Programmes involves 3 levels of planning

Level (stage) 1: Learning Programme (Learning Area Framework) for the phase

The Learning Programme (Learning Area Framework) is a Learning Area (Intermediate and Senior Phase) or Learning Programme (Foundation Phase) plan for the phase (all grades) and represents the first and broadest level of planning. It gives all teachers in the phase an overview of what teaching, learning and assessment will take place across the phase in a Learning Area/Programme.

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Level (stage) 2: Work Schedule per grade for a year

The Work Schedule is based on the Learning Programme (Learning Area Framework). It describes what is planned for one year in a particular grade, in a particular Learning Area. It sequences the Learning Outcomes and Assessment Standards to ensure progression across the four terms of the year. It also includes assessment planning and is more detailed than the Learning Programme (Learning Area Framework). It includes more information on resources and includes the assessment programme (the formal recorded assessments), assessment methods and tools and broad teaching and learning strategies. Normally Work Schedules will be planned by the teacher or group of teachers responsible for a Learning Area in a particular grade.

Level (stage) 3: Lesson Plan per class

A Lesson Plan is the third level of planning and is based on the planning in the Work Schedule. It describes in detail the **teaching, learning and assessment plans** for a single activity or a series of activities, spread over a few days or a number of days or a number of weeks. It is a **personal planning instrument for teachers** and allows them to use their own initiative and creativity.

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Unit 4: The Programme

THE HIV AND AIDS PROGRAMME:

Growing up healthy

Further Education and Training

Grade 12

Grade 11

Grade 10

General Education and Training

Grade 9

Grade 8

Grade 7

Senior Phase

Grade 6

Grade 5

Grade 4

Intermediate Phase

Grade 3

Grade 2

Grade 1

Grade R

Foundation Phase

The Life Skills and HIV and AIDS
Education Programme

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Unit 4: The Programme

LEARNING PROGRAMMES FOR THE PHASES

Senior Phase

In the Senior Phase, there are eight Learning Programmes based on the Learning Area Statements.

- Languages
- Mathematics
- Natural Sciences
- Technology
- Social Sciences
- Arts and Culture
- Life Orientation
- Economic and Management Sciences

Intermediate Phase

In the Intermediate Phase, Languages and Mathematics are distinct Learning Programmes. Learning Programmes must ensure that the prescribed outcomes for each learning area are covered effectively and comprehensively. Schools may decide on the number and nature of other Learning Programmes based on the organisational imperatives of the school, provided that the national priorities and developmental needs of learners in a phase are taken into account.

- Languages
- Mathematics
- Natural Sciences
- Technology
- Social Sciences
- Arts and Culture
- Life Orientation
- Economic and Management Sciences

Foundation Phase

In the Foundation Phase, there are three Learning Programmes:

- Literacy
- Numeracy
- Life Skills.

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Unit 4: The Programme

LIFE SKILLS AND HIV AND AIDS

Education Programme

- The programme extends from *Grade 1 to Grade 7*.
- Every grade has *15-20 units* (themes/lessons)
- The themes are *progressive* and build on each other, so units should not be presented out of context.
- There is a *Teacher's Manual* and a *Learner Activity* for each grade.
- *Teacher's Resource Guide is available*.
- A Guide for parents is available.
- Master trainers will also receive *textbooks*.
- *Posters*.

Themes in the programme

- I am special
- Relationships
- The whole me
- Touch talk
- Health and sickness
- Germs and viruses
- What about AIDS?
- What does the HIV virus do to the body?
- Preventing HIV and AIDS
- Making health choices
- Review
- Loving a sick person (practical things to do)
- Someone/Something we love has died: it's all right to grieve

HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Unit 4: The Programme

Aim of the programme

Please familiarise yourselves with the aims of sexuality education as indicated in Unit 2.

Please also note the following very specific aims of the programme:

- Abstinence from or postponement of sexual activity.
- If sexual activity and/or sexual intercourse has taken place, to encourage changing this lifestyle.
- If the choice is made to continue this lifestyle, responsible behaviour is essential, i.e. the use (correct and consistent use) of condoms.

It's time to start with the programme.
Good luck with your new adventure.

"There is no limit to what you can achieve,
but you need to begin."
(Kruger 1998)

HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Unit 4: The Programme

DICTIONARY OF TERMS

Abortion:

The termination of a pregnancy and the expulsion of the foetus before it is sufficiently developed to survive outside the uterus; may be spontaneous or induced by human intervention.

Abstinence (sexual):

Not engaging in sexual activity.

Acquired Immune Deficiency Syndrome (AIDS):

Lethal infection of the human immunodeficiency virus (HIV) which damages the body's immune system, leaving it incapable of fighting off opportunistic infections and certain cancers; transmitted by infected semen, body fluids and blood.

Adolescence:

Period of physical, psychological and social maturation between the ages of 10 and 24.

AIDS:

Acquired Immune Deficiency Syndrome – A combination of diseases caused by a virus which affects the immune system. The immune system becomes unable to fight off infections.

Antibodies:

Special chemicals produced by certain white blood cells to fight specific disease-causing organisms such as a particular virus or bacteria or other disease agent or substance.

Antibody positive:

With regard to HIV, this means someone's blood contains antibodies to HIV, the virus which causes AIDS.

Assertiveness:

The willingness to stand up for oneself without anxiety, treat oneself with respect in all human relations without denying the rights of others.

Asymptomatic:

With no symptoms of the disease.

AZT:

Zidovudine, a medicine which helps the body strengthen the immune system. It is very expensive.

HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Unit 4: The Programme

Bacteria:

Tiny disease-causing organisms.

Caesarean section:

Surgical procedure in which a baby is removed from the uterus through an incision in the abdominal wall because vaginal delivery is not medically advisable or possible.

Cervical canal:

Posterior end of the vagina next to the cervix.

Circumcision:

- (1) Removal of the male foreskin.
- (2) Removal of the female clitoris, or removal of the female clitoris and labia after which the vulva area is sewn together. Removal leaves a small opening for urination and menstruation. Scar is opened during childbirth and re-sewn immediately following delivery.

Clitoris:

Area of erectile tissue immediately below the labia minora.

Communication:

The process of giving, receiving, and understanding messages. It is about exchanging ideas, understanding, listening, expressing oneself, talking, using body language, facial expression and a host of other behaviours.

Community:

The people living in one place, district or country considered as a whole group of people of the same religion, race, occupation, etc.

Condom:

Method of contraception for males and females and protection against most sexually transmitted diseases for both sexes.

- (1) The male condom, a rubber sheath which fits over the erect penis, is sometimes covered with spermicide cream.
- (2) The female condom fits over the cervix and also protects the vagina and vulva. It is made of polymethane with two firm rings to hold it in place. One ring sits over the cervix; the other sits outside the vagina against the vulva and prevents the condom from being forced inside by the penis.

Both condoms can only be used once.

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Unit 4: The Programme

Contraception:

Methods to prevent conception (a sperm impregnating an ova).

Culture:

Customs, arts, and social institutions of a particular group or people.

Date rape:

Use of psychological and/or physical coercion to pressure or force an unwilling partner into sexual intimacy and/or intercourse in a dating or courting relationship.

Dating:

Appointment to meet a person at a particular time; meeting with a person of the opposite sex for the purpose of socialisation.

Decision-making:

The process of making up one's mind about an issue.

Deficiency:

An inadequacy, or weakness.

Developmental level:

Corresponding age of learning to the individual child's age and development.

Discrimination:

Treating a person or group of persons differently from others (usually worse).

Divorce:

Legally ending a marriage between a man and a woman.

Equity:

Fairness; right judgement.

Falling in love:

Deep affection, attraction, emotional feelings, and intimacy felt by a person towards another, not necessarily of the opposite gender.

Fallopian tube:

Two fine narrow tubes that carry eggs from the ovaries to the uterus.

Family life:

Of attitudes and skills related to dating, marriage, parenthood, and family health.

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Unit 4: The Programme

Fertilisation:

Impregnation of an egg by a sperm, following sexual intercourse. This results in an embryo being formed and pregnancy.

Foetus:

The baby in the uterus after the third month of pregnancy and until birth.

Gender:

The state of being male or female, one's personal, social, and/or legal status as a male or a female.

Gender identity:

The psychological sense or internalised conviction that one is a male or a female.

Genetics:

Information about the unit in a chromosome (gene) which controls heredity.

Genitals:

The sexual or reproductive organs.

Goal-setting:

Setting targets for one's life to be met through one's efforts.

Gonorrhoea:

Common sexually transmitted bacterial infection of the vagina, penis, rectum, throat, and/or eyes caused by the bacterium *Neisseria gonorrhoea*. Many infected females and 5 % to 20 % of infected males show no early symptoms. Male symptoms include painful urination, penile discharge, swollen glands, and/or sore throat.

Health education:

Programme focusing on all aspects of health, including all factors that contribute to the well-being of a person. Focuses on the totality human being, and not merely on factors leading to ill-health.

Herpes:

Sexually transmitted, incurable viral infection characterised by intermittent, mildly painful outbreaks of open sores or blisters at the site of infection in the sexual organs, during which the individual is infectious, caused by Herpes Simplex II virus.

HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Unit 4: The Programme

Heterosexual:

A person who is sexually attracted to, or engages in sexual activity with persons of the other gender (members of the opposite sex).

HIV:

Human immunodeficiency virus, the virus that causes AIDS.

HIV test:

A blood test which detects whether the body has reacted to the presence of HIV. The body will have tried to protect itself against the virus by producing antibodies. The reaction takes an average of three months after infection to show in the blood.

Homosexual:

Person whose sexual desires are directed wholly or largely toward people of the same sex.

Hormones:

Secretions that stimulate activity within the body. An example of this is testosterone, which produces male characteristics.

Human development:

The continuous growth in the anatomy, physiology, emotional, psychological, spiritual and intellectual aspects of the human being, beginning from conception and terminating at death.

Human sexuality:

The experiential combination of one's biological sex and psychological gender, co-extensive with one's gendered personality as a male or female. It includes all the feelings, thoughts and behaviours of being male or female.

Hymen:

A fold of skin or thin membrane that may partially cover the vaginal opening.

Immune:

Safe from getting seriously ill with an infection. Immunity against some diseases can be created by giving a vaccine (immunisation/vaccination).

Immune system:

The body's main defence mechanism which protects the body by recognising diseases, killing them and then remembering what they look like so that they will be able to fight them off again.

HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Unit 4: The Programme

Infection:

Invasion by a disease-causing agent.

Infectious:

Communicable, a disease or disease agent that can be passed on to other people.

Infertility:

Inability to conceive and carry a foetus to term and delivery.

Interpersonal skills:

Ability to relate with all persons.

Intrauterine contraceptive device (IUCD):

Plastic device, sometimes containing metal or a hormone, inserted into the uterine cavity and left there; it appears to speed up transport of the ovum through the fallopian tube and prevent implantation of a fertilised ovum.

Life Planning:

Developing the skills for good communication, decision-making, assertiveness, goal setting and other tough issues children are confronted with as they are growing up (drugs, sexual behaviour, pregnancy and health). Involves sexuality and career education with the goal of motivating adolescents to delay parenthood until they achieve their educational and vocational goals.

Marriage:

Legal union between a man and a woman as husband and wife.

Masturbation:

Sexual stimulation of the male or female sexual organs, usually with the hands.

Menstruation:

Monthly discharge of blood from the uterus through the vagina. Amount can vary in volume and duration (two to seven days). Women start to menstruate at puberty and continue until menopause. During the month, the lining of the uterus thickens with extra blood, preparing to feed and protect the fertilised egg. If the egg is not fertilised, the lining breaks down and is expelled from the body. Menstruation stops during pregnancy.

Menopause:

The natural and gradual cessation of menstruation in a woman, usually between ages 45 and 60 years.

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Unit 4: The Programme

Miscarriage:

Spontaneous, premature loss of a foetus from the womb before it is viable, as a result of natural causes (not medical intervention).

Monogamy:

Normally, it is the practice of being married to one person at a time. In the context of this document, having only one sexual partner for life.

Negotiation:

Process of arranging, settling something or trying to reach an agreement by discussion.

Parenthood:

State of being a parent.

Parenting:

Art of being a parent.

Peer:

For any individual, other people of about the same age and standing in the community, equals or colleagues.

Pills:

Birth-control pills that are taken to prevent ovulation, and conception, contain oestrogen and progesterone.

Pneumonia:

Serious lung infection causing coughing and breathing difficulties.

Prenatal:

Before birth.

Puberty:

Transitional biological stage marking the end of childhood and the start of adolescence, the period of time during which the body matures and achieves reproductive capacity, usually between 10–16 years, sometimes earlier or later in some people.

Rape:

Forcible sexual relations with an individual without that person's consent, other sexual intimacies or contact forced on one person by another, using either physical force the threat of physical force, coercion, and/or a weapon.

HIV and Aids Lifeskills and Sexuality Education Primary School Programme

Unit 4: The Programme

Refusal skills:

In the context of sexuality, the ability to ward off unsolicited sexual advances (e.g. saying 'no').

Religion:

Particular system of faith and worship based on certain spiritual beliefs.

Reproductive health:

State of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions and process, ability to have a satisfying and safe sex life, capability to reproduce and freedom to decide if, and when and how often to do so.

Reproductive system:

That part of human physiology that is responsible for reproduction, in the woman, e.g. ovary, fallopian tube, uterus, vulva, in the man, e.g. scrotum, penis, testis.

Romantic relationship:

Intimate, loving, caring, emotional and affectionate friendship or contact between two persons, may or may not involve sexual intercourse, or end in marriage.

Safer sex:

Sex that is as free as possible from disease, pregnancy and the abuse of power.

Secretion:

Body fluid.

Semen:

Fluid that carries sperm from the testicles to the penis.

Shingles:

Painful inflammation of nerve endings (herpes zoster) with a blistering skin rash. Common with HIV infection.

Screening for HIV:

Analysing the blood of whole populations or of groups within a population.

Self-esteem:

The disposition to experience oneself as competent to cope with the basic challenges of life and as worthy of happiness, recognise and exercise one's bill of rights.

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Sexual abuse:

When one adult forces another adult or a child to have sexual intercourse or perform other sexual acts against their will.

Sexual attitude:

Outward expression of one's feelings about sexual issues.

Sexual behaviour:

Behaviour that produces arousal and increases the chances of orgasm.

Sexual development:

The maturing of the emotional, physiological, physical and sensual make-up of a person.

Sexual differentiation:

Determination of the sex of a person by the sex chromosomes during fertilisation. Information is passed on to the various body organs, giving them instructions on how to differentiate in the course of development.

Sexuality:

Ability to have sexual feelings. Involves a person's feelings about the self - self-esteem, body image, ability to relate sexually to others and ability to communicate those feelings.

Sexual harassment:

Unwanted imposition of sexual requirements in the context of a relationship of unequal power, any unwelcome or unsolicited sexual advance, request for sexual favours, or other verbal or physical conduct of a sexual nature whose acceptance or rejection is explicitly or implicitly used as a condition for employment, recognition, promotion or academic grades.

Sexual information:

Messages received by persons which address issues surrounding human sexuality.

Sexual orientation:

A person's erotic and emotional orientation towards persons of his or her own gender, or of persons of the other gender. (opposite sex).

Sexual partners:

Persons who have sexual contacts between them.

Sexual relationship:

That which involves sexual acts.

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Unit 4: The Programme

Sexual rights:

Ability to express one's sexuality in a positively enriching way, the exercise of such rights.

Sexual violence:

When one adult forces another adult or a child to have sexual intercourse or perform other sexual acts against their will.

Sexually transmitted disease:

Anyone of a variety of diseases which are transmitted primarily by sexual contact, including gonorrhea, syphilis, chlamydia, venereal warts, herpes, candidiasis, public lice, and AIDS.

Single parenting:

A situation whereby only one parent brings up a child due to marriage break-up or having a child out of wedlock.

STDs:

Sexually Transmitted Disease, e.g. syphilis, gonorrhoea, chancroid and AIDS infections passed from one person to another during sexual intercourse.

Sterile:

Thoroughly cleaned of all dirt and disease causing organism e.g. using bleach or boiling.

Society:

System whereby people live together in organised communities, social way of living, with shared customs, laws, et.

Stereotype:

A generalisation about a group of people (e.g. men) that distinguishes them from others (e.g. women).

Sterilisation:

A surgical procedure that makes a person unable to reproduce, available for men (vasectomy), and for women (tubal ligation).

Symptom:

Perceived sign of disease or another problem.

Syndrome:

Collection of symptoms and signs that form a recognisable pattern of disease.

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Teenage pregnancy:

Pregnancy to a girl between 13–19 years of age.

Thrush:

An infection caused by a fungus which can be very severe in people with AIDS, causing a heavy white coating in the mouth and throat, in the gut or on the lining of the genitals (candida).

Transmission:

Spread

Tuberculosis:

TB, a serious bacterial disease of the lungs and bone. It is treatable.

Unintended/unwanted pregnancy:

Conception as a result of lack of information about contraceptives, its inappropriate use and non-usage, resulting from forced sexual intercourse (rape).

Unsafe sex:

Sexual activity that could spread the AIDS virus (such as sexual intercourse without a condom).

Uterus/womb:

Pear-shaped organ inside the female pelvis, where the fertilised embryo is nourished and protected and grows during pregnancy, until birth.

Vaccine:

An injection which prevents people from becoming sick from certain diseases even if they come into contact with them.

Values:

Moral or professional standards of behaviour, principles.

Viruses:

Tiny organisms or germs which can cause disease in humans, animals or plants. HIV is just one type of virus.

White blood cells:

Clear blood cells that fight against infection.

Resource Guide

Appendices

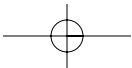
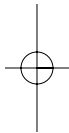
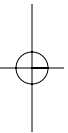
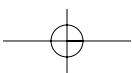
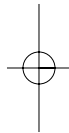
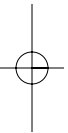


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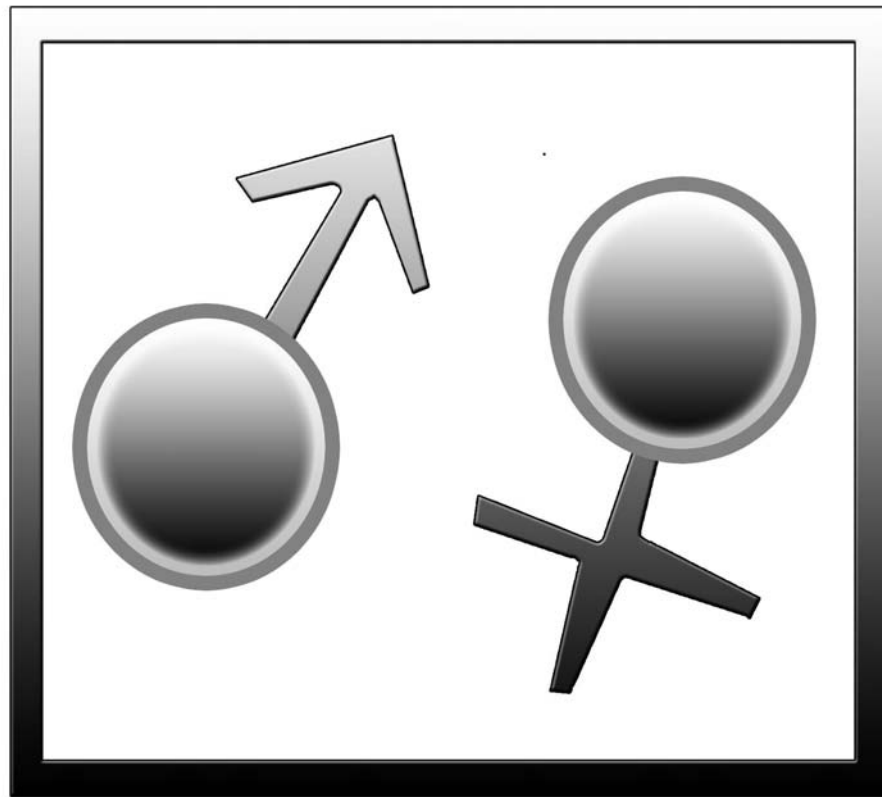
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Appendix A

Sexually Transmitted Diseases (STDs)



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Sexually Transmitted Diseases (STDs)

What is STD?

SEXUALLY TRANSMITTED DISEASE (STD) is serious, sometimes painful, and can cause a lot of harm and suffering.

Some STDs infect your sexual and reproductive organs. Others (HIV, hepatitis B, syphilis) cause general body infections.

Sometimes you can have an STD with no signs or symptoms. At other times, the symptoms simply disappear. Either way, you still have the STD until you get treated.

A few STDs cannot be cured. But most STDs can be cured if the person receives treatment.

How is STD spread?

STD is spread during intimate sexual activity – during vaginal, anal and oral sex. Some STDs (HIV and hepatitis B) are also spread through contact with infected blood.

Most STD germs need to live in warm, moist areas. That is why they infect the mouth, rectum and sex organs (vagina, vulva, penis and testes).

What to do?

IF YOU THINK you may have an STD, go for an examination. Don't just hope the STD will go away. It won't!

Most country health departments have special STD clinics. Private doctors also treat STD.

If you don't know where to receive help, call your local family planning clinic for information. Your case will be kept private.

You may feel embarrassed about having an STD. It may be difficult for you to consult a doctor or clinic for help.

But you must get treatment for the STD, even if it is a difficult thing for you to do. This is the only way you will get well.

Most STDs can be treated with antibiotics. Do exactly what your doctor tells you. Be sure to use all (ed deleted 'of') your medicine.

You also must tell your sexual partner(s). If they are not treated, they can spread the STD. They may even give it to you again!

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Sexually Transmitted Diseases (STDs)

What to watch out for

Women

- An unusual discharge or smell from your vagina.
- Pain in you pelvic area – the area between your belly button (navel) and sex organs.
- Burning or itching around your vagina.
- Bleeding from your vagina that is not your regular period.
- Pain deep inside your vagina when you have sex.

Women and Men

- Sores, bumps or blisters near your sex organs, rectum or mouth.
- Burning and pain when you urinate or have a bowel movement.
- Need to urinate often.
- Itching around your sex organs.
- A swelling or redness in your throat.
- Flu-like feelings, with fever, chills and aches.
- Swelling in your groin – the area around your sex organs.

Men

- A drip or discharge from your penis.

If you have any of these symptoms, go to an STD clinic or your health care provider. Don't put it off/delay – go for an examination now!

You can Protect yourself!

Not having sex is the best way to protect yourself against STD.

Having sex with only one uninfected partner who has sex only with you is also safe.

Talk to your partner about past sex partners and about needle drug use. Don't have sex with someone whom you think may have an STD.

Before you have sex, **look closely at your partner for any signs of STD** – a rash, a sore, redness or discharge. If you see anything you are worried about – don't have sex!

Use a latex condom (rubber) for vaginal, anal and oral sex. Condoms will help protect you from STD much of the time. Both men and women should carry condoms.

In addition to condoms, **use birth control foam, cream or jelly**. These kill many STD germs.

Get examined for STD every time you have a health examination. If you have more than one sex partner, have an STD examination any time you think you may be at risk, even if you don't have symptoms.

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Sexually Transmitted Diseases (STDs)

Know the signs and symptoms of STD. If you notice a symptom that worries you, go for an examination!

If you have an STD, **your partner(s) should get treated when you receive treatment.**

If you have an STD, **don't have sex until your treatment is complete.**

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Sexually Transmitted Diseases (STDs)

STD	What to watch for:	How do I get the STD	What happens if I don't get treated?
Genital Warts	Symptoms show up 1-8 months after having sex. Small, bumpy warts on the sex organs and anus. The warts do not go away. Itching or burning around the sex organs. After warts go away, the virus stays in the body. The warts can come back/re-appear.	Spread during vaginal, anal and oral sex with someone who has genital warts.	You can give genital warts to your sexual partner(s). Warts cannot be cured. More warts grow and are harder to get rid of. A mother with warts can give them to her baby during childbirth. May lead to precancerous conditions.
Hepatitis B	Symptoms show up 1-9 months after contact with the hepatitis B-virus. Many people have no symptoms or mild symptoms. Flu-like feelings that don't go away. Tiredness. Jaundice (yellow skin) Dark urine, light coloured bowel movements.	Spread during vaginal, anal and oral sex with someone who has Hepatitis B.	You can give Hepatitis B to your sexual partner(s) or someone you share a needle with. Some people recover completely. Some people cannot be cured. Symptoms go away, but they can still give Hepatitis B to others. Can cause permanent liver damage. A mother with Hepatitis B can give it to her baby during childbirth.
Herpes	Symptoms show up 1-30 days after having sex. Some people have no symptoms. Flu-like feelings. Small, painful blisters on the sex organs or mouth. Itching or burning before the blisters appear. Blisters last 1-3 weeks. Blisters go away, but you still have herpes. Blister can come back.	Spread during vaginal, anal and oral sex with someone who has herpes.	You can give herpes to your sexual partners. Herpes cannot be cured. A mother with herpes can give it to her baby during childbirth.

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STD	What to watch for:	How do I get the STD	What happens if I don't get treated?
HIV and AIDS	Symptoms show up several months to several years after contact. Can be present for many years with no symptoms. Unexplained weight-loss or tiredness. Flu-like feelings that don't go away. Diarrhoea White spots in the mouth. In woman, yeast infections that don't go away.	Spread during vaginal, anal and oral sex with someone who has HIV. Spread by sharing needles to inject drugs, or for any other reason. Spread by contact with infected blood.	You can give HIV to your sexual partner(s), or someone you share a needle with. HIV cannot be cured. Most people die from this disease. A mother with HIV can give it to her baby in the womb, during childbirth or while breastfeeding.
Syphilis	1st Stage: Symptoms show up 3–12 weeks after having sex. A painless, reddish-brown sore or sores on the mouth, sex organs, breasts or fingers. Sore lasts 1–5 weeks. Sores go away, but you still have syphilis. 2nd Stage: Symptoms show up 1 week to 6 months after sore heals. A rash anywhere on the body and flu-like symptoms that go away, but you still have syphilis.	Spread during vaginal, anal and oral sex with someone who has syphilis.	You can give syphilis to your sexual partner(s). A mother with syphilis can give it to her baby during childbirth to have a miscarriage. Can cause heart disease, brain damage, blindness and death.
Vaginitis	Some women have no symptoms. Itching, burning or pain in the vagina. More discharge from the vagina than normal. Discharge smells and/or looks different than normal.	Spread during vaginal, anal and oral sex with someone who has vaginitis. Men can carry vaginitis infections without symptoms.	You can give vaginitis infections to your sexual partner(s). Uncomfortable symptoms will continue. Men can get infections in the penis, prostate gland or urethra.

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STD	What to watch for:		How do I get the STD	What happens if I don't get treated?
Chlamydia or NGU	Symptoms show up 7–21 days after having sex. Most women and some men have no symptoms.	Women	Spread during vaginal, anal and oral sex with someone who has Chlamydia or NGU.	You can give chlamydia or NGU to your sexual partner(s). Can lead to more serious infections. Reproductive organs can be damaged. Both men and women may no longer be able to have children.
		Men		
Chlamydia or NGU	Symptoms show up 2–21 days after having sex. Most women and some men have no symptoms.	Women	Spread during vaginal, anal and oral sex with someone who has gonorrhea.	You can give gonorrhea to your sexual partner(s). Can lead to more serious infections. Reproductive organs can be damaged. Both men and woman may no longer be able to have children. A mother with gonorrhea can carry it over to her baby during childbirth. Can cause heart trouble, blindness, skin diseases and arthritis.
		Men		

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Appendix B

Child Abuse



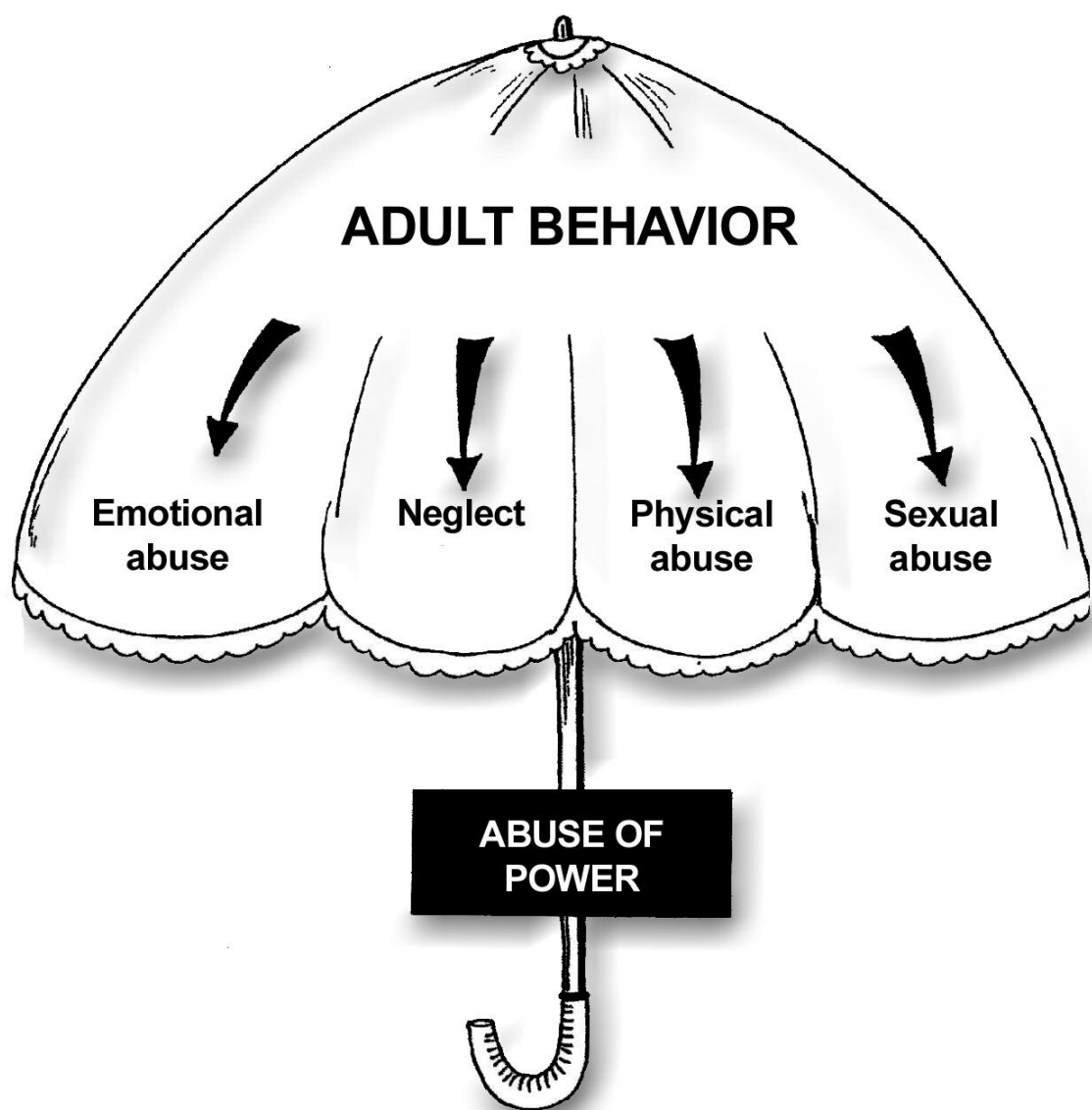
*Refer to document
"Abuse No More"
Dealing effectively with child abuse*

WCED 2000

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Child Abuse

Child abuse and neglect are behaviours perpetrated by adults. These behaviours take different forms, but all have the abuse of power in common. This can be illustrated as follows:



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Child Abuse

Definitions

The following are the categories of abuse:

1. Physical abuse
2. Physical neglect
3. Emotional neglect
4. Emotional abuse
5. Sexual abuse

1. Physical Abuse

The Johannesburg Child Welfare Society defines physical abuse as follows:

"Any interaction or lack of interaction which results in non-accidental harm to the child's physical or emotional state".

(Helfer, 1982).

2. Physical Neglect

"Failure of a child's parent/caregiver who has available material resources to provide minimally adequate care in the areas of health, nutrition, shelter, education, supervision, affection, attention and protection"

(Wilcock and Horwitz, 1984).

3. Emotional Neglect

"The deprivation suffered by children when their parents do not provide opportunities for the normal experiences producing feelings of being loved, wanted, secure and worthy, which results in the ability to form healthy object relations"

(Child Welfare Services, Alfred Kadushin).

4. Emotional Abuse

This is difficult to define but is said to be:

"The willful destruction or significant impairment of the child's competence"

(James Gornariro, Psychologist) YEAR?

5. Sexual Abuse

Child sexual abuse includes contact/s between a child and an adult in which the child is used for the sexual stimulation of the perpetrator. It may also be committed by a person under the age of 18, when the person is significantly older than the victim or is in a position of power or control over the child. When sexual abuse is perpetrated by a family member, it is referred to as incest. Such abuse may not involve physical contact.

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Child Abuse

Types of sexual abuse

Non-contact sexual abuse

1. Sexy talk

Comments to the child by the perpetrator about the child's "sexual attributes", what he/she would like to do to the child, and other sexual comments.

(Faller 1989 a:12).

2. Exposure

The perpetrator shows his or her intimate body parts to the child with or without masturbating.

Nudity with seductive overtones, e.g. the adult walking around the home unclad and in provocative manner.

Exposing the child to pornographic material.

3. Voyeurism

Overt or covert watching the child, e.g. when undressing, in the bath, or on the toilet.

French kissing

Kissing of the child by an adult in a lingering and intimate way "normally reserved for adults".

Sexual contact

Touching or fondling of the (clothed or unclothed) intimate parts of the child by the perpetrator or vice versa. This includes masturbation of either one by the other, and also rubbing of the perpetrator's genitals against the child's body or clothing.

Oral-genital sex

The perpetrator applies his/her mouth and tongue to the child's anal or genital area, or induces the child to do likewise to him/her.

Sexual penetration

1. Digital penetration i.e. placing of the perpetrator's fingers in the vagina and/or anus of the victim or vice versa.
2. Penetration with objects: The perpetrator inserts an object, e.g. a pencil into the vagina **or** anus of the victim.
3. Genital intercourse involving penile penetration of the vagina.

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Child Abuse

Causes of abuse

The child

Children who are abused have certain characteristics in common:

- May be small at birth and difficult to look after
- May be hyperactive and demand a great deal of attention from parents
- May have physical handicaps
- May be mentally handicapped
- May not be the sex the parents wanted

Abusive parents

Many instances of physical abuse are not premeditated sadistic attacks on children. Rather they are the result of outbursts of anger or rage.

Contributing factors

- Immaturity
- May have unrealistic expectations of their children
- May have been abused as children themselves
- Drug and alcohol addiction – often family violence
- Major mental illness
- Absence of social and emotional supports
- May have suffered recent stress
- Factors that add to stress:
 - Intelligence level of parents
 - State of their health
 - Socio-economic status, e.g. poverty, unemployment
 - Cultural background
 - Psychological make-up
- Inability to bond with a child or children
- Marital instability

Indicators of abuse

Physical Neglect

- Child is undernourished
- Medical attention not received when needed
- Ingrained dirt
- Impaired social and intellectual development
- Insecure behaviour, e.g. thumb sucking
- Truancy
- "Failure to thrive" syndrome

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Child Abuse

- Educational neglect
- Child often left alone or unsupervised
- Child has repeated accidents where caretaker is unaware of injury

It is important to note that in low socio-economic areas the abovementioned points could indicate circumstantial neglect as opposed to deliberate neglect.

Physical Abuse

- Injuries on child's body, e.g. brain damage, broken bones, burns, bites, bruises, injuries to the mouth, internal injuries, administration of substances/poisoning
- Marks of differing ages
- Marks in specific localities – buttocks, backs, thighs, upper arms, near eyes, inconspicuous places
- Shape of mark – straight edges, teeth or hand mark still visible, handfuls of hair pulled out
- Delay in seeking medical attention or seeking treatment from different doctors to mask the pattern
- Inconsistent or contradictory explanations as to cause of injury

Emotional Neglect

This is where the child does not receive adequate attention, affection or guidance from his/her caregiver

- Rejection – may manifest in starving or abusing the child emotionally
- It is difficult to define and its consequences are difficult to establish conclusively
- It is an act of omission

Emotional abuse

- Rejection – adult does not acknowledge the child's worth
- Isolation – adult cuts the child off from normal social experiences
- Terrorizing – adult assaults the child verbally and creates a climate of fear
- Ignoring – adult deprives the child of essential stimulation and responsiveness

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Child Abuse

Behavioural consequences of abuse

Frozen watchfulness

Self-destructive behaviour

Moving into deviant subcultures

Running away from home

Inability to form relationships

Manipulative behaviour

Poor school performance

Low self-esteem

Behaviour such as enuresis and encopresis

Passive aggressiveness

Attention-seeking behaviour/Testing-out behaviour

Impaired ability for enjoyment

Poor peer relationships

Poor concentration span

Bonding difficulties

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Child Abuse

Recognising child sexual abuse

Powerlessness

Nightmares

Phobias

Depression

Running away: unwilling to go home after school

Somatic complaints: eating and sleeping disorders

School problems, truancy

Employment problems

Vulnerability to subsequent victimisation

Aggressive behaviour, bullying

Becoming an abuser

Fear of being alone with an adult

Over-compliance

Rebellion

(using traumagenic dynamics – Finkelhor & Browne – 1986)

Loss and betrayal

Clinging indiscriminately

Vulnerability to subsequent abuse and exploitation

Isolation

Discomfort in relationships, disconnected

Marital problems

Aggressive behaviour

Delinquency

Hoarding

Apathy

Anxiety, depression

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Child Abuse

Disconnected

Somatic reactions

Suspicious, mistrustful

Attention problems

Regression

Ambivalence to perpetrator

Stigmatisation

Isolation

Drug or alcohol abuse

Criminal involvement

Self-mutilation

Suicide or suicide attempts

Poor self-esteem

Poor body image

Drive to achieve

Never believes himself/herself good enough

Unwillingness to undress

Acting out "attention-seeking behaviour"

Self-destructive behaviour

Wearing layers of clothing

Neglect of personal hygiene (particularly during menstruation of a girl)

Traumatic sexualisation

Age-inappropriate sexual knowledge

Sexual preoccupation and compulsive sexual behaviour

Seductive behaviour

Aggressive sexual behaviour

Promiscuity

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Child Abuse

Sexual dysfunction, difficulty in achieving arousal/orgasm

Avoidance of or phobic reaction to sexual intimacy

Inappropriate sexualisation of parenting

Sexualises attention

Sexual victimisation of others or self

Responds to neutral touching as sexual approach

Fear of being touched

Physical signs

There are often no physical indicators – does not mean abuse has not occurred

Enuresis

Encopresis

Sexually transmitted diseases

Vaginal or penile discharge

Difficult/Painful urination

Offensive smell

Pregnancy at young age

Odd bruises/bites that might be caused by sucking

Self-mutilation

Hypoactive/Hyperactive

Psychosomatic symptoms

Gross weight loss/gain

Blood on underwear

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Child Abuse

Worksheet 1

For your own notes:

1. The abusive family

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2. The child

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3. The perpetrator

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4. Contributing factors

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Child Abuse

Role of the teacher

Role of the teacher in responding to abuse

The teacher plays a vital role in identifying and supporting the neglected or abused child. This role can be divided into five categories:

1. Detection

It is often difficult to be sure when you suspect that a child may have been abused, especially emotionally or sexually. If you have suspicions though, based on the indicators mentioned before, it is important to act on the suspicions and to try to be more sure.

The first thing to do is formulate your concerns and write them down – for example behavioural signs like the fear of being touched, the child not wanting to go home, Discuss your concerns with the guidance teacher or school principal (depending on the school's prescribed procedures). Consult a social worker in your area and decide on a plan of action, for example for you as a teacher to speak to the child or for the social worker to follow up the matter.

2. Support

There are five important messages to get across when responding to a child who has disclosed some form of abuse:

- I believe you.
- I'm glad you told me.
- I'm sorry this happened to you.
- It is not your fault.
- We will get you some help (C.A.R.E. Educational Kit).

3. Ten guidelines for teachers at the time of disclosure

Whether the child's disclosure is accidental or deliberate, the teacher should do the following:

- Acknowledge the child's statement.
- After any kind of disclosure, try not to show any shock.
- Give matter-of-fact answers.
- Always speak to the child quietly and privately.
- Stay calm, reassuring and non-judgmental.
- Believe what the child tells you.
- Do not ask "why" questions – they sound accusatory.
- Tell the child he/she is not responsible for the abuse, whatever the circumstances.
- Sometimes the child will want to tell everything – do not encourage or discourage this.
- Help the child by saying that you know how difficult it must be for him/her to talk about the subject.

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Child Abuse

4. Reporting Procedure

Recommended procedure for reporting child abuse

Step one:

When a teacher suspects that a child has been abused, the teacher should note the:

- (a) name, age, grade, address and telephone number of the child;
- (b) names of the parents and/or guardians;
- (c) reasons for concern, documentation of indicators, and any relevant statements made by the child.

Step two:

Appropriateness

Immediate contact should be made with the non-abusive parent/s as the child may have experienced difficulty in disclosing sexual molestation to a parent. This may have been for various reasons, e.g. threats, bribes, fear of consequences.

This could be the appropriate time for the principal/teacher to request a meeting with the parent/s at the school. The parent/s would obviously want to be party to this serious disclosure by the child, if they were unaware of the abuse. Or they might appreciate the meeting if they could not deal with the problem themselves. It is advisable to request the support of a social worker at this initial meeting.

The school would therefore serve as a support system by following the appropriate procedure for intervention.

If the parent/s are un-co-operative and do not attend the meeting at the school, the social worker or the Child Protection Unit should be contacted.

NB: All teachers and professionals are legally bound by the Family Violence Act (No. 133 of 1993) to report any abuse they encounter. Even if it is just a reasonable suspicion (see Indicators).

Step three:

The designated staff member (counsellor or school principal) should contact the social worker. The following should be noted:

- The name of the person making the call.
- The name of the social worker receiving the call.
- The time and date the call was made.
- The action proposed by the social worker.

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Child Abuse

Step four:

A social worker (and/or a police officer in many cases) will interview the child as soon as possible.

Step five:

A social worker and/or the police will then interview the alleged abuser and family members. A decision concerning the safety of the child will be made by the social worker without delay.

Step six:

The counsellor or principal should be prepared to follow up the case by contacting the social worker to learn the results of the investigation as far as they concern the school.

Step seven:

At the conclusion of the investigation the teacher, counsellor and school principal should meet to discuss the steps the school could take to assist the abused child.

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Child Abuse

Worksheet 2

1. Preventive Programme

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2. Principles

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3. Some ideas

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4. Designing a Preventive Programme

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Appendix C

Alcohol and Drug Abuse



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Alcohol and Drug Abuse

What parents need to know about drug use

Attitudes to alcohol and other drug use are formed early, usually during pre-adolescence and early adolescence. Consequently, the prevention of alcohol and other drug use must begin early as well.

Children are increasingly beginning to use alcohol and other drugs at younger and younger ages, often as early as the senior primary grades. According to a Weekly Reader National Survey, 34 percent of sixth graders (Standard 4) experience peer pressure to use dagga and 51 percent experience peer pressure to drink beer, wine or other types of liquor.

The early use of drugs is likely to follow a predictable sequence: first tobacco, then beer and wine, progressing to other types of liquor, followed by dagga and then other illicit drugs.

The earlier in life a young person starts using any drug, the more likely he/she is to experience dependency and go on to other more potent drugs.

Early drug use is strongly associated with other problem behaviours such as lying, stealing, poor school performance and promiscuous sexual activity.

Most children learn about and are offered drugs the first time by their friends. Yet peer pressure to use alcohol or other drugs is likely to be subtle and indirect; it is usually not overt pressure.

Drug-abusing adolescents may set themselves up to be "caught" by their parents. Such adolescents may flaunt or even advertise their drug use in an attempt to provoke parental attention and concern.

In a major study of 1 000 young people, the majority stated that all drugs, from alcohol to crack and cocaine, are readily available to anyone who wants them. Many of those who did not use drugs gave as a reason, "My parents would be angry", or "I wouldn't want to disappoint my parents". These young people felt that their parents' expectations that they would not use drugs, and their family's open communication, helped them to resist drugs.

Alcohol

Alcohol is a depressant that slows down the nervous and muscular activity in the body. It affects the brain first, slowing down thinking and affecting judgement. Next it affects the emotions and the person may become silly, angry, worried or sad. It also affects the balance and reaction time. Because learners are still growing, alcohol has a greater effect on them and can cause permanent damage.

Dagga

Dagga is a drug that can act as a stimulant (speeding up the heart rate), a depressant (slowing down messages from the brain) and a hallucinogen (causing the user to see or hear things that

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Alcohol and Drug Abuse

aren't really there). Although some people claim that dagga has medicinal properties, this has never been scientifically proven.

One of the chemicals in dagga, THC, is absorbed by tissues in the brain, nerves and reproductive organs. The function of the cells in these organs are slowed down and they eventually die. Brain cells cannot be replaced.

Dagga remains in the body and effects the user for weeks.

Dagga users have problems with thinking, judgement and memory. Smoking dagga carries five times the potential cancer risk as smoking ordinary cigarettes.

Dagga also affects the user's memory, attention span, speaking, listening, comprehension, problem solving and decision making. It leads to a decline in school performance.

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Alcohol and Drug Abuse

Prescription and over-the-counter drugs

General description

Many types of over-the-counter drugs can be purchased in pharmacies and supermarkets. They are called over-the-counter because anyone can buy them by simply walking up to a counter in a store and ordering them. They include aspirin, cold remedies and diet pills.

Prescription drugs are almost always more powerful than over-the-counter drugs and potentially more dangerous. They can be purchased legally only with a doctor's prescription. The only persons who can legally sell prescription drugs are licensed pharmacists.

How can medicines be helpful?

By preventing sickness – Vaccines are prescription drugs that help prevent diseases such as polio, whooping cough, measles and mumps. Other drugs help prevent illness by controlling conditions so they don't become problems. For example, people who have diabetes often take insulin to help control the amount of sugar in their blood.

By helping to heal the body – Some prescription drugs, such as penicillin, fight infections in our ears, eyes, throat and other places. Some over-the-counter medicines kill bacteria in cuts and scrapes.

By helping to alleviate pain – Aspirin and many other over-the-counter drugs (called analgesics) help control aches and pains while our bodies heal. Doctors prescribe stronger pain-killing medicines after serious accidents or surgery. Dentists use forms of novocaine during treatment.

By helping to control symptoms – Sometimes medicine won't necessarily make a problem, like a cold, go away, but it can make us feel better while our bodies heal themselves. Medicines stop our coughs at night so we can sleep, clear up our stuffy noses, or prevent poison ivy and insect bites from itching.

How can medicine be harmful?

All prescription and over-the-counter drugs can be dangerous, mainly through overdose and misuse. Health hazards range from dizziness to death.

Prescription and over-the-counter drugs can also cause harmful **side-effects** – unwanted effects on the body or mind, such as headaches or upset stomachs. Any side-effects should be reported immediately to a trusted adult.

Rules for using over-the-counter and prescription drugs

All medicines, even over-the-counter drugs, should be used only with a trusted adult's help. It is important to follow the instructions on the container. Taking more than the recommended dose

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of even a simple medicine like aspirin can lead to consequences ranging from an upset stomach to death. Prescription drugs should be used only by the person for whom the prescription was written.

Here are key rules for young people to follow when taking any medicine:

- Take it only under a trusted adult's supervision.
- Take only the amount of medicine your doctor or another trusted adult says you should take.
- Never share your medicine with another person.
- Never take someone else's medicine.
- If you feel ill after taking medicine, tell a trusted adult right away. You may be experiencing a harmful side-effect.
- Never give medicine to anyone else, and always make sure younger children cannot reach medicines.
- Make sure child-proof caps are properly replaced so young children cannot use the particular drugs.

What the labels tell us

Labels on prescription drugs usually list the patient's name, the doctor's name, the drug and the dose the doctor says you should take, the pharmacy, the date and the number of refills allowed. The labels often include directions for using the drug, such as "Take with meals".

Over-the-counter drug labels include the symptoms treated by the drug, how much of, how often and how long the drug should be taken, and possible side-effects. These labels may also offer warnings or advice, such as "If this drug does not relieve symptoms, see a doctor" or "May cause drowsiness: do not use before operating a motor vehicle".

Cigarettes

Nicotine (nik-uh-teen), the main drug in tobacco, is a stimulant and makes the body organs work faster. Tobacco occurs in cigarettes and cigars, and is also sold as pipe tobacco, chewing tobacco and snuff.

Smokers inhale smoke from cigarettes, cigars and pipes. Smokeless tobacco includes chewing tobacco and snuff. Nicotine in tobacco products is highly addictive.

Effects on the Body and Health

Brain

Nicotine narrows the blood vessels, cutting down the quantity of blood that goes to the brain and other body organs. The amount of oxygen that reaches the brain is further decreased because some of the oxygen in the bloodstream is replaced by carbon monoxide from the cigarette smoke.

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Mouth, throat

Tobacco smoke irritates the lining of the nose, mouth, throat and lungs. People who smoke cigarettes, cigars and pipes may get cancer of the lips, mouth and throat. Smokeless tobacco can also lead to these forms of cancer and gum disease. It is just as dangerous to chew tobacco as to smoke it.

Smoking also deadens the smoker's sense of taste and smell.

Lungs

The tar from cigarette smoke coats the lungs and can lead to cancer and other serious lung diseases that are often fatal. Smokers are 25 times more likely than non-smokers to develop lung cancer.

Another lung condition associated with smoking is emphysema (em-fuh-ZEE-ma). In this disease, the air sacs in the lungs lose their elasticity. This makes breathing increasingly difficult and often leads to death.

Effects on Behaviour

Nicotine speeds up the various systems in the body, making people feel jittery and nervous. In spite of this, a person who smokes will often say "it calms me down" or "it gives me something to do with my hands".

The danger to non-smokers – Many laws have been passed to forbid smoking in public places because of the dangers of secondary smoke – smoke in the air that can harm non-smokers.

The high incidence of smoking related illnesses (lung cancer, heart diseases, cancer of the throat and mouth) among smokers has a negative effect on the immune system of these people – a factor which makes smokers even more susceptible to infections. Therefore smokers have even less resistance to the HIV virus.

Appendix D

Parent's Evenings



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Parent's Evenings

Strategies for parents meetings

1. School Governing Bodies

Obtain the support of the school governing body by:

- (i) organising a meeting with them,
- (ii) stating the problem,
- (iii) introducing the programme,
- (iv) indicating the training that was given,
- (v) informing them about the HIV AND AIDS policy.

2. Representatives

Choose a representative for parents.

Choose a representative for teachers.

(These two people lead the parents' meetings.)

3. Workshop method

Divide parents into groups. A teacher leads the discussion group.

4. Other

- Make sure that parents feel accepted in the group and that their contributions are respected.
- Make meetings positive social experiences – for example, by serving refreshments.
- Be prepared to make repeated phone calls and to send reminders to encourage participation.

Important note

You can obtain the support of your colleagues by informing them about the learning programme and the parents' meetings.

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5. Parent guidance

5.1 Introduction

Many parents are not prepared for parenthood and cry out for help: "Please help me to be a good parent. I am simply not coping." They appear to be ineffective in their parenting and experience problems with the following:

- building a relationship of trust with their children;
- discipline and setting limits;
- dealing with conflict;
- understanding certain kinds of behaviour (bridging the generation gap);
- truly listening and talking to their children;
- knowing when and how to talk to their children about sex;
- neutralising the effects of the media (especially television);
- protecting their children against alcohol and drug abuse.

All children should be at school – the school therefore has contact with many parents. Because teachers are professional educators, the school can help parents to cope by organising parent guidance sessions at least once a year. The principal and staff should decide which topics are the most relevant for their specific community. Parent guidance sessions could include guidance directed at:

- all the parents of the school;
- only the mothers;
- only the fathers;
- only the parents of the pupils in one grade (the same age group);
- the parents of children who are growing up (puberty phase) – specific guidance for sexuality education;
- single parents and parents in restructured families. The assistance and support of traditional leaders, religious leaders, social workers and other members of the community can reinforce what the principal or teacher is trying to accomplish.

5.2 Inviting the Parents

Getting parents to attend an event at school sometimes requires a great deal of skill and creativity. Invitations should be friendly and should stress the fact that education can succeed only if parents and teachers work together, that parents are the primary educators and that the school would like to help wherever possible. Parents can be invited by letter, via the children, or by word of mouth. If refreshments are served, it makes the occasion an enjoyable, sociable, informal event. Parents need to feel welcome at the school. If they are made to feel comfortable and special, they will most probably become involved in other school activities as well.

Some schools organise bus transport for parents and combine a parent guidance session with other activities at the school (e.g. concert, sports event, exhibition of pupils' work) Where there is no school hall, parents can be accommodated in smaller groups in classrooms or at any other local venue.

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Even if only a few parents turn up, the school should not be discouraged – if only one parent has been helped, at least two or three children may have benefited. Furthermore, parents who have attended, will spread the word to other parents – the filter effect!

5.3 How do I speak to Parents

Parents are fellow adults and therefore a teacher should not talk down to them or make them feel ignorant or useless. The entire attitude should be one of "walking the path together". Parents respond positively if they are respected, are made to feel at home and if they are assured that the principal or teacher also cares for their children. The purpose of the gathering can be explained as follows:

"We are here because we care deeply for our children and together we (teachers and parents) can achieve more than if we work separately."

5.4 Making Parents aware of Problems

Parents should be made aware of problems in the community which may seriously affect their children's lives:

- absent fathers or mothers
- divorce and other reasons for disintegrated families
- single parenthood
- reconstituted families (step-parents, and other)
- violence in the family and the community
- child abuse or neglect
- lack of love, care and discipline
- the negative influence of certain friends and bad adult role models
- teenage pregnancy
- prostitution (also child prostitution)
- rape and other forms of sexual abuse
- availability of alcohol and drugs
- sexually transmitted diseases and AIDS
- pornography (also child pornography) and other negative sexual messages from the media

In guiding the parents to formulate possible solutions to parenting problems, allow the parents to offer their own opinions.

5.5 Searching for Answers

What can I do to give my child self-confidence, a positive self-image and a sense of security?

Discuss this matter.

- Children need food, clothes and a secure place to stay.
- The atmosphere in the home should be happy and family members should love, respect and support one another.

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- Parents should regularly show love towards each other and give their children a lot of love and affection: they should hug and kiss their children, speak lovingly to them and should be genuinely interested in all they do.
- Children should be praised whenever possible and told that they are special and that their parents are proud of them.
- Children should be allowed to become independent by progressively doing things for themselves and assuming responsibility for specific tasks in the home. This gives them a feeling of self-worth.
- Children should be allowed to have friends (friends who influence them positively).
- Children should be taught about the love and forgiveness of God.

Religious anchors provide a tremendous sense of security.

- Children will copy their role models and therefore a parent's example is of prime importance.
- Children should learn that there are limits: explain to them that particular types of behaviour are unacceptable.
- In order to ensure that children's behaviour is acceptable they should be disciplined whenever the occasion arises.

Parents should

- Explain clearly why certain behaviour is unacceptable (cultural norms);
- Stay calm but be firm about rules;
- Tell the child that they care about him/her and that they want him/her to be responsible (not to hurt himself/herself or get into trouble);
- Set down rules and limits and mutually agree with child on what constitutes acceptable and unacceptable behaviour even if they are separated from each other;
- Be consistent ("No" today, should be "No" tomorrow);
- Punish the child if he/she misbehaves on purpose; steals, lies or is dishonest or disobedient in other ways.

5.6 How should I punish my child

- Punishment should be fair: the child should understand that what he/she has done is unacceptable and the child should be offered an opportunity to explain (if he/she is old enough).
- Children and parents are unique. Some children show remorse and change their behaviour if the parent's face and voice show disapproval, or if they are scolded. Others will not react in such a way and others will respond defiantly.
- Taking away privileges from the child is often a good form of punishment (not allowed to play with friends or watch TV).
- On occasion the naughty child may be given some unpleasant, though not dangerous, task to perform as punishment.

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- Slapping or corporal punishment should be a last resort, if it is used at all. Physical punishment could easily become abuse. If the parent decides on this kind of punishment, he/she should
 - explain to the child why he/she is being smacked;
 - hit only once or twice on the buttocks (not the face or head);
- after a while make friends with the child again and assure him/her of your love.

Note: "never punish in anger!"
 "don't degrade a child in the presence of other people"
 "punish in private and praise in public"
 "don't just talk and talk – act!"
 "judge the behaviour, not the person!"

5.7 How can I Improve Communication with my Child?

Discuss this issue.

Most parents are extremely busy and work long hours, sometimes far away from their homes. This makes it very difficult to build good relationships with their children. However, all is not lost. There are ways of rising above difficult circumstances. Tell the parents the following:

- When you and your child are together, take a while to really make contact by talking about what has happened to each of you that day, week or month. Express genuine interest. Do not judge or criticise. Tell the child that you have missed him/her and you wish you could be together more often.
- Spend time together as a family by working or playing together or going out somewhere whenever possible.
- Be really interested in his/her school work, friends and activities. Ask questions to determine if he/she is happy or troubled about something. Help him/her to find solutions to problems.
- Try to understand why he/she likes a particular friend, certain types of clothes, music or activities. Do not always criticise, but also do not always accept behaviour or tastes that may be contrary to your own.
- Encourage your child not to keep secrets from you and to tell you if something is worrying him/her.
- If you do not see your child often, try to phone or write a letter, showing that you really care.
- Remember birthdays and other special days.
- Treat your child with something special (a small gift) now and then.
- Do not give too much money and too many gifts just because you perhaps feel guilty – it spoils the child. Rather provide more love and attention.

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Parent's Evenings

Example of invitation to parents

Dear Parents

The times we live in demand much from the educators of our children. An important and demanding facet of education is sexuality education.

At this school we realise the importance of the topic and have prepared ourselves to support parents in the sexuality education of their children. Because of the sensitive nature of the subject, we would appreciate a personal discussion with you on the matter.

We therefore invite you, as parents, to a special meeting where we can discuss various aspects of sexuality education with you.

Date:

Time:

Place:

It would be beneficial to your child if both parents could attend this meeting. We hope that the arrangements will suit you.

Any queries can be directed to at the above telephone number.

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Appendix E

"Energisers"



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"Energisers"

"Energisers" and other great co-operative activities for all ages

Reaching out

1. Invite the group to stand, and then say, "reach out to someone wearing red". That means players move around to find someone wearing red. As soon as a player finds someone, he/she reaches out a hand to the person and, without touching, both the "reacher" and the person wearing red immediately "freeze". Several players may reach out to the same person.
2. As soon as all the players are frozen in place, they introduce themselves to the person they're reaching out to.
3. Then call out another description, keeping categories general and the pace brisk so that everyone's on the move.

Here are some ideas. (Adapt them to fit your group.)

Reach out to someone:

- Wearing an earring.
- Wearing blue jeans.
- With a belt.
- With brown eyes.
- With longer hair than you have.
- With the same colour eyes as you have.
- With hair shorter than you have.
- With a pony tail.
- With white tennis shoes.
- Taller than you.
- Who parts his/her hair.
- With something purple.
- Wearing a ring.
- You didn't know until this year.

Variation: Have players move around in exaggerated slow motion.

Rare Birds

For a well-acquainted group to find out what they know about each other.

Materials and preparation: A pencil and a strip of paper for each player.

1. Explain that each of us in our own unique way is a "rare bird". That is, we each have some unusual qualities, experiences, likes and dislikes that help to make us who we are. In this activity each player shares one of these and then the group tries to determine just which rare bird description belongs to whom.

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Some examples:

- Surprising facts ("I have a twin brother.")
 - Interesting jobs ("I'm the treasurer for the 4H band.")
 - Favourite food ("I love peanut butter, mayonnaise and lettuce sandwiches.")
 - Interesting experiences ("I spent five years in England.")
 - Special awards ("I won a blue ribbon at the state fair for my apple pie.")
 - Special skills ("I can fold my tongue in half!")
 - Special interests ("I pump iron.")
2. Pass out the materials. Ask the players each to write their names on the strip of paper as well as something unusual, interesting, or just plain funny about themselves that most people in the group don't know. And be sure to do one yourself.
 3. Collect the strips of paper. Then, without giving away the writers' identities, read them aloud, stopping after each one to let players guess who wrote it. After a few minutes, invite the real "rare bird" to please stand up!

Clap, Click and Pop

Through simple actions, players learn strange facts about each other.

1. Have the players sit at desks or in a circle and explain that as a way for members of the group to learn more about each other, you will call out some categories and actions. All those who fit the category, jump up from their places, complete the action and then sit down. Show what to do by giving an example, such as "Everybody with a brother, stand up and click your fingers!"
2. Keep the pace snappy and everyone involved as you call out a variety of categories and movements. Here are some ideas to adapt to your age group:

Stand up if you:

- Have lived here more than five years. Give a wave!
- Have moved more than twice. Raise both hands!
- Like rainy days. Click your fingers.
- Were born on a holiday. Call out the day!
- Like to wear hats. Wink an eye!
- Have read a book in the last week. Clap your hands twice!
- Like grapefruit. Give a whistle!
- Can spell "Mississippi" Spell it out!
- Dislike broccoli. Make a face!
- Make your bed every morning. Tap your heels!
- Know how to swim. Pound your chest!
- Like dogs more than cats. Let out a "Woof!"
- Like cats more than dogs. Let out a "Hsssss!"

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- Read or write poetry. Take a bow!
- Have more than two uncles. Show the number with your fingers!
- Play a musical instrument. Show us how you play!
- Exercise regularly. Run on the spot!

Rubbing Elbows

Players greet and rub elbows with some very important people – each other!

Preparation: Clear a large space so players can mingle.

1. Count off by fours and say:

Group One: Fold their arms behind their heads with elbows out to the sides.

Group Two: Place their hands on their hips, elbows out.

Group Three: Place their left hands on their hips, right hands on their right knees, elbows out.

Group Four: Fold their arms out in front, elbows up.

2. Now tell players they have three minutes to introduce themselves to as many people as possible by saying "Hi, I'm!" while touching elbows as they greet each other.
3. When the time's up, tell the players to find and greet their own elbow group.
4. For a grand finale, call out the group numbers while members stand connected in their "elbow positions" and everyone else gives them a hand.

Getting around

A roundabout way for everyone to talk to each other.

Materials and preparation: A note-card and pencil for each player.

1. Pass out note-cards and pencils, and tell everyone to write down the following:

Top left corner: Something you have in common with people in this group.

Top right corner: A way you may be different from people in this group.

Bottom right corner: A way you can contribute to this group.

Bottom left corner: Something you would like to learn or accomplish with this group.

(Adapt these so that they are age-appropriate, comfortable and relevant to your group.)

2. Now divide the group in half. One half forms an inside ring facing and walking clockwise; the other half forms an outside ring facing and walking counter-clockwise.

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3. The two circles move in opposite directions for a minute or so. Then tell everyone to stop, turn to the nearest person in the other circle, and share the answers they wrote down in the top left corner.
4. This pattern of walking, stopping and talking continues three more times until all four answers have been shared.

Match Makers

Matching up for games... Fast!

Paring Partners

- Pair up with the first person you meet who is wearing one of the same colours as you are.
- Place your hands either on your hips or on your shoulders. Now touch elbows with the first person you meet in the same position.
- Wave either your right or left hand. Now pair up with the first person you meet waving the same hand.
- Make the sound of either a cat or a dog. Now pair up with the first person you hear making the same sound.
- Call out either "chocolate" or "vanilla". Now pair up with the first person you hear saying the same flavour.
- Call out either "mountains" or "seashore". Now pair up with the first person you hear saying something different.

Dividing into teams

Players can quickly form teams by counting off in the following ways:

Arm positions

Example: For two teams, players count off by alternately raising both arms up high or holding them close to their sides. Arms up high are one team; arms close to the sides are the other team.

Colours

Example: For three teams, count off with red, white and blue. Reds are one team; blues, another; and whites a third. Select familiar groups of colours, such as school colours, state or province colours, or those in a country's flag.

Sounds

Example: For four teams, count off with Baa, Grrr, Woof and Moo.

Exclamations

Example: For five teams, count off with Oh no!, Ahhh, Wow!, Hmmmm and Huh?

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Motions

Example: For six teams, count off by motions, such as clap hands, snap fingers, pat thighs, wiggle fingers, circle arms, raise and lower elbows.

Days of the week

Example: For seven teams, count off by Sunday, Monday, Tuesday, Wednesday, Thursday, Friday and Saturday.

Group Puzzlers

Select a picture from a magazine or use an old poster for each group you need. Cut each picture into the same number of pieces as the group members needed, and jumble the pieces together in a container.

The players each draw a piece from the container with the challenge of finding other players with pieces from the same picture. When they find each other, they put their picture back together again.

Hint: Select pictures that are distinctive from one another.

The great handstacking race

A race that takes some HANDiwork and co-ordination.

1. To begin the Great Handstacking Race, divide the players into teams of six.
2. Have each team form a circle and get the members to stack their right hands on top of each other in the middle of the circle. Next, have them stack their left hands on top of their right hands.
3. At a signal, the player whose hand is on the bottom moves his/her hand to the top. The other players follow, moving one hand at a time.
4. When teams have learned to manoeuvre their hands, let the race begin! Teams complete a round when all their hands are back in their original positions. Races can be two or three rounds.

Hint: To help a group remember whose hand signals the end of the race, mark the original hand on top with an X.

Stretch out those kinks

A quick pick-me-up for energising both you and a room-bound group.

1. Take a break and lead the group in this easy rhyme. After the "sigh", get back to work!
2. Here is the rhyme:

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"Hands on hips, Hands on knees,

Touch the floor, If you please.

Now swing to the left, Now swing to the right,

Relax your body, Now squeeze it tight.

Stand up tall, Reach arms up high,

Tip back your head, Give a sigh."

Mirror, Mirror

Players get a good stretch and laugh while reflecting on each other's actions.

Optional materials: A tape or record of slow, melodic music (to help set the mood and keep the players moving).

1. Pair players and ask partners to face one another and pretend they are looking at themselves in a mirror.
2. One player initiates the action; the other "mirrors" it. This works best if the actions are smooth and flowing – and partners maintain eye contact. You may need to demonstrate first, but they will soon get the idea. Challenge them to mirror one another as closely as they can.

Here are some things they can try:

- Wide, sweeping arm movements
 - Leg lifts, backward and sideways
 - Left hand to right hand, right hand to left
 - Lifting eyebrows, winking eyes, frowning and smiling
 - Slow movements sideways, backward and forward
3. After some practice, get the players to imitate each other's actions simultaneously, with no designated leader.

Variations:

One partner gestures combing hair, brushing teeth, putting on a coat, putting up an umbrella, eating an apple, playing an instrument, or blowing up a balloon, while the other partner mirrors the action.

Small groups mirror the actions of an individual or another group.

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Giant Clocks

Time to stretch? Do it while standing in place.

1. With the players standing, ask them to pretend they are each giant clocks. If they hold their left and right arms straight overhead, palms together, their arms are the second hand of the clock.
2. When you call our numbers 1–12 on the clock, the players use their arms to assume the second hand's position. For example, when you say "six", the players bend over with their arms pointing to their feet. At "twelve" their arms are straight overhead. And at "three", both arms are pointed out to the left.
3. Keep the pace brisk as you randomly call out the location of the second hand. "Second hand is on the six, ten, three, eight", and so forth, and the players stretch and bend as they assume the various positions of the second hand.
4. For a final stretch, the players' left arms become hour hands and their right arms become minute hands. As you call out a variety of times, they stretch both their brains and arms to show the right time.

For example: 1 o'clock, 4:15

5. When time is up, the "clocks" wind down!

Ocean Waves

Players get plenty of exercise as they shift back and forth and up and down.

Materials and preparation: One vacant chair plus one chair for each player. Arrange the chairs in a circle, close together.

1. Seat the players on the chairs in the circle, and designate someone to stand in the centre as "It".
2. "It" directs them to "Move right!" or "Move left!" Depending on the command, everyone keeps shifting to the right or to the left to fill the vacant chair as it appears next to them. "It's" challenge is to sit in an empty seat; the players' challenge is to prevent this.
3. The location of the vacant seat is constantly changing, as players move in and out of seats. When "It" finally grabs a seat, the new "It" is the player who missed moving to the empty chair in time.

Description Duet

A guessing game which requires focusing on the details.

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Materials and preparation: A variety of small, everyday items, such as a spoon, rubber, paper clip, rubber band, leaf, rock, button, etc.

1. Set the stage by holding up an item, such as a pencil, and asking the players to pretend they do not know its name or how it is used. How would they describe it to someone else? What would they say about it? They might say, "Well, it's long, thin, and bright yellow. It has a sharp point on one end and soft rubber on the other".
2. Then, without letting anyone else see, show an item to two players, and have them describe what it looks like without saying its name or how it is used.
3. Challenge the listeners to guess the item based on this description. Once the item is guessed, discuss some of the description words that were most helpful – and how two people can see the same thing in different ways.

Do as I Say

Volunteers test their skill at following instructions.

Preparation: Write out a simple series of instructions appropriate to the players' ages. Example: Stand up and turn around twice. Then go to the door and knock once, return to your chair, clap your hands, cross your legs and say your name out loud.

1. Read the instructions aloud once to the group.
2. Choose a volunteer to follow them as closely as he/she can while the others carefully observe what happens.
3. Let the observers vote on whether the instructions were followed accurately or not – and make any needed corrections. This is also a good time to talk about the relationship between careful listening, clear instructions and following instructions.

Variation: Players can work as teams to follow a set of instructions.

De-Energiser

A test of time and also a time of total tranquillity.

1. Challenge the players to put their heads down or lie down with their eyes closed for exactly three minutes. As the players each think the three minutes are up, they quietly raise their hands without saying a word.
2. As the players raise their hands, mark down the time. Then discuss the differences in the guesses.

Top Secret Leader

Like "Follow the Leader", but here the leader works behind the scenes.

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1. Ask a volunteer to be "It" and leave the room. The rest of the group selects a Top Secret Leader to lead them in a series of actions, such as winking, clapping and raising arms.
2. When "It" returns, he/she stands in the centre to observe while the group tries to imitate the leader's actions – without indicating who the leader is. "It" has three guesses to figure out just who is leading whom. If correct, Top Secret Leader becomes the new "It". If incorrect, select a new "It" and play again.

Paint it with words

Players create a "word picture" of remarkable detail.

1. With the players seated in circles of six to eight, explain that someone in each group will begin this activity by naming an object, such as a "tree".
2. The person on his/her right adds a detail about the tree.
3. Then a third person adds something else.
3. This continues on around the circle until a picture has been created – a vivid "still life" painted with words.

Here is how it might go:

First player:	A tree
Second player:	A tall tree
Third player:	A tall, shady tree
Fourth player:	A tall, shady tree growing on a hill
Fifth player:	A tall, shady tree growing on a lonely hill
Sixth player:	A tall, shady apple tree growing on a lonely hill
Seventh player:	A tall, shady tree full of bright red apples growing on a lonely hill

5. When the small groups complete their "still life", ask them to share it with the whole group. As a follow-up, how about recreating these pictures with actual paint?

Variations:

Perform this activity in a large circle with the players randomly volunteering descriptions and details. When an image has been satisfactorily completed, start another. Give several groups the same word to begin with. At the end, they can compare their word pictures.

Do you padoodle?

A key figure in the grammar world is missing, and the Word Detective needs some clues.

1. Explain that this is a mystery word game with a Word Detective, a "missing" action verb, and a secret code name – Padoodle.
2. Select a Word Detective and have him/her leave the room.

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"Energisers"

3. Then ask the rest of the group to agree on an action verb – such as "study", "laugh" or "walk". (Keep the word simple and concrete.)
4. When Word Detective returns, he/she tries to guess the action verb by asking questions. The trick is that everyone must talk around the action verb by substituting the word Padoodle. For example, if the missing verb is "study", Word Detective may ask a player, "Do you Padoodle at home?" The response might be, "Yes, I Padoodle every evening after supper". With the right questions, Word Detective should soon figure out the missing action verb.

Hint: For younger players, begin with a list of questions that the Word Detective can ask, such as:

Does everyone *Padoodle*?

Is it fun to *Padoodle*?

Where do people *Padoodle*?

5. When the word's uncovered, be sure to Padoodle your hands in a round of applause. Then begin again with a new super sleuth and missing word.

Five Finger Fling

A co-operative effort that requires careful counting and a bit of luck.

1. Divide the players into groups of three to four, and have the members of each group face one another – one hand behind their backs and the other in front, fist closed.
2. At the count of "one, two, three!" the group members each fling out zero to five fingers. The challenge is, without any talking, to have the combined fingers add up to a certain number, such as 13. It's likely to take several "flings" before they reach the exact number. When they do, be ready for the cheers!

Gatherings for Goodbye

Some closings after a time together.

Preparation: Clear a space for a group circle.

Cinnamon Roll Squeeze

Stand together in a circle with everyone holding hands. Ask a player to break hands with the person on the right. The player you ask then walks to the centre of the circle, still holding hands with the person on his/her left.

The person originally on the centre player's right, slowly walks clockwise around the outside of the circle, leading the group that follows. As they walk, they wrap tighter and tighter around the centre player until they are like a giant rolled-up cinnamon roll.

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When everyone takes a small step to the centre, they make a cinnamon roll squeeze.

Jelly Roll Squeeze

Stand together in a line and have group members put their arms around each other's waists. Then someone at the end begins to roll into the group, arms still around the person on both sides. As the group wraps, they are like a giant jelly roll. When the roll is tightly wrapped, it is time for a jelly roll squeeze. "One, two, three!"

Texas Hug

Stand together in a circle with arms around each other's shoulders. Then take a small step to the centre. Try another. Gently, one more time. Now that's a "Texas Hug!"

Appendix F

Reference List

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