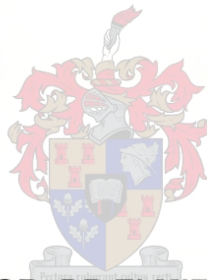
THE DESIGN, IMPLEMENTATION AND EVALUATION OF A PEER GROUP SEXUALITY PSYCHO-EDUCATION PROGRAMME FOR UNIVERSITY STUDENTS

LISE-MARIE GREEFF

Thesis presented in fulfillment of the requirements for the degree of Master of Science (Psychology) at the University of Stellenbosch



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APRIL 2003

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

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OPSOMMING

Die gesondheids- en maatskaplike probleme wat verband hou met die hoë-risiko seksuele gedrag van jongmense wêreldwyd het daartoe gelei dat seksonderrig gedurende die afgelope dekade voorrang geniet het. Ondanks die toespitsing op seksuele gesondheid, en die doelwitte daarvoor gestel, toon peilings dat die VIGS-epidemie steeds versprei, seksueel-oordraagbare siektes (STDs) toeneem, en 'n groeiende aantal ongewenste swangerskappe jaarliks aangemeld word. Dit blyk dus dat 'n groot aantal jongmense nie in staat is om hulle seksuele gesondheid effektief te bestuur nie en seksopvoeders word gekonfronteer met die uitdaging om meer effektiewe seksopvoedingsintervensies te verskaf.

Met hierdie studie is onderneem om die behoefte aan doeltreffende seksualiteitsopvoeding vir jongmense aan te spreek, deur die samestelling, toepassing en evaluering van 'n portuurgroep seksualiteit psigo-opleidingsprogram gemik op universiteitstudente. Die proses van programontwikkeling is gelei deur die fases wat voorgestel is deur die Psigo-onderrigmodel: *Fase 1: Probleemidentifikasie*: Dié fase het kennisname van die probleem behels as gevolg van die aandag daaraan gewy in die media en as gevolg van maatskaplike bewustheid, asook deur bespreking met lede van die gemeenskap en deur ondersoek van probleme in verband met die seksuele welstand van jongmense deur middel van `n uitgebreide literatuurstudie. *Fase 2: Situasieanalise*: Gedurende hierdie fase het die navorser die geïdentifiseerde probleem duideliker omskryf deur die relevante konsepte te konseptualiseer en omskryf, en teoretiese raamwerke en beginsels te identifiseer wat gebruik kon word om die probleem aan te pak. *Fase 3: Ontwikkeling van die program:* Die Informasie-Motivering-Gedragsvaardigheidsmodel (IMG) en die Guerny-model is gebruik as raamwerke vir die ontwerp van die program. *Fases 4, 5 en 6: Implementering, evaluasie en her-evaluasie*. Hierdie interafhanklike fases het drie opeenvolgende implementerings van die seksualiteit-psigo-opleidingsprogram behels. Die beginsels van Aksienavorsing is toegepas in die implementering- en evaluasieprosesse. Evaluasie van kwalitatiewe data, verkry deur deelnemende navorsing na elke implementering, het deurlopende aanpassing en verbetering van die program moontlik gemaak. Aan die einde van die derde implementering is kwantitatiewe data aangevul deur data wat verkry is deur 'n pen-en-papier toets-hertoets-metode. *Stap 6 en terug tot by stap 1: Finale re-evaluasie en probleemidentifikasie.* Gedurende hierdie fase het die navorser die resultate van die intervensie ontleed. Nuwe probleme is geïdentifiseer en aanbeveliings vir toekomstige voortsetting is gemaak.

Die navorser het tot die gevolgtrekking gekom dat die tekortkominge in die navorsingsmetodologie - byvoorbeeld, 'n gebrek aan gestruktureerde kwalitatiewe evaluering - verhinder het dat effektiewe evaluering van die program kon plaasvind. Verdere navorsing word benodig om

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toepaslike teoretiese raamwerke en meetinstrumente te ontwikkel wat aangewend kan word om die ontwerp van seksopvoedingsprogramme te rig en die effektief van programme te evalueer.

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ABSTRACT

Health and social problems associated with the high-risk sexual behaviour of young people worldwide gave rise to the priority status accorded to sex education in the past decade. Despite the attention focused on and the goals set for sexual health education, surveys indicate that the AIDS epidemic is still spreading, STD infections are increasing and a growing number of unwanted pregnancies are reported every year. It seems therefore that many young people are not yet able to manage their sexual health effectively and sex educators are confronted with the challenge to provide more effective sexl education interventions.

This study attempted to address the need for effective sexuality education for young people by designing, implementing and evaluating a peer group sexuality psycho-education programme targeted at university students. The process of programme development was guided by the phases proposed by the Psycho-education model: *Phase 1: Problem-identification.* This phase entailed becoming aware of the problem through media attention, social awareness, discussions with members of the community and exploring problems around young people's sexual health through an extensive literature review. *Phase 2: Situation Analysis.* During this phase the researcher clarified the identified problem by conceptualizing and defining relevant concepts and identifying theoretical frameworks and principles that could be used to address the problem. as well as the Action Research model were identified as useful theories. *Phase 3: Development of the programme.* The Information-Motivation-Behavioural skills (IMB) model and the Guerney model were used to guide the design of the programme. *Phases 4, 5 and 6: Implementation, evaluation and re-evaluation.* These interdependent phases entailed three consecutive implementations of the sexuality psycho-education programme. The principles of Action Research were used to guide the implementation and evaluation processes. Evaluation of qualitative data obtained through participatory research after each implementation allowed for continuous adaptation and improvement of the programme. At the end of the third implementation quantitative data was supplemented by quantitative data obtained with a pen-and-paper test-retest method. Quantitative results indicated that the sexuality education programme significantly increased subjects' knowledge regarding sex en sexuality, but did not have a significant impact on attitudes and perceived behavioural skills. There was an indication that clarification of attitudes had been promoted, and that attitudes relating to the use of contraception had positively changed. Furthermore, a significant change in perceived behavioural skills regarding communication about and behaviour for the prevention of HIV/STDs had been achieved. Qualitative evaluation indicated that subjects felt more positive about using condoms and about communicating with their partners about the use of contraceptives. *Step 6 and full circle back to step 1: Final Re-evaluation and problem-identification.* During this phase the researcher reviewed the outcomes of the intervention. New problems were identified and recommendations made for future continuation.

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The researcher concluded that the deficits in research methodology, such as a lack of structured qualitative evaluation, hampered effective evaluation of the programme. Further research needs to be conducted to develop appropriate theoretical frameworks and measuring instruments with which to inform and evaluate the effectiveness of sex education programmes.

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CHAPTER 1: INTRODUCTION, MOTIVATION AND THEORETICAL DEPARTURE POINT

Despite growing preventive educational efforts over the past decade, the impact of the HIV/AIDS epidemic on young people is expected to grow, particularly in hard hit countries that already have very young populations. With little prospect of an AIDS vaccine in the foreseeable future, HIV prevention requires sustained efforts of social mobilisation towards healthier and safer sexual behaviour, combined with other interventions such as effective management of STDs, the prevention of unplanned pregnancies (Henry J. Kaiser Family Foundation, 2002) and an overall effort to promote the emotional and psychological sexual health of young people. Prevention programmes must create a social consciousness and environment that leads to appropriate behavioural change (Love Life and The Henry J. Kaiser Family Foundation, 2000). Also important is the need to sustain positive behaviour change through adulthood, particularly among those in their twenties (Department of Health, 2000b).

UNICEF, UNAIDS and the WHO suggest that as a precondition to mounting effective prevention programmes the world has to realize firstly that young people do have sex. Secondly it must be acknowledged that young people still do not have the required knowledge and skills to protect themselves. Accordingly, in 2002, the WHO once again gave priority status to the prevention of HIV/AIDS by setting goals to –

> *by 2005 ensure that at least 90%, and by 2010 at least 95%, of young men and women aged 15-24 have access to the information, education (including peer education and youth-specific HIV education) and services necessary to develop the life skills required to reduce vulnerability to HIV infection. (*UNICEF, UNAIDS and WHO, 2002, p12).

South Africa, a country especially hard hit by the HIV/AIDS epidemic and other sexuality-related problems like high prevalence of STDs and unwanted pregnancies, and specifically South African educational institutions, still have a long way to go with regards to providing effective preventive information and education to young people.

The University of Stellenbosch has been trying to introduce effective sexuality education to their students since 1990. Although several departments of the university have implemented a variety of isolated interventions on selected groups on campus, lack of central support, campus-wide coordination and quality control seem to result in most of these efforts eventually terminating. The need exists for a structured and tested programme that could promote control over programme effectiveness and evaluation.

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The **aim of this study** was to contribute to youth-specific sexuality education by compiling, implementing and evaluating a peer group sexuality psycho-education programme targeted at the students of Stellenbosch University. The objective was to create a programme that can readily be used by any university student to teach sexuality-related life skills to a group of his/her peers.

The psycho-education model was identified as a theoretical departure point for the current research as it provides basic guidelines for the presentation and development of educational interventions such as the sexuality education programme designed by the researcher. The model is congruent with the definition for patient counselling as formulated by the Delphi group on patient education: "a planned learning experience using a combination of methods such as teaching, counseling and behaviour modification techniques which influence patients' knowledge and health behaviour...(and) involves an interactive process which assists patients to participate actively in their health care" (Bernier, 1992). Psycho-education also endorses the training of leaders to participate in the education of their peers and promotes the development of so-called psycho-technology (programmes, books, multimedia and other resources) with which to enhance the learning experience (Schoeman, 1983).

Schoeman (1983) proposed that there are four basic characteristics that define psycho-education. These characteristics and how these were incorporated in the current research will briefly be discussed below:

1.1 Orientation towards prevention

The psycho-education model is important in that it defines a type of intervention different to that of psychotherapy. Whereas psychotherapy focuses on remediation, psycho-education focuses on the prevention of problems and the development of human potential (Schoeman cited in Botha, 1994). The psycho-education model thus clearly supports the aims of the sexuality education programme, namely the prevention of high-risk sexual behaviour and the development of relevant life skills. This approach is partly derived from the non-directive school and Skinner's operant school of behaviour modification, but the model also provides for the use of cognitive, behaviouristic as well as psychosocial intervention methods and techniques (Bernier, 1992). In this context education refers specifically to the learning of specific skills. The components of skills-training which are included in psycho-education include information, problem-solving, self-instruction, coping strategies and communication (Weinstein & Rosen, 1988).

The current research followed a preventative approach in that it developed a programme that aims to provide students with knowledge, motivation and behavioural skills to prevent sexually related problems.

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1.2 Development during the whole life cycle

Psycho-education aims to involve humans in the course of their entire life cycle (Roos, Taljaard & Lombard, 2000). Whereas traditional approaches emphasized the extreme changes from birth to adolescence, and little change during adulthood (Santrock in Roos et al., 2000), the life-cycle approach calls attention to changes that occur from before birth till death. This life cycle approach is multidimensional, as it comprises biological, cognitive and socio-emotional components. The approach encourages the co-operation of various relevant disciplines. The life-cycle approach also recognises that the developmental process can not be addressed without consideration of the life circumstances and context in which development took place (Newman & Newman in Roos et al., 2000).

The current research focused on addressing, within a holistic multidimensional framework, the sexual behaviour of a group who find themselves in a specific life-cycle stage. For the purpose of this study this group will be referred to as '*young people*' or *'youth'*. The life-cycle approach to this group is discussed in 3.3.

1.3 Complex Systems

Psycho-education is appropriate for the development of complex systems (Schoeman, 1983). In Schoeman's model (1983) he proposes a hierarchy of living systems that interact with and influence each other. In such a hierarchy the individual's personality and behaviour would be a first level of intervention. On the second level one would find a system of groups. Following levels suggested by Schoeman are the system of organizations, the community and the greater social context. A change in one part of the system affects other parts of the system and the system as a whole. Psycho-education thus postulates that in order to bring about change in one system the educator should take into account and address the influences of and impact on all other interdependent systems (Roos et al., 2000). To promote healthy sexual behaviour of young people, for example, one would have to consider the individual development of the participants, address the influences of peer groups, teachers and parents, as well as, where applicable, pay attention to the impact of cultural, economical and other societal contexts. Human sexuality as part of complex interactional systems is conceptualized in 3.2.

1.4 The cyclical nature of Psycho-education

The process of psycho-education indicates a cyclic nature. Psycho-educators should define their tasks in terms of cybernetic systems – autonomous, self-regulating and goal-orientated (Schoeman, 1983). Such systems allow for monitoring of effectiveness through recursive feedback

and situation analysis. Figure 1 demonstrates psycho-education as a cybernetic cycle (Schoeman, 1983):

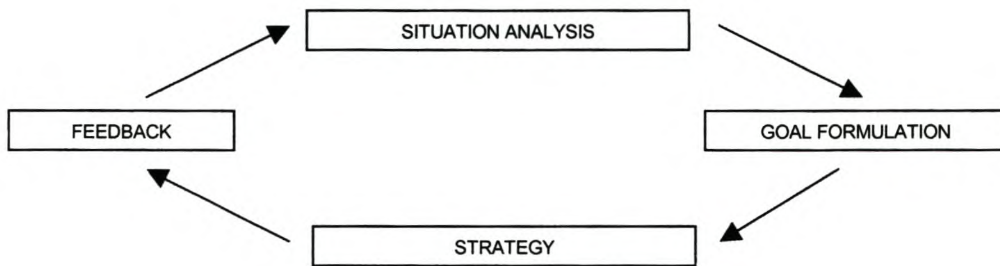

Figure 1: Psycho-education and the Cybernetic Cycle (Schoeman, 1983, p17)

Roos et al. (2000) provides an integrated representation of the development of a psycho-education programme in which they not only demonstrate the cyclic nature, but also the interdependency of phases in the psycho-education process. Figure 2 provides a graphic representation of the development of a psycho-education programme as proposed by Roos et al. (2000).

2. Situation analysis
- Theoretical background
- Discussions with interested parties
- Theory

3. Development
Development of psycho-education programme

1. Becoming aware of the problem
- Media
- Social awareness
- Discussions with members
- of the community

Interdependency of phases

4. Evaluation
- Evaluation by experts
- Implementation of proposals

6. Re-evaluation
- Continual adaptation of programme during application
- Test whether programme meets initial objectives

5. Implementation of psycho-education programme
Application of the programme through action research

Figure 2: Integrated representation of the development of a psycho-education programme (Roos et al., 2000, p7)

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From figure two it is clear that they suggest the following steps should be followed to ensure an effective psycho-education intervention:

1. Problem-identification
2. Situation analysis
3. Development of the intervention
4. Evaluation
5. Implementation
6. Re-evaluation and adaptation

Step 6 frequently leads to new problem identification and the re-initiation of the cycle. All the steps 1-6 are also interdependent and can at any time during the process influence each other or cause a change of direction to another non-sequential step.

The above-mentioned cyclic approach was used to conceptualize the current research:

Step 1: Problem-identification

The sexual health problems that are addressed in this study were identified through social awareness and discussion with members of the community. Further inquiry into the problem was conducted through extensive literature studies that are discussed in *Chapter 2: Problem-identification.*

Step 2: Situation analysis

The researcher analyzed the situation by firstly defining key concepts as provided in *Chapter 3: Situation Analysis I - Conceptualization of concepts.* Secondly in-depth analysis was done of the current situation regarding the characteristics of and challenges facing sexuality education in *Chapter 4: Situation Analysis II – Overview of sexuality education programmes.* Lastly *Chapter 5: Situation Analysis III – Theoretical frameworks guiding programme design, implementation and evaluation* presents the theoretical models underlying the current research. The researcher experienced the interdependency of the psycho-educational phases first-hand as new information that was gathered during the situation analysis frequently impacted on the problem-formulation.

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Step 3: Development/design of programme

Through analysis of available literature the researcher found the IMB-model to be an effective framework for the design and implementation of a sexuality education intervention. The Guerney model was used as guideline for the didactic structure of each session. These models are discussed in *Chapter 5: Situation Analysis III – Theoretical frameworks guiding programme design, implementation and evaluation.* The application of the IMB and Guerney models to the design of the programme is discussed further in *Chapter 6: Development of the Programme.*

Steps 4, 5 & 6: Implementation, evaluation and re-evaluation

The researcher used the principles of action research to guide the implementation and evaluation processes.

In chapters 7 (*Implementation and evaluation of the programme through action research – Implementation I*), 8 (*Implementation and evaluation of the programme through action research – Implementation I*) and 9 (*Implementation and evaluation of the programme through action research – Implementation III*), the cyclic and interdependent nature of the phases of psycho-education is clearly demonstrated. The researcher used the method of participatory research in an attempt to, through repeated implementation, feedback and adaptation, create population-specific programme design and implementation techniques. The initial programme and implementation design were based on information gathered from experts, successfully implemented programmes and basic assumptions about the target group. Participatory methods were used to evaluate content and techniques. The feedback obtained was used to adapt it accordingly. This cycle was repeated three times. For the purpose of the third evaluation the qualitative feedback obtained through group participation was supplemented with quantitative evaluation of pen and paper tests. In *Chapter 9* the quantitative and qualitative results are analysed and discussed.

Step 6 and full circle back to step 1: Final re-evaluation and problem-identification

Chapter 10: Summary, critical evaluation and recommendations brings the cycle to the end and back again to the possibility of a new beginning. In this chapter the researcher discusses the outcomes, implications and limitations of the intervention. New problems are identified and recommendations made for future continuation.

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CHAPTER 2: PROBLEM-IDENTIFICATION

2.1 Youth and reproductive health issues: The international context

When this research study was started in 1995 the World Health Organization (WHO) had released a report, which concluded that sexual activity among young people was increasing around the world. In the light of the health and social problems associated with the high-risk sexual behaviour of many young people, the WHO deemed it necessary to give sexual health education and contraceptive services priority status on their list of youth orientated programmes (Olsen, Jensen & Greaves, 1991). The so-called "sexual-revolution" among young people was causing specific negative effects which included the promotion of the Acquired immunodeficiency syndrome (AIDS) epidemic, the spread of sexually transmitted diseases (STDs) and an increase in the number of unplanned pregnancies among the youth (Olsen, Weed, Gail & Jensen, 1991). AIDS had reached global epidemic proportions and was perceived to be the most serious public health challenge of the 20th century. It was estimated that approximately 8 to 10 million adults and 400 000 children had been infected by HIV worldwide, and the WHO predicted that there would be 30 million new HIV infections and 6 million new AIDS cases by the year 2000 (Livingston, 1992).

Seven years later, in 2002, the early predictions of the WHO seemed to have been correct, with an estimated 40 million people now living with HIV/AIDS worldwide, more than a third of whom are teens and young people between the ages of 15 and 24. Despite the priorities and goals for sexual health education and contraceptive services set in 1991, surveys indicate that although many young people across the world have now heard about the HIV/AIDS epidemic, awareness is not universal. Many are still uninformed about protection against infection with HIV and other STDs (Henry J. Kaiser Foundation, 2002). In 2002 UNICEF, UNAIDS and the WHO published a landmark report "Young people and HIV/AIDS: Opportunity in Crisis", which focuses on behaviour and knowledge regarding HIV/AIDS of young people aged 15-24. Findings in this report indicated that despite the fact that it is well-known that young people seem to be hardest hit by the HIV/AIDS epidemic, strategies for responding to the epidemic generally still disregard this group. Overall surveys from 60 countries indicate that more than 50% of young people aged 15-24 harbour serious misconceptions about HIV/AIDS transmission (World Health Organization, UNICEF & UNAIDS, 2002).

In North America and Western Europe almost 1.4 million and in Asia 7 million people were infected with HIV by 1998. Less is known about the HIV/AIDS epidemic in North Africa and the Middle East than in other parts of the world, but it is estimated that a total of 210 000 people are living with HIV in this region. In all of these regions the greatest prevalence of infection was found in the age group 18-25 (American Association for World Health, 1998). Sub-Saharan Africa is the region

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worst affected by the AIDS epidemic, having close to 70% of the global total of HIV-positive people. Most of the infected populations will die in the next ten years, joining the 13.7 million Africans already claimed by the epidemic (Love Life & Henry J. Kaiser Family Foundation, 2000). Most of these people who will die will be between the ages of 15 to 44, the age group that constitutes the backbone (in terms of work, productivity and family stability) in most societies.

In matters regarding the prevention of unhealthy sexual behaviour, much emphasis is placed on the prevention of the spread of HIV/AIDS. It is important however not to forget about the other possibly devastating consequences of unhealthy sexual conduct, namely sexually transmitted diseases (STDs), unplanned pregnancies and the possible negative emotional impact of early sexual intercourse.

In the USA more than 12 million cases of STDs are reported yearly. What should be noted is the fact that more than 80% of these 12 million cases are people aged 15 through 29 years (Pepe, Sanders & Symons, 1993). Sexually transmitted diseases constitute a major medical and social threat in African countries. Aside from the fact that being infected with a STD can be life-threatening in itself, these STDs also pose a secondary threat, because being infected with another STD increases the likelihood of both acquiring and transmitting HIV. This contributes greatly to the rapid spread of AIDS in African countries.

The early onset of sexual activity of young women result in several serious problems. Each year, 75 million women around the world experience unwanted pregnancies. Millions of these women risk their lives and health to end the pregnancies. Approximately 20 million unsafe abortions take place around the world each year, resulting in some 80,000 maternal deaths and hundreds of thousands of disabilities. The vast majority of these deaths take place in developing countries (World Health Organization, 1998c). Young women aged 15-19 account for about 5 million of induced abortions each year. About 11% of all births each year – a total of 15 million births annually – are to girls aged 15-19 years. The highest levels of adolescent childbearing worldwide occur in sub-Saharan Africa, where more than half of women aged 20-24 have given birth before age 20 (World Health Organization, 1998a). Many of these women who give birth are also HIV positive, and could thus leave behind a child either infected with or orphaned by AIDS. The AIDS epidemic has already created a cumulative total of 13.2 million AIDS orphans (Henry J. Kaiser Family Foundation, 2002).

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2.2 Youth and reproductive health issues: The South African context

Currently just over 50% of all HIV/AIDS infections in southern Africa are occurring in South Africa. In 2000 over 3.5 million people were estimated to be HIV infected. Younger people are most severely affected by the disease, with around 60% of all adults who acquire HIV becoming infected before they turn 25. Nicholas (1993) found that the percentage sexually active students at one South African university campus increased by 5%, from 48% to 53%, over a period of 3 years (1990-1992). In a recent KwaZulu-Natal voluntary survey of university students HIV infection rates of 26% in women and 12% in men, aged 20 – 24 were found. In the age category 25-29 36% of women and 23% of men, were found to be HIV positive (Love Life & Henry J. Kaiser Family Foundation, 2000). In a survey done in South Africa in 2001, 24,8% of 16 730 pregnant women tested were HIV positive. 29% of participants between 20-24 were infected with HIV (Department of Health, 2001). Six to ten million South Africans could die of AIDS in the next ten to 15 years. Although it is too late to turn around the epidemic it still seems possible to reduce its duration and impact. This can be achieved through carefully targeted prevention strategies, particularly among the 45% of the South African population still under the age of 20 (Love Life & Henry J. Kaiser Family Foundation, 2000).

Even without the HIV epidemic, STDs in itself pose a serious public health problem (Department of Health, 2000a). There are approximately 11 million STD episodes treated annually in South Africa. Of significance is the fact that statistics recorded by health clinics of the Department of Health during 1996 revealed that in every province of South Africa the 20 – 29 age group, in both males and females, produced most instances of STD infection. It is of specific interest to this study that in the Stellenbosch area 60% of all males and 56% of all females infected with STDs were between the ages of 20-29 (Department of Health, Provincial Administration Western Cape, 1996). Compared to older adults, adolescents and young adults are at higher risk to acquire STDs for a number of reasons: they may be more likely to have multiple sexual partners rather than single, long-term relationships; they may be more likely to engage in unprotected intercourse; and they may select high-risk partners. In addition, for some STDs, young women may have a physiologically increased susceptibility to infection due to increased cervical ectopy (Centers for Disease Control and Prevention, 1999).

Van Rooyen and Louw (1994) stated that 11% of all babies born in South Africa are the products of unwanted or unplanned pregnancies among the youth. It should be noted that in 1996 women in the age group 15-24 contributed approximately 47% to all South African births that were annotated by the Department of Health. A more recent survey (Love Life & Henry J. Kaiser Family Foundation, 2000) indicated that by the age of 19 years, 35% of young girls have been pregnant or have had a child. Apart from the emotional and financial impact of having to bring an unwanted child into the

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world, young mothers are also at risk of maternal death as a result of their physical immaturity and are at greater risk for infection with STDs and HIV as they are physiologically more susceptible than adult women. Increased likelihood of tearing of the vagina during first intercourse further augments risk of infection.

Unwanted pregnancies, unsafe abortions, STDs and HIV/AIDS cost health public services and private insurance companies billions of rands each year. AIDS is affecting our nation's future professionals and leaders. The youth are an important target group to protect against future HIV infection as they represent both the present and future economic powerhouse of the country (Department of Health, 2000a). AIDS deaths will soon exceed all other causes of death put together in the South African work force (Love Life & Henry J. Kaiser Family Foundation, 2000).

2.3 Youth and sexual development

It should be remembered, however, that the problems relating to the sexual activity of young people encompass more than the above-mentioned financial and health costs. There is an emotional price associated with having sex at a young age. Bennett (1988) addressed this problem when he stated that:

> *...to suggest to our children that really the only things that matter about sexual activity are pleasure, or "comfort", or getting pregnant, or getting a sexually transmitted disease - to suggest that the sexual intimacy is not significant in other ways - is to offer them still another bad lesson. Why? Because it is false, as every adult knows: sex is inextricably connected to the psyche, to the soul...Sexual intimacy changes things - it affects feelings, attitudes, one's self-images, one's view of another.* (pp. 10-11)

The youth of today find themselves in a society in which clear guidelines regarding sexual behaviour are often lacking (Weinstein & Rosen, 1988). Young people are consequently left no choice other than to deal with their sexuality and related problems in their own way. The period of youth is a transition period between childhood and adulthood during which physical and sexual energy reaches maturity, while the individual is perceived as still being psychologically immature. Many choices concerning different aspects of life have to be made (Gerdes, 1988). The psychologically immature young person is not always able to handle the difficult decisions, emotional development and the various responsibilities associated with sexual activity. During the past two decades, the age of initiation of sexual activity has steadily decreased while the age of first marriage increased, resulting in increases in premarital sexual experience among young people and in an enlarging pool of young people at risk (Centers for Disease Control and Prevention,

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1999). Weinstein and Rosen (1988) have found that young people exhibit increased stress of which the origins can be found in the problems they experience with their transition to a sexually mature adulthood.

2.4 Sex education

Most health workers studying sexual behaviour agree that the physical and psychological problems related to sexual activity can best be addressed through effective health/sexuality education. Young people generally lack knowledge about the consequences of unhealthy sexual activity. They face substantial barriers to sexual and reproductive health services and also lack skills to negotiate no sex or safe sex. At the International Conference on Population and Development in 1994, it was agreed that: "Young people's sexual and reproductive health needs should be met through appropriate programmes which address unwanted pregnancy, unsafe abortion, sexually transmitted diseases and HIV/AIDS, gender relations, sexual violence, ... They must meet young people's needs for information about sexuality, reproduction and contraception." (World Health Organization, 1998a, p1).

The spread of HIV/AIDS and other STDs among young people is known to be due to a combination of unsafe sexual and drug practices, inadequate prevention services, and a misconception among young people that they are not at risk. One of the best ways to prevent the spread of these diseases is to promote open communication and greater honesty about issues of postponing sex, using safer sex practices and avoiding the sharing of needles and other injection equipment (American Association for World Health, 1998). Education is critical for reducing the public health problem of unwanted pregnancy and unsafe abortion. The WHO suggests that the problems associated with unwanted pregnancy should be addressed through education that promotes the idea of delayed childbearing and informs women of the options and services available to them. Despite the fact that family planning services are more effective and more available than ever, estimates suggest that at least 350 million couples worldwide lack access to information about contraceptives and a range of modern family planning methods (World Health Organization, 1998b). In a national survey on the attitudes of South African youth, young people indicated that education ranked as their number one priority, but they worry most about HIV/AIDS and unwanted pregnancy (Love Life and The Henry J. Kaiser Family Foundation, 2001).

2.4.1 Parents and sex education

Parents undoubtedly have a crucial role to perform in the sex education of their children (Sapire, 1988). According to Nicholas (1993) several studies have found, however, that parents' share is small in the sexual education of their children. Parents might be able to relate adequate information

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when confronted with simple and even embarrassing questions about sexuality, but once the possibility of sexual activity is broached, parents' anxieties, fears and embarrassment prevent them from openly discussing sexual matters with their children (Nicholas, 1993). McIntosh (1991) and Coetzee & Kok (2001) suggested that it is very difficult for parents of young people to see their own children as sexual beings and as a result the parents avoid the subject of sexuality and depend on schools to do the job. Parents voice concern about HIV/AIDS, but have mixed views on whether open communication with their children can help promote healthy sexual behaviour. And while they are likely to talk about HIV/AIDS with their children, parents are less likely to report having conversations about other sexual health concerns. While young people seem open to more communication and believe it could help to ensure good sexual outcomes, parents seem more reluctant and less convinced that it could make a difference. South African youth almost universally watch television and listen to the radio, and rank media as among the most common sources from which they get information about sex and sexuality (Love Life and The Henry J. Kaiser Family Foundation, 2001)

2.4.2 Sex education in South African schools

Although the necessity of sexuality education had been recognized in South Africa by 1992, it still did not exist in most South African schools (Devenish, Funnel & Greathead, 1992; Nicholas, 1994). In 1994 the Department of Health, in collaboration with the Departments of Education and the South African Law Commission, drew up a policy for the management of HIV\AIDS within South African schools (Departement van Nasionale Gesondheid en Bevolkingsontwikkeling. (1994).). Sexuality Education was introduced into the school curriculum in 1997 (Planned Parenthood Association of South Africa). The South African Department of Education and Culture tried to introduce certain sexuality-related topics to school learners through integration of these topics within the syllabus frameworks of school subjects such as Biology and Religious Studies. Sexuality education as a defined discipline within South African school education was however still lacking. Only recently the South African Education sector began to integrate the projected effects of HIV/AIDS into its planning and thinking. HIV/AIDS is now officially recognized as one of the top priorities of the national Department of Education. The Life Skills Education programme is now a compulsory component in secondary schools (Department of Health, 2000c). However, full integration of HIV/AIDS into education and training at all levels have a long way to go (Love Life and The Henry J. Kaiser Family Foundation, 2000). Reports indicate that despite the fact that implementation is required by national education policy, it is not happening in all schools. Where it is being implemented, various problems still hinder the success of such programmes. These are for instance selection and motivation of teachers, resources, the diversity of learners, lack of support from parents and the community and many administrative hurdles (Coetzee & Kok, 2001). It will take some time for sexuality education in South Africa to provide effectively specific sexuality

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curricula that consolidates HIV-prevention initiatives through reproductive health and life-skills programmes, from primary to tertiary education levels.

2.4.3 Sex education at South African universities

As a result of the lack of or still insufficient education in sexuality which young people receive from their parents and schools, thousands of first year students enrol at universities every year without being equipped with the skills and knowledge which they need to manage sexuality in their own lives (Nicholas, 1993). In a recent survey by the Department of Health, a slight decrease in HIV infections seemed to suggest that increased efforts to provide sexuality education to school age youngsters had resulted in a change in sexual trends amongst these teenagers. What was of concern however, was the fact that the adolescents did not seem to maintain this behaviour change in adulthood. This suggests that HIV infection and other consequences of unhealthy sexual behaviour might simply be delayed and not prevented, as should ultimately be the aim (Department of Health, 2000b). The responsibility of educating the youth of South Africa in matters of sexuality is increasingly being placed on university health and counselling services (Nicholas, 1993). An analysis of the median age at first sexual intercourse of South African young people shows that most women experience their first sexual intercourse at about the age of eighteen years (Department of Health, 1998), the age of the average first year university student. University students are at risk of contracting AIDS and other sexual diseases to the degree that they are sexually active and have multiple sexual partners at the same time that they experiment with the consumption of large amounts of alcohol and use drugs. Their actual risk is further enhanced by their sense of invulnerability to sexual problems (Cline, Freeman & Johnson, 1990).

Several universities in South Africa, including the University of Stellenbosch, have started implementing peer group sexuality education on an informal basis on their campuses. Peer group education is perceived to be a powerful and possibly essential component of health and sexuality education. Peer group leaders who are the same age or a few years older than their group members are perceived as role models and more acceptable sources of information about risky sexual behaviour than adults. They seem to have more success in helping young people make independent choices and develop skills pertaining to effective sexual behaviour (Mellanby, Phelps & Tripp, 1992). The peer group education programmes that have already been implemented on university campuses in South Africa, are to a great extent unstructured and informal. As far as the researcher could establish, there is no published peer education sexuality programme that caters specifically for the needs of university students.

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2.4.4 Sex Education at Stellenbosch University

The University of Stellenbosch has been trying to introduce effective sexuality education to their students since 1990. The Student Health Services of the University of Stellenbosch recruited specialists in the field of sexuality to lead discussions and give lectures on sexuality-related topics such as breast cancer, pregnancy and contraception. Only a handful of students actually attended these education sessions and the project did not prove to be successful (Sister Stichling, Student Health Services, personal communication, 24 February 1995). In 1993 the University of Stellenbosch, in conjunction with the Department of National Health and Population Development, followed the example of other South African universities, like the University of Pretoria, by initiating peer group sexuality education on their campus. Other recent attempts to educate students about sexuality include the screening of an educational video to first years during orientation and the provision of an inexpensive HIV-testing service which includes pre- and post-test counselling (Mr. van der Westhuizen, Centre for Student Counselling and Development, personal communication, 20 September 2002). The Department of Social Work at the University also contributed to sex education on campus by having their students present informal sexuality education sessions in some residences as part of their four-year undergraduate course. This part of the Social Work undergraduate course has since been discontinued (Prof Green, Department of Social Work, personal communication, 25 September 2002).

At present there are no sexuality/AIDS related programmes that are being offered to all students on the Stellenbosch University campus (Miss Gaofhiwe, Office for Student Affairs, personal communication, 25 September 2002). Operational issues seem to be one of the biggest problems standing in the way of successful implementation of sexuality education initiatives. Projects are initiated in isolation by individual units of the university and usually only implemented on a selected group of students. Many organizational units are not aware of efforts by other departments. Lack of administrative and financial support as well as the absence of central management and coordination of the projects seem to have contributed greatly to the eventual discontinuation of most initiatives during the past few years. There is currently no one person appointed to coordinate HIV/Aids projects and initiatives at Stellenbosch University. The Division of Student Affairs has however realized that the coordination and development HIV/Aid related matters is an issue of great importance and they are in the process of finalising a HIV/Aids coordinator post. They hope to make an appointment before the end of 2003.

The feedback from students who have participated in sex education projects on the Stellenbosch campus seem to suggest that the peer group sexuality education efforts had been the most effective method of sexuality education on campus thus far. Accordingly, the Division of Student Affairs together with the Centre for Student Counselling and Development, plan to incorporate a

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peer education component during the training workshop given to student advisers in each Residence. (Advisers are appointed in each residence to provide religious, personal and academic guidance to their peers.) Sexuality education efforts on campus seem to be finally moving in the right direction. However, in the absence of a formal approved programme which is supported by the University management and the community, peer group sexuality education will still pose many administrative, ethical and evaluation problems. A structured and tested programme that could promote control over programme effectiveness and evaluation, is needed. Such a programme could also contribute to the empowerment of students through their active involvement in setting agendas for a sexuality education programme specifically designed for and adapted to students' needs.

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CHAPTER 3: SITUATION ANALYSIS I - CONCEPTUALIZATION OF CONCEPTS

High-risk sexual behaviour, *human sexuality*, *young people* and *sexuality education* are concepts that can have varying meanings for different people and in different situations. Chapter 2 will be dedicated to conceptualize clearly these labels in a manner that will allow the reader to understand them from the perspective of the researcher, and in the context of the research done.

In the light of the significant role of the attributes of a target population in the motivation for and eventual design and implementation of a psycho-educational intervention, the researcher found it necessary to include in this chapter, not only a brief definition, but a detailed discussion of the concept: *Young people/Youth.* The conceptualization of *Young people/Youth* provides the reader with a broad insight into relevant developmental characteristics, sexual and otherwise, of the proposed target population for the current study, namely today's so-called *Youth.*

3.1 High-risk behaviour

The concept *high-risk sexual behaviour* is used by the researcher to describe any sexual behaviour that holds a significant probability of producing sexuality-related problems. Specifically high-risk sexual behaviour refers to sexual intercourse and other sexual activities which are practised without the use of contraceptive methods, and which thus increase the possibility of unwanted/unplanned pregnancy, infection with sexually transmitted diseases and/or the transmission of HIV/AIDS. Within a multidimensional conceptualization of sexuality (see 3.2), a definition of *high-risk sexual behaviour* includes sexual activities that promote the possibility of negative psychological and/or emotional outcomes.

3.2 Human sexuality

It was not until the nineteenth century that the noun ***sexuality*** first came into use. Its original meaning, narrowly applied, referred only to the qualities of being male or female and thus capable of reproduction (Weinstein & Rosen, 1988). Further conceptual analysis indicated, however, that sexuality is manifested multidimensionally: sexuality incorporates the totality of personality and sexual characteristics including biological, psychological, moral and religious, and socio-cultural attributes. A definition formulated by P. Scales (1990), an American expert in sexuality education, clearly states the importance of a multidimensional view of sexuality: "embracing not only the physical but also the social, emotional, psychological and spiritual aspects of being human" (p. 61). The combination of and interaction between these dimensions result in the total sexuality of each individual (Coetzer, 1993).

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Today *sex* refers to the biological aspects of gender or the varied forms of intimate human behaviour, while *sexuality* refers to the much broader and holistic concept of the complete person. This holistic approach includes all of those aspects of the human being that relate specifically to being boy or girl, woman or man (Welbourne-Moglia & Moglia, 1989). Sexuality is defined as a part of every individual's life that starts with conception and continues to develop and change throughout the lifespan. It is the basis for some of our most passionate feelings and commitments. Through it, we experience ourselves as real people; it gives us our identities, our sense of self, as men and women (Weeks, 1986).

The definition of sexuality is conceptualized with **four dimensions**: biological, psychological, ethical and religious, and cultural (Welbourne-Moglia & Moglia, 1989). Each of these dimensions of sexuality will be discussed briefly below.

3.2.1 The biological dimension

The biological dimension of sexuality is manifested through the reproductive and genital behaviour of human beings. Being male or female, the experience and expression of gender, is to a large extent biologically determined by the chromosomal and hormonal constitution within the human body. This dimension of sexuality includes sexual characteristics of the two genders - the physiology and anatomy of the genitals - as well as physiological manifestations such as response to sexual stimuli, conception, masturbation, menstruation, pregnancy and aging (Coetzer, 1993; Welbourne-Moglia & Moglia, 1989).

3.2.2 The psychological dimension

Human sexuality is characterized by an interaction between the somatic and the psyche in the experience and expression of gender. The psychology of sexuality involves how we come to define and view others and ourselves as sexual beings (Welbourne-Moglia & Moglia, 1989). We work, play, converse, pray or whatever we do as either men or women. For example, when a man and a woman engage with each other, their sexuality partially influences the way they perceive, think, and express themselves (Weeks, 1986). Sexual perception, sexual thoughts and sexual expression (the cognitive, functional, and perceptual processes of the human mind), as well as the affective influences (emotions, sexual and sensual feelings, longings/desires, tenderness and love), all constitute the psychological dimension of sexuality (Coetzer, 1993; Weeks, 1986).

All the constituent elements of sexuality have their source in either body or mind, as represented by the biological and psychological dimensions of sexuality mentioned above, but the capacities of the body and the psyche are given meaning only in social relations. Sexuality exists as a palpable

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social presence, shaping our personal and public lives (Weeks, 1986). Thus it is only befitting that sexuality should also incorporate dimensions - ethical-religious and socio-cultural - which are manifested in the intricate and multiple ways in which our emotions, desires and relationships are shaped by the society in which we live.

3.2.3 The ethical-religious dimension

Ethics and religion are usually used to guide human behaviour to be expressed in such a way that human rights are not violated. The ethical-religious dimension involves how we treat ourselves and other people (Welbourne-Moglia & Moglia, 1989). This dimension of sexuality consists primarily of the individual's value systems, religious beliefs and ethical norms that influence the way in which the individual chooses to express his/her sexuality. These value systems, beliefs and norms can be seen as the '*rules of sexuality*': individuals use these to guide their sexual behaviour and expression in personal as well as public interaction with others.

3.2.4 The socio-cultural dimension

The socio-cultural dimension of sexuality is manifested in the way in which the two sexes express their gender-roles according to what is seen as sexually accepted and normal within their specific communities and cultures (Coetzer, 1993). Every individual arrives at views based on learning experiences at home, in the community and within a specific cultural climate. Through these learning experiences the individual gets to know the nature of the sexual roles viewed as appropriate for males and females in his/her society and culture (Welbourne-Moglia & Moglia, 1989). The socio-cultural dimension of sexuality thus includes cultural beliefs, cultural traditions, social circumstances, social prohibitions and social norms that influence the way in which an individual chooses to express his/her sexuality.

A multidimensional view of sexuality is especially valuable in current times which are characterized by widespread transmission of sexually transmitted diseases and AIDS, as well as a steady increase of unwanted pregnancies and resulting abortions, specifically amongst the youth (Coetzer, 1993). In the light of these problems it is imperative to have a broadened view of sexuality. Only when researchers recognize all the biological, religious, ethical, affective, cognitive and social influences as essential facets of sexual development will they be able to provide an effective foundation for education about sexuality (Coetzer, 1993; Welbourne-Moglia & Moglia, 1989).

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3.3 Young people/Youth/ University students

In this thesis the researcher continuously refers to *youth* and *young people*. These terms are used to refer to the target group of university students, within the context and nature of the human developmental stage - youth - as postulated by Gerdes (1988). In the following section the researcher will conceptualize *youth* as a developmental stage and discuss the characteristics thereof as also relevant to university students. (For more information on the specific sexual behaviours and patterns of university students, see 4.1)

3.3.1 The developmental stage of Youth

The period of youth is an extension of adolescence, a transitional stage during which individuals - young people - get the opportunity to prepare themselves for the adult roles and responsibilities expected of them in a complex society. It is a period during which critical definition of the young person's identity, values and aims must take place. Although it is difficult to ascribe a specific age-span to such a transitional phase, the period of youth can be placed approximately around the ages of 18-22 years (Gerdes, 1988) - the age at which many adolescents enter into colleges or universities.

The developmental stage of youth evolved parallel to the development of modern society as we know it today. In the days when the majority of young people went to work at 17 or 18, after graduation from high school, or before, there were two discernible groups: adolescents in the traditional sense, and adults (Conger, 1977). In the past decade, however, increased visibility has been assumed by a third group - *new* young men and women, variously identifiable as post-adolescents, or more simply young people or youth, who reflect the social, economical and educational trends found within a post-industrial, technological, technotronic age. The psychological phase of youth was originally identified among those young people who delayed their move into the adult world with prolonged studies at colleges and universities. The high educational demands of a post-industrial society result in continuously increasing numbers of young people entering tertiary educational institutions. University students find themselves moving into the traditional psychological development of young adults, while they are, because of their status in society, faced with a society unwilling to allow them to exercise their newly emerging adult powers (Keniston, 1971). These university students find themselves in what Levinson (as cited in Egan & Cowan, 1980) calls a 'developmental bridge' - a dynamic transition period during which the passage from childhood to adulthood takes place. Keniston (1971) accurately describes these young people as being: " neither psychological adolescents nor sociological adults; they fall into a psychological no man's land, a stage of life that lacks clear definition (p. 3)". It is within this

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psychosocial bind that the characteristics of being young, the period of youth, then manifests itself. Some of these characteristics will be discussed below:

3.3.1.1 Sexual identity

Conditions of life in the contemporary world have changed for many young people, and, with it, patterns of sexual behaviour (Friedman, 1992). It seems that growing into adulthood is happening faster today, but taking a longer time. Young people have to grapple with the problems arising from early sexual maturity and later marriage. If young people were to marry at an early age, as in earlier times, or if puberty could be postponed till adulthood, then the sexual standards of abstinence or only masturbation before marriage would be considerably more feasible. But with the lengthening of adolescence (or the creation of a new stage of *youth*) combined with an evolution of sexual norms, the sexual aspect of the young peoples' lives can be difficult. Somehow the young people in their process of individuation also have to resolve their individual answers to what they are going to do with their sexual identity (Kimmel, 1974).

Sarrel and Sarrel (as cited in Weinstein & Rosen, 1988) propose a series of nine interactive processes through which young people develop their sexual identity and an increased capacity for emotional and sexual maturity:

(i) An evolving sense of the body - toward a body image that is gender specific and fairly free of distortion (particularly about the genitals);
(ii) The ability to overcome or modulate guilt, shame, fear and childhood inhibitions associated with sexual thoughts and behaviour;
(iii) A gradual loosening of the primary emotional ties to parents and siblings.
(iv) Learning to recognize what is erotically pleasing and displeasing and being able to communicate this to a partner;
(v) Resolution of conflict and confusion about sexual orientation;
(vi) A sexual life free of sexual dysfunction or compulsion;
(vii) A growing awareness of being a sexual person and of the place and value of sex in one's life, including options such as celibacy;
(viii) Becoming responsible about oneself, one's partner, and society, e.g., using contraception and not using sex as a means of exploitation of one another; and
(ix) A gradually increasing ability to experience eroticism as one aspect of intimacy with another person - not that all eroticism occurs in an intimate relationship, but that the fusion of sex and love is possible.

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3.3.1.2 Intimacy versus Isolation

The transitional period between childhood and adulthood is characterized by sexual maturation and a conflict between intimacy and isolation. Erikson (1974) postulates that where the late adolescent or young adult does not succeed in accomplishing intimate relationships with others, it may lead to a deep sense of isolation. Important to the psychological health of the young person is thus the development of the capacity to take chances with one's identity by sharing true intimacy. Two primary sources of intimacy during the stage of *youth* are close friendships with peers (see 3.3.1.7) and romantic partnerships (Berger, 2001).

University students are confronted with a new and expanding sense of their sexuality, and definition of their roles as sexual beings is therefore especially meaningful (Gerdes, 1988). Sexuality takes on new dimensions during this period: feelings become more intense, relationships become more complex (Friedman, 1992). There is a major shift from masturbation, sexual fantasy and adolescent sexual exploration to interpersonal sexual behaviour, including the integration of sexual feelings with intimacy with a real person. Despite the enormous importance of adolescent sexuality and sexual development, actual sexual intercourse often awaits the *youth* (Keniston, 1971).

3.3.1.3 Career choices

Young people face the complex sociopsychological process of career formation. A process that goes well beyond the mere selection of an occupation (Craig, 1996). The motivation to achieve, or the drive to be generative, is a powerful theme in the progression to young adulthood (Berger, 2001). At university the young people have to start grappling with the stress associated with making the correct career choices and achieving what is necessary for them to pursue these careers successfully.

3.3.1.4 Life-style choices

The stage of *youth* is a time of rapid growth and change, and a period of anxiety because of the need for decisions about career (see 3.3.1.3) and life-style (Weinstein & Rosen, 1988). During adolescence the central focus is placed on the search for one's own identity. Once in university the students now begin to make sense of who they are and relationships between assigned labels of society and the "real self" become more problematic and constitute a focus of central concern. The students' awareness of an actual or a potential lack of congruence between what they are and the resources and demands of the existing society increases. It becomes important to them to be able to maintain personal integrity while still achieving social effectiveness in society (Keniston, 1971).

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In an attempt to define clearly the roles they are supposed to fulfill, young people constantly explore and question the world around them. They attempt to understand themselves and their roles in society by exploring the powers, dangers and possibilities of the adult world (Gerdes, 1988).

3.3.1.5 Autonomy vs. dependence

Keniston (1971) sees this period of *youth* as a period of 'psychosocial moratorium' during which the young person strives towards greater independence and experiments with new types of behaviour, life-roles, values and belief systems.

One of the central tasks of young people during the transitional period of youth is to establish their own set of values and belief-systems which they can use to direct their behaviour, design their life-goals and guide their decisions (Gerdes, 1988). Weinstein and Rosen (1988) propose that in their quest for maturity young people need to resolve moral conflicts and develop personal value systems and ideologies that allow for a fruitful life. Moral development, like intellectual or personality development, proceeds in sequential steps. Choices about sexual behaviour follow a process of reasoning that is at first heavily influenced by the family (see 3.3.1.6), then by peer groups family (see 3.3.1.7), and society and, finally, for those who achieve some autonomy of moral reasoning, by personal standards and values organized in a self-established ethical system (Weinstein & Rosen, 1988). In earlier days beliefs and values were more clearly defined and emphatically applied than nowadays. Family, peers and society, the first influences in the process of mature moral development, thus provided moral foundations on which university students could structure their own standards and moral dimensions. In present times a lack of distinctly defined moral principles and values is placing increasingly greater responsibility on these students to formulate their own life-philosophies and convictions, and to choose their own values. The task of establishing their sexual identity is becoming increasingly more difficult for young people as a result of the moral inadequacies and contradictions that exist in the society and world they live in (Gerdes, 1988).

3.3.1.6 Parental influence

During the transition to greater independence, adult rules of behaviour are gradually replaced with individual or peer-influenced motivations. Family rules and values become less important and frequently become a source of disagreement and dispute. At the same time that university students feel independent, they continue to demonstrate family dependency - for example for economic support. This creates confusion between independence and dependence and frequently leads to emotional conflict. Parents may use financial issues (or other dependencies) as levers for

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maintaining control and to establish rules regarding sexual conduct. These controls are usually ineffective and can create an atmosphere for sexual acting-out behaviours (Weinstein & Rosen, 1988).

3.3.1.7 Peer group influence

Students rely on their peers as their most important source of information. Understandably, young people are most likely to seek support with their physical, emotional and social changes, from others who are going through the same experience. These others are their peers. The development of young peoples' social competence is based, in part on their ability to make social comparisons. These comparisons enable them to form personal identity and to sort through and value the characteristics of others (Craig, 1996). Brown (as cited in Berger, 2001) also agrees that the peer group aids the young person in the search for self-understanding and identity by functioning as a mirror that reflects dispositions, interests, and capabilities. Brown goes on to postulate that in the development from adolescent to adult, peers can also influence a young person's process of value clarification. Friends are a sounding board for exploring and defining values and aspirations. By experimenting with viewpoints and attitudes towards themselves and the world with others who are willing to listen, agree and disagree, these young people begin to discover which values are truest to them.

University students often learn about taking risks in areas such as sexuality or alcohol use from uninformed peers, other unreliable sources, or personal experimentation. In an unpublished study of American undergraduate culture conducted by Deshon and Sweezy (quoted in Sloane & Zimmer, 1993), it was found that students who were surveyed almost never discussed issues of deep personal significance with an adult. The study also found that in a variety of educational situations peers were the most important source of help for university students (Sloane & Zimmer, 1993). The number of close friends perceived to be sexually active but reliable contraceptive users has been identified as among the most influential variables in predicting sexual attitudes and behaviours for young men and women (Duagherty & Burger; Sack, Billingham & Howard in Sloane & Zimmer, 1993). DiClemente (1991) found that young people's perceptions of peer normative behaviour strongly influence their use of condoms. Based on his findings DiClemente concluded that if young people can be convinced that their use of condoms/their practice of safer-sex behaviours is consistent with peer group norms, they might be more likely to practice low-risk behaviours. Role-modeling for mastery of health-giving knowledge, attitudes and skills, can have a life-saving impact on young people faced with complex, life threatening health problems connected to high-risk sexual behaviours (Sloane & Zimmer, 1993).

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It must be remembered that peers serve as counsellors, teachers, role models and enablers for one another, regardless of their ability to do so. Much of the information and many of the recommendations that peers share are inaccurate and naïve. Empowering peers to help one another in informed, health-enhancing ways increases the likelihood that students will use health care resources appropriately (Sloane & Zimmer, 1993).

3.3.1.8 Youth within a multi-cultural society

Within a multicultural South African context it is difficult to define the society and world young people live in. It can be postulated that all university students between the approximate ages of 18-22, irrespective of their culture or race, will experience to some extent the same psychological and social developmental tasks of youth Sexual activity is influenced by sexual urges which in turn are influenced by physiological responses as well as psychological and sociocultural factors. Sexual patterns among young people seem to vary depending on age, social background, and geographical region. Much variety also exists among cultures, religions, communities or even within families as to the appropriateness of sexual activity (Weinstein & Rosen, 1988). Because of differences in the beliefs, demands and traditions of their respective cultures, white and black students could differ in the sexual developmental tasks that they have to cope with during this transitional developmental stage of youth. Within a society of multiple cultures and stages of societal development, the way in which young people experience the psychological phase of youth, cannot be separated from the societal and cultural context in which the young people are rooted. Educators counselling young people in sexuality must bear in mind these diverse factors that influence sexuality. They should also be aware of and understand the multi-dimensional nature of sexuality and the developmental tasks and sexual concerns that may cause difficulties for young people (Weinstein & Rosen, 1988).

3.4 Sexuality education

Sexuality education is a process of interaction between professionals and clients that allows the clients to explore and understand their sexual feelings, values, responsibilities, needs and behaviour (Weinstein & Rosen, 1988). Sexuality education today encompasses both education and counselling as defined by Mary Calderone (as cited in Weinstein & Rosen, 1988):

> *... (sexuality education is a) process by which factual information about sexuality is offered and assimilated so that attitudes about the information undergo modification and internalization by individuals to fit their needs. (Sexuality) Counseling is the art of helping individuals transmute their sexual education into fulfilling and socially responsible sexual behaviour* (p. 2).

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Sexuality education is defined by how human sexuality is conceptualized. Within a framework of a multi-dimensional sexuality, sexuality education would have to address the biological, psychological, sociocultural as well as the ethical-religious dimensions of sexuality. Sexuality education should, within this framework, assist young people with normal developmental tasks that allow them to achieve a mature sexuality, by providing them with the knowledge and skills needed to understand and negotiate sexuality in their lives (Welbourne-Moglia & Moglia, 1989). "To the extent that we can help young people become comfortable with their bodies and sexual expression, and clearer about their sexual values, the more effectively they will function in all other areas of their lives (Weinstein & Rosen, 1988, p. 36)."

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CHAPTER 4: SITUATION ANALYSIS II – OVERVIEW OF SEXUALITY EDUCATION PROGRAMMES

A rapid increase in sexually-related health problems among young people during the past three decades has motivated researchers to focus more attention on the sexual behaviour patterns of adolescents and young adults, with the intention of designing interventions aimed at the prevention and reduction of sexuality-related problems. While barriers to the offering of sexuality education have decreased, many barriers to the effectiveness of sexuality education remain (Scales, 1990).

Chapter 3 contains a brief overview of research findings on the design and implementation of sexuality education programmes, with specific reference to *target groups, programme content* and *programme presentation*.

4.1 Target populations

Targeting groups in society for sexuality education is a sensible strategy since it makes it easier to prepare and deliver health education messages according to the needs of specific groups, in relevant language and using well-liked, trusted sources. Utilizing target-specific content and methods for education increases the chance of effectiveness in providing information and altering sexual behaviours (Gillies, 1994).

Sexuality education programmes have up till now mainly targeted school-age youngsters in their early to late adolescent years (see, for example, Barth, Fetro, Leland, & Volkan, 1992; Diclemente, 1991; Parcel & Luttmann, 1981; Schinke, Blythe & Gilchrist, 1981). Other programmes focused on the education of health personnel or specific groups like homosexuals, prostitutes or intravenous-drug users, who are at high risk for contracting sexually related diseases (see, for example, Cohen, Byrne, Hay, & Schmuck, 1994; Fisher & Fisher, 1992; Kelly, St. Lawrence, Betts, Brasfield, & Hood, 1990; Schinke et al., 1981). Very few of the programmes already designed and implemented actually focused on university or college students, although it seems as if research in that area is rapidly developing (see, for example, Franzini, Sideman, Dexter, & Elder, 1990; King, Parisi, & O'Dwyer, 1993; Patton & Mannison, 1993; Rosen & Petty, 1989; Strouse, Krajewski, & Gilin, 1990). Targeting university students for sexuality education makes sense seen in the light of recent findings on the sexual behaviour of this focus group (see also Chapter 2 and 3.3):

4.1.1 University students

University students are a sexually active group who tend to postpone marriage and childbearing in order to complete their education. This leads to several casual sexual relationships for many

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students (Tyden, Björkelund, Odlind, Olsson & Strand, 1994). Dunn, Knight and Glascoff (1992) found a significant increase in the proportion of unmarried students of both sexes who, after entering college, reported that they had heterosexual relations that included sexual intercourse.

In America college and university students are becoming a major target population for sexuality and AIDS prevention programmes. These students were identified as a priority target group by the American College Health Association (ACHA) who found that college and university students participate in specific behaviours which put them at risk for AIDS. The ACHA stated that they found university and college students to be generally experimental in nature, while in the process acting out differing elements of their sexuality and exercising inconsistent judgement in the selection of sexual partners (Gray & Saracino, 1989). McDonnel, Metheny & Standton (1992) found that the experimental nature of university and college students often result in these students taking health risks as they test various behavioural options. In their search for the underlying motivation for the irresponsible behaviour of university students, various researchers have found that these students reflect an unspoken belief of invincibility (Mcdonnel et al., 1992; Cline et al., 1990). They tend to underestimate their risk of contracting disease and seem to have a characteristic sense of invulnerability.

Nicholas (1994) found in a South African study similar findings as Dunn et al. (1992), namely that many students become sexually active during their university years. He also found that due to the primarily unplanned nature of the sexual act many students do not use contraception during their first intercourse. The risks associated with unprotected sex seem thus to be particularly pertinent to first intercourse. Nicholas therefore stressed that guidance for freshmen, who have to make decisions about this important transition from virginity to nonvirginity, is crucial.

It is vital that student affairs professionals focus their attention on helping students understand and cope with all critical life transitions, including the development of mature sexual desires and needs. By so doing, positive coping alternatives can counter the frequently occurring destructive coping patterns. Through group education the young people experience that they are not alone in their transition. As students confront sexual and other life transitions, college systems have the opportunity to facilitate actively effective coping strategies (Hill, 1990).

(For more information regarding the sexual developmental stages and tasks of university students, see 3.3)

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4.2 Programme content

Research indicates that for sexuality education interventions to be effective at university student level, the following issues should be taken into account in terms of programme content:

4.2.1 Information

Knowledge is power - knowledge gives young people control over what they choose to do in sexual situations (McIntosh, 1991). In a review of AIDS-preventive and sexuality education programmes targeted at university students, Fisher and Fisher (1992) found that these types of programmes have generally focused on delivering *information* rather than on increasing motivation or teaching relevant behavioural skills. Kirby (1985) also found that many studies have focused specifically on measuring the impact of sexuality education on the knowledge of young people. The findings in these studies were nearly unanimous: instruction in sexuality education increases sexuality knowledge. There appears to be nothing exceptional about sexuality that prohibits students from learning factual material and gaining insight (Kirby, 1989).

Objective sexual information is essential to serve as a foundation for insight in sexual problems, clarification of values, learning of behavioural skills, and the acceptance of responsibility for one's own sexuality and sexual satisfaction (Robenstine, 1993). The information included in a sexuality education programme should therefore be such that it provides an effective basis for the behavioural training and motivation of young people (O'Keeffe, Nesselhof-Kendall & Baum, 1990). The information students receive from their educators needs to be accurate and up to date (McIntosh, 1991). It is also important to convey specifically information that will improve knowledge where it is lacking (Fisher & Fisher, 1992). Sexual information should thus be provided according to the current needs of the target group.

Barth, Middleton and Wagman (1989) found that information should be presented in a way which allows students to personalize it and apply it to their own behaviour. Information that is presented in a concrete and personal way is more likely to have an emotional impact and, therefore, to be stored and used. The information conveyed in sexuality education programmes should enable students to identify high-risk sexual situations, make objective assessments of their degree of personal risk, and empower them with knowledge as to how a high-risk situation can be avoided, prevented or made safe (Fisher, 1990a).

Most researchers agree, however, that in order for sexuality education to have a reasonable chance of changing risk-taking behaviour, they must do more than increase knowledge. While knowledge is critical, the key to successful sexuality education is teaching students what to do with

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the information they are receiving (McIntosh, 1991). Although information may be both necessary and sufficient when risk-reduction behaviour requires a relatively uncomplicated behavioural performance, information alone will not promote the maintenance of behaviour change across time (Fisher & Fisher, 1992). In view of these findings, and as most sexual problems are behaviourally related, a new group of sex education programmes have emerged which focus primarily on behavioural training.

4.2.2 Behavioural skills

Of critical importance is the extent to which educational interventions influence behaviour, as opposed to knowledge and attitudes. Most educational efforts, however, have not produced demonstrable changes in behaviour. This is especially true among college students, who continue to engage in risky sex, despite adequate knowledge about AIDS and STD's (Abrahamson, Sekler, Berk & Cloud, 1989). Failure to affect behaviour has raised the question of whether changing behaviour should even be a goal of any sexuality education programme. Some researchers argue that goals should be to provide accurate information, assist students in understanding their values, needs and themselves more generally, improve decision-making skills, and ultimately make their own decisions. Some state that many programmes achieve these goals and that evaluating programmes only on the basis of behavioural change is inappropriate.

Kirby (1989) suggested that programmes must help young people personalise information, increase their motivation either to avoid sex or use birth control, change their perception of peer group norms regarding having sex and using condoms and improve their *decision-making, communication and other behavioural skills, th*ereby reducing their risk-taking behaviours.

It was found that sexual assertiveness skills and communication skills are associated with the practice of safer sex (Diclemente, 1991). Cotton, Higgins, Person and Darrow (1994) identified assertiveness skills, listening and conflict resolution skills as essential skills to be taught in sexuality education programmes aimed at eventual behaviour change. Fisher and Fisher (1992) also proved the teaching and rehearsal of behavioural skills for protected sexual behaviour to be successful in having a sustained impact on reducing risky sexual behaviour. Sloane and Zimmer (1993) found that underdeveloped problem-solving and communication skills of young people often prove to be significant barriers to understanding and coping with health issues. Lack of effective skills of young people are often more significant barriers to understanding and coping with health issues than is ignorance (Moy, 1987). All these skills are necessary to enable a person to negotiate effective sexual behaviour with a partner - "knowing how to use a condom is not sufficient to lead to behaviour change if a person can not ask his or her partner to use a condom!" (Baldwin, Whiteley & Baldwin, 1990, p. 261).

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Assertiveness is considered a crucial element in the effective communication between partners regarding mutual health protection against sexual problems (Yesmont, 1992). Franzini et al. (1990) employed behavioural techniques to teach assertiveness strategies designed to promote "safer-sex" behaviours. They found that only three sessions of social skills training, which included live modelling, role-play, behaviour shaping, corrective feedback and assertiveness training, proved to be effective in teaching students to discuss sex in an assertive and straightforward manner. Role-play needs to be situationally specific. Situationally specific role-play can be used extensively to enhance abilities to avoid risk-taking behaviour by both personalizing information and teaching skills. Role-play, or other behavioural activities, should also be used to demonstrate that other teens support the avoidance of risk-taking behaviours, thus in this way reinforcing desirable peer group norms (Kirby, 1989).

It should be noted that, according to Fisher (1990b), there is also a broader spectrum of behavioural skills that are needed for the practice of sexually related preventive behaviour. These skills include being able to accept one's own sexuality, having the skills to acquire accurate information about prevention of sexuality-related problems and being able to engage in public behaviour, such as condom purchasing or visiting a family planning clinic for information or HIV/STD-testing (Fisher & Fisher, 1992). Developing these skills in combination with communication, decision-making and assertiveness training should equip young people with the necessary skills that they need to engage in healthy sexual behaviour.

Programmes which address only the affective and/or cognitive aspects of sexuality are usually not successful in changing sexual behaviour, because they ignore the modelling, learning and rehearsing of skills and behaviour which are needed for effective sexual behaviour (Lagana & Hayes, 1993). Schinke et al. (1981) found that combining cognitive and *behavioural elements* within group training was a very effective method of helping young men and women acquire skills to prevent unplanned pregnancy. Follow-up testing by Schinke et al. (1981) six months after intervention, revealed that young people who had received cognitive-behavioural training were more favourably disposed toward family planning and were practising more effective contraception than were control-condition young people. Cognitive-behavioural skills training as well as social norm change was recommended as promising approaches for promoting behaviour change. Cognitive-behavioural and skills training programmes have proved useful provided they were accompanied by appropriate risk reduction education and were developed to motivate skill learning and use (Kelly & Murphy, 1991). Gray and Saracino (1989) found in favour of a more integrated approach to sexuality education after studying the sexual behaviours of college students. Their research led them to conclude that, although essential, knowledge did not translate into behavioural change. They proposed that sexuality educators increase role-play and sexual decision-making strategies as a means of closing the credibility gap between what may be intellectually ingested but

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not behaviourally translated. In addition they stated that sexual behaviour should be discussed within a personalised framework to enhance decision-making skills. By this they meant including open discussion of personal attitudes, values, relationship status and religious beliefs in programme content.

4.2.3 Attitudes and beliefs

Literature on sexuality has in the past few years been dominated by purely didactic and/or behavioural theories on sexuality education. However, recently there has been an increase in cognitive approaches to sexual problems, which recognize the importance of beliefs and attitudes as influences on our sexual behaviour (Cupitt & De Silva, 1994). The majority of sexuality educators agree that a primary goal of sexuality education is to equip the youth with knowledge and skills that will enable them to make effective decisions about their own sexuality. It is relatively easy for educators to teach and young people to learn factual information and behavioural skills. It is, however, ultimately up to the young people to decide whether they will use the knowledge and skills they have acquired. Sexuality related decision-making skills are largely based on personal attitudes, beliefs, feelings and value-systems. More researchers seem to realize that sexually-related health problems cut across the entire behavioural spectrum, including attitudes, and that intervention strategies determined by multiple factors are thus required to address the need for behaviour change. Such an approach is far superior to mere didactic educational information alone. Attitudes need to be taken into account in such a strategy (Schlebusch, Bedford, Bosch & Du Preez., 1991).

A number of studies have examined the impact of sexuality education on a wide range of attitudes. These studies produced mixed results. Some of them indicate that certain courses had a small impact on students' attitudes when the course explicitly tried to change them, while other courses had no such impact (Kirby, 1989). Fisher and Fisher (1992) proposed that people's *attitudes, values* and *beliefs* concerning risk-reduction sexual behaviour constantly predict their practice of preventive behaviours. Ajzen and Fishbein's Theory of Reasoned Action (TRA) suggests that an individual's intentions to act in a specific manner will determine actual behaviour. These behavioural intentions are influenced and moderated by attitudes that the individual holds toward the behaviour and by perceived subjective norms regarding the behaviour (Fishbein, 1990). Intentions to practise preventive behaviour will be formed by individuals who have positive attitudes towards the personal performance of preventive acts and/or perceptions of social support for performance of these acts (Ajzen & Fishbein, 1980). Results of a study by Miller, Booraem, Flowers and Iversen (1990) showed that changes in knowledge or attitude that resulted from a sexuality education intervention predicted a significant change in commitment to behavioural change. Moore and Barling (1991) found that attitudes were predictive of intention to use a condom. They

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concluded that it is important for sexuality education programmes to concentrate on knowledge development as well as attitude formation and change. The Theory of Planned Behaviour (TPB) is an extension of the TRA. From the perspective of the TPB preventive behaviours are determined by intentions, attitudes, norms and perceived behavioural control over the performance of preventive behaviours. According to the TPB perceived control may affect the performance of preventive behaviour indirectly as a determinant of prevention intentions. On the other hand perceptions of control could also affect preventive behaviour directly insofar as a person who believe they have control over certain behaviour might be more likely to enact the behaviour (Ajzen as cited in Fisher & Fisher, 2000). In a study conducted in 1996 by Bryan, Aiken and West (as cited in Fisher & Fisher, 2000) a HIV prevention intervention guided in part by the TPB's emphasis on changing perceptions of control successfully modified female university students' condom use self-efficacy and perceptions of control over sexual encounters. These changes were associated with increases in condom use intentions and ultimately with increases in condom use behaviour across a six-month time-span.

O'Keeffe et al. (1990) stated that the task of modifying high-risk behaviour includes determining how to motivate people so that their intentions are consistent with desired behavioural outcomes. The attitudes, perceptions, beliefs and feelings which young people have toward the sexual facts, skills and high-risk sexual behaviours determine to a great extent their level of motivation toward risk-reduction sexual activities. It is therefore important for young people to acquire clarity and awareness of their frequently implicit attitudes, values and feelings about various personal and social sexual issues (Strouse et al., 1990).

Clarity about social sexual issues includes emphasis on attitudes and feelings towards responsibilities and decisions within sexual and/or romantic relationships. It is important for the different sexes, and different cultures to share and gain insight into the differences in male/female, black/white, feelings, value systems and attitudes towards romantic relationships, sex and sexual partners. Sex education programmes have been devised which allow for more informed discussions about relationships and the problems faced by young people (Mellanby et al., 1992).

The notion of prevention is an abstract one that entails taking action now in order to increase the probability of desirable consequences some time in the future. To the young person, the long-term consequences of current actions may be too remote and abstract to guide current behaviour effectively (Campbell & Campbell, 1990). Many young heterosexuals who are at an increased risk for HIV infection, have sufficient knowledge and skills to engage in risk reducing sexual behaviour, but do not recognise their susceptibility. These young people do not perceive the seriousness of the AIDS threat or are not sufficiently motivated to adopt behavioural modifications (Franzini et al., 1990). Reinforcing effective and/or changing young people's ineffective perspectives and attitudes

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toward consequences of early sexual intercourse or high-risk sexual practices should be a major concern of sexuality educators. Attitudes, beliefs and perceptions contribute significantly to motivation toward certain behaviour. Without meaningful attitudes and beliefs toward consequences of high-risk sexual behaviour, young people will not be sufficiently motivated to engage in risk-reducing activities.

The goals of sexuality education should include the promotion of self-awareness and tolerance for differences in self and others. These goals can be achieved through attitude reassessment in small group discussions (Strouse et al., 1990). Several studies have found that sexuality education increases the tolerance of young people's attitudes toward the sexual practices of others, but rarely had impact on their beliefs about their own sexuality and sexual behaviour with others (Kirby, 1985). However, earlier studies with primarily heterosexual college students, proved that perceived self-efficacy regarding prevention was strongly related to the practice of preventive behaviour (Fisher & Fisher, 1992). Breakwell, Fife-Schaw and Clayden (1991) found perceived self-control in sexual matters to be an important predictor of intended use of condoms. Perceived self-control is in turn closely associated with a person's perceived self-efficacy. It seems vital to focus attention on the definition or redefinition of attitudes, beliefs and feelings that these young people have about themselves, their own sexuality and their sexual behaviour. It is essential that young people learn the necessary behavioural skills that will enable them to negotiate sexuality in their own lives. Whether a person will use the skills they possess is, however, inextricably connected to the person's belief in his/her rights and his/her ability to use them.

4.2.4 Values

One of the issues that stimulate debate is how values about sexuality will be handled within sexuality education. On the one hand there are those in the field of sexuality education who believe that moral principles should not be preached in sexuality education. Opposing them directly are educators who believe that moral principles and therefore sexual abstinence programmes are the only way to solve the sexual problems of the youth. The most important critique against abstinence programmes is that these programmes set unrealistic goals. Although many people agree that abstinence among unmarried young people would be wonderful and effective, most people also realize that very few young people will actually succeed in following such strict moral guidelines. Research has shown that abstinence programmes can be successful to a significant degree, but that it is important to realize that such programmes are to a great extent only successful when they are applied specifically to young children who do not yet find themselves in an advanced stage of sexual development and activity (Olsen, Weed et al., 1991).

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The best way of addressing the problem of values is to find a level between these two extreme options discussed above. For a number of years there has been a move toward a "double-message" approach Society and educators believe that it is necessary and appropriate to encourage students explicitly not to have sex, but then if they do, to use birth-control (Kirby, 1989). There are groups who realise the advantages of promoting personal value systems, and try to do so without preaching specific values or moral guidelines that should be followed. They work from the perspective of instilling so-called universal values, for instance, that all people should be treated with respect and dignity and all individuals should carefully consider the consequences of their actions for themselves, others and society. Within this framework of universal values recognition must be given to students' personal values acquired at home, or within their respective communities.

The single greatest fear at the beginning of a sexuality education course is the fear of value change. For this reason, it is essential to start at the comfort level of the students. The students should be encouraged to integrate personal value systems with sexuality, not to view them as separate entities (Moy, 1987), and to make their own decisions about their value-systems in the context of their personal and sociocultural environment (Welbourne-Moglia & Moglia, 1989). The purpose of the course should not be to change values, but to examine, and perhaps, to crystallize them.

4.2.5 Single focus vs multiple foci

Sexuality education programmes that have been implemented cover a broad spectrum of programme content. The programmes often differ in the specific topics addressed as well as in the type of content, i.e. affective, cognitive and/or behavioural aspects of sexuality.

Some programmes only focus on isolated aspects of sexuality, such as contraceptive programmes or AIDS-programmes. With an increase in HIV/AIDS much of the recent research done on sexuality has focused on the development of HIV/AIDS-specific preventive programmes. The problems of sexually transmitted diseases and unwanted pregnancies, despite increasing prevalence and the fact that both these problems often have fatal consequences for human health, are being overshadowed by the focus on HIV/AIDS. Young peoples' risk of pregnancy, sexually transmitted disease and HIV/AIDS is produced by a number of similar factors and therefore has related behaviourally focused solutions. Despite this overlap in causes and potential solutions, health and sexuality educators often still fail to deal with these problems in an integrated fashion (Fisher, 1990a). Sexuality educators have suggested that to be effective, programmes should follow a more integrated approach and teach general life-skills within the framework of a multidimensional view of sexuality and sexual problems.

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The multidimensional nature of sexuality implies that an individual's sexuality, and consequent sexual behaviour, depends on learning from the inter-relationship between biological, psychological and cultural factors (Mellanby et al., 1992). The studies referred to above indicate that knowledge, attitudes, values, beliefs, feelings and behavioural skills all contribute significantly to a person's sexuality and sexual behaviour. It seems that in order to deal with all the factors that influence sexuality and sexual behaviour, sexuality educators have to include affective, cognitive and behavioural aspects of sexuality in the programme content. Many authors have stressed the need for sexuality education interventions to include integrated informational, motivational and behavioural skill elements. A combination of these elements seems to favour risk reduction behaviour change (Fisher & Fisher, 1992).

4.3 Programme presentation

After a study of available litarature the researcher came to the conclusion that there are two methods of programme presentation that are frequently used to enhance the effectiveness of sexuality education programmes, namely *small group discussions* and *peer education*. In light of the important role that the peer group seem to play in the lives of university students (see 3.3), it seemed ideal to address such a sensitive subject as sexuality within an intimate simulated peer group gathering.

4.3.1 Small group discussion

Interactive discussion is a widely recommended method of helping students to acquire a more clear-cut awareness of their frequently implicit values and feelings about sexual issues (Strouse et al., 1990). A major purpose of small group discussion is to create an atmosphere where the students would feel free not only to explore their own sexual feelings, discomforts, and mental blocks, but also to become more accepting of others whose sexual attitudes and behaviours are different from their own (Mims, Brown & Lubow, 1976). Small group discussions provide students with the opportunity to receive stimulating feedback in response to their own and others' sexual values, behaviour and feelings.

Strouse et al. (1990) found that student-centred discussion groups result in improved motivation and ability to apply abstract concepts when compared with lecture learning. In the light of this finding it seems as if insight into the relationship between sexual attitudes, values and sexual behaviour will be easier to obtain, and learning of behavioural skills will be better facilitated, within group education.

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The success of discussion groups is largely related to the degree of structure and autonomy in the group. Instructors must yield authority and leave student peers to govern and pace their activity in at least a semi-autonomous fashion. Autonomous discussion is essential for sexuality groups. An over-authoritative group leader might have a serious "chilling" effect on spontaneous and free discussion of personal sexual issues (Strouse et al., 1990). Students need supportive spaces in which they can freely discuss their fears and confusions about sexuality and sexual health risks (Christensen, 1991).

4.3.2 Peer educators

Peer education is a powerful and probably essential component of health and sexuality education (Mellanby et al., 1992). A basic assumption underlying educational interventions is that active participation by peers and influential members of the lay community is essential for desired changes in behaviours and norms (Cotton et al., 1994). Behaviour eventually depends on the individual and the attitudes of his/her peers. If peers support particular behaviour patterns, individuals are more likely to adopt these patterns. Getting peer support is often the key factor in long-term behaviour change (SALUS, 1991).

On college and university campuses in South Africa peer education is in a process of developing from self-educated students responding to campus health issues to state of the art health education and motivational models designed to empower students to help one another promote positive health beliefs and behaviours. Peer educators are highly valued as change agents on the campus because they convey information and communicate with their contemporaries in ways that the professional staff cannot (Edelstein & Gonyer, 1993).

Peer educators focus primarily on designing and conducting health promotion activities that influence students to reduce behavioural risk, promote positive health behaviours, and reduce barriers to maintaining health. Peer educators are viewed as non-threatening authorities. They live among their constituents, have access to students, are present in resident halls, student organisations, social gatherings and classrooms, and are privy to students' personal lives in a manner that campus health professionals are not. Using the same language as their peers, they have the unique ability to influence peer-group behaviour by providing credible role models (Edelstein & Gonyer, 1992).

Probably the most beneficial aspect of peer education is role-modelling related to perceived attitudes, integrated with skills in decision-making, problem solving and communication. People are more likely to hear and personalize a message that may result in changing attitudes and behaviours if they believe their messenger is similar to them in lifestyle and faces the same

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concerns and pressures. This appears to be particularly true for youth, who are often at a stage in their lives when they are unable to trust, communicate with, or identify with adults (Sloane & Zimmer, 1993).

The basis of the peer education approach is that both trainers and trainees benefit from the experience. Participating in the practice of health promotion and in the role of community leadership helps peer educators perceive themselves as growing, both personally and professionally from their training and education experience (Sloane & Zimmer, 1993). Yogev and Ronen (1982) found that peer educators tended to be more emphatic and have a higher sense of self-esteem than did students who had not participated in such a programme. Peer initiatives appear to be interventions that both the peer educators and student participants enjoy (Sloane & Zimmer, 1993). Participant evaluations and random surveys have indicated that trained peers enjoy a rapport with students that allows them to provide accurate and essential health information that might otherwise be unavailable. These peer educators also serve as an essential means of communication between health service professionals and the students. Well-trained peer educators are among the best public relations people operating between the health services and the rest of the institution. Health officials should nurture their peer educators as they provide a direct link to the students who do not walk through the door of the health centre seeking medical care (Edelstein & Gonyer, 1993).

Summary:

From the literature reviewed it seems that to be effective a sexuality education programme should facilitate group sessions in which: peer group educators teach correct, unambiguous information; peer group members investigate values, attitudes and feelings which influence their sexual activity; programme content address behaviour which has to be changed; and training exercises provide and strengthen social skills with which to combat health-risk behaviour.

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CHAPTER 5: SITUATION ANALYSIS III - THEORETICAL FRAMEWORKS GUIDING PROGRAMME DESIGN, IMPLEMENTATION AND EVALUATION

In the previous chapter the researcher discussed research findings that suggested that to be effective, programmes should follow a more integrated approach and teach general life-skills within the definition of a multidimensional view of sexuality and sexual behaviour. In recent literature on theoretical principles underlying behaviour, researchers supported these findings by suggesting that interventions should be based on *theoretical frameworks* and principles which address an integration of all the relevant sources which could influence behaviour (O'Keeffe, Nesselhof-Kendall & Baum, 1990; Ross & Rosser, 1989).

In this chapter the researcher will discuss the theoretical principles on which the design, implementation and evaluation of the sexuality psycho-education programme was based. Theoretical frameworks underlying the programme design, implementation and evaluation include *The Psycho-education model*, the *Information-Motivation-Behaviour Skills (IMB) model*, the *Guerney-model*, and the *Action-research model*. The implications of using the Psycho-education model as a broad theoretical departure point were discussed in Chapter 1. In this chapter the three remaining models and their implications for this research will be presented.

5.1 The information-motivation-behaviour skills (IMB) model

The following four properties of the IMB model motivated to a great extent the researcher's choice of this model as main theoretical framework on which to base the design and implementation of a sexuality psycho-education programme for university students:

(i) The IMB Model was developed, in part, to address the theoretical and methodological shortcomings that appeared to limit the impact of sexual health-risk behaviour reduction interventions up to date (Fisher & Fisher, 1992).

In reviewing recent literature on the subject the researcher identified the Social-Cognitive Theory (Bandura, 1986), the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980; Fishbein, 1990), the Health Belief Model (HBM; Becker, 1974), as well as the AIDS-Risk-Reduction Model (Cantania, Kegeles & Coates, 1990) to be models which could serve well as general conceptual bases for interventions aimed at the prevention of high-risk sexual behaviour. In terms of empirical foundation however, although support for particular univariate relationships has been reported, these models remain greatly untested as integrated multivariate models. Secondly, with respect to translation into sexual health-risk reduction interventions, no single model readily translates into a comprehensive intervention, although elements of each contain valuable suggestions for

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constructing components of a comprehensive intervention. The IMB Model incorporates in generalized form many of the effective constructs of social-cognitive theory, the TRA, the HBM and the ARRM, and extends its authors' previous work on the motivational and behavioural bases of sexual high-risk preventive behaviour (Fisher, Fisher, Williams & Malloy, 1994).

(ii) The IMB Model proved to be successful in changing health-risk behaviour across different target groups.

The IMB-model was originally proposed as an AIDS risk-behaviour change model. The assumptions of the model have been confirmed in model-testing research across several populations at risk for HIV. Fisher et al. (1994) tested the IMB model successfully on a population of gay men. In 1998 the IMB model's assumptions about the determinants of preventive behaviour was tested using a sample of urban minority high school students, The results of the afore-mentioned study provided consistent and detailed evidence that information and motivation stimulate the application of preventive behavioural skills which result in the practice of actual preventive behaviour (Fisher, Fisher, Williams & Malloy, 1999). The model has also been used to design, implement, and evaluate a successful AIDS risk-reduction intervention targeted at young adults (Fisher, Fisher, Misovich, Kimble and Malloy, 1996). On a population of heterosexual college students an IMB model-based AIDS risk reduction intervention produced increases in multiple indicators of AIDS risk reduction information, motivation, and behavioural skills, and sustained increases in AIDS preventive behaviour. At the time of this study (1995/6), the above mentioned study of heterosexual college students provided the sole example of a conceptually based, rigorously evaluated intervention that had been effective in modifying risky sexual behaviour in a college student population (Choi & Coates, 1994; Fisher et al., 1996).

Increasingly, the model is being viewed as a general health behaviour change/promotion model. Fisher and Fisher (1996) believe that behaviour-specific information, motivation and behaviour are critical to change many unhealthy behaviours. The researchers of the IMB model also believe that in being behaviour and target specific the model can be employed effectively to design and evaluate interventions aimed at changing a broad array of behaviours. Support for this viewpoint is provided by successful interventions which have involved information, motivation, and behavioural skills components in the areas of preventing adolescents from smoking (Botvin, Dusenbury, Baker, James-Oritz and Kerner, 1989), reducing cardiovascular risk (Farquhar et al., 1990), and increasing contraceptive behaviour (Fisher, 1990a; Gilchrist and Schinke, 1983). The IMB-model has also recently been successfully tested as applied to the desirable practice of breast self-examination among women over the age of 40 (Misovich, Martinez and Fisher, 1995). In addition to the early tests of the model with mostly white, highly educated samples, the IMB model research team has recently found support for the model with a minority, inner-city adolescent sample (Fisher

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et al., 1994). The research suggests the utility of the IMB-Model as a highly general conceptualization of health behaviours.

(iii) The motivational factor in an integrated formula for behaviour change

As noted in Chapter 4, it is relatively easy for educators to teach and young people to learn factual information and behavioural skills. It is, however, ultimately up to the young people to decide whether they will use the knowledge and skills they have acquired. With this in mind most researchers agree that the most difficult, and to date the most unsuccessfully implemented part of any psycho-educational programme, has been to identify and address those factors which translate knowledge and behavioural skills into sustained behaviour change. O'Keeffe et al. (1990) stated that the task of modifying high-risk behaviour includes determining how to motivate people so that their intentions are consistent with desired behavioural outcomes.

There are models that have tried to address motivational factors which researchers deem necessary for active behaviour change. One model that seems to conceptualize successfully motivational aspects of behaviour change is the TRA model (Fishbein, 1990). The IMB model, however, differs from the TRA and other models in that it focuses attention not only on knowledge or skills, and not only on motivational and intentional factors, but combine them to conceptualize an effective equation for behaviour change. The specific hypothesized relations among the three factors in the model (information, motivation, behaviour) have been empirically tested as part of an integrated multivariate model using structural equation modelling techniques. The theoretical framework - elicitation, implementation and evaluation guidelines - of the IMB model is formulated and tested according to the principles defined by the information-motivation-behavioural skills equation. Interventions based on the IMB model prove to be highly successful because of this effective conceptualization of behaviour change underlying the model. The researcher has up to date found no other model that provides such a sensibly integrated and empirically successfully tested formula for behaviour change (Fisher & Fisher, 1992).

(iv) The IMB model is both conceptually based and consistent with an extensive review of relevant literature.

The IMB model provides a basic framework for understanding which factors influence, and how they influence, the process of behaviour formation and change. The model clearly imply that attention should be given to cognitive, affective and behavioural factors in sexuality education programmes by focusing on such aspects as knowledge, attitudes, values, beliefs, feelings and behavioural skills which influence unhealthy behaviour. In the light of the findings of recent studies (as discussed in Chapter 4) which indicated that all of the above-mentioned aspects contribute

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significantly to a person's sexuality and sexual behaviour and should thus be addressed in sexuality education programmes, this model therefore seems to be a most appropriate model to use.

The following discussion describes the principles of the IMB model as applied to sexual behaviour.

5.1.1 Fundamental determinants of the IMB model

The IMB-model holds that *information, motivation and behavioural skills* are the fundamental determinants of behaviour.

According to the model, information that is directly relevant to the specific behaviour is an initial prerequisite of that behaviour. Motivation to engage in such behaviour, including personal motivation (relevant attitudes pertaining to the behaviour) and social motivation (perceived social support for the behaviour) is a second critical prerequisite of the behaviour. Finally, behavioural skills for performing such behaviour, including objective skills for performing such behaviour and a sense of self-efficacy in doing so, are a third critical prerequisite of the behaviour. To promote the initiation and maintenance of certain behaviour, such as healthy sexual behaviour, one should increase the levels of each of these three factors.

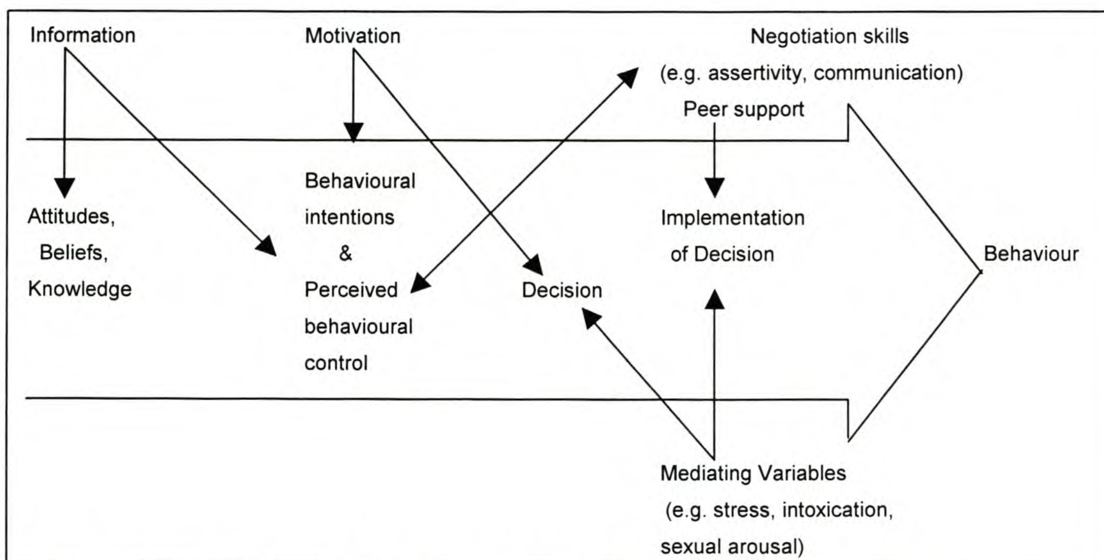

Figure 3: Factors influencing the adoption of behaviours.
(Adapted from O'Keeffe et al., 1990, p176)

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5.1.1.1 Information

The IMB model stresses the fact that information is a necessary, but not sufficient condition for the initiation and maintenance of healthy sexual behaviour. According to the IMB model the types of information necessary for the promotion of healthy sexual behaviour should be specific behaviourally relevant information. The information provided should form a basis for effective decision-making and provide a realistic background for the reinforcement of attitudes, beliefs and enactment of behaviour. Within the framework of sexuality education, information refers to basic knowledge concerning reproduction, the transmission of Aids and other sexually transmitted diseases (STDs), as well as the prevention of Aids, STDs and unwanted pregnancies.

5.1.1.2 Motivation

Motivation has an integral role in the enactment and changing of behaviour: even a well-informed and behaviourally well-skilled person must generally be highly motivated to initiate and maintain healthy sexual behaviour. For further definition of motivation the IMB model uses Fishbein and Ajzen's *Theory of Reasoned Action* to provide a well-articulated social psychological conceptualization that may be applied to understand and promote the motivation of healthy behaviour within diverse target groups (Fisher & Fisher, 1992):

> The theory of reasoned action
>
> According to the theory of reasoned action a person's behaviour is motivated by his or her intention to behave in a certain manner. These behavioural intentions are ultimately determined by one's underlying beliefs: the person's personal attitude toward performing the act in question (personal beliefs), as well as his or her subjective perception of how significant others think he/she should behave (social influence). The theory asserts thus that in order to assure increased motivation to perform healthy sexual behaviours, attitudes (beliefs, misconceptions) toward the performance of such sexual behaviour and perceptions of social normative support for the behaviour, should be changed or enhanced. Promoting or changing behaviour is thus viewed as a matter of enhancing or changing an underlying cognitive structure (Fishbein, 1990).

Motivation as necessary for the promotion of healthy sexual behaviour refers to personal attitudes towards sexual behaviour and high-risk preventive sexual behaviour, personal beliefs and value-systems concerning sexuality and sexual behaviour, as well as subjective perceptions of peer group norms regarding sexuality and sexual behaviour.

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Fisher and Fisher (1992) postulate that information and motivation work largely through behavioural skills that result in the enactment of specific behaviour and maintenance of that behaviour. Information and motivation may also have direct effects on risk-reduction behaviour, particularly when risk-reduction behaviour requires relatively uncomplicated behavioural performances. Although information and motivation both influence behaviour, there is no necessary strong relationship between information and motivation. Information and motivation are viewed as separate entities that influence the utilization of behavioural skills and the enactment of risk-reduction behaviour in quite separate ways.

5.1.1.3 Behavioural skills

Behavioural skills are a third critical determinant of behaviour formation and change. Information and motivation gain effectiveness mainly through behavioural skills. Behavioural skills are necessary because they enable people to perform specific health-promotive acts and thus has an effect on whether even a knowledgeable, highly-motivated person will be able to change or enact his/her desired behaviour.

In the behavioural skills component of health education interventions, those behavioural skills that are lacking or underdeveloped should be taught, rehearsed, and refined in an organized, script-like fashion that is readily translatable into improved behaviour in participants' own social settings. This can be done in several ways: observing models of similar others who enact risk-reduction sexual behaviours, personally role-playing these behaviours, receiving subsequent feedback and reinforcement, and then refining one's performance (Fisher & Fisher, 1992).

It is also important to remember that in order to engage in certain behaviours one should not only have the necessary behaviours in one's repertoire, but one should also possess a self-belief - a sense of self-efficacy - in one's ability to use them. Intentions to perform behaviours will only be actualized if participants perceive they have the abilities (sufficient knowledge and skills) to do so (Livingston, 1992).

Within a broader conceptualization, behavioural skills include: skills to acquire accurate information about healthy sexual behaviours, skills with which to negotiate safe-sex behaviour with a partner (assertivity and communication skills), the ability to exit a situation in which safer sex cannot be negotiated, as well as the ability to engage in public behaviour required for healthy sexual practices like STD/AIDS testing and condom purchasing,. In addition to such "universal" skills Fisher and Fisher (1992) stressed the importance of the identification of additional behavioural skills which may be relevant for target groups characterized by differences in ethnicity, sexual orientation, gender, and the like.

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Once relevant behavioural skills have been taught and rehearsed, evaluation research must be performed to assess whether they have been mastered and retained and whether they are related to healthy sexual behaviour *per se*.

Even though the constructs of the IMB-model are regarded as highly generalized determinants of high-risk preventive behaviours in any population of interest, these constructs should have content that is specific to particular target populations and specific high-risk sexual behaviours. On the basis of population-appropriate data, population-appropriate interventions should be designed to produce changes in knowledge, motivation, behavioural skills that promote prevention and consequently high-risk sexual behaviour.

5.1.2 A three phase application of the IMB–model

Beyond identifying critical determinants of sexual risk-reduction behaviour, the IMB model also specifies a set of operations that can be used to understand and promote the application of the IMB model on sexual risk-reduction interventions within diverse populations.

There are three steps in applying this conceptualization to promote healthy sexual behaviour:

Step 1: Elicitation Research

For each population of interest it is necessary to perform elicitation research to identify: the population's existing level of relevant knowledge, the factors that determine the population's motivation to reduce high-risk sexual behaviour, and the behavioural skills which the specific target group need to master. The elicitation research is essential in that it provides a basis of population-specific data on which population-appropriate interventions can be created (Fisher & Fisher, 1992).

Step 2: Designing population-appropriate interventions

Interventions should encompass population-appropriate informational, motivational and behavioural-skills content. The IMB approach emphasizes the need to tailor sexual health promotion interventions to address empirically identified deficits in target populations' knowledge, motivation and behavioural skills, and to capitalize on existing strengths in the these areas (Fisher et al., 1994).

In light of the fact that the goals of elicitation research, namely to generate information and produce population-specific interventions, are similar to that of action research, the researcher will in this

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study not discuss elicitation research as a separate concept. The principles of action research will be discussed in 5.3.

Step 3: Evaluation research

Finally, long- and short-term changes in multiple indicators of knowledge, motivation and behavioural skills should be determined through methodologically adequate evaluation research. Evaluation should also attempt to assess to what extent changes in each of the critical determinants of the IMB model have resulted in long-term risk reduction behaviour change *per se*.

5.1.3 Critical evaluation of the IMB Model

Critique against many psychosocial theories that aim to guide behaviour change is that most of these models assume that risk behaviours and behaviour change can be explained by one general model (Amaro, 1995). Some models focus only on cognitive determinants of behaviour (e.g. knowledge, attitudes, beliefs, and intentions), and other on social influences (e.g. self-efficacy, social norms, perceived control). As discussed earlier in this chapter (see 5.1) the IMB model tries to address this critique by integrating many of the important determinants of both the cognitive and social behaviour modification models. The IMB model provides a comprehensive conceptual approach to understanding determinants of preventive behaviour. It also provides a generalizable methodology for intervening to promote health-risk reduction behaviour. A conceptual issue of concern which remains stems from the fact that the IMB model rests on the assumption that changing the proposed determinants of behaviour will be an effective means of changing behaviour. The causal assumption underlying the model is that having the correct information, being motivated to change and possessing the necessary behavioural skills will lead to effective behaviour. Human sexual behaviour is however very complex and possibly more than just the sum of its proposed parts. Some other models like for instance the Aids Risk Reduction Model and the Transtheoretical Model, focus more on the determinants of stages of behaviour change. Whether the models which focus on stages of behaviour or on behaviour in general prove to be more effective remains to be seen. More research should be directed at providing experimental tests of the IMB model's predictions regarding the effects of changes in each of the model's constructs of behaviour (Fisher & Fisher, 1992).

Experimental intervention research based on the constructs of the IMB Model, while consistently significant and dealing with diverse populations, remains limited. The model, published for the first time in 1992, is still in its infancy and some areas of the IMB model-based research are somewhat sparse. Much IMB-based research is still in the process of being submitted for publication and is not yet widely available (Fisher & Fisher, 2000). Questions arise specifically concerning the role of

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information in the IMB equation. Although the model has specific situations in which information is expected to be a substantial contributor to preventive behaviour, clearer conceptualization of the role of information in stimulating the development and application of behavioural skills and preventive behaviour appears necessary. The model's logic appear to permit at least the possibility of a relationship between informational and motivational factors. The connection between information and motivation constructs, however, is still somewhat undefined and needs to be evaluated. Another issue of concern which should be considered for future conceptualization and empirical testing involve the specification of when, in terms of populations at risk and preventive behaviours of interest, specific model constructs may prove to be most important (Fisher & Fisher, 2000).

In a critical review of existing models of sexual risk behaviour Amaro (1995) stated that these models were limited in so far as they (i) failed to consider the broader cultural and social context of sexuality, (ii) were based on the assumption that sexual behaviours and encounters were controlled totally by the individual, and (iii) ignored the role of gender roles as determinants of sexual behaviour. The IMB model does allow for the inclusion of cultural and social influences by recognizing personal beliefs and social norms as important determinants of motivation for behaviour change. The model also tries to address the issue of personal control by proposing the development and promotion of self-efficacy and perceived behavioural control within simulations of socially and environmentally specific situations. Even though there is some provision for issues concerning individual control the model still assumes that once one has developed a healthy sense of self-efficacy, perceives oneself as being in control and possessing the necessary negotiation skills, one will be able to take control of a high risk sexual situation. This ignores to a great extent many environmental and other external factors which might influence decision-making and individual control in such situations. Morrison, Gillmore and Baker (1995) pointed out that many health behaviours are at least partially outside of participants' control because of so-called "blocking factors". Some of these external or "blocking" factors are impossible to anticipate, and therefore, outside of the domain of any cognitive expectancy model. Such external factors could include financial dependence, relationship issues and gender roles (Wyatt, 1994). Gender roles and identities are important in that they could determine how sexual encounters are negotiated and who decides which sexual practices will prevail (Erhardt & Wasserheit cited in Amaro, 1995). The influence of gender dynamics on behaviour modification is however greatly lacking as a theoretical component of the IMB model. In 1996 Fisher et al. used the IMB model to reduce AIDS risk behaviour in a college student population. During the course of the study it became apparent that students' concerns about the conflict and dissonance that could be evoked by discussing or instituting safer sex practices with their partners in a relationship were major obstacles to overcome. Young people seem to find it much more difficult to initiate safer sex practices in affectionate than in casual relationships (Kelly & Kalichman, 1995). Fisher et al. (1996) suggested

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that future research should create couple-based interventions which conceptualizes factors unique to relationships that act to promote and sustain healthy sexual behaviour. Such interventions would thus have to address gender roles and identities as well as other external factors which might contribute to perceived loss of control within sexual negotiations.

Even though the basic conceptualization of the model is devoid of some seemingly critical components, the IMB does allow for adaptation in order to accommodate issues such as cultural and gender influences. This can be seen in their specific inclusion of elicitation procedures and the development of population-appropriate interventions as part of the application guidelines for the IMB (see 5.1.2). Wyatt (1994) proposed that intervention models should describe sexual practices within the context of age, income, gender, sexual orientation, religious beliefs and cultural values. The IMB operational methods allow researchers to tailor interventions, to some extent, according to specific cultural, societal and or gender group determinants. The success of the model in adapting to different target groups is confirmed in research conducted across a diversity of populations at risk ranging from university students (Fisher et al., 1996) to gay men (Fisher et al., 1994) to inner-city minority women (Carey, Maisto, Kalichman et al. cited in Fisher & Fisher, 2000). The model's approach to HIV risk reduction behaviour change has been similarly supported in elicitation, experimental intervention and evaluation research conducted with university students and adolescents. Effects of model-based interventions on risk-reduction behaviour changes have been significant and sustained (Fisher & Fisher, 2000).

Summary:

While a number of other models also address health promotive information, motivation, and behavioural skills as significant factors in the promotion of a wide spectrum of health behaviours, the IMB model is first to specify and to test empirically the specific linkages among these constructs. The application of these constructs to the implementation of health promotive interventions across a broad spectrum of target populations is facilitated by the provision of a specified three-step elicitation, implementation and evaluation process. The present research utilized the IMB model to guide the design, implementation, and evaluation of a high-risk sexual behaviour reduction intervention targeted at a university student population.

5.2 The Guerney model

Bernard Guerney designed a model that provides a basic structure for training sessions that can be applied to different fields of education, and is thus widely used by educators as a framework for the design of psycho-educational sessions (Gazda et al. in Meyer, 1988). The model proposes 5 phases for each training session:

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Phase 1: Intellectual discussion/didactic phase

Information is conveyed. The group member is informed about the information and skills that are to be learnt, and motivation for the learning of specific skills is discussed.

Phase 2: Discussion of concepts

A theoretical overview of the session content is given and the group is given the chance to discuss several related subjects.

Phase 3: Skills training

During this phase skills are learnt and practised through methods, as befitting the specific subject and skill, such as modelling and role-play.

Phase 4: Homework

Skills have to be rehearsed and practised. This can be done as part of the session or given as homework.

Phase 5: Feedback

Feedback is usually given during the first part of the following session and entails discussion of the success or failure of the skill that was taught in the previous session.

It is not always easy to stick to a predetermined session structure, as contrasting topics are discussed, in a group containing diverse individuals and using different methods to teach an array of skills. Although the layout of group sessions designed for psycho-education programmes can thus end up being more extensive than the basic Guerney model suggests, the Guerney model forms the basic framework on which the final structure of sessions can be built. It also served as guideline for group leaders in their initial preparation for the presentation of their sessions.

5.3 Action Research

Principles of action research were used to implement and evaluate the programme. It is specifically the cyclic nature of action research and the accompanying technique of participatory research that would be beneficial to gathering relevant information in order to develop population-specific interventions and maximize the nature and impact of the sexuality education programme.

Action research is seen as a way of characterizing a loose set of activities that are designed to improve the quality of education. Action research is systematic. It involves a spiral of planning, acting, observing, reflecting and re-planning (Mcniff, 1995). Action research always alternates between action and critical reflection. In the later cycles of such research one would continuously refine methods, data and interpretation in the light of the understanding developed in the earlier cycles (Dick, 1999).

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Action research envisages a collaborative approach to investigation that seeks to engage subjects as full participants in the research process (Stringer, 1999). This method is referred to as participatory research. Participatory research involves that researchers enter a community and listen, observe, reflect and question with a view to gaining insight into what it is like to be a member of that community. The method of enquiry is usually conceived as being a dialogue between the researcher and the community. It attempts to involve the community in expressing their needs and finding their own solutions (Kelly & Van der Riet, 2001). The researcher and the target population systems are seen to be fully interdependent and the direction of the action research process is influenced by the needs of the target group at all stages (Orford, 1992).

The spiral process of action research in the current study entailed repeated implementations and evaluation of the sexuality psycho-education programme on members of the target population of university students. Three implementations and evaluations were conducted. Throughout the process members of the student community actively participated in the research. The adaptation from one cycle of action research to the next was facilitated by the feedback and suggestions provided by the target-population themselves. Based on the information gained from the first implementation the research methodology for the second implementation was adapted. Accordingly the feedback received about the second implementation led to changes in the research methods used for the third implementation.

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CHAPTER 6: DEVELOPMENT OF THE PROGRAMME

It was the aim of the researcher to design a sexuality psycho-education programme that would impact positively on the sexual knowledge, attitudes and behavioural skills of university students. One of the objectives of this study was to design a population-specific peer group sexuality psycho-education programme aimed at sexually empowering university students and preventing high-risk sexual behaviour within the university student population. The design of the sexuality psycho-education programme had to be such that it could be used by students to educate fellow students through peer group education. The sexuality psycho-education programme should not only empower peer group leaders to be effective health educators, but also encourage group members to take initiative in health education within their different social groups.

6.1. Programme Objectives

In keeping with the principles of the IMB, as discussed in 5.1, the following programme objectives were specified:

6.1.1 Empowering peer group educators

(i) To empower peer group educators with the necessary knowledge, motivation and skills needed to maintain healthy sexual behaviour in their own lives.

(ii) To provide peer group educators with skills that will enable them to empower fellow peer members with the knowledge, motivation and skills which they need to maintain healthy sexual behaviour in their personal lives.

6.1.2 Empowering peer group members

(i) To empower peer group members with knowledge necessary for sustained healthy sexual behaviours by providing information that enable them to:

- understand male and female sexual development, and the physical and emotional changes that accompany it;
- gain insight into the sexual functioning of the male and female body/body parts;
- understand the implications (personal, physiological, psychological and social) of the risks associated with sexual activity: unwanted pregnancies, sexually transmitted diseases and AIDS;
- effectively obtain, use, and negotiate the use of contraceptives to prevent pregnancy or infection with a sexual disease; and
- engage in the identification and treatment of sexually transmitted diseases and AIDS.

(ii) To increase *motivation* for the adoption of healthy sexual behaviours by providing opportunities for peer group members to:

- clarify and gain acceptance for personal attitudes, convictions, values and belief-systems that influence their sexual identity and behaviour;
- gain insight into the place of sexuality and sex in close relationships with other people;
- gain insight into the place of sexuality and sex in the immediate social surroundings of young people (peer group norms and support); and
- gain insight in and tolerance for sexual preferences and behaviours that vary from their own.

(iii) To promote sustained healthy sexual behaviour by empowering the group members with *behavioural skills* that allow them to:

- engage in effective decision-making with regard to sexual identity and sexual behaviour; and
- negotiate safe sexual behaviour effectively, strengthen sexual confidence and maintain personal sexual integrity with the correct utilization of behavioural skills.

(iv) To promote the motivation for and maintenance of healthy sexual behaviour by promoting peer group members':

- sense of responsibility for their own sexuality and sexual behaviour; and
- sense of self-efficacy and perceived behavioural control

6.2 Programme Design

6.2.1 Content of the sessions

The first draft of the sexuality psycho-education programme consisted of eight sessions, of approximately 2 hours each. In keeping with the programme objectives as discussed in 6.1, the content of the sexuality education programme was designed to emphasize the reduction and elimination of risky activities. The choice of topics covered in the sexuality education programme was based on the most important sexuality-related health problems of young people as found in a review of recent literature (see chapter 4), guided by the principles of the IMB (see 5.1) and in keeping with the researcher's objective of maintaining a holistic multi-dimensional approach to sexuality education. Students' knowledge about sexual issues had to be increased to cover such areas as preventing unwanted pregnancy and the transmission of HIV\AIDS and other sexually transmitted diseases. Students had to be educated about the need for and the benefits of making responsible and informed decisions about their own sexuality. Young men and women had to be

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taught to assume equal responsibility in sexual decision-making. The content of the programme had to address the sexual empowerment of students by not only teaching them what to do but also most importantly how to do it through life-skills training. Each of the group sessions was designed to be presented to a group of university students by a peer group leader.

6.2.1.1 Information

The IMB proposes that information should be behaviourally relevant and include topics such as basic knowledge regarding reproduction and the transmission of sexually transmitted diseases (STD's), as well as the prevention of unwanted pregnancies and STD's (see 5.1.1.1). In keeping with the guidelines of the IMB the researcher included programme sessions which addressed the human reproductive system and human sexual response (Session 1), contraception (Session 7), HIV/AIDS (Session 5) and sexually transmitted diseases (Session 4) (see Appendix A).

6.2.1.2 Motivation

According to the IMB, motivational programme content should address personal attitudes towards sexual behaviour, beliefs and values concerning sexuality and subjective peer perceptions of peer group norms regarding sexual issues. (see 5.1.1.2). In order to address these attitudes the researcher included sessions in the programme designed specifically to promote open discussion in the peer group about topics such as attitudes and perceptions about sex and sexuality in the world around us (Session 2), perspectives on relationships, intimacy and love (Session 3), attitudes concerning the HIV and AIDS (Session 5), opinions about the use of contraception (Session 7), and feelings and norms regarding controversial sexual issues like abortion and homosexuality (Session 6). Group members were also motivated towards a greater awareness of personal values and attitudes through exercises in which they had to write a sexual autobiography and complete introspective sexual questionnaires.

6.2.1.3 Behavioural skills

In defining the behavioural skills component of interventions based on the principles of the IMB, Fisher and Fisher (1992) suggested that behavioural content include skills with which to acquire accurate information about healthy behaviours, skills with which to communicate and negotiate safe-sex behaviour as well as the ability to engage in so-called public behaviour like for example buying condoms (see 5.1.1.3).

In light of the above the researcher include activities and excercises in the programme which aimed to develop communication skills and assertiveness in sexual situations through role play in

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the enactment of population-appropriate case-studies (Session 8). Group members also took part in excercises in which they had to practice how to use a condom (Session 5) and purchase or collect condoms in a public situation (Session 6).

6.2.2 Format of the sessions

The group sessions, within the framework provided by the Guerney-model (see 5.2), included didactic facets, facilitation of discussions, as well as exercises for the learning of behavioural skills. In some instances group members received homework with which to personalize their experience in the group sessions.

The programme was implemented and evaluated three times using an action research model. Throughout the research period the programme was adapted according to the critique and suggestions received from the target group, to eventually produce the current version of the programme which is provided in Appendix A.

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CHAPTER 7: IMPLEMENTATION AND EVALUATION OF PROGRAMME THROUGH ACTION RESEARCH – IMPLEMENTATION I

7.1 Objectives

In 1995 the researcher implemented the first sexuality psycho-education programme on a group of 80 students from the University of Stellenbosch. The goals of this implementation were:

- To determine whether the programme content was appropriate for the target group of university students.
- To determine whether the presentation techniques were effective in promoting the aims of the programme.
- To determine the face validity of the measuring instruments used to *evaluate* the impact of the intervention on the knowledge, attitudes and behaviour of the target population.

7.2 Research design

The research design combined quantitative and qualitative methods. The quantitative component consisted of a test-re-test experiment. Peer group leaders were selected to present the sexuality psycho-education programme to groups of university students. Participants attended eight peer group psycho-education sessions. The participants each completed individual written pretests that measured their knowledge, attitudes and perceived behavioural skills concerning sexuality-related issues.

Participants and group leaders were encouraged to discuss any problems they encountered with programme content, presentation and/or evaluation methods. Group leaders were responsible for conveying these problems and other relevant issues to the researcher. The qualitative component of evaluation entailed the gathering and analysis of data from these discussions.

7.2.1 Group leaders

The group leaders were recruited from a group of third year Psychology Students at the University of Stellenbosch. As with the group members, the group leaders had to be white, aged 18-25, English or Afrikaans speaking, male or female, sexually active or sexually non-active. The group leaders, even though they signed up voluntarily, were put through a strict selection process of intensive interviewing before being allowed to lead a sexuality psycho-education peer group.

Group leaders were interviewed individually to determine whether they met with the following requirements:

- *Group leaders had to possess basic group communication skills.* As all of the prospective group leaders were third year psychology students who had passed modules in communications skills, the researcher made certain assumptions as to there knowledge and skills in terms of group communication. During the initial interview group leaders were then also confronted with the reality of the group training situation – namely that they would have to stand up in front of a group of their peers and be able to effectively and with authority address the group. They were also made aware of the sensitive and sometimes awkward nature of the programme content that they would have to present to the group. Prospective group leaders then had time to go and think about whether they really thought their group communication skills would allow them to effectively work with a small group.
- *Group leaders had to be able to communicate in Afrikaans and English* The success of a peer group education programme relies greatly on the group leader's ability to be able to communicate comfortably with a group of his/her peers. As participants could be Afrikaans or English speaking, group leaders had to possess excellent communication skills in both these languages. During the initial interview some questions were asked, and expected to be answered, in English and some in Afrikaans. In this way the researcher could to some extent determine the language proficiency of the prospective group leaders.
- *Group leaders were required to be able to speak freely and openly about all aspects of sex and sexuality.*

  The researcher found that possessing effective group communication skills was often not enough to be able to lead discussions effectively and communicate with peers about the controversial topic of sexuality. During their training the researcher constantly confronted candidates with a variety of sexual topics. Candidates were intensively scrutinized during these confrontations to determine whether they seemed at ease while discussing such sensitive issues. In light of the fact that one of the aims of the programme was to make young people more comfortable with their own sexuality and talk about the topic freely – the programme would not have had any impact if the discussion leaders themselves could not discuss the topic without any reserve.
- *Candidates who demonstrated the most tolerance toward all types of people were generally chosen as group leaders.*

  Candidates were encouraged to have strong views about their own life and sexuality as such characteristics generally reflect effective decision-making skills and well-formed attitudes. In the specific environment of the group session however, peer group leaders were required to be able to teach and enlighten others without prejudices against his/her peers. Only when unprejudiced, can group leaders refrain from dominating the group discussions with his/her own ideas, and guide peer group members eventually to make their own effective decisions. As tolerance is a very difficult characteristic to measure, the only recourse for the researcher was ask the straight-forward whether, for example, if they had a homosexual group member they would be

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able to function without prejudice. From the way the prospective group leaders responded to such questions, the researcher tried to determine whether they seemed to be unprejudiced enough to continue as a peer group leader.

- *Candidates had to be enthusiastic about the objectives of the research.* In the IMB-model motivation is identified as one of the main keys to ensuring a change in attitudes and behaviour. Group leaders had to be enthusiastic about the objectives of sexuality education and believe in what they were doing in order to be able to pass on this enthusiasm as motivation for more effective sexual behaviour to their peers. During the personal interviews they were asked to motivate whey, out of all the third year practical projects, they had chosen the possibility of sexuality education. From their responses the researcher could easily determine whether they had a true passion for the cause.
- *Group leaders were expected to be hard working and dedicated.* The responsibilities associated with being a peer group leader involved attending an intensive training programme, doing self-study for the presentation of each programme session, as well as sacrificing the time needed for the organization and eventual presentation of the group sessions. Group leaders thus had to be hard working and dedicated to the cause in order to ensure effective implementation of the peer group sexuality psycho-education programme. The researcher had access to the prospective group leaders' academic records from which it was possible, to some extent to determine whether they were dedicated to their projects or not. They were also represented with a realistic time frame of training events, preparation and administration hours and presentation times. This enabled them to, in light of their existing schedules, determine whether they could commit to the intervention.

The researcher selected 5 group leaders who complied with the above-mentioned requirements. Of the 5 group leaders, 4 were female and 1 male. Two of the female group leaders were English speaking while all the other group leaders identified Afrikaans as their first language. No other demographic information about the group leaders is available. The chosen peer group leaders were prepared for their task during two training sessions in which the programme content was discussed, programme exercises practiced, and general presentation and group communication techniques conveyed.

7.2.2 Participants

Eighty white university students of the University of Stellenbosch volunteered to participate in the study. Owing to the researcher's belief in target-specific interventions, the decision was made to focus the research on white students. At the time of the research (1995), white students formed the bulk of the US student population. The researcher also supports the premise of Kelly and St. Lawrence (1990) and Robenstine (1993) who both postulate cultural relevance and sensitivity to be

a critical element in programme development and presentation. The white student population was both the target group best known to and thus most effectively addressed by the researcher. The researcher does realize however that for the programme to be useful in the South African context, follow up studies would have to include the implementation of the programme on other South African population groups.

The participants could be male or female, aged 18-25, undergraduate or postgraduate, English or Afrikaans speaking, sexually active or sexually non-active. One important requirement was that the participants had to join the sexuality education groups voluntarily. Group leaders mostly recruited participants through word-of-mouth advertising in residences and student societies. Some participants volunteered for the programme after hearing public announcements in their classes.

Table 1 provides demographic information of the research population.

Table 1

Demographical Data of Participants in the First Implementation

		Experimental Group		Control Group		Total	
		N=40	**100%**	**N=40**	**100%**	**N=80**	**100%**
Gender	**Female**	33	41,25	28	70.00	61	76.25
	Male	7	17.50	12	30.00	19	23.75
Language	**Afrikaans**	20	50.00	28	70.00	48	60.00
	English	15	37.50	11	27.50	26	32.50
	Afrikaans/English	4	10.00	1	2.50	5	6.25
	Other	1	2.50			1	1.25
Study course	**BA**	17	42.50	22	55.00	39	48.75
	BSc	6	15.00	6	15.00	12	15.00
	Business Science	6	15.00	5	12.50	11	13.75
	Engineering	1	2.50	2	5.00	3	3.75
	Other	10	25.00	5	12.50	15	18.75
Average Age							
Experimental Group	20.43						
Control Group	20.72						

7.2.3 Group composition

The 80 participants were divided into five groups of 16 participants per group. Each of the 16 participants in a group was randomly assigned to either an experimental or a control group. There

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was an even number of participants in the control and experimental groups - eight in each. The participants in the experimental group attended the sexuality psycho-education course and completed pre- and post-test evaluation. The control group also completed the pre- and post-test evaluation, but did not attend the sexuality education course. Members of the control group were given the option of full participation in the sexuality psycho-education programme at a later stage.

7.2.4 Programme design

See Chapter 6 for information on the design of the first sexuality education programme.

7.2.5 Programme implementation

The sexuality psycho-education programme consisted of eight sessions (see 6.2.1), of approximately 2 hours each. Group members belonging to the experimental group were required to attend all eight group sessions. Throughout the course they were also encouraged to give feedback about their experience of the content and presentation techniques used in the programme sessions.

Peer group leaders were provided with the basic material needed to present the group sessions. Within the framework of the topics that had to be discussed and the techniques discussed in their training session, peer group leaders were allowed freedom to present the sessions in their own manner.

7.2.6 Quantitative evaluation

The impact of the sexuality psycho-education programme on the sexual knowledge, attitudes and behaviour of the target population was determined through pre- and post-test evaluation of each of the above-mentioned factors with The Sex Knowledge and Attitude Test for Adolescents (SKAT-A). The SKAT-A seemed to be the most appropriate/suitable measuring instrument available for pre- and post-test evaluation of sexuality on a target population of university students.

7.2.6.1 Measuring Instrument: The SKAT-A

The Sex Knowledge and Attitude Test (SKAT) was designed by Dr. Harold Lief and Dr D. Reed of the University of Pennsylvania in the early seventies. The test was initially designed for university students and adults. In 1986 Lief, Fullard & Devlin (1990) developed a modified version of the SKAT: The Sex Knowledge and Attitude Test for Adolescents (SKAT-A) (Appendix B). The SKAT-A was designed for specific use on populations of adolescents and young adults.

The SKAT-A consisted of three main sections: knowledge, attitudes and behaviour. The knowledge section contained 61 questions that varied between true/false questions and multiple-choice questions. Topics such as abortion, contraception and pregnancy, masturbation, premarital sex, sexual behaviour and sexually transmitted diseases were covered by the questions in the knowledge section. The section on attitudes contained 43 statements that the participants had to judge according to a 5-point Likert scale (1=very strongly agree; 5= does not agree at all). The statements were grouped within 4 categories: sexual myths, sexual responsibility, the consequences of sex, and forced sexual activity. The last section about behaviour contained 43 questions about sexual behaviour and experience. In the last section there were questions which required yes/no answers as well as questions which required the participant to choose, from a list of 8 choices, the response which was most applicable to him/herself (Lief, Fullard & Devlin, 1990).

In 1988 the SKAT-A was tested on a group of 40 undergraduate students between the ages of 17-25 in order to determine the test-retest reliability of the test. The reliability factors for the knowledge and attitudes sections were determined as 0.804 and 0.916 respectively (Lief et al., 1990).

The validity of the SKAT-A was determined by comparing this test with two other measuring instruments: Kirby's (1984) Knowledge and Attitude Scales and Hendrick and Hendrick's (1987) Multidimensional Sexual Attitude Scale. The relationships between the scales of the three tests were determined by calculating Pearson's correlation coefficient. Very few meaningful correlations were found between the three tests because the three tests differ in terms of what they measure for knowledge and attitudes. It was clear that the SKAT-A incorporated several distinctive aspects of attitudes concerning sexuality, for instance the consequences of sexual behaviour and relationships towards others in sexual situations, which were not included in the other tests.

The knowledge section was marked like an ordinary academic test with one mark given for each correct answer. The marks were then added up to get a sum total for the section. In the attitude section two totals, a liberal- as well as a conservative total, were determined with the help of a standard marking mask. A total sum for the section about attitudes was calculated by using the liberal and conservative totals in formulas provided on the marking mask. Only descriptive statistics can be derived from the behaviour section.

The SKAT-A seemed at that time, of all available measuring instruments, to be the most applicable measuring instrument to use in the evaluation of the research study. The test was translated into Afrikaans by way of the translate-re-translate method.

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7.2.7 Qualitative evaluation

During the last group session participants were given the opportunity to report on their experience of the content, presentation and evaluation of the sexuality programme. The group leaders encouraged discussion by reminding the participants of the importance of their honest feedback to the research process. The comments and suggestions offered by the participants were recorded in writing by the group leaders.

The intervention was concluded with a final meeting between the researcher and group leaders. During this meeting the group members shared their experience of the programme and also discussed issues that had been identified by their group participants. Written notes containing the feedback of both group leaders and group participants were handed to the researcher. Using the material presented in the discussions and written notes, the researcher identified those themes that (i) occurred frequently and/or (ii) corresponded with or clarified problems/successes that had been reported by participants during the course of the intervention. These themes are discussed in 7.3.

7.3 Results of the first implementation

The implementation served not only to identify problems, but also to confirm the effectiveness of certain aspects of the chosen programme design and evaluation methodology:

7.3.1 Programme design

The topics addressed in the programme content were generally accepted as being relevant and interesting. The programme content seemed to be specifically capitalizing on the motivational strengths, and addressing deficits in behavioural skills, of the target-group. Negative feedback was however received concerning the way in which these topics, with specific reference to informational content, were presented. The peer group members felt that the programme content could be improved to make it more suitable to the needs of the target population. Information, as well as case studies used in discussions and exercises, was experienced as being inappropriate to address problems at the sexual and psychological developmental level of university students. Information regarding human physiology had to be expanded to include details on the sexual response cycle. Participants felt that the information on human physiology was also too similar to what they learnt in school biology and they expressed the need to be informed of these matters in more depth. Role-play situations were experienced as ranging from the depiction of extreme promiscuousness to absurd innocence. On the one hand some role-play exercises reflected situations that seemed too naïve for the age and developmental stage of the participants. On the

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other hand some scenarios were found to be too explicit and somewhat unrealistic with regards to the specific target group. Role-play exercises thus had to be adapted to reflect more effectively the difficult, but realistic high-risk situations that university students could find themselves in.

Peer group members as well as peer group leaders also felt that more detailed guidelines and aids could be provided for the facilitation of discussions and exercises.

Group members identified a need to know more about the underlying objectives of each session and the planned activities, as they felt it would give them goals to work for, improve their motivation and give meaning to what, to them, sometimes seemed meaningless exercises.

7.3.2 Participants

Gender and ***language*** were the two differentiating attributes of the participants that were monitored closely during the first implementation of the programme. The written reports completed by peer group leaders suggested no problems with language differences. Even though most group sessions were to a great extent presented in either Afrikaans or English according to the preferred language of the peer group leader, any language barriers which might have arisen were prevented by firstly choosing peer group leaders who were bilingual enough to communicate with both Afrikaans and English speaking group members (see 7.2.1), and secondly preparing the programme content for both group leader and group member in English and Afrikaans.

Gender differences also did not prove to result in many problems. Written reports as well as verbal feedback from group leaders and group members did suggest however that the groups which were gender-mixed seemed to show the highest level of fun, open communication, learning and general group cohesion. The group members who were in mixed-gender groups felt that group discussions about sexuality as well as exercises in sexual assertiveness and communication were only successful and worthwhile because of the fact that views of both sexes were heard. Group members in single-gender groups showed confusion in exercises and discussions where the views of the other gender group had to be simulated through role-play and guessing.

7.3.3 Group design

The basic experimental-control group design proved to be best suited for the current research study. Some methodological problems were caused however by the fact that participants in the experimental and control groups could not be paired off for evaluation procedures, because of a lack of correlation in gender numbers in the two groups.

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7.3.4 Peer group leaders

The strict peer group selection process produced peer group leaders who were efficient and dedicated. Feedback from both peer group leaders and group members contained mostly positive feedback about the concept of peer group leadership and the individual peer group leaders themselves. Peer group leaders did however feel that more intensive training was needed for them to maximize the effectiveness of their programme presentation. They suggested that peer group leaders should be trained by having the programme implemented on themselves, and thus experience the group sessions as group members, before going out and training others.

The group leaders also mentioned that they were struggling to handle the workload associated with this programme within the context of their already full undergraduate schedules. They suggested that group leaders might be more productive if in future implementations they were allowed to work together in pairs. This would lighten the workload as well as enable more productive group sessions as they could assist each other in the control and facilitation of the group.

7.3.5 Programme implementation

Overall, few problems were experienced with presentation techniques and general implementation design:

7.3.5.1 Programme presentation

In view of feedback from peer group members and peer group leaders the specified programme presentation techniques, namely group sessions and peer group education, proved to be both popular and effective.

7.3.5.2 Implementation design

With the initial onset of the intervention the group members seemed apprehensive about attending eight 2-hour group sessions. In feedback received at the end of the intervention most members and peer group leaders agreed however that less time spent on such a multifaceted issue as sexuality, would not have had any positive effect at all. Groups who experienced discussions to be most effective were mostly those groups who had the time to keep sessions going till they were done talking, and not just till the two hours ran out.

7.3.6 Programme evaluation

Programme evaluation proved to be the most difficult part of this research study. Even in the early stages of research the researcher had to accept the fact that, in these early days of sexuality research in South Africa, finding a measuring instrument that suited the study perfectly would be unlikely. The SKAT-A seemed to be the most appropriate/suitable measuring instrument available for pre- and post-test evaluation of sexuality on a target population of university students. After the first stage of the implementation evaluation, namely the pre-testing, negative feedback about the measuring instrument had already convinced peer group leaders, group members and the researcher that the SKAT-A was not suitable for the specific study at hand. The following three specific problems were encountered:

- Group members found it difficult to identify with the language and terminology used in the formulation of SKAT-A items. Terminology used in the SKAT-A items - '*school*', '*girls*', and 'boys' - were found to be outside their frame of reference as young people and university students. The formulation of the test items did not address the issue of sexuality at the sexual and psychological developmental level that the young people in the relevant target group had already reached.
- The SKAT-A items did not reflect the content of and aspects of sexuality discussed in the sexuality education programme that was designed for this study. It would be impossible to determine the effectiveness of the programme by evaluating it with a measuring instrument that did not reflect the aims and content of the programme itself.
- The SKAT-A did not provide at all for the evaluation of the effect of a sexuality psycho-education programme on a participant's mastering of behavioural skills.

With all the problems encountered with the SKAT-A test it was concluded that it was not an appropriate measuring instrument for the evaluation of the effects of the sexuality psycho-education programme on the knowledge, attitudes and behavioural skills of the target group.

Summary:

The first implementation provided the researcher with useful feedback regarding peer group design, programme content and measuring instruments. Feedback from group leaders and group members indicated that:

- Although it did to a great extent address deficits in, and capitalize on the strengths of, the participants' knowledge, motivation and behavioural skills, programme content needed to be more population specific and user friendly.

- The group dynamic and peer group leaders proved to be highly appropriate techniques for use in the current research study.
- The basic implementation framework with regards to number, length and theoretical design of group sessions worked well.
- Evaluation methods needed to be changed.

The researcher used the information received to modify the sexuality psycho-education programme and the implementation procedures, to fit the needs of the target population of university students. An important implication of the findings of the first study was that a new measuring instrument had to be designed which would reflect the developmental level of the target group and the aims and content of the sexuality psycho-education programme.

In order to confirm changes made to the programme design and implementation, and most importantly test the new measuring instrument, it was necessary for the researcher to conduct a second implementation. The methodology for the second implementation will be discussed in Chapter 8.

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CHAPTER 8: IMPLEMENTATION AND EVALUATION OF PROGRAMME THROUGH ACTION RESEARCH – IMPLEMENTATION II

8.1 Objectives

In 1996 the researcher implemented the second sexuality psycho-education programme on a group of 80 students from the University of Stellenbosch. The programme had been adapted according to the feedback received in the first implementation. The goals of this implementation was:

- To determine whether the reformulated programme content could better address the nature and needs of the target population.
- To determine whether the adapted presentation techniques were more effective in promoting the aims of the research project.
- To determine the face validity of the new measuring instruments.

8.2 Research design

The researcher followed the same basic research design as in the first implementation (see 7.2). Once again participants and group leaders were encouraged to discuss any problems they encountered with programme content, presentation and/or evaluation methods. The information gathered from these discussions was used to evaluate the sexuality psycho-education programme in terms of the goals for the second implementation.

8.2.1 Group leaders

The selection procedures and specifications were kept identical to that of the first implementation (see 7.2.1). Thirty group leaders were selected for the second implementation. There were 24 female and 7 male group leaders. Two of the group leaders identified English as their first language, while the others were all Afrikaans speaking. No other demographic information about the group leaders is available. The training of peer group leaders differed from that of the first implementation in that the training was intensified in terms of time spent on educative sessions as well as the nature of the material taught. The training of peer group leaders in the first implementation involved training in necessary teaching and communication skills, provision of guidelines for possible troubleshooting, as well as a brief overview of the basic content of the sexuality psycho-education programme. In the second implementation group leaders were expected to "attend" the sexuality education programme, presented by the researcher, as group members, in order to experience first hand what their group members would experience. In so doing they gained insight into the possible needs and problems that group members might

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encounter during group sessions. The programme material was discussed extensively and detailed motivation and implementation procedures for group sessions were provided. The content of each group session was also modified to include clearly defined instructions for the peer group leaders. The researcher followed the suggestion of the group leaders in the first implementation (see 7.3.4) and allowed the group leaders in the second implementation to work together in pairs.

8.2.2 Participants

As no problems were experienced with the participant profile in the first implementation, no changes to participant specifications were made in second implementation (see 7.2.2 for participant specifications.). In the second implementation 480 volunteers who fit the participant profile were selected to take part in the intervention. Detailed biographical information on these participants was unfortunately lost during the research process.

8.2.3 Group composition

The basic experimental-control group design, as implemented in the first implementation (see 7.2.3) was continued. Based on feedback received about the participant specifications and group design of the first implementation the following requirements were added to the specifications for group design:

- Groups had to contain members of both sexes (see 7.3.2)
- The distribution of female and male group members was controlled in order to correlate the number of each gender in the experimental group with that of the control group. This correlation was needed in order for group members of the experimental group to be paired off with members of the control group for later evaluation procedures (see 7.3.3)

8.2.4 Programme Design

Based on feedback provided by peer group leaders and peer group members about the programme implementation of the first implementation, programme presentation techniques and the basic implementation design were left unchanged. Several changes in programme content however were necessary:

In general the basic topics addressed in the sexuality psycho-education programme was left unchanged. According to the extent to which group members had reported enjoying and/or benefitting from certain topics, some group sessions were redefined and/or expanded. The group sessions presented in the second implementation were: Group session 1: The human

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sexual/reproductive organs and the cycle of sexual response in humans; Group session 2: Sexuality – attitudes, values and perceptions; Group session 3: Sexuality – perspectives on relationships and love; Group session 4: Sexually transmitted diseases; Group session 5: The HIV and AIDS; Group session 6: Sexuality in controversy; Group session 7: Contraception; Group session 8: Assertiveness in sexuality.

In order to comply with requests of group members and group leaders during the first implementation, special attention was given to upgrading the content included in the group sessions to address the developmental status, sexual and otherwise, of university students. Information was revised to more effectively address deficits in sexual knowledge, and basic topics of interests, which university students had identified in the first implementation. Case studies used for the facilitation of discussions and exercises were updated to depict situations relevant to the social environment of young people at university level. Guidelines for the facilitation of exercises and discussions were set out in more detail to maximize the use by group members and group leaders.

The researcher also expanded on the basic framework for the design of group sessions provided by the Guerney-model (see 5.2, *The Guerney model*). New sections were included in the layout of each session to provide for discussion of: objectives for the group session; guidelines for the peer group leaders; and the basic structure of the session. Group members had expressed their need to know the objectives underlying the session content and structure in order to increase their insight into, and consequent motivation for, group session activities.

8.2.5 Programme Implementation

As both group members and group leaders in the first implementation indicated that they felt comfortable with the basic programme presentation techniques and implementation design, these aspects were left unchanged (see 7.2.5 and 7.3.5).

8.2.6 Quantitative evaluation

In the first implementation a need was identified for the development of a measuring instrument that would reflect the nature of the target group as well as the content and aims of the sexuality psycho-education programme. The researcher therefore designed three tests that could be used for pre-and post-test evaluation of change in knowledge, attitudes and behavioural skills of a population of university students.

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8.2.6.1 The Sexual Knowledge Test

In designing the Sexual Knowledge Test (Appendix C) the researcher kept to the format of the Aids Risk Behaviour Knowledge test (ARBK) designed by Fisher, Fisher, Williams & Malloy (1994) to test the IMB model on populations of gay men and heterosexual university students. Statements that reflected programme content effectively were formulated and compiled into a 40-item knowledge test. Participants had to respond to the test items by deciding whether the statements were true or false. A category for 'don't know' answers was also provided.

8.2.6.2 The Sexual Attitudes Test

Test items were carefully selected to reflect as much as possible the attitudes and perceptions which the researcher wished to clarify and/or change through the sexuality psycho-education programme. These included attitudes towards their own sexuality; towards so-called socially acceptable sexual behaviour; regarding the use of contraception; AIDS and AIDS patients; and attitudes towards communication regarding sexual issues. The Sexual Attitudes Test (Appendix D) was formed by compiling and adapting test-items from other sexual attitudes tests that had been already empirically tested by researchers (Youth Survey in Olsen et al., 1991; Sexual Attitudes Scale in Hendrick and Hendrick, 1987; The Attitudes Towards AIDS Scale in Goh, 1993). Participants were expected to rate their level of acceptance of such attitudes by rating each of the 40 test-items on a 5-point Likert type scale: 1= strongly disagree, 2= disagree, 3= don't know, 4= agree, 5= strongly agree.

8.2.6.3 Perceived Sexual Behavioural Skills test

The Perceived Sexual Behavioural Skills test (Appendix E) was formulated in keeping with the behavioural skills test designed by Fisher, Fisher, Williams and Malloy (1994). The test included 25 items that reflected the behavioural skills taught in the sexuality psycho-education programme. Each item had to be evaluated by the participants according to: (a) How easy they think the behaviour is to perform, and (b) How effectively they think they would be able to perform the behaviour. As with the Sexual Attitudes test a 5-point Likert-type scale was provided for answering both (a): 1= very difficult; 2= difficult; 3= Don't know; 4= Easy; 5= Very Easy; and (b): 1= .very ineffectively; 2= ineffectively; 3= Don't know; 4= effectively; 5= very effectively.

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8.2.6.4 Reliability and Validity

It should be noted that the purpose of the current research was not to design effective measuring instruments, but that the focus was place on the design, implementation and evaluation of the peer group sexuality psycho-education programme.

The reliability of a measuring instrument reflects the consistency with which it measures whatever it is supposed measure (Foxcroft & Roodt, 2001). In the current research the researcher did not test the three measuring instruments in terms of reliability.

There are several forms of validity including content validity, face validity, concurrent validity, predictive validity and construct validity. The measuring instruments used in the current research were tested in terms of face validity.

In the first implementation the researcher used the SKAT-A as measuring instrument. Feedback from the target group about the SKAT-A was very negative (see 7.3.6). The most significant problems which were identified were that the items used in the SKAT-A were not population-appropriate in their content and language and did not seem to measure the issues addressed in the sexuality education programme. In designing the new measuring instruments the researcher focused primarily on solving the above-mentioned problems. The most effective way of ensuring that the new measuring instruments were population-appropriate was to determine the face validity of the new tests through feedback from the target population.

Face validity refers to whether the measure seems valid for test-takers who have to undergo testing for a specific purpose (Foxcroft & Roodt, 2001). During the second implementation of the current research the measuring instruments were implemented not to assess the effectiveness of the intervention, but with the aim of receiving feedback from peer group leaders and peer group members about the test items. Group leaders and group members were asked to provide feedback on whether they experienced the test items of The Sexual Knowledge Test, The Sexual Attitudes Test and The Perceived Behavioural Skills Test to be relevant in terms of the issues addressed during intervention. They also had to comment on issues like sentence construction and identify any ambiguous, target group–inappropriate, or otherwise ineffective test-items. Critique and suggestions acquired from this procedure was noted, analysed and used to adapt the measuring instruments in order to maximise their face validity (see 8.3.4).

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8.2.7 Qualitative evaluation

The researcher followed the same qualitative evaluation techniques as in the first implementation (see 7.2.7) The information obtained through qualitative feedback is discussed below in 8.3.

8.3 Results of the second implementation

8.3.1 Programme design

Group leaders and group members seemed in general to be satisfied with the changes made to the content of the programme sessions. Feedback from group members conveyed that they experienced the group sessions to be on the level expected of a sexuality psycho-education programme designed for university students. Group members could identify with exercise scenarios and case studies used in discussions. The upgrade in informational content also seemed to be successful in that group members all felt that they were learning something new about sex and sexuality. Group leaders reported that providing them with insight into the objectives of group sessions had motivated the group members to greater participation in group discussions and activities.

8.3.2 Group design

The modifications made to the group design seemed to be effective in that all groups enjoyed two-way feedback – from the viewpoints of both sexes – about sex and sexuality, and no more methodological problems were encountered in terms of experimental and control group attributes.

8.3.3 Group leaders

No negative feedback concerning peer group leaders was received. Peer group leaders seemed to feel well equipped with skills learnt during the training sessions and new defined instructions and aids to their disposal. Working in pairs allowed them to share the work-load and also enabled them to have one group leader presenting the session while the other facilitated discussion as part of the group. Working together made them feel more confident as they had an ally when working with sensitive and/or seemingly embarrassing material. Sharing the workload also contributed to more successful execution of administrative tasks. As they were able to share responsibility and tasks it was easier for them not only to put more effort into session presentation, but also to follow the strict methodological guidelines required more efficiently to produce meaningful research outcomes.

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8.3.4 Programme evaluation

The newly designed measuring instruments seemed to solve to a large extent the problems that were encountered with the SKAT-A in the first implementation. Group members experienced that the formulation of test items addressed them on a level appropriate for university students. No negative feedback was received about the relevance of the test items in terms of programme content. Group members could identify with the terminology used in and the content included in the test items of the Sexual Knowledge, Sexual Attitudes as well as the Sexual Behavioural Skills tests.

Some problems with specific items in the Sexual Attitudes Test and the Perceived Behavioural Skills Test were identified and had to be addressed in order to increase face validity.

8.3.4.1 Sexual Attitudes Test

A few of the test items were identified as being ambiguous. In preparation for the final programme implementation and evaluation these items were either removed from the test or rewritten according to the feedback received from the group members. Some items were also removed because group members felt that the items did not reflect values, perceptions or attitudes that were relevant to the aims and/or content of the sexuality psycho-education programme. In the final Sexual Attitudes test 37 items were retained.

8.3.4.2 Sexual Behavioural Skills Test

Test items in the Behavioural Skills Test were received well by the group members. They found the items relevant to skills taught and rehearsed in the sexuality psycho-education programme. Some of the items were evaluated as being unclear as a result of weak sentence construction and translation. In preparation for the final programme implementation and evaluation these items were rephrased with the help of group members and group leaders. For instance Item 5 that had been translated to read "Ask a new sexual partner to only have sex with you" was reformulated to read "Ask a new sexual partner to have sex with only you". Two items were removed from the test because of a lack of relevance to the behavioural skills programme content. Finally, many of the participants felt that they could not complete the behavioural skills questionnaire because they understood the questions to be relevant only if you were already sexually active. The questions were however specifically formulated with the use of the word "sexual partner" referring not only to a partner you have sexual intercourse with (a sex partner), but to a partner with which you are physically/sexually intimate. Group members as well as group leaders requested that the

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instructions for completing the test be appended to include the above-mentioned definition for the term "sexual partner". The final Sexual Behavioural Skills Test included 23 test items.

Summary:

Feedback from group leaders and group members about the second implementation indicated that:

- Programme content seemed to address deficits in, and capitalize on the strengths of participants' knowledge, motivation and behavioural skills concerning sex and sexuality.
- Group sessions and peer group leaders proved to be appropriate presentation techniques for use in the current research study.
- Implementation and evaluation methodology were relevant in terms of the aims and content of the sexuality psycho-education programme, as well as the developmental status and general nature of the target population of university students.

The pilot studies were most useful in that it provided an opportunity for the young people to stipulate how they wanted their needs to be addressed. Programme content, presentation techniques and methods of evaluation were modified and redesigned to comply with the nature and needs of the target population of university students.

The researcher now felt equipped to initiate a final implementation of the sexuality psycho-education programme with the purpose of testing the effects of it on the knowledge, attitudes and perceived behavioural skills of the proposed target group of university students. In Section C the researcher will provide a detailed account of the specific objectives of and the research methodology used for the final implementation and evaluation of the sexuality psycho-education programme.

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CHAPTER 9: IMPLEMENTATION AND EVALUATION OF PROGRAMME THROUGH ACTION RESEARCH – IMPLEMENTATION III

9.1 Objectives

In 1996 the researcher implemented the third sexuality psycho-education programme on a group of 64 students from the University of Stellenbosch. The programme had been adapted according to feedback received in the first and second implementations. The goals of this implementation was to

- determine whether the peer group sexuality psycho-education programme increased the *knowledge*, relevant to the prevention of high-risk sexual behaviour, of the research participants;
- determine whether the peer group sexuality psycho-education programme furthered the development, clarification and/or change of the *attitudes*, which promote healthy sexual behaviour, of the research participants;
- determine whether the peer group sexuality psycho-education programme facilitated participants' mastering of *behavioural skills* that are relevant to the prevention of high-risk sexual behaviour;
- gain insight into the research participants' *personal experience* of the peer group sexuality psycho-education programme.

9.2 Research design

The research design was that of a test-re-test experiment. The 32 participants in the three experimental groups each completed individual written pre-tests that measured their knowledge, attitudes and skills concerning sexuality-related issues. These 32 participants then attended a programme of 8 sexuality psycho-education sessions of ±2 hours each. As part of their last session they were again subjected to testing of their sexuality-related knowledge, attitudes and skills. The control group also completed individual pre- and post-test evaluation, but did not attend the sexuality education course. Members of the control group were given the option of full participation in the sexuality psycho-education programme at a later stage. All tests were completed anonymously. Qualitative data was obtained from feedback reports written by the group leaders.

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9.3 Research Methodology

9.3.1 Group leaders

9.3.1.1 Recruitment and Selection

Group leaders were recruited from a group of third year Psychology Students at the University of Stellenbosch. As with the group members, the group leaders had to be white, aged 18-25, English or Afrikaans speaking, male or female, sexually active or sexually non-active.

Third year psychology students were, as part of their Community Psychology course, expected to take part in one of a few proposed community projects. The sexuality psycho-education course was offered as one of these projects. Approximately 30 students volunteered as group leaders for this programme. Prospective group leaders underwent a selection process to determine whether they met with the requirements as discussed in 7.2.1. Of the 30 initial volunteers, 8 students who seemed to possess the required characteristics were selected as peer group leaders for the purpose of this study. All the group leaders were female undergraduate students between the ages of 20-22. Two of the group leaders identified English as their first language, while the other 6 were Afrikaans speaking.

In the light of the intense and extensive nature of the programme the group leaders opted to team up in pairs. Each team of two group leaders was assigned to a group of 16 participants.

9.3.1.2 Training

Formal lectures on Community Psychology provided the group leaders with basic skills needed for the presentation of community based educational programmes, as well as insight into the scientific research approach needed for the evaluation of such projects. They were however ignorant concerning the techniques required to manage the specific subject at hand. Consequently the group leaders underwent extensive training in order to prepare them for their task. (See 8.2.1)
Possible needs and problems that group members might encounter during group sessions and general troubleshooting, were discussed. Group leaders brainstormed workshop-style in order to practise techniques with which to solve and/or cope with these possible problems. The intense training left the group leaders with no misconceptions concerning the complicated and serious nature of the issue, and the enormity of the task that they were about to undertake. As a final sign of their commitment to their task as group leaders they each signed what we decided to call a Contract of Reliability (see Appendix F).

9.3.2 Participants

For the purpose of this study 64 participants were recruited from the white student population of the University of Stellenbosch. Participant specifications remained the same as in implementations 1 & 2 (See 7.2.2)

Recruitment was done through word-of-mouth advertising on the campus of the University of Stellenbosch. Group leaders were also responsible for participant recruitment.

The composition of the research population had to be such that an even number of male as well as female participants had to be included – *"even"* not referring here to an equal number of each sex, but to a number that could be divided by two. This prerequisite had to be followed keeping in mind the pairing off of control and experimental participants for evaluation purposes. The final research population consisted of 34 male and 30 female participants.

Table 2 contains demographic details for the research population:

Table 2

Demographical Data of Participants in the Final Implementation and Evaluation

		Experimental Group		Control Group		Total	
		N=32	100%	N=32	100%	N=64	100%
Gender	**Female**	15	46.88	15	46.88	30	46.89
	Male	17	53.13	17	53.13	34	53.13
Language	**Afrikaans**	20	62.5	23	35.94	43	67.19
	English	10	31.25	9	28.13	19	29.69
	Afrikaans/English	2	6.25			2	3.13
Study course	**BA**	14	43.75	16	50.00	30	46.89
	BSc	6	18.75	3	9.38	9	14.06
	Business Science	8	25.00	9	28.13	17	26.56
	Engineering			1	3.13	1	1.56
	Other	4	12.50	3	9.38	7	10.94
Average Age							
Experimental Group	21.36						
Control Group	20.75						

All the participants were 18-24 year old undergraduate students at Stellenbosch University. In view of the fact that participants were recruited from the general population of university students a variety of study courses, including B.A., B.Sc., business sciences, medical and arts degrees, were

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represented. The level of sexual activity was not formally noted. At that time the researcher did not realize the importance of identifying whether participants were sexually active or not. Creating a safe and unthreatening environment for the participants was foremost on the researcher's agenda and such a personal question seemed intrusive and unnecessary. Through personal conversation with group members and group leaders, the researcher did learn that sexually non-active and sexually active students were represented in the research population. The researcher got the impression that most of the participants were however quite conservative and sexually inexperienced. Participants were reported to be mostly heterosexual although a small percentage of the participants reported in group discussions that they had been involved in bisexual experiences. The research population contained 62.5% Afrikaans and 31.25% English speaking participants. The remaining 6.25% of the students claimed to have both Afrikaans and English as their first language.

An important question that arose in this research was the issue of participant selection. There is no substitute for random assignment of participants to experimental and control groups. External validity is jeopardized in that participants volunteered for the programme. Many questions have arisen about the attributes of people who volunteer for such a programme and the way in which these attributes could affect the research outcome. Within a school or other controlled institutional environment, where sexuality education might be mandatory for all, the ideal participant distribution might be achieved. Within a university environment, and working with young people who have been given the freedom to choose their own activities, the only way to involve the participants is by voluntary participation. The issue of participant selection is discussed further in 10.2.4.

9.3.3 Group composition

The 64 participants were divided into four groups of 16 participants per group. Each of the 16 participants in a group was assigned randomly to either an experimental or a control group. There were an even number of participants in the control and experimental groups - eight in each. The distribution of female and male group members was controlled in order to correlate the number of each gender in the experimental group with that of the control group (See 7.3.3).

Random assignment of male and female participants to each group resulted in the following group compositions:

- Group One comprised of 6 female and 10 male participants. Three female and 5 male participants were assigned randomly to form the control group.
- Group Two comprised of 8 female and 8 male participants. Four female and 4 male participants were assigned randomly to form the control group.

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- Group Three comprised of 8 female and 8 male participants. Four female and 4 male participants were assigned randomly to form the control group.
- Group Four comprised of 8 female and 8 male participants. Four female and 4 male participants were assigned randomly to form the control group.

9.3.4 Programme design

The sexuality psycho-education programme for university students (See Appendix A) is an educational programme consisting of eight sessions that address knowledge, attitudes and behavioural skills relevant to the following issues:

Group session 1:	Human Sexual/Reproductive Organs & The Cycle of Sexual Response in Human Beings
Group session 2:	Sexuality: Attitudes, Values and Perceptions
Group session 3:	Sexuality: perspectives on Relationships and Love
Group session 4:	Sexually Transmitted Diseases
Group session 5:	HIV and Aids
Group session 6:	Sexuality in Controversy
Group session 7:	Contraception
Group session 8:	Assertiveness in Sexuality

The researcher will not discuss the content of each group session in detail here as the session objectives, content and motivation for the use of specific content and activities for each session, is explained at length as part of the programme in Appendix A.

The programme sessions were all designed to be presented by a peer group leader to a group of his/her peers. The basic framework of the sessions is based on the Guerney-model for educational group sessions (see 5.2). As with the Guerney model the programme sessions of the sexuality education programme include didactic facets, facilitation of discussions, where applicable exercises for the learning of behavioural skills and in some instances homework assignments with which group members could personalize their experience in the group sessions at home.

Each of the programme sessions followed the same basic design. This continuity made it easier for peer group leaders to use the programme material as a manual with which to prepare for the presentation of diverse session topics. Each programme session included Objectives, Structure, Content and an Appendix. Each of these sections will be discussed briefly below:

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Objectives

Understanding and agreeing with the main aims of the project is essential for peer group leaders' full dedication to the cause. In order to motivate group members' full participation in group sessions it is also necessary for them to understand why they are being taught certain facts and asked to participate in specific activities. They need to be able to identify a goal to strive towards.

In the light of these above-mentioned factors, each group session starts with a section that sets out the objective(s) of that specific session. The goal(s) that group leaders and group members should strive for when presenting/attending the group session is named and motivated. The programme session objectives are discussed in terms of how they contribute to the aims of the sexuality psycho-education programme as a whole.

Peer group leaders were instructed to use the insight gained from this section as they felt necessary. They were not expected to relay the details of programme session objectives to the group members as a rule or as was written in the programme session manual. Aims of programme sessions were discussed whenever group leaders or members felt that explanation of or motivation for learning/participation was necessary.

Knowing and understanding the aims of each session also made it easier for peer group leaders to prepare the presentation of their sessions. It enabled them to identify the key aspects of the session content, and structure their presentation towards the reaching of specific, realistic goals.

Structure

In the section entitled '*Structure* ' a proposed layout for the presentation of the specific session was provided.

All activities (lectures, games, discussions) included in the specific session were named, and listed in a sequence that was thought to provide the best results. Where needed, activities were discussed briefly in terms of relevance and guidelines for presentation.

Although all planned activities had to be included, peer group leaders were mostly not restricted to keeping with the proposed presentation sequence. They were advised to plan the basic session structure accordingly, but could let the group members mould the session to suit their educational and emotional needs. Where a certain build-up or growth process required group members' participation in certain activities at specific times, it was so specified.

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Contents of the Group Session

This section provides the peer group leader with everything he/she needs to present the session: all the information which has to be taught, the games to be played, exercises and homework to be completed, as well as various relevant discussion topics. All programme sessions did of course not include all of the above listed facets, but included activities appropriate to the session subject and objectives.

Factual information, otherwise referred to in the programme material as ' *lectures* ', was set out in detail and accompanied by diagrams where applicable. Although the lecture material was sufficient in terms of the goals of the sexuality psycho-education programme, peer group members were encouraged to study other references to ensure that they would be well prepared for group members' questions about various relevant subjects. Peer group leaders were also provided with a comprehensive list of references for use in those instances where group members' answers could not be answered from the lecture material or group leaders' knowledge base.

Games and exercises were included where possible to promote active participation of group members in each session. Provided with each of these activities were instructions for the group leaders, instructions for the group members (where necessary), exercise/game content, and answer sheets or other aids which could be copied and handed out to participating group members.

Discussion topics were also accompanied, as far as was possible, by instructions for the group leaders. This provided the group leaders with ideas, guidelines, as to how specific discussions topics could best be addressed, i.e. how to initiate discussion, how to stimulate the discussion, how to steer and keep the discussion in the right direction, how to handle destructive debate, and when and how to end the discussion. (These aspects were either addressed in '"*Guidelines for the group leader* " or in the instructions for discussions in "*Content of the Group Session*" , as was best suited for the specific programme session)

Aids for enabling discussion, like topic references or case studies, were also provided where necessary.

Homework was only included in a few programme sessions. Assignments to be completed at home were mostly only required when there were issues which were too personal to be discussed effectively in a group session, and could only be addressed by the group member in the privacy of his/her own home. In these cases the assignment was set out in detail on paper to enable peer group leaders to copy and hand it out to the group members. Homework assignments included

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instructions for the group members as well as a letter addressed to the group member which explained to him/her how the assignment was going to be dealt with in the group sessions and requesting commitment in participation from the group member. All homework assignments were filled in anonymously.

Appendix

The ' Appendix ' contained diagrams, photographs and other aids which were needed to further group members' insight into the issues of the specific programme session.

9.3.5 Measuring instruments

The set of measuring instruments were The Sexual Knowledge Test, The Sexual Attitudes Test and The Perceived Sexual Behavioural Skills Test (see 8.2.6).

All three test are pen-and-paper tests. They were used for pre-and post-testing of knowledge, attitudes and perceived behavioural skills. The tests are available in Afrikaans and English. Translation of the tests were done with the translate-retranslate method. The face validity of the tests were evaluated and improved during the second implementation (see 8.2.6 and 8.3.4).

9.3.5.1 The Sexual Knowledge Test

The main aim of the test (see Appendix C) is to determine the level of a person's knowledge of key sexuality-related issues. It should be kept in mind that the test was designed specifically to evaluate young peoples' knowledge concerning sexuality-related issues which are addressed in the *Sexuality psycho-education programme for university students,* as designed for the current research.

The 40 test items in The Sexual Knowledge Test mainly cover:

- knowledge concerning human sexual/reproductive organs and reproduction;
- the human sexual response cycle;
- transmission, symptoms and prevention of sexually transmitted diseases and HIV/Aids; and
- ways in which to obtain and effectively use contraceptives.

The aim of the researcher was to increase the total score of each participant from pre- to post-testing.

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9.3.5.2 The Sexual Attitudes Test

The main aim of The Sexual Attitudes Test (see Appendix D) is to determine a person's attitudes towards sex and sexuality. The test was designed specifically to measure attitudes regarding sexuality as they are encouraged/discouraged through the content and aims of the *Sexuality psycho-education programme for university students* designed for the current research.

Participants were instructed to answer questions as specifically relevant to his/her own attitudes and not to provide socially desirable answers. Test items were formulated in the first person to encourage the above-mentioned required response.

The researcher scored highest those attitudes that were promoted in the sexuality psycho-education programme. These were attitudes that seem to promote sexual well-being. An increase in total score from pre- to post-testing would thus indicate attitude development beneficial to healthy sexual behaviour. A further goal was to facilitate the clarification of attitudes. A lower instance of "Don't Know" and a move towards more "Strongly disagree" and/or "Strongly Agree" answers from pre- to post-testing would indicate a move towards attitude clarification.

9.3.5.3 The Perceived Sexual Behavioural Skills Test

The main aim of The Perceived Sexual Behavioural Skills Test (see Appendix E) is to determine the extent to which a person feels comfortable with and perceive him/herself to be able to execute effectively, sexual health-risk preventive behavioural skills. The test items in this test relate mainly to those behavioural skills taught and rehearsed as part of the *Sexuality psycho-education programme for university students* implemented for the current research.

The test items included in The Perceived Sexual Behavioural Skills Test explore participants' perceived ability to be assertive and communicate effectively in situations where they need to take responsibility for their own sexual well-being. These so-called *sexual situations* include incidences where it might be necessary to protect the individuals' right to make decisions about his/her own sexuality, as well as incidences where participants' physical-health might be jeopardised by the threat of AIDS, sexually transmitted disease and unwanted pregnancy.

With regard to The Perceived Sexual Behavioural Skills Test it was the aim of the researcher to increase total scores of sections (a) (How easy they think the behaviour is to perform) + (b) (How effectively they think they would be able to perform the behaviour), thus a total score for all test items, from pre- to post-testing. The researcher also aimed to determine whether there would be a

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parallel increase in score for each section by evaluating the total scores of sections (a) and (b) separately .

9.4 Ethical considerations

Two basic ethical principals that govern data collection are: (i) the principle of informed consent and (ii) protecting research participants' right to privacy. (Oppenheim, 1992). In a study that addresses such a personal and sensitive issue as sexuality, it was especially important to protect participants' right to privacy. These principles were implemented by making use of volunteers as participants in the research. Secondly, potential participants were thoroughly briefed about the nature of the sexuality education programme beforehand. Participants who decided to enroll in the programme signed an informed consent form and also a contract in which they committed themselves to the project (see Appendix G).

In order to protect participants' privacy and provide a safe environment in which they could feel at ease to address all issues with honesty, all assignments and questionnaires were completed anonymously. Through the process of random assignment each participant of each experimental group as well as each participant of each control group picked a number between 1-8. Participants used these numbers, which were known only to themselves, as identifier on all documents that were handed in during the course of the intervention.

Lastly the issue of confidentiality was addressed by training group leaders to assume responsibility for their group members and hold themselves to high ethical standards. Group leaders had to sign an informed consent form and contract in which amongst other things they committed themselves to protecting the group members privacy by not discussing group matters beyond the group.

9.5 Evaluation procedures

Parametric and non-parametric tests were used to analyse the research data on four different levels. The researcher also made use of basic frequencies analysis of the research data, as well as thematic content analysis of qualitative data, to clarify further certain aspects of the research results.

9.5.1 Statistical analysis

9.5.1.1 T-tests

Firstly t-tests were used to compare the pre- and post-test sum total scores of each of the

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Knowledge, Attitudes and Skills tests.

The Knowledge Test consisted of 40 true/false questions. The answers were scored with a 1 for correct and a 0 for incorrect answers. The scores were added up to a total for each participant for each of the pre- and post-tests. The sum totals of the pre- and post-tests were compared through statistical analyses in order to determine whether the sexuality education programme had brought about a significant change in sexual knowledge for participants in the experimental group.

The questions of the Attitudes Test were in the 5-point Likert scale format and were thus scored accordingly with a score of 5 being given to the most likely answer. The scores for the 36 items in the Attitude test were added up and a mean score obtained for each participant for the pre- and post-tests. These mean scores were compared with parametrical t-tests to determine whether the sexuality psycho-education programme had the desired effect on the sexual attitudes of the participants.

The Skills Test consisted of 23 statements that described a sexuality/sex-related behaviour. Participants had to rate these statements according to: (Part A) How easy they think the behaviour is to perform, and (Part B) How effectively they think they would be able to perform the behaviour. For the Skills Test the average of the 23 items of the pre- and post-tests for each participant were used in t-tests to determine whether a positive development of skills had taken place from pre- to post testing.

9.5.1.2 Category Analysis

Specific test items in each of the Sexual Knowledge, Sexual Attitudes and Sexual Skills Tests can be grouped together into categories pertaining to specific aspects of sexuality and sex. In order to investigate whether certain issues in the psycho-education programme might have been better addressed and more effective than others, the test items of the different tests were grouped into applicable categories and the difference in pre-and posttest scores for the experimental group for each of those categories analysed with t-tests.

9.5.1.3 Non-parametric tests

Finally, to analyze the possible effect that different group leaders might have had on the success of the intervention, Wilcoxon signed ranks tests were performed on the Knowledge, Attitudes and Skills Tests scores for each of the four experimental groups. Group scores were compared to determine whether there was a significant difference between the performances of the four experimental groups, which could be contributed to the influence of their respective group leaders.

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9.5.2 Frequency Analysis

Throughout the evaluation process the researcher made use of basic frequency analysis in order to determine further patterns and anomalies that might be visible in the distribution patterns of the research data.

9.5.3 Qualitative Analysis

Each of the four group leaders was instructed to keep a detailed diary on group members' experience of and feedback in each group session. At the end of the intervention the group leaders had to formulate their accounts of each session in a formal report. These reports contained references to comments and feedback made by group members, descriptions of the events in each group session – from the group members' and leaders' perspectives, and the group leaders' final conclusions and suggestions.

Thematic analysis was used to evaluate these reports: Firstly recurring topics in each report were noted after which the topics of all reports were compared. Then the most prominent themes that could be validated by all accounts were identified. Instances related to each theme were grouped and quoted. Lastly the researcher interpreted the content of each theme by looking at the discussions thereof in the feedback reports, adding the researcher's own insights as formed through experience and personal discussions with intervention participants, and finally validating the probability of the results with concurrent and/or opposing findings in recent literature.

9.5.4 Long-term evaluation

Limited time access to the participants prevented the researcher from continuing with both qualitative and long-term evaluation.

Summary

Through action research the researcher tested the programme content, presentation techniques, implementation procedures and evaluation methodology of the sexuality psycho-education programme on university students. Feedback from group leaders and group members were analysed and used to adapt the programme design, implementation and evaluation to best suit the needs of young people. In a final effort the sexuality education programme was implemented with the purpose of empirically testing the effects on the knowledge, attitudes and behavioural skills of the target group. The results of the final implementation and evaluation of the sexuality psycho-education programme will be presented and discussed in 9.6.

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9.6 Results of the third implementation

The aims of the third implementation included the evaluation of the effect of a sexuality psycho-education programme on the knowledge, attitudes and perceived behavioural skills of the target population. In this section the researcher will relate and discuss the methods used to measure the above-mentioned variables, as well as briefly analyse the results of the research.

For each of the variables, knowledge, attitudes and perceived behavioural skills, the researcher will discuss:

- the parametric statistical methods used to evaluate the results of the experimental and control research populations;
- parametric t-tests used to evaluate the scores of different categories of items that were identified within each measuring instrument for the experimental research population;
- thematic analysis of qualitative feedback received from group leaders in the form of a post-intervention written report.

Finally the researcher will briefly discuss non-parametric statistical methods that were used to evaluate the effect of different group leaders on each of the smaller subgroups of the experimental and control research population. Qualitative feedback about the impact of peer group leaders will also be presented.

9.6.1 Impact on Knowledge

9.6.1.1 T-tests

The pre-test scores for the knowledge test for the experimental and control groups were compared with their post-test scores by using parametrical t-tests. A significant difference between the pre- and post-test scores of the experimental group, with the bigger value being measured post-intervention, would indicate meaningful change as a result of the intervention. The ideal model would also have the control group display no significant change between pre- and post-testing, thus making it possible for the researcher to attribute any changes in the scores of the experimental group solely to the effect of the intervention.

Table 3 contains descriptive data for the Knowledge test of the experimental and control groups, before and after intervention.

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Table 3

Descriptive Data of the Knowledge Test for the Experimental and Control Groups

		N	M	SD	Minimum	Maximum
Knowledge Pre-testTotal Score	Experimental Group	32	25.56	4.28	19	34
	Control Group	32	23.19	4.93	10	31
	Total	64	24.38	4.74	10	34
Knowledge Post-test Total Score	Experimental Group	32	31.16	3.19	23	37
	Control Group	32	24.97	5.63	10	35
	Total	64	28.06	5.51	10	37

In Table 3 there is a noticeable difference between the mean of the pre-test scores (M=25,56) and the mean of the post-test scores for the experimental group (M=31,16). T-tests were used to compare these scores before and after intervention.

The results of paired sample tests on the pre- and post-test scores of the Knowledge Test for the experimental group appear in Table 4.

Table 4

Paired Samples Results for Knowledge Test Scores of the Experimental Group

		Mean difference score	t	df	P p
Pair 1	Knowledge Pre-test Total Score - Knowledge Post-test Total Score	-5.59	-6.788	31	.000

Table 4 indicates a meaningful difference (p=<0.01) between the pre- and post-test scores. There was a significant increase in scores for knowledge after intervention for the experimental group. The findings of the present study regarding knowledge change supports the majority of research in this area. Most research almost unanimously conclude that instruction in sex education does increase sexuality knowledge (Parcel & Luttman, 1981; Kirby, 1989; Kelly & St. Lawrence, 1990; Barth et al., 1992; Tyden et al., 1994; Visser, 1996).

T-tests were also performed on the pre- and post-test scores of the control group. The results of these T-tests are reviewed in Table 5.

Table 5

Paired Samples results for Knowledge Test scores of the control group

		Mean difference score	t	df	PP
Pair 1	Knowledge Pre-test Total Score - Knowledge Post-test Total Score	-1.78	-3.221	31	.003

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Table 5 indicates that the Knowledge Test scores of the control group also differ meaningfully (p=0.003) from before to after intervention. Although both the group that underwent the intervention as well as the control group seem to have displayed an increase in test scores in the right direction, it is important to note that the difference between the mean scores of the control group is very small (Pre-test: M = 23,19; Post-test: M = 24,97), whereas the difference between the mean scores of the experimental group is noticeably larger. Some studies explain that control group changes are related to the effect of being in a university environment, the generalized effects of any learning and/or the simple fact of maturation. Another possible explanation could be that control group members who completed the questionnaire on both occasions were more open to learning about the issues of sexuality (Patton & Mannison, 1993). In the present study the small positive increase in scores for the control group could be attributed to a level of contamination which was possible as the participants of the experimental as well as control groups were volunteers from the same student population, many being from the same geographical and/or departmental environment and some even being from the same circle of friends.

9.6.1.2 Category Analysis

The categories identified within the Knowledge Test are provided in Table 6:

Table 6

Categorization of Knowledge Test items

Test Item(s)	Categorization
1, 2, 7, 9, 12, 14, 20, 23, 28, 30, 33, 35, 39	Human sexual/reproductive organs and functioning thereof in terms of reproduction and the human sexual response cycle. (1, 2, 12, 20, 28, 33, 39 could also be categorized as items that test participants' knowledge concerning general so-called 'sexual myths'.)
6, 10, 13, 31, 34, 37	Transmission, symptoms and prevention of sexually transmitted diseases
5, 11, 19, 25, 26, 32	Transmission, symptoms, consequences and prevention of HIV/AIDS
3, 4, 8, 15, 16, 17, 18, 21, 22, 24, 27, 29, 36 , 40	The function and correct use of different contraceptives. 18, 29 and 36 questioned knowledge of the way in which contraceptives can be obtained.
38	Item 38 tested whether or not the issue of having the right to take responsibility for their own sexuality had struck home.

The categorization of test items as presented above enabled the researcher to evaluate and compare changes in knowledge within the boundaries of relevant sexuality-related categories such as HIV, STD's and Contraception.

The difference in pre- and post-test scores for the experimental group for each of the above categories was compared with t-tests. Descriptive statistics for each category for the experimental group can be seen in Table 7.

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Table 7

Descriptive Data per Category of the Knowledge Test for the Experimental Group

	N	M	SD	Std. Error Mean
KSXPHYPR	32	8.16	1.48	.26
KSXPHYPO	32	9.12	1.39	.24
KCONTRPR	32	10.22	2.25	.40
KCONTRPO	32	12.28	1.90	.34
KSTDPR	32	5.41	1.52	.27
KSTDPO	32	7.81	1.71	.30
KASSERPR	32	.84	.37	6.521E-02
KASSERPO	32	.97	.18	3.125E-02

Note:

KSXPHYPR: Knowledge regarding sexual physiology - Pre-test Scores

KSXPHYPO: Knowledge regarding sexual physiology - Post-test Scores

KCONTRPR: Knowledge of contraceptives - Pre-test Scores

KCONTRPO: Knowledge of contraceptives - Post-test Scores

KSTDPR: Knowledge about STD's - Pre-test Scores

KSTDPO: Knowledge about STD's - Post-test Scores

KASSERPR: Knowledge regarding principles of assertive behaviour - Pre-test Scores

KASSERPO: Knowledge regarding principles of assertive behaviour - Post-test Scores

Table 8 contains the results of the t-tests performed with the scores for each category.

Table 8

Paired Samples Results per Category for the Knowledge Test Scores of the Experimental Group

		Mean difference score	t	df	PP
Pair 1	KSXPHYPR - KSXPHYPO	-.9688	-3.007	31	.005
Pair 2	KCONTRPR - KCONTRPO	-2.0625	-5.044	31	.000
Pair 3	KSTDPR - KSTDPO	-2.4063	-6.073	31	.000
Pair 4	KASSERPR - KASSERPO	-.1250	-1.679	31	.103

Note:

KSXPHYPR – KSXPHYPO: Knowledge regarding sexual physiology - Pre-test versus Post-test Scores

KCONTRPR – KCONTRPO: Knowledge of contraceptives - Pre-test versus Post-test Scores

KSTDPR – KSTDPO: Knowledge about STD's - Pre-test versus Post-test Scores

KASSERPR – KASSERPO: Knowledge regarding principles of assertive behaviour - Pre-test versus Post-test Scores

The programme was successful in increasing participants' knowledge regarding Sexual Physiology (p=<0.01, p=0.005), Contraception (p=<0.01, p=0.000), and Sexually transmitted diseases and HIV/Aids (p=<0.01, p=0.000). The category addressing knowledge regarding Sexual Assertiveness and Communication (KASSERPR – KASSERPO) however, seems to be one area of sexual knowledge that was not effectively addressed (p=>0.05, p=0.103). This category was made up by one test item only – participants had to decide whether the statement: "It is a human assertive right to be allowed to express your sexuality", was true or false. This question, although not really one which can be scientifically proven as "true" or "false" was placed in the test by the researcher to get an idea of whether participants would get the message during the course of intervention, that they had

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a right to be assertive about their sexual needs and preferences. The question was however more related to behaviour and attitude than knowledge, and thus fairly abstract, which could have caused confusion on the part of the participants, and account for the negative results.

9.6.1.3 Qualitative feedback

Through content analysis of feedback reports formulated by the group leaders the researcher was able to identify the following themes relating to knowledge:

Learning more about the opposite sex

In all the intervention groups it was clear that there was a need to get to know and understand more of the opposite sex, as can be seen from some of the report entries provided below.

> "...and eager to learn more about the opposite sex"

> "What was very prominent was how different the men and women thought about sexuality and many misconceptions about the opposite sex was cleared up"

> "The group members talked about the different emotional and physical needs of the different sexes and many new insights were brought about."

> "It seems thus that the group became aware of definite differences between men and women"

> "During this session the group members realized that they could use the presence of members of the opposite sex to ask questions..."

> "According to the group leader it was educational for everybody as the male and female group members talked about what is important in romantic relationships."

> "Male and female group members became aware of each others' opinions..."

> "Both sexes asked questions of one another and exchanged ideas"

The first implementation already indicated that single gender groups did not function as effectively as mixed gender groups. The above report content confirms the feasibility of having a mixed gender group dynamic.

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As soon as the different gender groups realized the potential of the situation they were in – namely having a group of the opposite sex available as a source of information about issues they are not usually able to address openly – there was no end to the discussions and debates revolving around relationships and opposite gender preferences, needs and sexual functioning. One gets the impression that the participants were grateful for the opportunity that they were given to talk openly about sex and sexuality within a relaxed non-threatening environment. The need of university age students for more information about the opposite sex is also apparent in findings of a study on gender-specific sexuality issues conducted by Dunn et al. in 1992. In their study students identified that second to information about AIDS, their educational needs were to learn more about relationships, gender differences and related issues which would prepare them for marriage. From the qualitative data of the current study one can see that group leaders are of the opinion that the group sessions were very valuable in establishing in group members a stronger base of knowledge about and insight into the differences and similarities of the opposite sex. This is very important as a better understanding of potential sexual partners not only gives one the confidence to act more assertively in sexual situations, but also provides a knowledge base from which to select the most effective behaviour to elicit the desired or appropriate response from your partner. Galligan and Terry (1993) postulated that enabling young people to communicate more effectively about their intimate sexual concerns goes beyond simple skills training. It requires that young people are given the chance to reflect on and become more aware of the multiple meanings evoked within sexual relationships and encounters. Only then can they make informed decisions about healthy sexual behaviours.

Knowledge concerning Sexually Transmitted Diseases (STDs) and HIV/AIDS

Content analysis suggests that students possessed insufficient knowledge about STDs and HIV/AIDS. This deficit in knowledge seems to have been successfully addressed with the current intervention. The following are some of the entries from all four reports regarding knowledge about STDs and HIV/AIDS :

> "The group members only had knowledge of the following diseases: syphilis, herpes and pubic lice"

> "The group members were very surprised at the extent of the diseases"

> "The group members were very uncomfortable at the beginning, especially after they also saw the photographs. It was effective as it helped the group members realize the seriousness thereof"

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"They were especially interested in the working of the AIDS virus...and even though they were squeamish for the medical photographs, it emphasized the reality of this feared disease."

"Based on this the group members decided that knowledge is power and that a person can be more in control of him/herself if he/she is equipped with knowledge about the dangers of AIDS."

"Group members also did not realize that condoms deter the transmission of AIDS."

"...the group members listened to the information, shocked. Furthermore the whole group was disillusioned by the visual material provided to them in the form of medical photographs."

"...it created a definite realization with the students of the possible consequences of irresponsible and thoughtless sexual behaviour."

"Although they were aware of the symptoms, workings and treatment of AIDS, they were relatively uninformed about other sexually transmitted diseases."

"They definitely became more aware of STDs and were shocked at the general occurrence and danger thereof"

"The group could name quite a few diseases,..., but had no detailed knowledge of any of them."

The session definitely succeeded in providing factual knowledge to the group members. They undeniably now had more information regarding transmitted diseases than before the session."

"It provided the information well and at the same time kept the groups' attention. The group knew very little of the information already."

The students admitted that although many of them were aware of the better known STDs like Herpes and Syphilis, most of them had no idea of the symptoms, consequences and prevention of these diseases. Graphic demonstrations have been found to be very useful in facilitating greater understanding of sexual practices and consequences (Shayne & Kaplan in Olsen et al., 1991). Some studies also report that evoking strong emotions through visual images of AIDS deterioration, may be related to behavioural risk reduction (McKusick, Horstman & Coates in

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Griffore & Kallen, 1990). The students in this programme were shocked by the visual material that was presented to demonstrate the possible effects of infection with a STD or HIV. Shocked not so much because of the nature of the visual material, but the content that clearly depicted the possible serious or fatal consequences which infection could have. They did express the sentiment that so much attention was being given these days to AIDS that educators were neglecting to assure that young people receive enough information about other sexual diseases. Visser (1996) found that young people seemed to be relatively well-informed about AIDS and HIV before intervention, but many were not even aware of the existence of other STDs. In a study by Tyden et al. (1994) students also indicated that they thought it would be more beneficial to handle the risks of more common STDS than to focus entirely on AIDS.

The researcher found it surprising that one group was not even aware that condoms could prevent the transmission of STDs and HIV. Although the researcher expected deficits in knowledge she assumed that at least such a basic principle would be widely known. This just proves again that sexuality education for young people is a necessity as one can not rely on parents and/or school education to provide all the necessary knowledge.

All the group leaders expressed the opinion that the sessions on STDs and HIV/AIDS were very successful in increasing participants' knowledge about sexual disease. Group members felt a new sense of self-confidence and shared the sentiment that armed with the right knowledge they could be more in control of their sexual behaviour. The increase in knowledge about the possible effects of unsafe sexual conduct, and the realization of the seriousness of such behaviour, seem to have strengthened their sense of responsibility for their own actions and motivated them towards risk-reductive sexual behaviour.

Knowledge regarding contraceptives

It seems that in the world of the young adult, contraception is equated to the contraceptive pill and the condom. Most students knew about these two methods of contraception, but did not know how to use these methods correctly, and were not aware that there were other contraceptive methods to choose from. The following entries from the group members' reports provide an idea of the ignorance surrounding contraceptives and their use:

> "There were, however, many deficiencies in the group members' knowledge, as many of the methods were completely unknown to them."

> "It was clear that nobody was knowledgeable about how to use a condom and for the female members the slippery condom was very gross"

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"...all the group members agreed that the session was very educational and that they now realized the importance of contraception,...and that they would also relay what they had learnt to their friends."

"At the end of the session the group member's admitted that contraceptives were now more of a reality and that they realized that there were more choices to select from than just the condom"

Although the group members were embarrassed about handling the condoms, they agreed that it was a necessity to know how to use it. They experienced the exercise as very educational..."

"The male members mentioned that their friends were very uninformed about the existence and use of many of the contraceptives"

"One can also say that all the information was meaningful and educational. It is clear that students do not possess a thorough knowledge of contraceptive methods and substances.

Contraceptives seemed to be unfamiliar to these young people. No one has ever taken them into a shop or clinic to show them and explain to them what is available and how you use it. One group expressed the sentiment that after the session contraceptives now seemed more "real" to them, as if before it had somehow been something that grown-ups use, something not applicable to them as young people. It is surpising that many of these young people are in serious relationships and/or sexually active and are still not aware of their choices or how to use contraceptives effectively. They knew nothing of spermicides for instance. Very few of them, male and female, knew how to use a condom, and thus found the practical exercise on the use of condoms very amusing, but also very beneficial. The group members' ignorance regarding contraception could be attributed to two possible reasons. In the first instance there is the possibility of a lack of effective education. A review of literature (see 2.4) suggested that the sexuality education provided to adolescents in schools and at home are still very inadequate. It should not be surprising then that young people of university age are often not sufficiently equipped with the necessary knowledge regarding these matters. Secondly, their lack of knowledge could be attributed to the fact that many of the participants in the current research were still relatively sexually inexperienced and/or not sexually active (see 9.3.2). As a result many of them had probably not been confronted with situations in which they had to think about contraceptives. Students often enter first sexual encounters without the necessary knowledge and skills relevant to the use of contraceptives. It is therefore important for young people to internalize knowledge about such important issues as contraception before

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they are faced with situations in which they have to make health-risk preventive decisions. Morrison et al. (1995) found that both men and women's' intentions to use condoms increase as their self-efficacy increases. With limited knowledge about contraception, it would be impossible for young people to make effective decisions about the issue in heat of the moment situations. They need to be empowered to feel in control, so that they have the self-confidence to express informed opinions to their sexual partners and in so doing ensure safe sexual behaviour. Morrison et al. also pointed out that condom use specifically, requires partner cooperation and is largely under the control of the man. Women traditionally have less power in condom use negotiations and are more likely to give in to stronger partners' wishes. It seems necessary thus to ensure that both men and women are equipped with sufficient knowledge and skills as well as positively empowering attitudes (see 9.6.2) in order for effective negotiation about condom use to take place.

From the above excerpts from the reports it is clear that the group members found the session on contraceptives very informative and useful. The intervention seems to have increased not only their knowledge, but also their insight into the importance of knowing about these issues in order to be prepared to make their own decisions about using contraceptives. They felt empowered by their newfound insight.

It is interesting to note that as group members became aware of their lack of insight and knowledge, they realized and expressed the fact that their friends knew as little about contraception as they do, and it was worrying to them. Some of the group members resolved to share the information from this session with their peers. Young people discuss most of their sexual issues with their peers, and the problems in this respect is that many young people pass on incorrect information to their peers. This session seem to have at least empowered some of these young people to act as effective peer group educators within the informal group of their peers.

In general group members found the whole intervention very effective in broadening their base of knowledge about sex and sexuality. This can be seen in most group members' eager requests to have printed notes on all the issues discussed.

9.6.2 Impact on Attitudes

9.6.2.1 T-tests

The mean scores of the Attitudes Test were used in t-tests to determine whether the sexuality psycho-education programme had the desired effect on the sexual attitudes of the participants. An increase in mean score from pre-to post-test would indicate a change in the positive direction.

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Table 9 contains descriptive data for the Attitudes Tests of the experimental and control groups, before and after intervention.

Table 9

Descriptive Data for the Attitudes Test of the Experimental and Control Groups

		N	M	SD	Minimum	Maximum
Attitudes Pre-test Total Average	Experimental Group	32	3.61	.28	2.97	4.19
	Control Group	32	3.57	.21	3.14	3.97
	Total	64	3.59	.25	2.97	4.19
Attitude Post-test Total Average	Experimental Group	32	3.66	.31	2.92	4.17
	Control Group	32	3.57	.27	3.03	3.97
	Total	64	3.61	.29	2.92	4.17

Table 10 contains the results of t-tests on the mean scores of the Attitudes Test for the experimental group.

Table 10

Paired Samples Results for Attitudes Test Scores of the Experimental Group

		Mean difference score	t	df	PP
Pair 1	Attitudes Pre-test Total Average - Attitudes Post-test Total Average	-5.0312E-02	-1.253	31	.219

Although there is an increase in mean scores from before to after intervention for the Attitudes Test (pre-test= 3,6069 to post-test= 3,6572) the 2-tailed significance scores indicate that none of the test results prove a significant difference between the pre- and post-test scores for the Attitudes Tests for the experimental group (p=>0.05; p=0.219). The majority of research in the area of sexuality education seems to suggest that one of the outcomes of sexuality education is a significant change in attitudes (Patton & Mannison, 1993; Abrahamson et al., 1989; Hernandez & Smith, 1990). There are some studies however that seem to suggest that changing attitudes with educational intervention is not that successful (Tyden et al. 1994). Researchers have identified a variety of issues that might be the cause of such inconsistent findings. Some of these issues which might have had an influence on the results of the current research include the possible bias due to the influence of participant characteristics, the legitimacy of measuring attitudes over a short time span, and the appropriateness of available measuring instruments (Patton & Mannison, 1993; Patton & Mannison, 1994).

Some studies suggest a difference between attitudes toward behaviour in others and attitudes toward the same behaviour in self. A measuring instrument that contained only items formulated to address the behaviour of self (i.e. "I would not choose a gay person as a friend") may therefore be neglecting to ask about areas where change may have occurred (i.e. "I would not mind if a friend of

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mine chose a gay person as a friend"). Illustrated with just one item this issue might seem trivial. The effect on a whole questionnaire overlooking such a distinction could however be considerable (Patton & Mannison, 1993; Patton & Mannison, 1994). The Sexual Attitudes Test used in the present study contained mostly statements about the participants' personal behaviour, which might have contributed to the insignificant quantitative results.

Table 11 contains frequency analysis of the test scores for the Attitude Test before and after intervention.

Table 11

Frequency analysis: Distribution of Scores for the Attitude Pre- and Post-tests of the Experimental group

	Score Categories				
	1	2	3	4	5
Attitudes pre-test score distribution	77	188	159	372	321
Attitudes post-test score distribution	66	205	132	369	348

Frequency analysis indicates that the scores for the attitudes test were very high with pre-testing already, with 80% (see Table 9) of possible answers being 4 or 5 score answers (4 & 5 score being ideal answers). The post-test scores shows a slight decrease in less desired answers and an increase in most desired answers (with 83% of all possible answers being 4 & 5 score answers), but no clear pattern of change is visible. The high positive scores recorded with pre-testing make the measurement of any significant change post-intervention very difficult.

It appears, from the above numbers, that the group of participants who volunteered for this intervention seems to have been for the most part equipped with the desired attitudes and beliefs before intervention. The researcher would like to propose two possible reasons for this phenomenon. Firstly, it could be that the type of young people who choose to enroll in such a programme are students who not necessarily have the correct knowledge about or the desired behavioural skills for healthy sexual behaviour, but had been exposed to an environment (i.e. in the home, in their social group) where healthy attitudes toward the issues regarding sex and sexuality were promoted. The second reason could be related to the fact university students seem to be for the most part responsible and well-behaved young people. This can be attributed to the fact that the educational environment in which they find themselves advocates healthy and socially acceptable behaviour. These students therefore know what attitudes and beliefs are expected of them. High scores with pre-testing could thus possibly be the result of participants who not necessarily shared their own attitudes and beliefs, but provided what they thought to be socially acceptable answers.

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One pattern of change in test scores from pre- to post-testing which might be important to mention is the distribution of *neither inappropriate nor appropriate* or the so-called "don't know" answers (scored 3). These answers decreased by 16% post-intervention. An aim of the sexuality education programme was to bring about clarification of sexual attitudes and values. In effect a move away from "not knowing" indicates a change in the positive direction towards clarification of attitudes. An indication of initial attitude clarification hopefully reflects the participants' attempts to internalize new information and influences that they were exposed to during intervention. Even a move in the wrong direction shows that the participants have at least started to think about what they believe in, and have tried to take responsibility for their own feelings and decisions concerning, in the current research milieu, their sexuality. Getting young people to take the time and effort to at least realize that these issues need to be discussed and thought through, is already a very small, but promising change. Moy (1987) successfully used the technique of value and attitude clarification to facilitate a greater sense of sexual empowerment and awareness in university students. In keeping with the theoretical principles of the IBM model, clarification of attitudes, values and beliefs is a very significant step towards healthy behavioural intentions and effective decision-making

T-tests were also performed on the pre- and post-test scores for the Attitudes Test of the control group. The results of these t-tests are reviewed in Table 12.

Table 12

Paired Samples Results for Attitudes Test Scores of the Control Group

		Mean difference score	t	df	P
Pair 1	Attitudes Pre-test Total Average - Attitude Post-test Total Average	4.062E-03	.101	31	.920

No significant changes in the scores of the Control group were recorded from pre- to post testing (p=0.920).

Table 13 contains frequency analysis of the Control group's pre-test scores for the Sexual Attitudes Test.

Table 13

Frequency analysis: Distribution of Scores for the Attitude Pre- and Post-tests of the Control group

	Score Categories				
	1	2	3	4	5
Attitudes pre-test score distribution	93	184	163	316	360

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The frequency analysis shows that, as with the Experimental Group, the Control Group scores for this test were already very high with pre-testing. In other studies, pre-tests revealed existing differences in attitudes between experimental and control groups, with students electing to enroll in human sexuality courses being more permissive, accepting and/or egalitarian in their attitudes (Allgeier & Allgeier, 1984, Yarber & Anno, 1981 in Patton and Mannison, 1993). In the current research one should keep in mind however that the members of the Control group were students who also volunteered for participation in the research study like those in the Experimental group. The Control group members were placed in the Control group through random selection. They had the option of participating in the group sessions at a later stage. Their pre-test scores seem to bring forth once again the question whether people who volunteer for such a programme are possibly people who feel empowered to do so because of the type of beliefs and attitudes they already have towards sexuality?

One must however also remember that Control group participants sometimes do not feel as committed to research projects as the members of the Experimental group. Control group members might thus put less effort and time into completing questionnaires and providing accurate feedback. Fast and careless completion of the pre-test questionnaires could therefore also be the cause of inconsistent scoring.

9.6.2.2 Category Analysis

The categorization of test items in The Sexual Attitudes Test, allowed the researcher to gain insight into participants' approach towards certain relevant sexuality related categories such as premarital sex, participants' acceptance of responsibility for their own sexuality, HIV, STDs and contraceptive behaviour. The participants' attitudes towards these issues are important in view of their role in participants' motivation to engage in sexual health-risk preventive behaviour.

The categories identified in the Attitudes Test is provided in Table 14.

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Table 14

Categorization of Attitudes Test items

Test item(s)	Categorization
1, 2, 21, 22, 25, 37	Premarital sex [1]
5, 6, 8, 13, 17, 30, 31	Own sexuality [2]
11, 12, 15, 27, 35	STDs and AIDS [3]
3, 4, 7, 14, 19, 28, 32, 33, 34, 36	Contraception and Preventive behaviour [4]
9, 10, 16, 18, 20, 23, 24, 26, 29	Controversial sexual topics [5]

Notes:

1. These items test to some extent the participants' attitudes towards premarital sex. In these items a 'for' or 'against' vote as such is not required, but the items explore the participants' attitudes more appropriately toward the relationship between love, commitment and sex, and the meaning and place of sex in this stage of their lives as young single university students.
Moral motivation for healthy sexual behaviour, with specific reference to religious and cultural morals, was not an issue pursued in the sexuality psycho-education programme. Although the subject of incorporating personal morals in sexual decision-making was discussed and encouraged, no specific set of religious and/or cultural moral values were promoted. In view of the before-mentioned it would have been impossible to score item 21 effectively: "For me it is morally wrong to have premarital sex", in which the word "morally" was by most participants' automatically related to religion and culture. This item was thus not included in the statistical analyses. The researcher did however decide to keep the item as part of The Sexual Attitudes Test in order to stimulate thought about this issue with the individual.

2. These items explore participants' attitudes toward their own sexuality. Whereas the items previously discussed referred more to attitudes concerning the act of having sex, this group of items attempt to explore the participants' approach to *sexuality* as part of their being. These items question participants' attitudes toward the recognition and acceptance of their sexuality, the taking of responsibility for their sexual health (mentally and physically), and the realization of their right to be sexual. The feeling of self-control that results from healthy attitudes toward the above-mentioned issues is very important for effective decision-making and pro-active assertive behaviour in sexuality-related situations.

3. These items test participants' attitudes toward STDs and AIDS. Most of these items question attitudes that result from misconceptions about the HIV-virus, AIDS and Sexually transmitted diseases. These attitudes are thus closely linked with the knowledge participants' possess about these sexual health issues. Socially promoted myths and norms could also influence the attitudes addressed by these items.

4. Although it seems that these items can be categorized as testing attitudes regarding contraception as such, they in reality question the participants' approach towards contraceptive and preventive *behaviour*. These items explore the extent to which the participants' adhere to socially accepted, but not necessarily health promotive, myths and norms concerning sexual behaviour and sexual assertiveness. The items try to identify whether participants' sense of sexual self-responsibility, and sexual self-control is present to such an extent that sexual intimidation, whether by an individual or society, can be replaced by assertiveness and sexual self-confidence in terms of engaging in sexual health promotive behaviour. (When analysing these items the connection between knowledge, attitudes and skills is again apparent: a lack of or incorrect knowledge concerning contraception, as well as a lack of or inefficient behavioural and assertiveness skills, will lead to a lack of self-confidence concerning contraceptive behaviour. This results in participants who would rather take on the sexual attitudes of others, whether healthy or not, than form their own healthy attitudes. No change in attitudes from pre- to post-testing can thus be expected in a sexuality education programme which does not also incorporate the development of a strong basis of relevant knowledge, and the teaching of relevant behavioural skills.)

5. The issues of abortion, homosexuality, pornography, masturbation, prostitution and formal sex education are addressed. These specific topics were identified during pilot implementations as issues that young people have the need to discuss with the purpose of redefinition and/or reclarification of relevant attitudes.

The difference in pre- and post-test scores for the experimental group for each of the above categories was compared with t-tests. Descriptive statistics for each category for the experimental group can be seen in Table 15.

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Table 15

Descriptive data per category of the Attitudes Test for the experimental group

	N	M	SD	Std. Error Mean
ASOMORPR	32	18.94	3.98	.70
ASOMORPO	32	19.41	4.32	.76
ACONTRPR	31	22.16	3.22	.58
ACONTRPO	32	22.91	3.08	.55
AHIVPR	31	12.26	2.48	.45
AHIVPO	32	12.59	2.50	.44
AOSXATPR	32	21.97	2.25	.40
AOSXATPO	32	22.19	2.49	.44
AASCOMPR	32	20.91	4.15	.73
AASCOMPO	32	21.13	4.40	.78
ACTROVPR	31	25.42	3.79	.68
ACTROVPO	32	25.13	4.16	.74
ASXEDUPR	32	8.22	1.58	.28
ASXEDUPO	32	8.31	1.45	.26

Note:
ASOMORPR: Attitudes towards "socially acceptable" values and premarital sex – Pre-test Scores
ASOMORPO: Attitudes towards "socially acceptable" values and premarital sex – Post-test Scores
ACONTRPR: Attitudes towards the use of contraceptives – Pre-test Scores
ACONTRPO: Attitudes towards the use of contraceptives – Post-test Scores
AHIVPR: Attitudes towards AIDS risk and people who have AIDS – Pre-test Scores
AHIVPO: Attitudes towards AIDS risk and people who have AIDS – Post-test Scores
AOSXATPR: Attitudes towards their own sexuality and the right to expression thereof – Pre-test Scores
AOSXATPO: Attitudes towards their own sexuality and the right to expression thereof – Post-test Scores
AASCOMPR: Attitudes pertaining to sexual assertiveness and communication – Pre-test Scores
AASCOMPO: Attitudes pertaining to sexual assertiveness and communication – Post-test Scores
ACTROVPR: Attitudes towards controversial sexual/sex issues – Pre-test Scores
ACTROVPO: Attitudes towards controversial sexual/sex issues – Post-test Scores
ASXEDUPR: Attitudes towards sex education for university students – Pre-test Scores
ASXEDUPO: Attitudes towards sex education for university students – Post-test Scores

Table 16 contains the results of the t-tests performed with the scores for each category.

Table 16

Paired Samples results per category for the Attitudes Test scores of the experimental group

		Mean difference score	t	df	P
Pair 1	ASOMORPR - ASOMORPO	-.4688	-1.077	31	.290
Pair 2	ACONTRPR - ACONTRPO	-.7742	-2.075	30	.047
Pair 3	AHIVPR - AHIVPO	-.2581	-.436	30	.666
Pair 4	AOSXATPR - AOSXATPO	-.2188	-.705	31	.486
Pair 5	AASCOMPR - AASCOMPO	-.2188	-.300	31	.766
Pair 6	ACTROVPR - ACTROVPO	6.452E-02	.109	30	.914
Pair 7	ASXEDUPR - ASXEDUPO	-9.3750E-02	-.442	31	.662

Note:
ASOMORPR – ASOMORPO: Attitudes towards "socially acceptable" values and premarital sex – *Pre-test versus Post-test Scores*
ACONTRPR – ACONTRPO: Attitudes towards the use of contraceptives - *Pre-test versus Post-test Scores*
AHIVPR – AHIVPO: Attitudes towards AIDS risk and people who have AIDS - *Pre-test versus Post-test Scores*
AOSXATPR – AOSXATPO: Attitudes towards their own sexuality - *Pre-test versus Post-test Scores*
AASCOMPR – AASCOMPO: Attitudes pertaining to sexual assertiveness and communication - *Pre-test versus Post-test Scores*
ACTROVPR – ACTROVPO: Attitudes towards controversial sexual/sex issues - *Pre-test versus Post-test Scores*
ASXEDUPR – ASXEDUPO: Attitudes towards sex education for university students - *Pre-test versus Post-test Scores*

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T-tests performed on the Attitudes Test scores of the entire test population indicated no significant change in attitudes from pre- to post-testing. Analysis of the different categories identified within the Attitudes Test however showed a significant change in the desired direction from before to after intervention for attitudes regarding the use of Contraception (ACONTRPR - ACONTRPO)($p=<0.05$; $p=0.047$).

9.6.2.3 Qualitative feedback

Attitudes regarding AIDS

The following entries from group leaders' reports show that the intervention had a positive influence on group members' attitudes towards AIDS:

> "After the session group members were more sympathetic and had more empathy for victims"

> "Except for the knowledge taught, the situations regarding AIDS and AIDS-victims were eye-openers"

> "The group members would now be more likely to weigh up the advantages and possible consequences of a sexual relationship before getting involved."

> "Group members mentioned that they all wanted their sexual partners to be tested for AIDS before having sexual relations."

As group members' knowledge about the disease increased, their insights evolved and their attitudes towards AIDS patients became more sympathetic and understanding. With this however came the realisation that although they had empathy for them, they did not want to become AIDS victims themselves. A greater sense of responsibility for their own health was instilled, and group members resolved to be pro-active regarding the prevention of AIDS.

Attitudes regarding contraceptives

Qualitative thematic analysis indicated that group members felt empowered by the knowledge they had gained about contraceptives. This concurs with the results of the quantitative category analysis as presented in Table 13. They seemed to allow themselves to think more realistically and openly about the role of contraception in sexual behaviour:

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"Group members realized that each individual was responsible for his/her own prevention of disease."

"The group leader enquired about the members' opinions regarding condoms and everybody agreed that it did not have to interfere with the sexual act if both parties discuss it beforehand and realize the importance thereof."

"Male and female group members decided that the act of putting on a condom could be a very erotic experience..."

"However, group members also decided that prevention is much more important than cure..."

The report entries regarding attitudes toward contraception, as provided above, indicate that group members realized the advantages of the use of contraceptives and accepted more responsibility for their own use of it. Group members tried to see the use of a condom in a positive light and discussed ways of incorporating the use of contraceptives as part of the erotic sexual act. This is a constructive mind shift as many young people state that using a condom breaks the intimate mood, or prevents maximum sexual stimulation. Morrison et al. (1995) found that especially within casual sexual relationships, immediate consequences are most highly related to overall attitudes toward condom use. Therefore it is very important to focus on changing the negative beliefs about these immediate consequences (i.e. interrupting sex, reducing pleasure, etc.). If young people go into sexual situations with a positive and realistic attitude towards the use of condoms they will be self-confident enough not to let such excuses prevent them from engaging in healthy sexual behaviour. The group members also realized the significance of taking responsibility to communicate about contraception with their sexual partners. Learning to talk about contraception comfortably with a partner might increase participants' sense of self-efficacy and ultimately lead to an increase in sexual safety behaviours (Morisson et al. (1995).

Attitudes toward casual sex

A very interesting theme that was visible in the feedback reports can be identified in the following two entries:

"Group members emphasized that the programme did not cause their values and attitudes towards sex to change in such a way that they would more easily engage in sexual intercourse after attending the program."

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"Group members said that they now feel more in control of their own sexuality and had stronger values as a result of knowledge about the consequences of unsafe sex."

Many people are afraid of sexual education interventions as they believe that informing young people about sex will lead them to become too curious and eventually engaging in sexual activities at a younger age. Coetzee and Kok (2001) found in a recent study that one of the greatest barriers to effective participation of teachers and parents in South African school sex education projects is their belief that talking about sex will promote earlier sexual activity and increase teenage pregnancy. The above two entries indicate that group members disagree with this opinion, and actually feel that they would be less likely to engage in casual sex after hearing all the relevant facts about possible consequences of their actions. Baldwin et al. (1990) also found that sexuality education does not increase risky sexual behaviour as some critics of such courses would argue.

In general the intervention was most successful, perhaps not in changing attitudes but helping young people for the first time to formulate and clarify their attitudes and values towards sex and sexuality:

"The value of this session lay therein that the group members were given the opportunity to air their opinions and then validate them to make sure how they feel about certain aspects of their sexuality."

9.6.3 Impact on Perceived Sexual Behavioural Skills

9.6.3.1 T-tests

The scores for the Perceived Sexual Behavioural Skills Test were used in t-tests to determine whether a positive development of skills had taken place from pre- to post testing. In evaluating the results of the Perceived Sexual Behavioural Skills Test the total score for the Perceived Sexual Behavioural Skills Test (Part A + B), as well as the separate scores for each of Part A and Part B (Part A: How easy they think the behaviour is to perform; Part B: How effectively they think they would be able to perform the behaviour), were analyzed. An increase in average score would indicate that the intervention had developed the sexual skills of the participants in the right direction.

Table 17 contains descriptive data for Skills Test of the experimental and control groups, before and after intervention.

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Table 17

Descriptive data for the Perceived Sexual Behavioural Skills Test of the experimental and control groups

		N	M	SD.	Minimum	Maximum
Total Average Skills Pre-test Part A	Experimental Group	32	2.98	.38	2.22	3.74
	Control Group	32	2.74	.47	1.67	3.61
	Total	64	2.86	.44	1.67	3.74
Total Average Skills Post-test Part A	Experimental Group	32	2.91	.45	2.17	3.83
	Control Group	32	2.83	.53	1.65	3.78
	Total	64	2.87	.49	1.65	3.83
Total Average of Skills Pre-test Part B	Experimental Group	32	3.96	.50	3.22	4.74
	Control Group	32	3.72	.63	1.95	4.55
	Total	64	3.84	.57	1.95	4.74
Total Average Skills Post-test Part B	Experimental Group	32	3.98	.52	3.00	4.91
	Control Group	32	3.84	.66	2.14	4.74
	Total	64	3.91	.60	2.14	4.91
Total Average Skills Pre-test Part A+B	Experimental Group	32	3.47	.41	2.80	4.17
	Control Group	32	3.23	.52	1.81	4.02
	Total	64	3.35	.48	1.81	4.17
Total Average Skills Post-test Part A+B	Experimental Group	32	3.45	.45	2.59	4.24
	Control Group	32	3.33	.58	1.89	4.26
	Total	64	3.40	.51	1.89	4.26

Table 18 contains the results of t-tests on the mean scores of the Perceived Sexual Behavioural Skills Test for the experimental group.

Table 18

Paired Samples results for Perceived Sexual Behavioural Skills Test scores of the experimental group

		Mean difference score	T	df	P
Pair 1	Total Average Skills Pre-test Part A - Total Average Skills Post-test Part A	7.656E-02	1.215	31	.234
Pair 2	Total Average Skills Pre-test Part B - Total Average Skills Post-test Part B	-1.6250E-02	-.210	31	.835
Pair 3	Total Average Skills Pre-test Part A+B - Total Average Skills Post-test Part A+B	2.594E-02	.407	31	.687

The 2-tailed significance indicate that none of the test results prove a significant difference between the pre- and post-test scores for Perceived Sexual Behavioural Skills Test of the experimental group. This result correlates with the general impression of various researchers who have investigated the impact of sexuality education programmes and have found that although educational efforts seem to have a significant change on knowledge and attitudes, many of them do not produce demonstrable changes in behaviour (Kirby, 1980; Abrahamson et al., 1989; Fisher & Fisher, 1992).

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One primary aim of the Perceived Sexual Behavioural Skills Test was to determine the extent to which an individual feels comfortable with, and perceive him/herself to be able to execute, sexual health-risk preventive behavioural skills effectively. The researcher supported the premise that an indication of high comfort with a specific sexual situation and accompanying behaviour, thus an increase in "Very easy to do" answers in part A of the Perceived Sexual Behavioural Skills Test, would indicate a positive impact of the intervention on sexual skills and consequent behaviour. The results of the test show no statistically significant change in the preferred direction from pre- to post testing.

An interesting phenomenon however, which becomes clear with closer inspection of frequency analysis, is that not only did the selection of "very easy to do" answers not increase after intervention, but a totally new pattern of answering is visible within the post-test results.

Table 19 contains frequency analysis of the test scores for the Perceived Sexual Behavioural Skills Test Part A before and after intervention.

Table 19

Frequency analysis: Distribution of scores for the Perceived Sexual Behavioural Skills Test Pre- and Post-tests Part A

	Score Categories			
	Very Difficult to do	Relatively Difficult to do	Relatively Easy to do	Very Easy to do
Skills pre-test Part A score distribution	53	159	254	263
Skills post-test Part A score distribution	66	165	272	229

The data in Table 19 indicates a decrease in the number of "very easy to do" and an increase in the number of "relatively easy to do", "relatively difficult to do" and "very difficult to do" answers from pre- to post-test. The researcher believes that, although the results indicated statistically that the desired impact on sexual skills and behaviour might not have been brought about, the above-mentioned pattern of change in test answers does indicate a possible positive impact of the programme on the attitudes that participants have regarding sexual behaviour. During the intervention the researcher found that participants were extremely naïve regarding how easy/difficult assertive communication about sex and sexuality in related situations were. Participants, before intervention, perceived these actions as being easy to perform and thus answered their pre-tests as if they already possessed the necessary skills. Young people tend to be "daring" and "over-confident" when approaching sexual situations for the first time. Growing up in an age and society where they are surrounded by sexual stimuli and facts in the media and from their peers, they tend to believe that they are prepared for sexual interaction. These young people

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frequently go into sexually high-risk situations unprepared because they enter into these situations with an unrealistic sense of empowerment and confidence. During personal conversations after intervention the participants in this research study indicated that they were under exactly such a misconception about behaving appropriately in high-pressure sexually-related situations, and accordingly tended to answer "very easy to do" to most Sexual Skills related questions during pre-testing. The characteristics of the participants might also have contributed to the unexpected pattern in results of the Perceived Sexual Behavioural Skills Test. Although there is no demographical data that noted participants' level of sexual experience and activity, information in group leaders' feedback reports brought the researcher to the conclusion that most of the participants were still quite inexperienced and conservative when it came to sex (see 9.3.2). The role-play scenarios and other exercises in this programme might have been for some of them their first exposure to such difficult and sensitive situations. Before intervention they were thus unaware of the problems and barriers one faces in health-risk situations, and imagined that they would be able to assert themselves easily if faced with such issues. During intervention they realized however how difficult and uncontrollable these situations can be, and they modified their ideas regarding the difficulty of such experiences. The researcher believes that after intervention they tended to regard these situations with more caution and this resulted in them choosing more realistic answers in the Sexual Skills Post-test. This corresponds with findings of a study conducted with college students in 1992 by McDonnel et al. They undertook a descriptive study to determine amongst other things the impact of AIDS on students' sexual practices. Results from this study indicated that college-age young people had a tendency to underestimate their risk of contracting AIDS. This perception is consistent with their developmental level – a stage in which they feel relatively invincible. McDonnel et al. (1992) suggested that programs should be developed to educate these students to estimate more accurately their risk and to develop safe sexual behaviours. There is tangential evidence that helping people deal pragmatically and cautiously with risky activities might establish generalized habits of cautiousness that could reduce health-risk behaviour (Bayer; Nisbett, Fong, Lehman & Cheng in Baldwin, 1990). Thompson, Anderson, Freedman and Swan (1996) found that instead of focusing on the behaviour that could put them at risk, college students tend to focus rather on their few risk-reduction behaviours and attributes, thereby allowing themselves to feel relatively safe. They found that within a protective campus environment students form a false sense of security that is associated with their decision not to take preventive actions such as using condoms. Thompson et al. warned that if education material was not delivered carefully students may focus selectively on and weigh more heavily the risk factors that do not pertain to them, as opposed the risk factors that do.

The researcher also believes, based on informal discussions with participants, that many "very easy to do" answers were given to questions in the Perceived Sexual Behavioural Skills Test before intervention because participants felt that peer group norms expected them to appear well-

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skilled and comfortable in these situations. The judgments, perceptions and actions of significant others play crucial roles in health decisions of young people (Sloane & Zimmer, 1993). Many people have thus questioned the reliability and validity of self-reports of sexual behaviour. Conscious distortions of self-reports of such intimate behaviour can be motivated by a number of factors including embarrassment and fear of reprisals (Gerrard, Gibbons & Bushman, 1996). If young people can be convinced that their risk-reduction behaviours are consistent with referent-group norms, they may become more likely to accept and engage in such behaviours (Diclemente, 1991). A more reliable knowledge base together with role-play and intimate interaction with their peers in a sexually loaded environment seemed to have provided the participants with a more realistic and practical view of assertiveness and communication, and insight into the complexity of effective behaviour, in high-risk situations. Open and intimate communication also enlightened them to the fact that many of their peers still feel unprepared and uncomfortable with these issues and that a pretense of experience/skills was not necessary. This resulted in them doing serious evaluation of their skills and comfort level in specific high-risk situations at the post-intervention stage, and answering more towards "relatively easy to do" and "relatively difficult to do", whereas before intervention misconceived confidence levels prompted them to answer quickly "very easy to do" for most behaviours on which they were questioned on.

The change in attitude towards a more cautious approach in high-risk situations is, within the framework of the IBM model and the Theory of Reasoned Action, a move in the positive direction as it provides motivation and a healthy perception of behavioural control needed to enhance healthy sexually related behaviour.

A second goal of the Perceived Sexual Behavioural Skills Test was to evaluate how effective participants' thought their behaviour would be in specific sexually related situations. A change towards more "Very effectively" answers in part B of the Perceived Sexual Behavioural Skills Test would have indicated a positive impact of the intervention on the development of healthy sexual behaviours. Although the data in Table 17 indicate that there was an increase in mean score (pretest= 3.96 to posttest= 3,98), the results in Table 18 show that as a whole no significant change from pre- to post-intervention was recorded for Part B.

Table 20 contains frequency analysis of the test scores for the Perceived Sexual Behavioural Skills Test Part B before and after intervention.

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Table 20

Frequency analysis: Distribution of scores for the Perceived Sexual Behavioural Skills Test Pre- and Post-tests Part B

	Score Categories				
	Very ineffectively	Somewhat Ineffectively	Neither Effectively or Ineffectively	Somewhat Effectively	Very Effectively
Skills pre-test Part B score distribution	22	65	128	279	237
Skills post-test Part B score distribution	23	71	72	294	272

Table 20 demonstrates that for part B, as with part A of the Perceived Sexual Behavioural Skills Test, very high scores were reported with pre-testing. Most of the participants already clearly perceived their skills as effective enough before intervention. It is thus difficult to determine whether the answers given after intervention were a true reflection of new perceptions and learned skills. In informal discussions participants indicated that as with Part A, they might not have answered the questions so boldly with pre-testing had they known how ineffective their skills proved to be during role-play as part of the programme.

Much emphasis have been placed in recent studies on the important correlation between perceptions of behavioural control and the intention to engage in a specific behaviour (Breakwell et al. 1991; Ajzen in Fisher & Fisher, 2000). Having the perception of being in control of your actions seems to promote a person's intention to and eventual enactment of specific behaviour. Being cautious could be seen as not being confident, which might for some people translate into the perception of not being in control. On the other hand being equipped with a realistic perception of one's abilities, and being cautious as a result of that, might be an indication of true self-efficacy and self-control. Students who took part in this progamme seemed to have learned something about themselves – they learned that they are not as skilled as they thought they were. These new perceptions about their limitations and strengths, and realizing that they've learnt something about themselves, should in itself promote confident caution and resulting intention to engage in more realistic, risk-reduced behaviour. Without a perception of vulnerability, a person is unlikely to change customary habits and behaviours (Fineberg in Olsen et al., 1991). It is hoped that their new perception of limitations will serve to motivate the students toward behaviour change where necessary.

Participants also discussed the possibility that they would only obtain a clear perception of exactly how their skills had been developed in this programme once they had been able to utilize these skills within real life situations. This just underlines one of the important limitations of this research, namely the lack of long-term follow-up evaluation.

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T-tests were also performed on the pre- and post-test scores for the Perceived Sexual Behavioural Skills Test of the control group. The results of these t-tests are reviewed in Table 21.

Table 21

Paired Samples results for Perceived Sexual Behavioural Skills Test scores of the control group

		Mean difference score	t	df	P
Pair 1	Total Average Skills Pre-test Part A - Total Average Skills Post-test Part A	-9.3437E-02	-1.446	31	.158
Pair 2	Total Average of Skills Pre-test Part B - Total Average Skills Post-test Part B	-.1188	-1.420	31	.166
Pair 3	Total Average Skills Pre-test Part A+B - Total Average Skills Post-test Part A+B	-.1050	-1.532	31	.136

No significant changes were recorded from pre- to post testing. A small visible increase in mean from pre- to post-test may be attributed to the participants' familiarity with the test items.

9.6.3.2 Category Analysis

The categories identified in the Perceived Sexual Behavioural Skills Test is provided in Table 22:

Table 22

Categorization of Perceived Sexual Behavioural Skills Test items

Test item(s)	Categorizing
1, 3, 5, 9, 11, 18, 21	Communication and assertiveness regarding own sexuality
4, 6, 14, 15, 17	Communication about sexually transmitted diseases
2, 7, 12, 16, 20	Communication about contraception
8, 10, 13, 19, 22, 23	Communication and assertiveness regarding contraceptive behaviour

The difference in pre- and post-test scores for the experimental group for each of the above categories were compared with t-tests.

Descriptive statistics for each category of Perceived Sexual Behavioural Skills Test for the experimental group can be seen in Table 23.

Table 23

Descriptive data per category of the Perceived Sexual Behavioural Skills Test for the experimental group

	N	M	SD	Std. Error Mean
SCOMASPR	29	51.03	5.92	1.10
SCOMASPO	31	49.39	5.93	1.06
SCMSTDPR	29	24.76	5.61	1.04
SCMSTDPO	32	29.19	7.69	1.36
SCONTRPR	31	37.00	4.82	.87
SCONTRPO	29	37.07	5.34	.99
SCONTBPR	30	42.23	5.14	.94
SCONTBPO	32	43.09	5.41	.96

Note:

SCOMASPR: Skills regarding sexual communication and assertiveness - Pre-test Scores

SCOMASPO: Skills regarding sexual communication and assertiveness - Post-test Scores

SCMSTDPR: Skills regarding communication about sexual transmitted diseases - Pre-test Scores

SCMSTDPO: Skills regarding communication about sexual transmitted diseases - Post-test Scores

SCONTRPR: Skills regarding communication about contraception - Pre-test Scores

SCONTRPO: Skills regarding communication about contraception - Post-test Scores

SCONTBPR: Skills regarding communication and assertiveness related to the use of contraceptives - Pre-test Scores

SCONTBPO: Skills regarding communication and assertiveness related to the use of contraceptives - Post-test Scores

Table 24 contains the results of the t-tests performed with the scores for each category.

Table 24

Paired Samples results per category for the Perceived Sexual Behavioural Skills Test scores of the experimental group

		Mean difference score	t	df	P
Pair 1	SCOMASPR - SCOMASPO	1.25	1.18	27	.25
Pair 2	SCMSTDPR - SCMSTDPO	-3.97	-3.51	28	.00
Pair 3	SCONTRPR - SCONTRPO	.57	.60	27	.56
Pair 4	SCONTBPR - SCONTBPO	-1.07	-1.31	29	.20

Note:

SCOMASPR- SCOMASPO: Skills regarding sexual communication and assertiveness – Pre-test versus Post-test Scores

SCMSTDPR - SCMSTDPO: Skills regarding communication about sexual transmitted diseases - Pre-test versus Post-test Scores

SCONTRPR - SCONTRPO: Skills regarding communication about contraception - Pre-test versus Post-test Scores

SCONTBPR – SCONTBPO: Skills regarding communication and assertiveness related to the use of contraceptives - Pre-test versus Post-test Scores

Analysis of the pre- and post-test scores for categories regarding sexual skills identified one area of sexual skills development with a significant difference in score from before to after intervention. The 2-tailed significance of 0.002 proves a significant change on the 1% level for the category regarding Communication about STDs (SCMSTDPR - SCMSTDPO). Participants' perceived abilities to communicate about and behave in such a manner to prevent STDs effectively seem thus to have been changed effectively in the desired direction. Self-perceived effective communication plays a prominent role in the promotion of safer sex behaviours (Yesmont, 1992).

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9.6.3.3 Qualitative Feedback

All the group leaders reported that group members had problems participating in the assertiveness and communication exercises. This was mostly due to shyness and unease to act out controversial situations in front of and with members of the opposite sex. Even though the participants struggled to relax into role-play at first, the role-play simulations eventually ended up being a fun-filled activity that led to intimate discussions about sexual behaviour.

> "The role-play did not work as well as it could have owing to the fact that issues and scenarios were discussed more than acted out. However this did promote one big group discussion that helped the session to be successful. It was agreed that assertiveness plays a very important role in sexuality and communication, and is a skill worth mastering."

> "Although the group members were initially very shy after they read the case studies, the exercise was a huge success. The group members were honest and acted with sincerity and seemed not at all afraid of the reaction of the rest of the group. After each role-play the group discussed why it is difficult to be assertive in certain situations."
> "The group members who had to role-play were shy and found it difficult. Nevertheless 'Assertivity and sexuality' in session seven was a good ending to the course. Most of the aspects discussed in previous sessions were brought together in this session and again stimulated discussion."

Barth et al. (1989) found the orchestration of role play in small groups to be an important challenge to group leaders. Group leaders should be able to facilitate and not force participation in uncomfortable role play and homework assignments. They proposed the use of scripted role plays to relieve awkwardness. They also suggested that students should be involved in the writing of these scripts for them to feel more at ease and ensure the likelihood of realistic scenarios.

What was clear in the feedback from group leaders was that, even though the intervention might not have equipped the group members with sufficient behavioural skills in communication and assertiveness, it did instill in them an awareness of its importance:

> "They decided that communication and assertiveness goes hand in hand in a relationship and that you cannot expect your partner to know what you're thinking and what you want if you are not assertive about your own needs."

> "The group members all agreed that the session focused their attention on the importance of communication in successful relationships."

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"The group members believed more strongly in their personal right to be assertive and also believed that it was necessary for emotional well-being to be able to express yourself in different situations."

"It was clear that the women found it difficult to be assertive in sexual situations. ...They either acted non-assertive or aggressive. ...The girls were relatively confrontational which unleashed aggression in the guys."

"The women realized that assertiveness was a necessary skill."

"The group could definitely also learn something. The group was faced with one great fact: that there is no substitute for assertiveness."

"Group members came to the conclusion that communication was extremely necessary in this case."

After the intervention the group members seemed to come to the conclusion that in order to talk about decision-making with your sexual partner, you need to be assertive and be able to communicate effectively. In role-play the women especially tended to be more aggressive than assertive. In 1992 Yesmont conducted a study to test the relationship of assertiveness to college students' safer sex practices. In the aforementioned study the women were also found to be more aggressive when dealing with sexual situations than the men. Students who took part in Yesmont's study recognized the social inappropriateness of aggressive behaviour and indicated that this method of communication would not have a strong impact in promoting safer sex behaviours. In the current research study feedback from the group made the women realize that they had to work on listening more and reacting in a less threatening manner. These realizations served as motivation for all group members to try at least to be more open and direct about their needs and preferences within sexual encounters. As stated in the IMB-model, motivation is the first step towards healthy sexual behaviour.

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9.6.4 Effect of Group leaders on Intervention Outcome

9.6.4.1 Non-parametric tests

Wilcoxon signed ranks tests were performed on the Knowledge, Attitudes and Perceived Sexual Behavioural Skills Test scores for each of the four experimental groups. This was deemed necessary seeing as each group had been presented by a different group leader and the effect, if any, of different group leaders on the effectiveness of the sexuality education programme on each specific group, had to be investigated.

The mean scores per group for the Knowledge, Attitudes and Skills pre- and post-tests are presented in Tables 25, 26 and 27 respectively.

Table 25

Descriptive Statistics for the Knowledge pre- and post-tests of each of the 4 experimental groups

Knowledge Test Scores	N	M	SD	Minimum	Maximum
Pre-test Total Group 1	8	27.63	4.75	20	32
Post-test Total Group 1	8	30.75	3.49	23	33
Pre-test Total Group 2	8	24.13	3.72	19	29
Post-test Total Group 2	8	28.88	1.89	27	33
Pre-test Total Group 3	8	24.63	4.78	20	34
Post-test Total Group 3	8	32.38	3.54	26	36
Pre-test Total Group 4	8	25.88	3.68	19	29
Post-test Total Group 4	8	32.63	2.56	29	37

Table 26

Descriptive Statistics for the Attitudes pre- and post-tests of each of the 4 experimental groups

Attitudes Test Scores	N	M	SD	Minimum	Maximum
Pre-test Total Average Group 1	8	3.57	.20	3.31	3.81
Post-test Total Average Group 1	8	3.60	.26	3.06	3.89
Pre-test Total Average Group 2	8	3.59	.28	3.28	4.03
Post-test Total Average Group 2	8	3.55	.25	3.25	3.92
Pre-test Total Average Group 3	8	3.78	.23	3.50	4.19
Post-test Total Average Group 3	8	3.86	.30	3.25	4.17
Pre-test Total Average Group 4	8	3.49	.35	2.97	3.92
Post-test Total Average Group 4	8	3.63	.37	2.92	4.14

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Table 27

Descriptive Statistics for the Skills pre- and post-tests of each of the 4 experimental groups

Perceived Sexual Behavioural Skills Test Scores	N	M	SD	Minimum	Maximum
Total Average Pre-test PartA Group 1	8	2.83	.26	2.48	3.26
Total Average of Pre-test PartB Group 1	8	3.75	.47	3.22	4.57
Total Average Pre-test Part A+B Group 1	8	3.29	.36	2.87	3.91
Total Average Post-test PartA Group 1	8	2.67	.32	2.17	3.09
Total Average Post-test PartB Group 1	8	3.75	.43	3.00	4.30
Total Average Post-test Part A+B Group 1	8	3.21	.29	2.59	3.61
Total Average Pre-test PartA Group 2	8	3.07	.44	2.43	3.61
Total Average of Pre-test PartB Group 2	8	4.00	.60	3.32	4.74
Total Average Pre-test Part A+B Group 2	8	3.54	.51	2.96	4.17
Total Average Post-test PartA Group 2	8	2.86	.48	2.32	3.57
Total Average Post-test PartB Group 2	8	3.90	.51	3.05	4.57
Total Average Post-test Part A+B Group 2	8	3.38	.48	2.68	4.07
Total Average Pre-test PartA Group 3	8	3.07	.44	2.27	3.74
Total Average of Pre-test PartB Group 3	8	4.03	.41	3.32	4.73
Total Average Pre-test Part A+B Group 3	8	3.55	.40	2.80	4.02
Total Average Post-test PartA Group 3	8	3.26	.31	2.91	3.74
Total Average Post-test PartB Group 3	8	4.22	.39	3.69	4.77
Total Average Post-test Part A+B Group 3	8	3.75	.30	3.37	4.24
Total Average Pre-test PartA Group 4	8	2.98	.38	2.22	3.43
Total Average of Pre-test PartB Group 4	8	4.05	.53	3.36	4.61
Total Average Pre-test Part A+B Group 4	8	3.51	.41	2.83	4.02
Total Average Post-test PartA Group 4	8	2.84	.52	2.17	3.83
Total Average Post-test PartB Group 4	8	4.04	.69	3.00	4.91
Total Average Post-test Part A+B Group 4	8	3.44	.55	2.59	4.24

Tables 28-31 display the results of the Wilcoxon signed ranks tests for the Knowledge, Attitudes and Perceived Sexual Behavioural Skills Tests, per group.

Table 28

Wilcoxon Signed Ranks results for Knowledge, Attitudes and Perceived Sexual Behavioural Skills Tests of experimental group 1

	Knowledge Post Pre-test Total Score	Attitude Post - Attitudes Pre-test Total Average	Total Average Skills Post-test Part A - Pre-test Part A	Total Average Skills Post-test Part B - Pre-test Part B	Total Average Skills Post-test Part A+B - Pre-test Part A+B
Z	-2.113	-.980	-1.120	.000	-.338
Asymp. P	.035	.327	.263	1.000	.735

a Based on negative ranks.

b Based on positive ranks.

c The sum of negative ranks equals the sum of positive ranks.

d Wilcoxon Signed Ranks Test

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Table 29

Wilcoxon Signed Ranks results for Knowledge, Attitudes and Perceived Sexual Behavioural Skills Tests of experimental group 2

	Knowledge Post-test - Knowledge Pre-test Total Score	Attitude Post-test - Attitudes Pre-test Total Average	Total Average Skills Post-test Part A - Pre-test Part A	Total Average Skills Post-test Part B - Pre-test Part B	Total Average Skills Post-test Part A+B - Pre-test Part A+B
Z	-1.893	-1.262	-2.197	-1.402	-1.820
Asymp. P	.058	.207	.028	.161	.069

a Based on negative ranks.

b Based on positive ranks.

c Wilcoxon Signed Ranks Test

Table 30

Wilcoxon Signed Ranks results for Knowledge, Attitudes and Perceived Sexual Behavioural Skills Tests of experimental group 3

	Knowledge Post-test - Knowledge Pre-test Total Score	Attitude Post-test - Attitudes Pre-test Total Average	Total Average Skills Post-test Part A - Pre-test Part A	Total Average Skills Post-test Part B - Pre-test Part B	Total Average Skills Post-test Part A+B - Pre-test Part A+B
Z	-2.380	-.561	-1.682	-1.120	-1.752
Asymp. P	.017	.574	.092	.263	.080

a Based on negative ranks.

b Wilcoxon Signed Ranks Test

Table 31

Wilcoxon Signed Ranks results for Knowledge, Attitudes and Perceived Sexual Behavioural Skills Tests of experimental group 4

	Knowledge Post-test - Knowledge Pre-test Total Score	Attitude Post-test - Attitudes Pre-test Total Average	Total Average Skills Post-test Part A - Pre-test Part A	Total Average Skills Post-test Part B - Pre-test Part B	Total Average Skills Post-test Part A+B - Pre-test Part A+B
Z	-2.371	-1.334	-1.120	-.280	-.280
Asymp. P	.018	.182	.263	.779	.779

a Based on negative ranks.

b Based on positive ranks.

c Wilcoxon Signed Ranks Test

The results of analysis are concurrent with the t-test results of the experimental group as reported in Tables 4, 10 & 18. Significant change from pre- to post-testing is recorded for knowledge, but no significant change in attitudes and skills. Only group two display inconsistencies in that participants in this group did not experience effective change in knowledge (2-tailed sig= 0,055), but do however indicate a significant change in skills (2-tailed sig= 0,028) on the 5% level.

Overall the fact that a different group leader led each group did not have an impact on the test scores of each group. The fact that all group leaders underwent the same training programme, were taught the same techniques and worked from the same sexuality psycho-education manual, helped to standardize their presentation methods and influence on the group members.

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Wilcoxon Signed Ranks tests were also performed on each of the 4 control groups. Tables 32-35 display the results of the Wilcoxon signed ranks tests for the Knowledge, Attitudes and Perceived Sexual Behavioural Skills Test s of the Control groups, per group.

Table 32

Wilcoxon Signed Ranks results for Knowledge, Attitudes and Perceived Sexual Behavioural Skills Tests of control group 1

	Knowledge Post-test - Knowledge Pre-test Total Score	Attitude Post-test - Attitudes Pre-test Total Average	Total Average Skills Post-test PartA - Pre-test PartA	Total Average Skills Post-test PartB - Pre-test PartB	Total Average Skills Post-test Part A+B - Pre-test Part A+B
Z	-1.476	-.560	-1.540	-.931	-1.362
Asymp. P	.140	.575	.123	.352	.173

a Based on negative ranks.

b Wilcoxon Signed Ranks Test

Table 33

Wilcoxon Signed Ranks results for Knowledge, Attitudes and Perceived Sexual Behavioural Skills Tests of control group 2

	Knowledge Post-test - Knowledge Pre-test Total Score	Attitude Post-test - Attitudes Pre-test Total Average	Total Average Skills Post-test PartA - Pre-test PartA	Total Average Skills Post-test PartB - Pre-test PartB	Total Average Skills Post-test Part A+B - Pre-test Part A+B
Z	-1.225	-.851	-.169	-1.192	-.841
Asymp. P	.221	.395	.866	.233	.400

a Based on negative ranks.

b Wilcoxon Signed Ranks Test

c Wilcoxon Signed Ranks Test

Table 34

Wilcoxon Signed Ranks results for Knowledge, Attitudes and Perceived Sexual Behavioural Skills Tests of control group 3

	Knowledge Post-test - Knowledge Pre-test Total Score	Attitude Post-test - Attitudes Pre-test Total Average	Total Average Skills Post-test PartA - Pre-test PartA	Total Average Skills Post-test PartB - Pre-test PartB	Total Average Skills Post-test Part A+B - Pre-test Part A+B
Z	-2.132	-.676	-.560	-1.014	-.631
Asymp. P	.033	.499	.575	.310	.528

a Based on negative ranks.

b Wilcoxon Signed Ranks Test

c Wilcoxon Signed Ranks Test

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Table 35

Wilcoxon Signed Ranks results for Knowledge, Attitudes and Perceived Sexual Behavioural Skills Tests of control group 4

	Knowledge Post-test - Knowledge Pre-test Total Score	Attitude Post-test - Attitudes Pre-test Total Average	Total Average Skills Post-test PartA - Pre-test PartA	Total Average Skills Post-test PartB - Pre-test PartB	Total Average Skills Post-test Part A+B - Pre-test Part A+B
Z	-1.023	-.771	-.350	-1.192	-.981
Asymp. P	.306	.441	.726	.233	.326

a Based on negative ranks.

b Wilcoxon Signed Ranks Test

Although t-tests on the results of the Knowledge Test for the larger control group, as seen in Table 3, indicated an unexpected significant change in knowledge from pre- to post testing, analysis of the subgroups reveal that only one group, group 3, had a significant difference (p=<0.05, p=0.033). It is possible that specifically members of Control group 3 was exposed to influence from members of the experimental group, thus contaminating the results. All the control groups show no significant change for attitudes and skills.

9.6.4.2 Qualitative Feedback

Using a peer group structure and leadership model proved to be very successful. Peer group leaders became part of the group, only assuming their role as educators, and guiding discussions and activities when necessary. Participants indicated that this put them at ease and promoted open communication on a level of depth and intimacy which would otherwise have been suppressed had their group leader been of an older age group.

> "The group leaders are of the opinion that the peer group sexuality psycho-education programme should be continued because students connect better with fellow students in a relaxed atmosphere. Students would experience the same information being taught by older people or authority figures as being preached to."

> "The exposure to an environment in which sex and sexuality related issues may be discussed freely and openly without any constraints benefited the leaders and group members alike."

> "The group leaders were successful in presenting the information at a tempo which suited the group members and they were in touch with the educative needs of the members."

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> "They all agreed that they had been exposed to an environment in which they could speak openly and honestly to members of their peer group about sex, sexuality and sexual orientation."

> "The group leaders approach was very flexible - emphasizing the "free thinking" and openness of each individual."

These opinions are corroborated in a study by Ward and Taylor (1991). In their study several focus groups of young people suggested that they would feel more comfortable asking questions and sharing information about sexuality with instructors who were in their same age group or slightly older.

The group leaders' success in creating an atmosphere conducive to real sharing could be due to the fact that they had been required to attend the programme as group members before signing up as group leaders. In personal conversation with the group leaders they indicated that experiencing the sexuality education programme as a group member first, made them sensitive to the possible impact of programme content on their group members, and consequently empowered them with insight into how they could most effectively handle the reactions of their group. Group leaders also indicated that being subjected to further intensive training in the presentation of each session before being allowed to lead a group of peers, was very important in that it gave them the self-confidence and skills they needed to present each session with enthusiasm. Some of the group leaders reported that they had been confronted with questions to which they did not have the answers straight away. These group leaders did however solve this problem themselves by researching the issues in their own time and providing adequate answers in the next session. Proper selection of efficient and dedicated peer group leaders was thus confirmed as a necessary part of the peer education process.

Summary:

The results as presented and discussed in this chapter will be summarized in Chapter 10. The researcher will also review the outcomes of the current research in terms of limitations and provide recommendations for future studies.

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CHAPTER 10: SUMMARY, CRITICAL EVALUATION AND RECOMMENDATIONS

In this chapter the researcher will summarize the outcomes and discuss limitations of the current research. In view of the limitations and failures of the programme, recommendations for future implementation will also be included in this chapter.

10.1 Summary

The effect of the peer group sexuality education programme will be summarized below in terms of peer group leadership, programme content, and the impact on knowledge, attitudes and behavioural skills.

10.1.1 Peer group leadership

The peer group structure and leadership model proved to be successful. Peer group leaders were able to create a non-threatening atmosphere in which group members felt that they could freely speak their mind at length. Group members appreciated the opportunity they were given to discuss sensitive issues openly and honestly with peer members who could understand and empathize with their situation.

10.1.2 Programme content

No negative feedback was received regarding the programme content. All the participants seem to find the content appropriate for their age group. Discussion topics seemed to be relevant and stimulating judging from group discussions that went on for hours, even extending past the given session time. Visual stimulation through photographs and objects (contraceptives, models, etc) seemed effective, especially in those instances where they were used in exercises and for shock-effect. Role-play and communication exercises were found to be intimidating. Although the execution of the exercises were not that successful, the issues addressed in the role-play case studies led to insightful discussions regarding communication and assertiveness. Overall it seems that changes made to programme content based on feedback received during action research, has eventually resulted in content which suits the needs and developmental stage of *young people*.

10.1.3 Impact on knowledge

Statistical analysis indicated that the sexuality psycho-education programme had a significant effect on increasing participants' knowledge regarding sex and sexuality. Of specific interest was

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the impact of the programme on participants' knowledge about characteristics of the opposite sex, STDs and contraceptives other than the condom.

10.1.4 Impact on attitudes

Statistical analysis indicated that the sexuality education programme did not overall significantly change the attitudes of the participants. Attitudes relating to the use of contraception did however show a significant change in the right direction. There was also a slight indication that clarification of attitudes had been promoted. Qualitative evaluation indicated that participants had developed a more empathetic view towards AIDS patients and displayed a more responsible attitude towards their own protection against HIV infection. Participants suggested that they felt more positive about using condoms and about communicating with their partners regarding the use of contraceptives.

10.1.5 Impact on perceived behavioural skills

Statistical analysis indicated that, although the sexuality psycho-education programme did not have a positive impact on perceived behavioural sexual skills in general, a significant change in perceived behavioural skills regarding communication about and behaviour for the prevention of HIV/STDs had been achieved. Closer analysis of results seemed to suggest that the participants had an over-estimated perception of their perceived behavioural skills before the intervention. A pattern of low scores in the Perceived Behavioural Skills Test after intervention indicated that they had altered their misconceptions and was approaching sexual behaviours with much more caution. Even though it seemed that the intervention had not equipped participants with sufficient skills in communication and assertiveness, qualitative results did suggest that it might have at least initiated the process of behaviour change by instilling in them an awareness of the importance of learning and utilizing such skills.

10.2 Limitations and recommendations

10.2.1 Programme objectives

Several interventions based on the IMB-model have proven to be successful in changing behaviour in several target groups. A significant factor in these studies is that, even though targeted at different societal groups, they all focused on one aspect of high-risk sex namely HIV/Aids prevention (Fisher et al., 1996; Fisher et al., 1994; Fisher et al., 1999). This is in sharp contrast with the current study that tried to focus on the prevention of a broad spectrum of sexual health issues.

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After struggling with the various limitations that accompany a sexuality education programme which addressed several major aspects of sex and sexuality, the researcher does see the advantages of focusing an education programme on one aspect of high-risk sex such as a HIV/Aids programme, or a programme focused just on the prevention of unwanted pregnancy. The researcher does believe however that even in these interventions all aspects of sexuality regarding that specific focal point should be addressed. The biological, socio-cultural, ethical-religious, psychological and behavioural dimensions of sexuality need to be addressed, as these are all influences that have an impact on young people's daily decision-making.

10.2.2 Situation Analysis

The psycho-education model postulates that to be successful the programme development process should include a situation analysis phase during which the theoretical background and underlying theoretical principles that clarify the current problem, as well as the needs and opinions of interested parties should be identified (Roos et al., 2000). This approach to programme development is consistent with the principles of elicitation research and population-specific interventions proposed in the IMB model. This model proposes that for each population of interest researchers should examine the existing level of knowledge and skills and the factors that determine the population's motivation (Fisher & Fisher,2000). Based on this information the researchers should then create population-appropriate interventions (Fisher & Fisher, 1992). Bruyniks (1994) agrees that before introducing a sex education programme it is essential to know more about the actual knowledge, attitude and practice with regard to sexuality and sexual health in the target population. In the current study the situation analysis phase did not include adequate collection of pre-intervention information about the target population of university students. It would have been beneficial to know more about the characteristics and social environment of the target group before intervention, not only to ensure a population-specific intervention, but also to be able to fully interpret intervention outcomes. Action research in future studies will have to include the collection of more pre-intervention information about participants' sexual orientation, level of sexual activity and experience, needs in terms of information and skills training, and the social influences they are subjected to in their immediate environment.

10.2.3 Theoretical model

The IMB model suggests that behavioural skills are a final prerequisite (after information and motivation) of preventive behaviour. The IMB further proposes that behavioural skills involve one's self-belief in the ability to enact specific behaviour accompanied by the possession of requisite skills to effectively perform preventive acts (Fisher et al., 1994). The IMB model assumes that

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significant changes in perceived difficulty of and perceived effectiveness of will be an indication of behavioural skill and consequent behaviour change. In this study therefore, the researcher assessed changes in preventive behavioural skills by measuring perceived difficulty and perceived effectiveness of relevant sexual behaviours. In the process of the research the researcher became aware of an important limitation of the IMB model. The IMB model fails to incorporate the idea that behaviour change can take place gradually and that changing the assumed determinants of behaviour might not immediately produce target-goal behaviour.

In the current study it often seemed that the level of sexual experience, thus the stage of sexual behaviour, of the target group had an impact on intervention outcomes. Many of the group members seemed to be sexually inexperienced. It seemed as if for some of them participation in this intervention provided their first confrontation with such serious sexual issues. From the results it seemed as if they were taking their first steps toward internalizing information, clarifying attitudes and deciding about behaviour change. To the researcher they appeared to be a first stage of behaviour change. In view of these perceptions the researcher would like to challenge the IMB model's conceptualization of behaviour change by proposing that the development of perceived behavioural control and perceived self-efficacy are initial stages in the process of behaviour change. A theoretical model which conceptualizes the concept of stages of behaviour change is the Transtheoretical Model (TM).

The TM states that change is viewed as a process and for this reason change should not be viewed solely as a discrete overt behavioural outcome. According to the TM there are specific stages of change towards eventual maintained behaviour change. These stages are precontemplation, contemplation, preparation, action, and maintenance (Prochasko & Velicer, 1997, in Fisher & Fisher 2002). In light of the constructs of the TM, many of the participants in the current research find themselves somewhere between the first stages, the so-called pre-contemplation, contemplation and/or preparation stages of behaviour change.

The TM suggests that an appropriate goal for a single intervention would be to move participants one stage along the change continuum (Fisher & Fisher 2002). This implies that behaviour change should be measured in terms of stages of behavioural development which has implications for the implementation and evaluation of future interventions. Interventions would ideally have to be matched to participants' stage of change. To understand intervention outcomes clearly one would have to know the stage distribution of participants who engage or might engage in the problem behaviour. Participant selection and elicitation research would thus be very important issues. In order to provide effective interventions the participants should as far as possible be homogenic in amongst other things their stage of sexual behavioural change. Researchers would have to

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interpret intervention outcomes within the context of influences and processes relevant to specific stages of change.

Another issue of concern is the fact that the IMB model lacks the inclusion of gender identification and roles in its basic construction. The researcher proposes that future evaluation of the sexuality education programme should include specific analysis of the impact of the programme on gender groups. It could be beneficial to evaluate if and how male and female participants react differently to the programme. Such information will help to identify content and/or theoretical principals that might need to be adapted in order to address the needs of both men and women.

10.2.4 Participant selection

The nature of the target group made it impossible for the researcher to obtain participants for this study in any other way than by advertising for volunteers. University students could not be ordered by authorities to participate in such a study. This jeopardized the validity of the study in that volunteers for a sexuality education programme might imply a certain type of person. Participants were also not controlled in terms of sexual preference and/or sexual activity. The ideal selection process would produce a randomly selected homogenic group of participants. This would make it easier to evaluate research results in the context of well-defined participant characteristics.

In a multicultural South Africa future research will also have to include the adaptation and implementation of the peer group sexuality psycho-education programme on different cultural and social groups.

10.2.5 Programme Content

Programme content should be revised frequently to change as the area of sexuality reflects new attitudes and concerns. Stagnation must be prevented and continuity promoted by keeping the programme flexible in rapidly changing times. On-going research, new contraceptives, the focus on other sexual health problems and maybe even shifts in general social norms and support systems are all examples of issues which might necessitate reconceptualization and the implementation of creative presentation alternatives.

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10.2.6 Evaluation methodology

10.2.6.1 Measuring instruments

The researcher believes that the greatest limitations of the research lie in the lack of appropriate measuring instruments.

Firstly the researcher has come to the conclusion that behaviour and skills cannot be effectively measured by the isolated use of pen-and-paper measuring instruments that only provide forced-choice items. With the Sexual Attitudes and Perceived Sexual Behavioral Skills Tests the participants were required to choose one of 4 or 5 predetermined answers (Strongly Agree to Strongly Disagree, Very Hard to do to Very Easy to do, and Very Effectively to Very Ineffectively). The forced-choice items leave no opportunity for the participants to convey the finer nuances of experience and change which they might have encountered during intervention. The questionnaires thus place limits on what can be said about any degree of change. In view of the multidimensional nature of sexuality and with such a multifaceted programme as used in the current research, participants more often than not experience change outside of the specific determinants and hypothesized outcomes the researcher initially included in the measuring instruments. A platform should be provided for participants to contribute these unexpected intervention outcomes to research. The researcher thus proposes that the only way to effectively evaluate the impact of such a comprehensive intervention on young people and gain insight into the multi-factoral character of behaviour modification, is to measure the impact of it through structured qualitative open-question interviews.

Secondly, various problems were also experienced with the pen-and-paper measuring instruments that were designed by the researcher for the purpose of this study. The Knowledge, Attitude and Behavioural Skills tests were not properly tested in terms of validity and reliability. Face validity was evaluated through feedback from participants and group leaders during the two pilot studies. For future use a reliability coefficient for each test will have to be determined. The tests will also have to be evaluated in terms of criterion-prediction and construct-identification validation.

10.2.6.2 Long-term evaluation

The IMB model proposes that evaluation research should attempt to measure both whether behavioural change has been initiated and whether it has been maintained (Fisher et al., 1994). In terms of attitudes, the present findings on attitude change are limited to changes identified immediately at the end of the course. It is necessary to assess the stability or change in attitudes over a longer time frame following the completion of such a course (Patton & Mannison, 1993).

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The third limitation regarding evaluation methodology in this study is that no long-term evaluation of the effects of the intervention was performed. The absence of such data makes it impossible to determine whether the impact of the programme might just be temporary. The researcher believes that the impact of such an intervention could only be measured once the participants had time to try and utilize what they have learnt in the programme within real-life situations. Only then would they be able to determine whether they were able to combine the knowledge, attitudes and skills they had been exposed to during intervention, to produce healthy sexuality-related behaviour.

10.2.6.3 Structured feedback form

A final limitation was that participants did not complete a structured feedback form with which to evaluate factors such as the programme content, programme presentation and the impact of the peer group leaders. These issues were evaluated through informal feedback discussions about the programme during the last session as well as personal conversation with group leaders and some group members. Including extensive qualitative research in the methodology could successfully address this problem. The researcher recommends that a short feedback form measuring the impact of the programme sessions on different levels, as well as the impact of peer group leaders and group dynamics, be included in the post-intervention pen-and-paper tests.

10.3 Conclusion

The research study has led the researcher to the following three main conclusions:

i) Even in this age of sexual freedom and the revolution of sex education, young people between the ages of 18-25 still have much to learn about, and misconceptions to rectify concerning sex and sexuality.

Sexuality education programmes, which contain information specifically designed for the needs and circumstances of the target population, can have a positive impact in increasing knowledge and eliminating misconceptions.

ii) Young people, in their adaptation phase between adolescence and adulthood are very unsure and undecided about which attitudes, beliefs and norms they should internalize as their own.

Sexuality education programmes have a long way to go in addressing the issue of attitude modification. So many factors in a young person's life mould their value and belief systems. Parents, friends, teachers, religions, cultures and many others, all influence their attitudes from

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birth. It seems on the one hand ridiculous to expect to change these attitudes in a few group sessions. Therefore the researcher believes that it should not be a goal to have immediate attitudinal change. Many young people are confused about what to believe and which systems to live by, because they receive so much input from diverse sources, but rarely have the chance to verbalize and clarify how they see themselves internalizing the most appropriate of these attitudes. The researcher believes that the goal should be to provide an opportunity for young people to think about and discuss their options and their preferences. This opportunity should initialize the process of value clarification. And one can only hope that also exposing them to correct information, balanced attitudes and safe sexual behaviours during intervention, will provide them with an effective framework on which to base correct choices towards healthy values, beliefs and attitudes.

iii) Young people tend to overestimate their level of competency when it comes to making sexual decisions and adopting healthy sexual behaviour.

Young people need to be motivated to be more careful and on the other hand more realistically confident in sexual high-risk behaviours. It seems that just providing them with the facts about consequences, although an important part of the education process, will not be enough. Young people need to be confronted with the reality of sex. They need to experience the emotional confusion and the pressure of decision-making first-hand. They need to, through role-play and lifelike exercises and tasks, be given the opportunity to evaluate the sexual skills they have been taught in their lives. They need to be confronted with and admit to their own inabilities regarding these skills. They have to admit to their own misconceptions about their level of skill, and within the peer group environment identify the same misconceptions with their peers. Only then, will they be motivated towards developing their skills, learning new behaviours and approaching high-risk situations with a greater level of precaution.

As skills, knowledge and attitudes are all intertwined in the process towards effective behaviour, increasing motivation to change in the one might also promote change in the other. If young people can admit to misconceptions concerning their behavioural skills, they might also be motivated to identify misconstrued information and/or rethink unbalanced attitudes and intentions, which could have influenced their initial misconceptions.

The researcher still believes that sexuality-related problems such as the prevention of unwanted pregnancies, HIV/Aids, STDs and unsafe sexual practices, could only be addressed by using a holistic approach to sexuality education. Sexuality, not just sex, forms an integral part of people's lives, affecting their expectations and aspirations. How we feel about ourselves as sexual persons is critical, not only because it largely governs our sexual behaviour, but also because it affects our total health profoundly (Van Coeverden De Groot & Greathead, 1991). On a practical level this

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entails providing a safe environment in which young people can explore sexuality through open and honest discussion, learn the correct facts regarding sex and sexuality, start to think about and clarify their own beliefs and values, and learn and practise safe sexual behaviour through peer group interaction and role-play.

The researcher also shares to some extent the sentiments of those who argue that basing judgements of sexuality education only on its measurable impact instead of its intrinsic value is not acceptable. Should we not give sexuality education a prominent place in our educational systems and our society just because we define such knowledge as essential to being fully human? (Scales, 1990).

In the light of all the health problems educators need to prevent and address with such educational efforts in these times it unfortunately seems pointless to continue without proper evaluation of its impact on young people. Without adequate evaluative information, effective changes and improvements in programmes are unlikely. Until we can develop measuring instruments to evaluate really effectively the complex nature of human sexual behaviour and change, questions about the impact of such sexuality psycho-education peer group interventions on the health choices of young people will remain.

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APPENDIX A:
A PEER GROUP SEXUALITY PSYCHO-EDUCATION PROGRAMME FOR UNIVERSITY STUDENTS

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GROUP SESSION 1:
HUMAN SEXUAL/REPRODUCTIVE ORGANS
THE CYCLE OF SEXUAL RESPONSE IN HUMAN BEINGS

1.1 OBJECTIVES

- **To accustom the group members to speaking easily and without inhibition about sexual matters, by, among other things, introducing them to the use of the correct terminology to describe sexual organs, processes and practices.**

Successful communication is another essential component of effective sexual behaviour. Young people have intimated that poor communication is often the cause of problems within sexual relationships. These young people find it difficult to communicate about sexual matters because they may have never been permitted to treat sexuality as a subject about which there may be direct and open discussion. They should, therefore, be exposed to an environment and an atmosphere in which sexual terminology is used naturally, and sexuality-related matters are discussed in a relaxed manner. From this they can acquire skills that will enable them to communicate openly, honestly and with ease about sex and sexuality.

- **To provide students with the correct basic information regarding the structure and functions of the parts of the body concerned in sexuality and reproduction.**

If young people are to gain insight into their own and others' sexuality, they first need to be well-informed about the human sexual organs and the sexuality related processes that take place within the human body. It is true that factual information in itself will be inadequate if a change in sexual conduct is required, and that attitudes and values need to be altered to bring about more effective behaviour. Nonetheless, no one can build up value systems and attitudes towards sexual matters without possessing a source of correct, factual information on which decisions can be based.
In view of the importance of subjects that will be discussed later in the program it is necessary that group members establish a sound base of knowledge in this first session. Students who do not understand the structure and functioning of the sexual organs will not be able to grasp the rationale underlying contraceptive measures or the transfer of sexual disease.

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- **To place the function of the sexual organs in perspective with regard to sexual arousal and stimulation. The students must gain an insight into the physiological processes that occur in both the male and the female body and sexual organs during sexual arousal, and the physical experiences accompanying these processes.**

To ensure effective communication about sexual matters men and women should have an understanding of what it is that they themselves and their partners are experiencing sexually, so that they can react to it physically and cognitively. It is necessary, therefore, that young people learn about the physiological processes, and the resultant physical experiences, that play a role in their own as well as their partner's sexual arousal.

1.2 STRUCTURE OF THE SESSION

1.2.1 Word game

The session starts with a word game that aims to create a relaxed atmosphere within the group. After the game the group members ought to have an idea of the open and easy manner in which sexuality will be dealt with in the program. Having participated in the game, they should also be more comfortable with the use of the various terms and subjects pertaining to sexuality.

1.2.2 Self assessment

To introduce the subject of the human sexual and reproductive system group members are offered the chance to recall and test their own knowledge of the male and female sexual anatomy. The self-assessment takes place by means of diagrams of the male and the female sexual anatomy that are distributed to group members. The answers sheets for these diagrams are provided in 1.5. Each member fills in, as far as he/she is able to, the missing terminology in the spaces on the diagrams. This exercise gives group members the opportunity to focus on the subject that is going to be dealt with, and also gives members, as well as the leader, some idea of their level of knowledge of the subject.

1.2.3 Lecture and discussion

The first session is one of the few in this psycho-education program on sexuality in which the group leader conveys information mainly by means of the lecture method. The group leader must deal systematically with the structure and functions of the male and female genital systems (as presented in 1.4.2), referring to the diagrams used in the self-assessment. Participation by the group should, however, still be incorporated. The group leader should involve the group members

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in the session by asking them to provide the diagram captions they had to complete in self-assessment, and to describe the functions of the specific parts. The group leader must also encourage the members of the group to ask any questions that they might have.

When the group leader decides that the reproductive systems have been dealt with adequately, he/she may progress to the second part of this session, namely the cycle of sexual response in human beings. The Human Reproductive System (1.4.2) can easily be presented by combining the lecture method and discussions throughout, but when The Sexual Response Cycle (1.4.3) is tackled, the information is best conveyed solely in lecture format. The group leader may use any visual aid (chalkboard/ overhead projector) to facilitate the transmission of information. When the group members have received all the information, the group leader should provide an opportunity for questions and discussion of the subject.

1.3 GUIDELINES FOR THE GROUP LEADER

The group leader must realize that some group members might go into the session expecting to be bored - after all, everyone knows what a penis and a vagina are. On the other hand, however, one still finds university students who believe that a woman urinates through her vagina. And how many male students really know where a woman's most erotic little organ, the clitoris, is situated? Although it is likely, then, that each group member will learn something new from the session, it is necessary that the group leaders should allow themselves to be led, within limits, by the group. The implication is that the leader of a group should try to find out beforehand the extent of group members' prior knowledge of the subject. There is little point, for example, in spending hours on this session if the group consists of students from medical courses, who have a thorough knowledge of the sexual organs.

Although most students already have a basic knowledge of the physiology of the sexual organs, it is important to get the group members to ask questions about what they would still like to know. Such questions are often of a more sensitive nature, the type of question that one would not ask in a Biology class at school. Clearly, then, the group leader should strive to create an atmosphere in which members will have the confidence to ask any question. It is expected of the group leader that he/she is able to supply factual, correct answers, and therefore he/she will need to be well prepared for the presentation of this session. Furthermore, group leaders must themselves display the frank and open attitude that they wish to establish among the group members. Rather than concentrating on the anatomical detail of the reproductive organs, the functioning and consequent implications for effective sexual behaviour should be explained. The students should know "where it is" and "what it looks like", but more importantly, "how does it function", "how should I use it", and "how not to abuse it"!

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In the last instance, it is important that in every session the group leader has a professional approach. This does not mean that the session is conducted in a clinical and impersonal manner. However, group leaders cannot expect members of the group to start using sexuality related terminology in a natural way, or to have meaningful discussions about sexuality if the group leader frequently giggles about it or reveals discomfort. Group leaders will themselves have to be at ease with the subject before they can start training other young people in it.

1.4 CONTENTS OF GROUP SESSION 1

1.4.1 Word Game

1.4.1.1 Instructions for playing the Word game

1. Organize the group into pairs. Each person should then introduce himself/herself to his/her partner, using the name they are generally called by their friends.

2. Choose a term from the list supplied below (or any other appropriate sexual terminology). Request one member from each pair to explain the term to the other member and to supply information until the group leader signals the time to stop (40 seconds to one minute).

3. Choose a new term and repeat the procedure with the other member of the pair.

4. When both members of a pair have had a turn, pairs must be rotated so that each person gets a new partner, to whom the next term will then be explained. Each time there is teaming up with a new partner, introductions must first take place.

5. Continue with the game until all terms have been dealt with or the time allocated has expired.

6. The facilitator must ensure that all members possess the correct information on each term. A brief discussion of the terms may follow the exercise.

7. End off by asking group members to discuss briefly how they experienced the game.
   Explain to them the aims of the exercise:

- To help them to get to know one another
- To familiarize them with the sexual terminology and help them to be at ease when using the terms
- To make them more relaxed with one another so that they can readily discuss sexual matters

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- To introduce them to the frank, open and direct manner in which all sexual matters will be dealt with in the course of the program.

Once the aims of the exercise have been explained it might be an ideal time to ask the group members how they feel about open and honest discussion of sex and sexuality. Reassure them that at no time will any group member be forced to speak about something or participate in activities with which they do not feel comfortable. However, also mention that the maximum participation by the group members in a sexuality education peer group, greatly promotes the eventual success of the program for both the group members and the group leader.

1.4.1.2 Terminology for the Word game

Please note: The sexual slang of a community changes continuously. In this exercise the group leader must try to incorporate the latest terms used by young people. Any new sexuality- or sex-related terms may be added to the list.

Erection - the swelling, stiffening and lifting of the penis when a man is sexually aroused.

Coitus - sexual intercourse between a man and a woman by means of a man inserting his penis into the woman's vagina.

Body rocking - a method of sexual stimulation in which the partners carry out sexual movements in sex positions while fully clothed.

Rimming - Oral stimulation of the anal area.

Penis - the male sexual organ consisting of spongy erectile tissue and a bulbous tip called the glans.

Contraceptive - a method used to prevent pregnancy

Rhythm method - a contraceptive method that requires a couple to abstain from sexual intercourse during the woman's fertile period, i.e. around ovulation.

Oral sex - sexual stimulation of a partner's genitals with the mouth and tongue.

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Clitoris - a small structure in the external female sexual organs which is built up of mostly erectile tissue, like the erectile tissue found in the male penis, and is therefore very sensitive to erotic stimulation.

Erogenous zones - body areas that, when they are touched, cause or increase sexual excitement.

Abortion - spontaneous or induced premature termination of a pregnancy.

Ejaculation - the expulsion of semen from internal reproductive organs through the penis during orgasm.

Ovulation - the process in which an ovum or egg is released from the ovaries of a woman.

VD - venereal disease; any disease of the sexual organs.

Doggie style - a position for sexual intercourse in which the woman kneels on all fours while the man kneels behind her and penetrates her from behind.

Fist fucking - method of sexual stimulation in which one partner stimulates the other by means of penetration of the anus with the hand/fist.

1.4.2 The Human reproductive system

(Resources: Department of National Health and Population Development, 1987; Hawton, 1985; Hyde, 1994; Rosen & Beck, 1988)

Please note: *It is possible to treat this subject extensively and in much detail. For the purposes of this session the focus will be only on the basic structure and functions of the genital organs. Group leaders must be aware, however, that questions may arise which are not covered in the content of this information document. It is recommended that, in the first place, group leaders be well prepared with regard to the factual information, which is supplied here. Secondly, it is requested that questions that could not be answered during the session from the information supplied here be researched by the group leader so that answers may be provided to group members in the course of the next sessions.*

The reproductive system in the human body is a group of related organs with a dual role: it performs several sexual functions, and it is responsible for the conception and birth processes. In

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general the reproductive system corresponds with the genital/sexual organs, although the reproductive system also includes other related organs, such as the female breasts.

1.4 2.1 The female reproductive system

(i) External organs

The external genitals of a woman comprise the mons pubis (pubic protuberance), the labia majora (outer folds or lips), the labia minora (inner folds), the clitoris, and the vaginal opening. Collectively these parts are referred to as the vulva. Other (coarse) terms, such as "pussy" or "cunt" may refer to the vulva or only to the vagina.

"'Vulva' is a wonderful term but, unfortunately,
it tends to be underused - the term, that is"
- Hyde, 1994 -

The clitoris

The clitoris is a bud-shaped structure situated to the front of the vaginal and urethral openings. The clitoris consists of a shaft and a glans (just like the male penis). The shaft disappears into the body under the so-called clitoral hood, which is an extension of the labia minora. The shaft stops against the pubic bone where it forms the crura. The crura serves as a cushion during sexual intercourse and also increases stimulation of the deeper parts of the clitoris. The size of the clitoris at rest varies slightly in adult women, but the average length is approximately one centimeter. Like men women have an erection when they are sexually stimulated. This erection takes place when the blood vessels of the clitoral tissue become enlarged and there is an increased blood supply to the area during sexual arousal.

The clitoris is unique in that it is the only component of the sexual anatomy that has no reproductive function. The clitoris has been given to women purely for their pleasure: it is the part of the female body that is most sensitive to erotic stimulation.

Men often cannot understand why women fail to reach orgasm after intensive stimulation by penetration. The reason is that many women need to have clitoral stimulation to experience optimal satisfaction and attain a climax. Because the clitoris is an external organ, and can thus not be reached by penetration, alternative stimulation or special positioning during intercourse is required to arouse the clitoris and achieve orgasm. It must be remembered however that there are many women who can reach orgasm without their clitoris being touched at all.

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The mons pubis

The mons pubis is the rounded layer of adipose (fatty) tissue covered with pubic hair at the front of the body. It is situated on the pubes, the bones of the groin, and is the most visible part of the female genitals. This area is rich in nerve endings and is sensitive to both touch and pressure. For some women the stimulation of the mons can cause as much arousal as direct clitoral stimulation. The area is sometimes also referred to as the "mons veneris", which in Latin means the mountain of Venus - from Venus, the Roman goddess of love.

The labia

The word "labia" means lips. The labia majora are the externally visible, thickened structures that surround a woman's vaginal opening and are an elongation of the mons pubis. The labia majora are covered with pubic hair and are composed of smooth muscle tissue, nerve tissue and adipose tissue. In their unstimulated position the labia majora protect the sexual openings and the urethra by partially covering them. The labia minora are two hairless skin folds lying between the labia majora and around the edge of the vaginal opening. The labia minora can be observed only when the labia majora are opened up. Like the labia majora, the labia minora have a large number of nerve endings, and both area are therefore sensitive to erotic stimulation.

One of the reasons why "foreplay" is important (besides the purely pleasurable) is that the woman should be adequately stimulated in order that her sexual organs may prepare themselves effectively for possible penetration by the male penis. During erotic stimulation the labia majora prepare for penetration by tautening and drawing away from the vaginal opening. When the stimulation is not sufficient, the labia remain flaccid and hanging over the opening that the penis must enter. The soft skin folds inside the labia majora, the labia minora, are then pushed into the vaginal passage along with the penis, causing pain to the woman and possibly also friction and irritation to the man's penis.

Orifices in the female genital area

There are three orifices, each with its own function, in the female genital area. The hindmost orifice is the anus, the opening through which the bowels are cleared. The two other orifices, along with the clitoris, are situated within an area enclosed by the labia minora and known as the vestibule. These two orifices are the vaginal opening or introitus, and the urethral opening. [The introitus is the opening through which the menstrual discharge from the uterus leaves the body, the exit into the world for a baby at birth, and the receptacle for the penis during sexual intercourse]. The urethral opening is for the passing of urine from the bladder. It is important to note that urine is not

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excreted through the sexual passage and from the sexual opening as in the case of men, but that women have a separate duct and opening for urination.

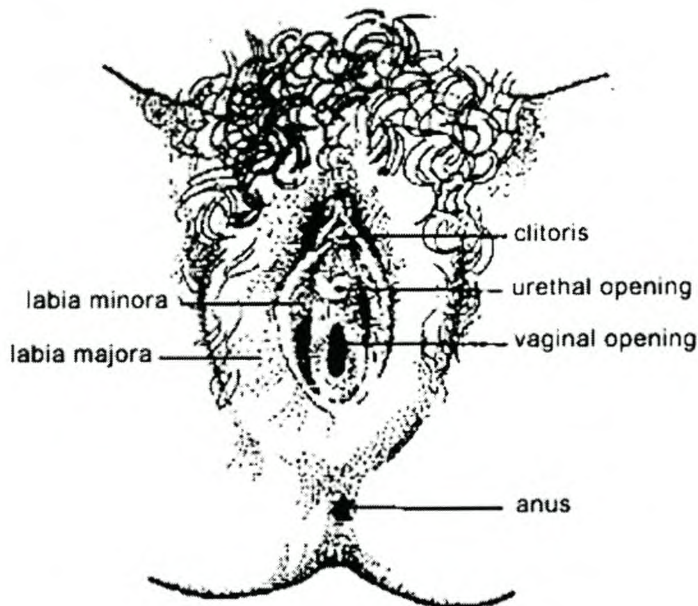

Figure 1: The external female reproductive organs

Other external structures

There are a few very small, externally situated structures, of which note should also be taken. On either side of the vaginal opening are the *vestibular nodes/nodules*. These nodules consist of erectile tissue that is extremely sensitive to stimulation. During orgasm these nodules contribute to the sensation by performing involuntary contractions.

The entire vestibule is covered in *mucous glands* that provide the lubrication for the vagina during stimulation in order to prepare the vagina for the possible reception of the penis. Just behind the vestibular nodules are the *Bartholin glands*. Their function is to secrete very small amounts of moisture during stimulation. The secretion is, however, so little, and takes place at such a late stage in the process of sexual arousal, that it not really functional. It is important to know about these glands, however, as they often become infected.

Finally, there is a term that is often used and which should be noted, namely the perineum. The perineum is the area of smooth skin separating the end of the vaginal opening from the anus. This area, although not one generally regarded as an erotic zone, has quite a high concentration of nerve endings and may, therefore, be an added source of sexual stimulation.

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The hymen

It is difficult to classify the hymen (maidenhead) as either internal or external as regards its position, but it is mostly dealt with under external structures. The hymen, when present, is situated within the entrance of the vaginal opening, 1-2 centimeters towards the internal side of the vaginal opening. The hymen can be a thin membrane partially covering the opening or just a thickening of the sides that narrows the vaginal opening. The function of the hymen is unknown, but through the ages human beings have used the presence of the hymen as an indication of a woman's virginity. This practice can be very misleading, however, as many women are born without a hymen, and others may lose it during participation in sports. It is important to remember that even if a woman's hymen has remained intact until her first act of coitus, the tearing of the hymen is not necessarily a painful, bloody experience. Often the hymen stretches gradually and naturally, and there is no pain or bleeding accompanying the first intercourse. Young women must also remember that the hymen rarely covers the entire vaginal opening and that the use of internal sanitary material (tampons) seldom cause the hymen to tear. If a woman is concerned about extreme pain and bleeding during her first intercourse, a doctor should be consulted to arrange for gradual stretching of the opening of the hymen.

(ii) Internal organs

The internal reproductive organs of the female are the vagina, the uterus, a pair of ovaries and a pair of oviducts (the Fallopian tubes).

The vagina

The vagina is the passage that receives the penis during sexual intercourse. It is also the passage through which a woman gives birth, thus it is often called the birth canal. The vagina is a flexible organ of about 8-10 centimeters in length. The vagina [operates much like a balloon, because it] increases in size during sexual arousal to accommodate a penis of any size. It is important that men realize that only the lower third of the vagina has an effective concentration of nerve endings - the upper two-thirds contains hardly any nerves. This means that even the smallest penis should be able stimulate the vagina adequately. (If one considers the fact that in erection most penises attain more or less the same length irrespective of their dimensions when at rest, it is clear that men should, in any case, not worry about the size of their organ.)

Women should realize that the size of the vaginal opening will to a large extent determine the degree of stimulation that the penis will receive. The muscle tissue of the walls of the vaginal opening could stretch or could have stretched, or could be very slack after a birth. If the muscles

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are very weak they do not provide effective stimulation to the penis. The muscle tone can, however, be improved by specific exercises for the pelvic region.

Because the vaginal opening is very sensitive to both pleasure and pain, and as the opening is surrounded by muscle tissue, the condition of the opening could reflect the psychological experience of a woman. The vaginal muscles of a woman who experiences pain or is afraid during sexual intercourse can contract to such an extent that is becomes very difficult or even impossible for the man to penetrate the vagina. The vaginal walls are covered in mucous glands that secrete moisture during stimulation to enable the penis to penetrate the vagina more easily for sexual intercourse.

A description of the vagina would be incomplete without reference to the renowned G spot. This is an exceptionally sensitive area in the anterior vaginal wall adjacent to the urethra. When the G spot is stimulated there is at first the sensation of having to urinate, but if the stimulation continues there is a sexual sensation that can lead to orgasm without clitoral stimulation. The G spot is thus an area of the vaginal wall that is more sensitive than the rest. BUT not more sensitive than the clitoris or the other outer parts of the sexual female organs.

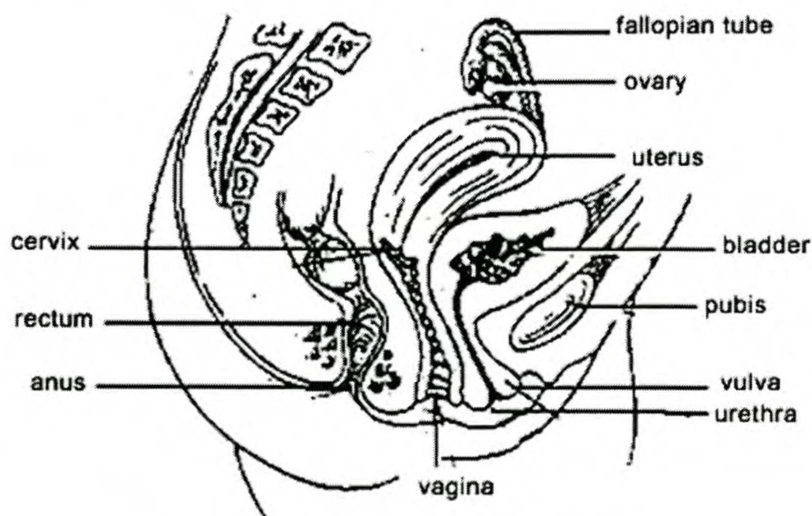

Figure 2: The female reproductive organs

The uterus or womb

The uterus or womb is approximately the size of a fist and is shaped like an upside down pear. It is usually tilted forward slightly in the abdominal cavity. The lower, narrower third of the uterus is called the cervix. This part opens into the vagina. During pregnancy the womb is the home and nutritional source of the developing foetus. The womb can expand considerably to accommodate the growing baby. The smooth muscle of the wall of the womb is very strong and thick, and causes

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the intense contractions during labour and during orgasm. It is, of course, also the womb that causes menstrual flow. (Menstruation is discussed in detail later.)

The Fallopian tubes

The Fallopian tubes extend from the ovaries to the uterus (although they never touch the ovaries). These tubes are the route along which the female eggs (ova) travel from the ovaries and also the ducts through which the male sperm reach ova. The Fallopian tubes are approximately nine centimeters in length and narrower than a drinking straw. They end on either side of the upper part of the uterus in a funnel shape, called the infundibulum. It is in the infundibulum that fertilization of ova usually occurs. On each side the infundibulum curves towards the ovary and has small, finger-like protuberances, the fimbriae, which help to attract the ovum from the ovary to the Fallopian tube.

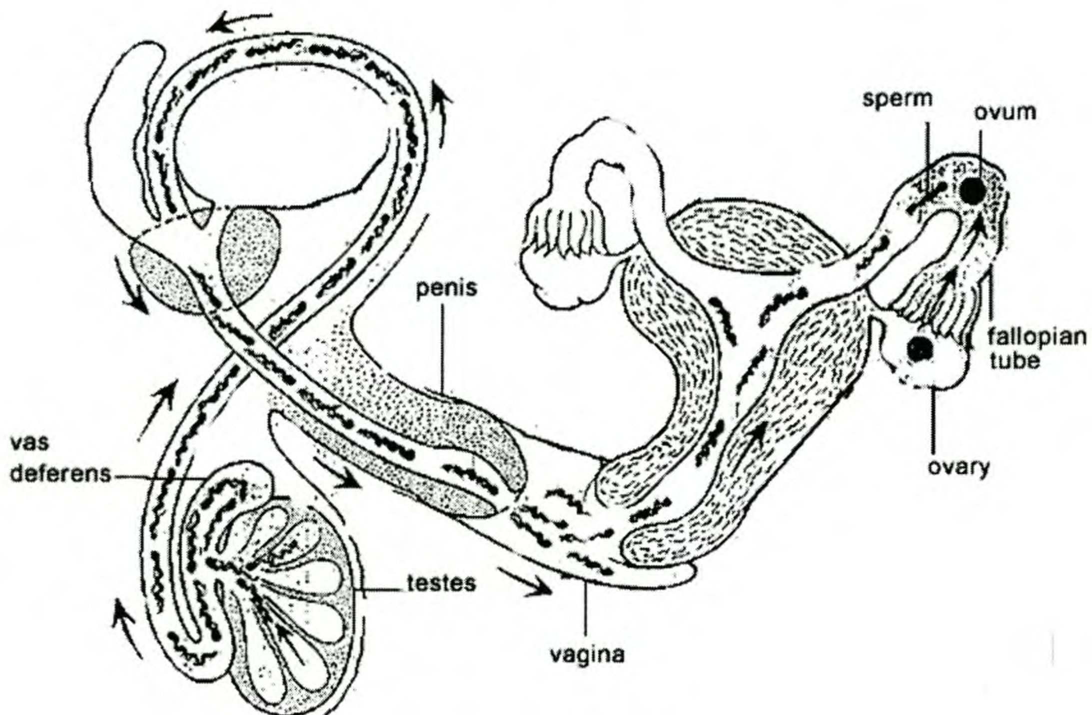

Figure 3: Fertilization

The ovaries

A woman has two ovaries, one on each side of the uterus. An ovary is about the size of an unshelled almond. At birth a woman has approximately 400 000 immature ova. When a girl reaches puberty, her ovaries start to release one ovum or egg per month. This process is called ovulation. If the ovum that has been released (usually only one per cycle) is not fertilized, it is discharged with the menstrual flow.

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1.4.2.2 The breasts

Although the breasts are not really sex organs, they do have an erotic as well as a reproductive role. The aims of this program do not require a detailed discussion of the physiology of the breasts. It is necessary to know that the breasts consist mainly of mammary glands that are able to produce milk. Each gland has its own duct that opens into the nipple. Women's nipples differ in shape, size and colour as a result of hereditary characteristics. The main function of the breasts is to serve as the organs that supply nourishment to babies. However, the breasts may also serve important sexual functions: men are strongly attracted by a woman's breasts, and the breasts can also contribute to the sexual stimulation of the woman. The nipples have many nerve endings and are, therefore, very sensitive to erotic stimulation. The nipples also have erectile tissue that causes them to stand erect when they are stimulated. Male and female nipples consist of the same erectile tissue.

It is well known that, while men worry about the size of their penises, women are often dissatisfied with the size of their breasts. These can be either too small or too large. There is a belief that men prefer a full bosom, and therefore many women have resorted to operations or paper tissues to augment their breasts. For women who feel that they have too little, there is this interesting point to remember: there are the same number of nerve endings in all breasts, irrespective of size, therefore smaller breasts should be more erotically sensitive than large ones.

1.4.2.3 The menstrual cycle

The menstrual cycle is regulated by fluctuating levels of sex hormones that cause certain changes in the ovaries and the uterus. The cycle has four phases. In a perfect 28-day cycle the menstrual phase extends from day 1 to day 5, the follicular phase from day 5 to day 8, ovulation takes place on day 14, and the luteal phase is from day 15 to day 28. The first day of menstruation is generally accepted as the first day of a new cycle because this is the most easily identifiable day. (Biologically, however, menstruation is the last phase of the cycle.)
The average duration of the female menstrual cycle is about 28 days. There are, however, great variations from one woman to another. Although few women have a perfect 28-day cycle, the length of the luteal phase remains fairly constant within the variations of menstrual cycle that women experience. This means that in almost all women there is 14 days between ovulation and menstruation.

A woman should understand the course of her menstrual cycle, because this will contribute to her insight into her own sexuality. The various phases of the cycle have different implications for reproduction and contraception. During ovulation changes take place in the woman's body -

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particularly in the reproductive organs. These changes promote the reception of sperm and the fertilization of the ovum. Women will know that this phase is characterized by an increase in the normal vaginal mucous discharge. This change in the vaginal secretions is but one way in which the reception and transport of sperm within the vagina is facilitated. If pregnancy is to be avoided, this is, then, a phase in the menstrual cycle in which special care must be taken to ensure effective contraception. The menstrual phase, on the other hand, is the phase in which sperm will find it most difficult to reach their final destination. A woman can fall pregnant during this phase, but the chances are slimmer than during any other phase of the menstrual cycle.

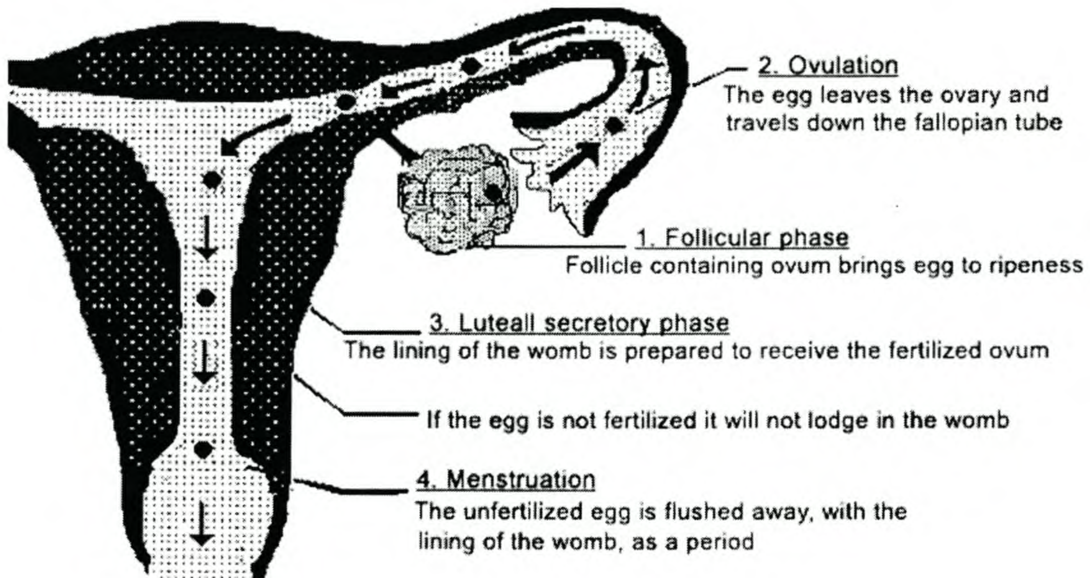

Figure 4: The menstrual cycle

Please note: If pregnancy is to be avoided, contraception must always be used. If, however, a woman is trying to fall pregnant, she must realize that sexual intercourse during menstruation will probably not have the best results.

1.4.2.4 The male reproductive system

The male reproductive system consists of the penis, the testes, the seminal vesicles, the vas deferens, and the prostate gland.

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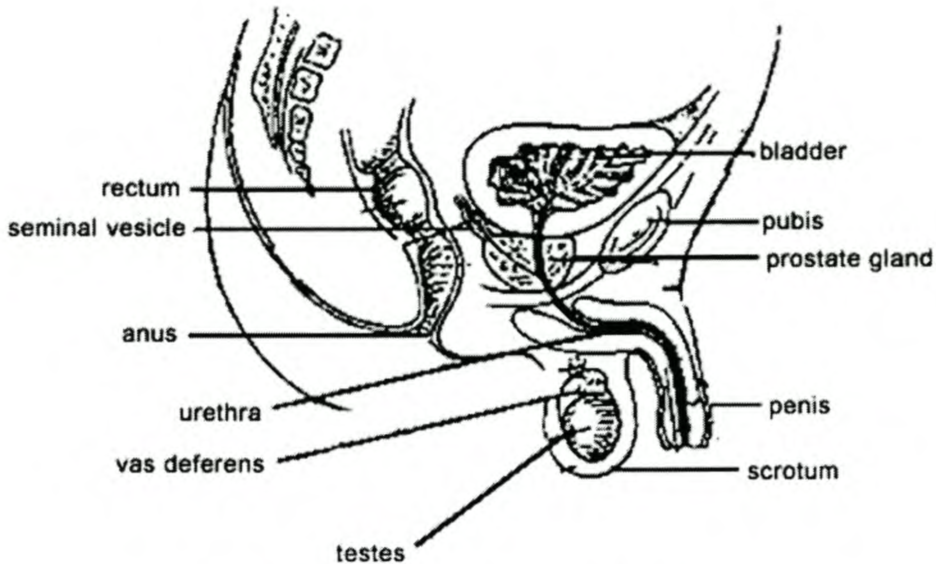

Figure 5: The male reproductive organs

(i) External organs

The penis

The penis (phallus, prick, cock) has a number of important functions: it provides sexual pleasure, takes part in the reproductive process, and eliminates body wastes through urination. The penis is a tubular organ consisting of two parts, namely the rounded end, called the glans, and the main body or shaft, which stiffens during erection. The glans is separated from the shaft by a raised ridge, the corona. Although the entire penis is sensitive to erotic stimulation, the glans and the corona are by far the most sexually excitable areas of the male anatomy. The penis contains erectile tissue (the penis is not a muscle!) that become filled with blood during sexual stimulation and causes the erection of the penis. The skin of the penis is usually hairless and loose so that it can accommodate the penis during erection.

“It is not much of an exaggeration to say that the penises in fantasyland come only in three sizes - large, gigantic, and so big you can hardly get them through the doorway” (Zilbergeld, quoted in Hyde, 1994, p408). During erection a penis that is considered large in its unaroused state does not however become notably larger than a smaller one. The average length of a penis in erection is approximately 10-12 centimeters. At the tip of the glans is the urethral opening through which urination takes place, and through which sperms are released. Sperms and urine use the same passageway, but not simultaneously. It is physically impossible for a man to pass urine during ejaculation, as the opening from the bladder to the urethra is closed at that stage.

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The penis is covered with a loose foreskin that protects the penis and specifically the glans. Underneath the foreskin there are glands that produce lubricating fluids. The glands also produce an excretion, called smegma, which has a cheesy texture. If men do not see to it that the foreskin is retracted to clean underneath regularly, the smegma can cause infection and the smell can be unpleasant.

The testes and the scrotum

The testes or testicles are the male sex glands. They are also called gonads. Colloquially they are referred to as a man's "balls". Each testis contains numerous very thin tubes curled up into spirals. Production and movement/storage of sperm take place in these tubules. The testes are protected by a loose-fitting pouch of skin, the scrotum. The scrotum has a characteristic wrinkled appearance and is sparsely covered with pubic hair. Inside the scrotum there are muscles that are sensitive to heat and cold. The testes need to be kept at the right temperature to ensure that they manufacture sperm and keep the sperm alive. The ideal temperature for sperm production is slightly lower than body temperature, therefore the testes usually hang away from the body. When the male reproductive organs are exposed to cold, however, the muscle in the scrotum contracts, pulling the testes closer to the warmth of the body. The contraction of the scrotum also takes place when a man is sexually stimulated, when the body - particularly the genitals - have been injured, and when a man has had a fright. Some people believe that tight athletic supporters and very hot baths can cause infertility. This is not really true or untrue - it rarely happens that wearing tight clothes or taking hot baths causes infertility; when a man tends to have fertility problems however, these factors can worsen the problems. Men with infertility problems are often advised to wear looser underclothing to eliminate all possible negative influencing factors.

(ii) Internal organs

Al the tubules inside a testis eventually join up to pour their content into the *vas deferens* or seminal duct. From each testis there is a vas deferens that conveys sperms produced in the testis to the seminal vesicles. The seminal vesicles are the storehouse of the sperms until they are released by ejaculation. The seminal vesicles secrete a fluid that forms part of semen and holds the sperm. Approximately 70% of the fluid in the semen eventually emitted by the penis comes from the seminal vesicles.

Sperm - the male reproductive cell that is capable of fertilizing an ovum. Sperms are microscopic and are manufactured in the testes. There are approximately 300 million sperms per ejaculation.

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Semen - the fluid released through ejaculation from the penis at the climax of sexual stimulation. Semen contains sperms, seminal fluid and the secretion of Cowper's glands.

Emission - the release of the seminal fluid containing sperm from the seminal vesicles to the urethra. Emission is a phase of ejaculation.

Ejaculation - the total process by means of which semen is released by the male genital system and discharged externally by the penis.

Summary:

Sperms are manufactured in tubules within the testes. During their maturation process they are gradually conveyed through the tubular system to the vas deferens (the seminal duct). When they are mature they are transferred to the seminal vesicles via the vas deferens. The sperms are stored in the seminal vesicles in a seminal fluid. When an orgasm is experienced the seminal fluid and the sperms are emptied into the urethra by means of the process of emission. The seminal fluid, sperms and the secretions of Cowper's glands move through the urethra and are discharged as semen by the penis. Sperms that are not ejaculated within one week are simply reabsorbed by the man's body.

The fluid that is secreted by the seminal vesicles and Cowper's glands facilitate the release of sperm and assist the movement of sperm inside the woman's body. These fluids are also important because they maintain the right acid-alkaline balance for the sperm inside the woman's reproductive system.

1.4.3 The Sexual Response Cycle of Human Beings

The cycle of sexual response of the human being consists of four stages that fuse naturally into one another during sexual arousal: excitement, plateau, orgasm and resolution.

1.4.3.1 Excitement

The excitement phase is the first stage of erotic arousal. The basic physiological process that causes the change in the sexual organs is called vasocongestion - the flow of a large volume of blood-to-blood vessels in one particular region of the body. This process causes both the erection of the penis and the secretion of vaginal lubricants. The lubricants help to prepare the vagina to receive the penis. A man can get an erection as a result of direct stimulation of his genitals, stimulation of another part of the body, or erotic thoughts. The penis is capable of achieving a full

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erection within a couple of seconds. During arousal lubrication of the vagina also happens rapidly, but it is not quite as fast as the male erection.

Women also have an `erection', in the sense that the glans of the clitoris swells. Furthermore, both men and women can experience nipple erection, and women's breasts can enlarge a little. In order to receive the penis, the vagina lengthens and widens within the abdominal cavity. To accommodate this vaginal expansion, the uterus and the cervix pull upwards, increasing the size of the opening in the cervix. This probably makes it easier for sperm to move into the uterus. The labia (majora and minora) also swell and open up to expose the vaginal opening.

During this excitement phase a `sex flush' may be visible on the skins of both men and women. Blood pressure and pulse rate increase, and general myotonia (muscular contractions) may also occur. The woman (sometimes also the man) reveals increased arousal by means of characteristic restless movements of her hands and feet. In men the skin of the scrotum thickens and the scrotum pulls up to lie closer to the man's body.

Discussion topic: What factors may hinder excitement with men and women? Think of physiological dysfunctions; environmental factors like atmosphere, interruptions etc.; and psychological factors like stress, self-concept, the love factor, mood, etc.

1.4.3.2 The plateau

During the plateau the processes that began in the excitement phase build up to a maximum level and remain there until the third phase, orgasm, is reached. The penis now has a complete erection. A few drops of fluid, usually from Cowper's glands, appear on the tip of the penis. Although this fluid is not the ejaculate, it can contain active sperm. In both male and female there is a further increase in pulse rate and blood pressure. The tissues around the lower third of the woman's vagina thicken, reducing the size of the vaginal opening and increasing the gripping of the penis by the vagina. The clitoris retracts into its hood, while the uterus enlarges and draws up even further into the abdominal cavity. The increased blood flow to the labia causes them to darken in colour, indicating that the woman is close to orgasm.

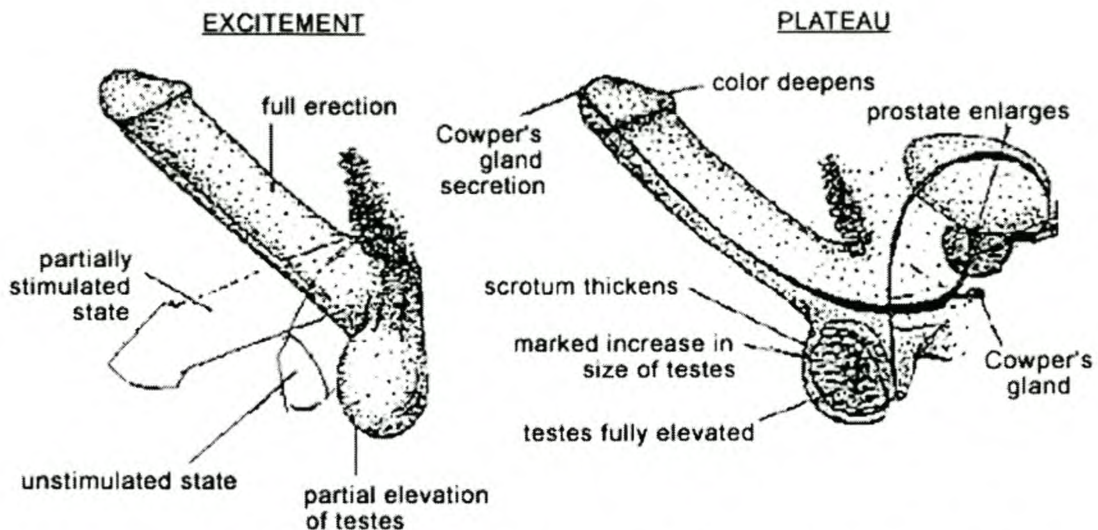

Figure 6: Excitement and Plateau phases of the male sexual response cycle

1.4.3.3 Orgasm

This is the phase referred to by young people as "coming". In the male, orgasm consists of a series of rhythmic contractions (at intervals of 0.8 seconds) of the pelvic organs. Male orgasm has two stages: the first sensation that ejaculation is about to occur is experienced when the ejaculate is forced by contractions from the seminal vesicles to the urethra; in the second stage the urethra and the penis itself contract rhythmically, ejaculating the semen. Both men and women experience a sharp increase in blood pressure, pulse rate, and breathing rate (hyperventilation) during orgasm. Contraction of various bodily muscles may take place. The female orgasm is also a series of rhythmic contractions in the genital area. Waves of contractions are transmitted from the uterus to the cervix and from there to the internal and external vaginal structures. The intense pleasure experienced often manifests itself in vocalization of some kind, such as screaming, laughing or groaning.

Although all orgasms are physiologically the same, the locus of stimulation may differ. As mentioned earlier some women need clitoral stimulation, others can have an orgasm through vaginal stimulation, others can have orgasms through stimulation of any other erogenous zones like for instance the breasts or thighs.

Discussion topic*:* The group might discuss their feelings about "faking" an orgasm and about the over-emphasis nowadays on the attainment of orgasm in sexual activity.

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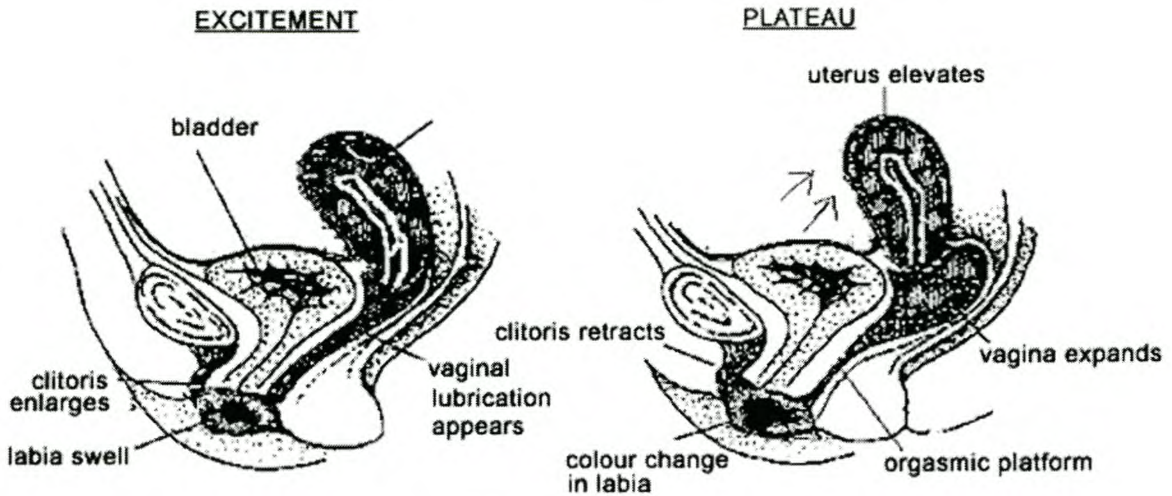

Figure 7: Excitement and Plateau phases of the female sexual response cycle

1.4.3.4 Resolution

During this phase the body returns to its unaroused physiological state.

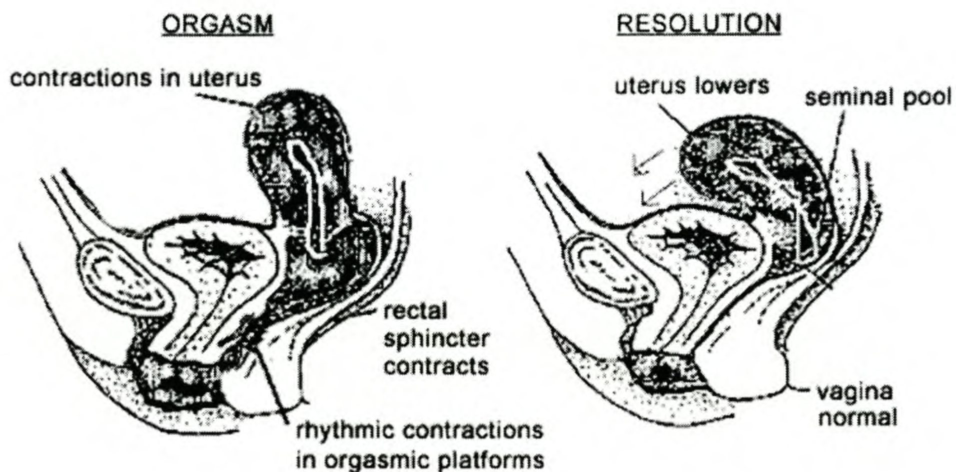

Figure 8: Orgasmic and Resolution phases of the female sexual response cycle

The processes that occurred in the preceding phases are now virtually reversed:

- Massive amounts of muscular tension are released.
- The penis loses its erection.
- The clitoris relaxes and is over-sensitive.
- The female internal sex organs return to their normal size and position.
- The breasts return to their unstimulated size.
- The engorged blood vessels in the genitals return to normal.
- The sex flush disappears.
- The scrotum and the testes return to their normal position.

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- There is an increase in perspiration.

After the resolution phase men still experience a **refractory phase**. During this period the penis is over-sensitive and therefore incapable of arousal. This means erection and orgasm are not possible. The duration of this phase varies between a few minutes and as much as twenty-four hours. The over-sensitivity of the penis directly after sex is also often the reason why men do not want to cuddle or participate in "after-play". Women do not have a refractory period and are, therefore, capable of being aroused to orgasm again virtually immediately. This is the reason, then, why women are able to have so- called multiple orgasms, i.e. more than one orgasm within a short time. BUT research has recently proved that there are men who can have multiple orgasms as well.

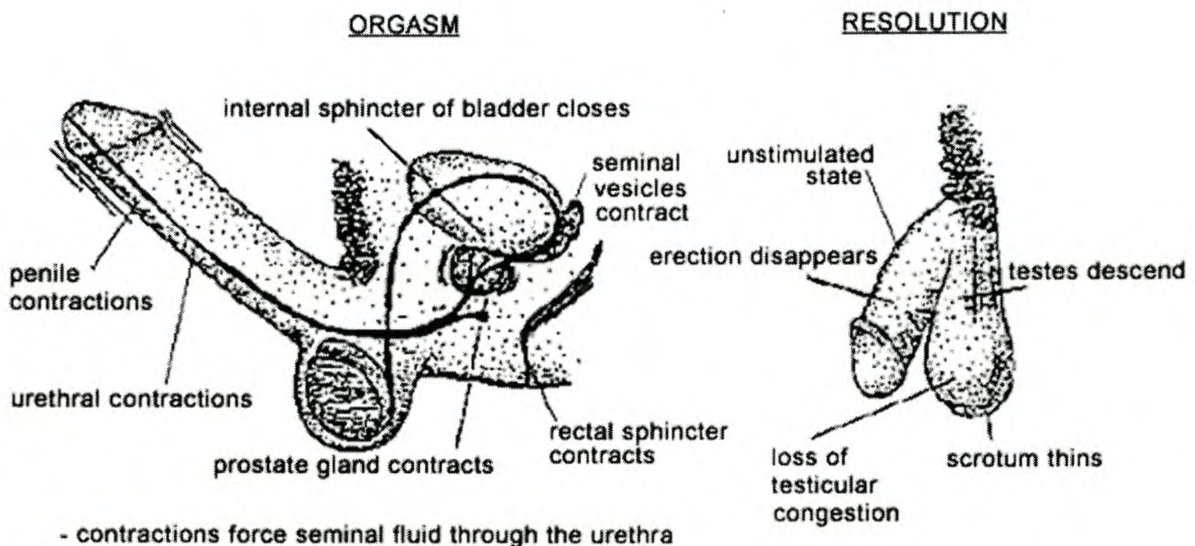

Figure 9: Orgasmic and Resolution phases of the male sexual response cycle

Knowledge of the processes involved in sexual arousal gives you an insight into your own experiences and those of your sexual partner. If you know what he/she is experiencing, it enables you to understand why your partner is reacting in a particular manner and how you should respond. Communication and mutual understanding are thus much easier.

Discussion topic: What do men and women want after sexual intercourse? What is the group members' general opinion of "after-play"?

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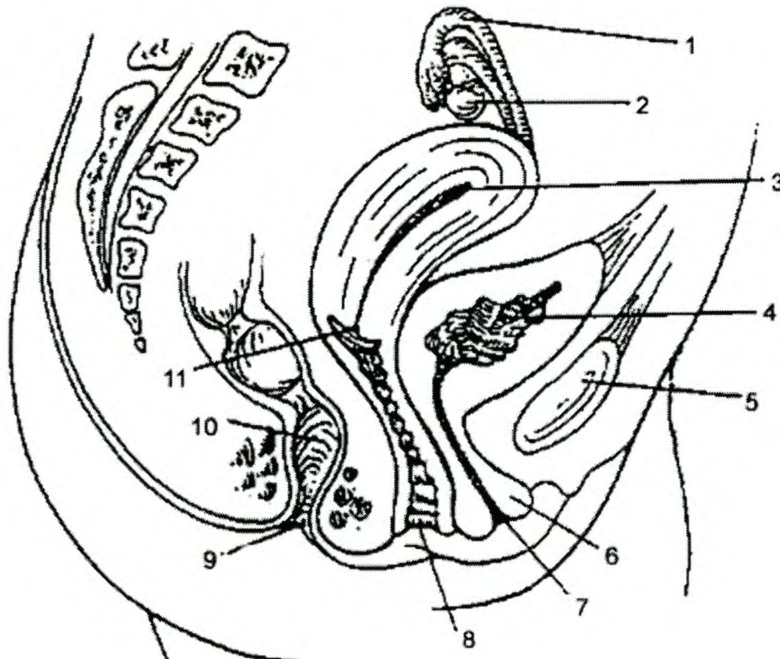
1.5 APPENDIX

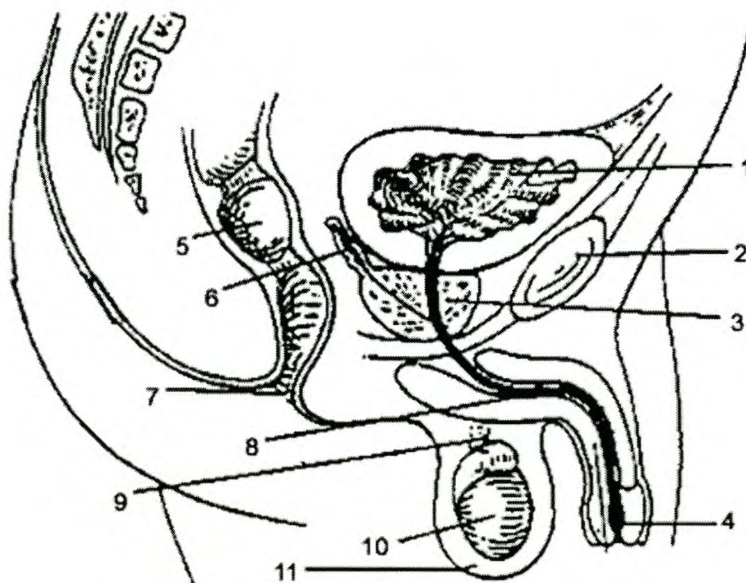
1.5.1 Answer sheets for self assessment

(Each group member must receive a copy of the answer sheets)

1.5.1.1 The reproductive system of the woman



1.5.1.2 The reproductive system of the man



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GROUP SESSION 2:
SEXUALITY - ATTITUDES, VALUES AND PERCEPTIONS

2.1 OBJECTIVES

In order for young people to make effective decisions concerning sexuality they must know what sexuality means to them personally, be able to discuss and think about sexuality freely, and thus determine what they want and need in terms of their sexuality and sexual behaviours.

The aim of Group session 2 is to make students aware of sexuality and the important part it plays in their lives. The students will have the chance to discuss the part that sexuality plays in different areas of their everyday existence. Many young people grow up with the perspective that sexuality is something to be ashamed of, and that it is not, like for instance health and personality, a dimension of being human which should be attended to. They must now be made aware of sexuality as an essential and normal dimension of the human constitution.

Young people get little chance throughout their lives to give more attention to their sexuality than that which they physically experience during puberty. How many young people have really taken the time to think about the part that sexuality plays in their lives? It is interesting to note that most people can clearly describe their personality when asked, but how many can answer the question: " What does your sexuality look like?"

In order to enable students to make effective decisions about their own sexuality, it is necessary for them to determine what exactly their sexuality means to them. A second aim of session two is therefore to give students the chance, through introspection, to get to know their own sexuality. They must form an awareness of sexuality as a clearly defined dimension of themselves. The young people must obtain insight in their own sexuality, in their sexual constitution and sexual needs. They must form an awareness and an acceptance of themselves as sexual beings.

An awareness of the importance of sexuality in their lives, as well as acceptance of sexuality as essential and normal, will promote students' motivation to, as with other aspects of their lives, develop sexuality to be an effective and healthy dimension of their being.

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2.2 STRUCTURE OF THE SESSION

2.2.1 Discussion

Session two consists of discussions and informal chatting. To cover the issue of sexuality as a dimension of general existence, the group members will be provided with topics that they have to write about and then discuss with the group. Group leaders must read through the instructions that are provided for the discussion to understand exactly what to do with the group members in this session.

2.2.2 Homework

It is unlikely that the students will be prepared to discuss personal facts about there own sexuality with the group. Therefore they are given the chance to self-examine their thoughts about their own sexuality in the privacy of their own homes. The group leaders must give the group members the homework assignments included in this session. The group members must complete the homework assignments at home and then hand it in - anonymously - in the next session.

2.3 GUIDELINES FOR THE GROUP LEADER

The session does not require much preparation by the group leaders. It is however preferable that the group leaders try to do the exercises, given in this session, themselves beforehand. This will ensure insight into the subjects which will be discussed and stimulate thoughts about possible questions which might be asked. Doing the exercises beforehand will also enable the group leaders to prepare ways of initiating discussions if it should be necessary. The group leaders should be aware of the fact that each subject encompasses much more than the stimulation-questions included with each subject. They can therefore include all related questions and ideas brought forth by the group members or the group leaders. If, in the flow of discussion, someone should bring up an idea which clearly fits in with one of the subjects which have yet to be discussed in this session, the group leader should bring the discussion back to the subject at hand, while asking the group member to remember his questions until the relevant subject will be discussed.

Encourage the group members to disagree with each other when they consider it to be necessary. The best discussions result from friendly debates. In these cases however the group leader should act as referee - not to determine right from wrong, but to keep the peace if the discussion starts getting out of hand or when group members start getting offensive and aggressive. The group leaders must also remind group members that nobody expects them to share personal details of

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their own sexuality and sexual experiences, but that if they feel comfortable enough they are welcome to enhance the discussion by sharing openly.

2.4 CONTENTS OF GROUP SESSION 2

2.4.1 Discussion of sexuality

2.4.1.1 Instructions for the introduction of discussion topics

1. The topic of sexuality is divided into eight categories. The different categories are given in the following pages.

2. The group members must each choose one category at random. The categories must not be handed out in order as they appear on the following pages.

3. The group members must form pairs.

4. The group members must now write down their thoughts on the topic that they have. They can use the questions provided with each topic as guidelines, but should not in any way restrict themselves to answering just that which is given. Each group of two members must write approximately a page about each of the two topics they have. They must discuss their topics only within their group of two.

5. When all the group members/pairs have had enough time to prepare and discuss their topics, they can start discussing the topics in the larger group. Each group member must give feedback on the topic that he/she had to prepare. General discussion of the topic can then follow.

6. The group leader should leave discussing of the topics to the group members as far as possible. The group leaders must however see to it that the group discusses at least those questions and ideas which are included with each topic. Only when the group members stray too far from the topic or when they do not seem to get to the important questions pertaining to the topic, should the group leader intervene and unobtrusively guide the discussion.

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2.4.1.2 Discussion topics

- Sexuality in the world around us
- Sexuality in our culture
- Sexuality in our home
- Sexuality in our peer group
- Sexuality and the way we dress
- Sexuality and our senses
- Sexuality and our attitude - the attitude of our body, the attitude of our mind
- Sexuality in our social settings

The discussion topics listed above are set out in detail on the following pages:
(The group leaders must remember to make a copy of the discussion topics to hand out to the group members)

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(i) Sexuality in the world around us

What are the first thoughts that go through your mind when you read the above subject?

Sexuality can be recognized in different forms in the world around us. Think of some of the places you will find some or other nuance of sexuality or sexual messages (posters, media, adverts, etc.) How is sexuality used by people in the modern world? For what purposes is sexuality being used? For example in what type of advertisements are they being used, what is the use of sexuality in certain films, etc.? If you look at where and how sexuality is used in the world around you - what is the message that the world is trying to get across to the people? What is the world's general attitude towards sexuality as deduced from films, advertisements, magazines, etc? What is the message that is eventually sent across to the public? What is your opinion of the way sexuality is used in the world around you? ETC.

What other thoughts can you associate with "sexuality in the world around us"?

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(ii) Sexuality in our culture

What are the first thoughts that go through your mind when you read the above subject?

What is your opinion of the way sexuality is perceived within different cultures? Is there a significant difference from one culture to the next (pertaining to sexuality)? Which culture are you a part of? Is there a clear difference between the way sexuality is perceived and handled in your culture and the way in which other cultures handle it? Does your culture influence people to still perceive sexuality in a conservative way or is sexuality something that has a prominent place in your cultural ways? How would you describe the relationship between culture and sexuality? Are you happy with the way sexuality is handled within your culture? Describe how sexuality is perceived within your culture. Are the roles of the sexes strongly separated in your culture - feminine and masculine roles? ETC.

What other thoughts do you associate with "sexuality in our culture"?

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(iii) Sexuality in our home

What are the first thoughts that go through your mind when you read the above subject?

How is sexuality generally handled within the family atmosphere in South Africa? Could a generalization be made? If it is not possible to generalize would it perhaps be possible to point out one or two types of ways in which sexuality is commonly handled in the home? If you think back to your own family and to the home atmospheres of your friends' homes - how was sexuality generally perceived and handled? Do people talk freely about sex and sexuality in the home? Do children and parents walk around naked in front of each other? Is a brother allowed to scratch his genitals in front of his mother or sisters? Do brothers and sisters talk openly to their parents about their romantic relationships? About their sexual relationships? Will children ask their parents to assist in obtaining contraception? Is there sexual rivalry/jealousy between family members? What about masturbation? ETC.

Something else - what does the young person's room look like in the family home? Does it reflect anything of the child's sexual identity? Think of your friend's room at home - does it differ from his/her room on campus (for example)? Is it possible to see more expression of his/her sexuality in the room away from home? Not?

What other thoughts can you associate with "sexuality in our home?"

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(iv) Sexuality in our peer group

What are the first thoughts that go through your mind when you read the above subject?

How is sexuality generally perceived and handled in the young person's group of friends? Does everybody talk freely and openly about sex and sexuality? Do friends tend to talk jokingly and rudely about sexual matters or is the subject handled with seriously? Is there a difference in the way sexuality is handled within a single-gender group as opposed to a double gender group? How are romantic relationships handled within the group of friends? Do you easily swap romantic partners from one friend to the next? Is there sexual rivalry between friends? Do young people feel that their peer group (friends) contributes to the development of their sexuality? Do young people learn a lot concerning sexuality - clothes, attitude, body language, etc. - from their friends? Does sexuality and sex really play a big role in the daily doings and goings-on of the peer group of young people?

What other thoughts do you associate with "sexuality in our peer group"?

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(v) Sexuality and the way we dress

What are the first thoughts that go through your mind when you read the above subject?

What is the relationship between clothes and sexuality? How is sexuality manifested in what we wear? Think of specific extreme examples of people whose clothes clearly betray their sexuality. Everybody's expression of sexuality is not as extreme however - which more subtle expressions of sexuality can you pick up in the clothing of the people around you? On campus? When people go to buy clothes - does their sexuality affect their choice of clothes (even unconsciously)? How do people use their clothes to express their sexuality?

What other thoughts do you associate with "sexuality and the clothes we wear"?

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(vi) Sexuality and our senses

What are the first thoughts that go through your mind when you read the above subject?

How do the senses contribute to the way in which we experience and express our sexuality? Which senses can clearly be related to sexuality? And the more subtle senses? How do we use the senses to express our sexuality? How is our sexuality influenced when somebody else nearby uses his/her senses to express his/her sexuality? Think of after-shave, perfume, make-up, touching, colours, music, ETC.

What other thoughts do you associate with "sexuality and our senses"?

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(vii) Sexuality and our attitudes

The attitude of your body, the attitude of your mind

What are the first thoughts that go through your mind when you read the above subject?

What do our body attitude, your posture and your body language say about our sexuality? Think also of the attitude of your mind - what you think, what you say, and the way in which you say what you think!? Is it possible to form correct opinions of a person's sexuality by looking at his/her body language and posture? What about the tone or volume of their voice? Could you spot the feminist in a group of people by just perceiving her attitude - bodily attitude and otherwise? Think of the various body attitudes of different people in a place like a bar. Discuss the different body attitudes which could be seen there - the body-language of the man trying to pick up a girl, the body-language of the girl who is being flirted with, the body attitude of the girl wearing the tight, short mini-skirt. How do people use their bodies to express their sexuality or blatantly put it on show!?

What other thoughts do you associate with "sexuality and our attitudes - the attitude of your body, the attitude of your mind"?

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(viii) Sexuality in our social settings

What are the first thoughts that go through your mind when you read the above subject?

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In which social settings are young people likely to be most aware of their sexuality? Which social events cause young people to pay special attention to their sexuality? To which type of social settings are young people most likely to go? Do the places young people go to socially reflect anything of their sexuality? Does sexuality or sexual preferences play a role in the choice of social setting young people choose? What about the atmosphere of a social setting - could sexuality be related to atmosphere and thus to the choice of social setting? Do the sexual expression of people change from one social setting to another? How?

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What other thoughts do you associate with " sexuality in our social settings"?

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2.4.2 Homework for Group session 2

(Each group member must receive a copy of 2.4.2)

2.4.2.1 Instructions for group member

Dear group member

Please complete the homework assignments as thoroughly and honestly as possible. Remember that even though you have to hand it in at the next session, it will be anonymous and the content will not be revealed to anybody in the group.

Thank you

2.4.2.2 Homework assignments

(I) Homework assignment 1: Sexuality Questionnaire

(The Questionnaire was adapted from The Sexual Awareness Questionnaire in Snell, Fisher and Miller (1991).)

Questionnaire: My sexuality

Instructions: For each of the following statements decide how true it is of your sexuality or not by indicating whether you: 1 = Strongly Disagree; 2 = Disagree; 3 = Don't Know; 4 = Agree; 5 = Strongly Agree.

	1	2	3	4	5
1. I am very aware of my sexual feelings.					
2. I am assertive about the sexual aspects of my life					
3. I wonder whether others think I'm sexy.					
4. I worry about being criticized because of my sexual behaviour.					
5. I'm very aware of my sexual motivations.					
6. I'm concerned about the sexual appearance of my body.					
7. I don't think about my sexuality very much.					
8. I would like to feel less anxious about my sexual behaviour.					
9. I'm very alert to changes in my sexual desires.					
10. I try to avoid situations where I might get involved sexually.					
11. I do not hesitate to ask for what I want in a romantic relationship.					
12. I am very aware of my sexual tendencies.					
13. I wear attractive clothing to feel good about myself.					
14. I usually worry about making a good sexual impression on others.					

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15. The sexual messages in advertisements, magazines and films have influenced my sexual attitude.					
16. I'm concerned about what other people think of my sex appeal.					
17. I'm very aware of the ways in which I express my sexuality.					
18. My parents taught me a lot about sexual expression.					
19. I have avoided sexual relations because of my sexual fears.					
20. I'm very aware of how my mind works when I am sexually aroused.					
21. I don't care what others think of my sexuality.					
22. I know immediately when others consider me sexy.					
23. I wear attractive clothing to look good for others.					
24. I am very aware of how I use my body to be sexually attractive.					
25. I am somewhat passive about expressing my sexual desires.					
26. I worry a lot about sex.					
27. Before I go out I spend a lot of time seeing to it that I look my best.					
28. I feel sexually inadequate.					
29. When I was a child I was punished because of my sexual behaviour.					

(ii) Homework assignment 2: Write a sexual autobiography

***Guidelines*:** Think of all the different subjects that were discussed in this session. What would you say if you had to discuss all the questions pertaining to the different subjects from a purely personal point of view? Thus - how is culture influencing your sexuality? How is sexuality handled in your family home? What is the role of clothing in the expression of your sexuality? These are the type of questions that you have to answer in writing your sexual autobiography. Use the subjects discussed as guidelines to stimulate your thoughts, although you do not have to limit yourself to them. When/at what stage in your life did you first become aware of your sexuality? What was, in your opinion, your first 'sexual' experience? How did you express your sexuality in the beginning? Have you perhaps changed your sexual image since then? What do you do to define your sexuality? Are you very focused on being totally masculine/feminine? What is type of sexual image that you would like to have? In which situations/places are you more aware of your sexuality? ETC. Write anything that you think might be relevant. Don't just focus on the visible dimensions of sexuality, but also discuss your sexual feelings and sexual personality. How do you want to be when you want to be sexually appealing - timid, aggressive, teasing? What is your sexual language? What is your attitude and body language like in a sexual situation, while communicating with someone from the opposite sex? How would you describe your sexuality?

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GROUP SESSION 3:
SEXUALITY - PERSPECTIVES ON RELATIONSHIPS AND LOVE

3.1 OBJECTIVES

To help the group members gain new and a clarified insight in their own, and other young peoples', expectations and needs pertaining to romantic relationships

In the previous session the group members were given the opportunity to think about and discuss the role that sexuality plays in the world around them. They also had a chance to have a closer look at their own sexuality and to determine its place in their personal lives. In Group session 3 this process of understanding sexual awareness is continued by giving the group members an opportunity to discuss the topics of relationships, love and intimacy openly with persons of the same and opposite sexes. Through discussion of these topics within the relaxed and safe atmosphere provided by the sexuality psycho-education peer group, the group members get the opportunity to put into perspective the role that sex and sexuality play in their romantic relationships.

3.2 STRUCTURE OF THE SESSION

3.2.1 Group discussions

To promote discussion of the relevant subjects, the group members are given assignments that consist of various tasks. The group members have to complete and discuss these tasks. There are three tasks:

In ***Assignment 1, Task (a),*** the group members must try to find answers for the question: "How sexually intimate should/may young people be with their romantic partners?"
In ***Assignment 1, Task (b),*** the group members have to discuss the question: "What determines how sexually intimate young people become in romantic relationships?"
Assignment 2 looks at the needs and expectations, differences and similarities, of men and women in romantic relationships.

The group leaders must explain the assignments to the group members as set out in *Instructions for the group leader* of each assignment. The group members complete the assignments by using the Answer sheet provided for each assignment. Some of the assignments require that the group be divided in smaller groups, while other assignments must be completed by the group as a whole. After the completion of each assignment on the answer sheet, there must be a full discussion of

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the subject at hand. Feedback must also be given about the relevant questions that are provided on the *Answer sheet* as well as in *Instructions for the group leader* of each assignment.

3.2.2 Homework

It is necessary that group members not only talk and think about the expectations and needs for romantic relationships of young people in general, but that they also get the opportunity to focus on their own personal needs and expectations for relationships. ***The purpose of the homework is to provide the group members with such an opportunity to think about their personal needs and expectations for their own relationships and sexual intimacy.*** To stimulate such more personal thoughts, each group member is given two short questionnaires that he/she has to complete at home. The questionnaires are closely interlinked with the content of session three. The questionnaires must be handed in, anonymously, at the next session.

3.3 GUIDELINES FOR THE GROUP LEADERS

It is always difficult for young people to discuss intimacy and relationships, and particularly so when the discussions seem to get too close to their personal lives and own experiences. The abstract and comprehensive nature of the topics that are dealt with in this session encumbers its presentation. In the light of these above-mentioned problems it is important that the group leaders are very well prepared for the presentation of Group session 3.

This session requires good guidance from the group leader. It would be preferable that the group leaders read through and complete the assignments themselves beforehand in order to identify possible problem areas as well as useful discussion topics before they present the session to the group. In *Answer sheet* as well as *Instructions for the group leader* of each assignment there are questions that the group leaders can use to stimulate group discussions. The group leaders do not however have to restrict themselves to the given questions - on the contrary - it is always beneficial when group leaders can supplement the given material with questions and topical issues with which to liven up the group discussions.

On the other hand it is also important for the group leaders to see to it that discussions do not deviate too far from the central topics that have to be discussed. As soon as the group members start to stray too far from the topics at hand in their discussions, the group leaders should use the questions provided in this session to lead the group members back to the important issues.

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In their discussions the group members should cover:

- the role of sexual intimacy in romantic relationships of young people
- the role which love plays in the romantic relationships of young people
- the relationship between love and sexual intimacy
- the needs and expectations of young men and women for their romantic relationships

It is preferable that, even though the topics of the session are tackled by using three separate tasks, the group leader should, as far as it is possible, try to show the connection between the different assignments/tasks, through a logical continuum of questions and discussion. By placing the most important topics of this session within a total image of sex, love and relationships, and presenting it that way, the group leaders make it easier for the group members to gain a clear and organized insight in the important issues at hand.

It is often difficult for the group members to discuss topics such as sexual intimacy and love openly, as they have to refer frequently, if only in their thoughts, to their own life and experiences. The group leaders therefore have to make it clear to the group members that it is not expected that they share personal information with the group. It is hoped, of course, that the group members will, during the discussion of sex, love and intimacy, be stimulated to at least think about these issues as applicable to their personal situations. Group leaders should however not discourage group members who *want* to speak about their personal life and experiences, because it is always beneficial to the other group members if such issues can be frankly discusses within the group situation. If the group leader is willing to use his/her own personal experience and knowledge to stimulate discussions, group members also tend to contribute to the session more freely. During the group discussions however, it is never *required that* personal thoughts be shared directly with the group. The group members can then focus on the discussion of the way in which young people around them on campus, in their peer groups and in their social settings, handle sex, intimacy, love and relationships. Through the completion of the homework assignments the group members will have a chance to focus their attention on their *personal* expectations and needs concerning sexual intimacy and love.

While the homework might be the only opportunity for personal reflection in this session, it could be useful to motivate the group members to give their the homework their fullest attention by explaining to them the objectives of the homework (as set out in 3.2). Group members can do the homework together with their girlfriend/boyfriend in order to determine each other's needs, expectations and guidelines for their relationship. The group leaders must once again stress that all homework will be handled in the strictest confidence.

If the group leaders are well prepared and feel comfortable with the topics of Group session 3, they will be able to give good guidance to the group members when needed, and it will also be easier for the group members to speak openly and honestly about love and sexual intimacy.

3.4 CONTENT OF GROUP SESSION 3

3.4.1 Group discussion

3.4.1.1 Assignment 1: Sexual intimacy

(i) Instructions for the group leaders

1. Divide the group into two mixed-gender groups.

2. Give each group a copy of Answer sheet Assignment 1.

3. Explain to the group members that:

Assignment 1, Task (a), centres on the well-known question: "How sexually intimate should/may young people become with their romantic partners? And how fast?". The groups must study the levels of sexual intimacy, as set out by National Health, and then discuss the above-mentioned question with reference to the levels of sexual intimacy and the instructions as given in Answer sheet Task (a). ***The task basically involves that the group should ask themselves: If they could compile a document which would tell young people on campus how far and fast they could go in terms of sexual intimacy, what would the group say to the young people in this document?***

(Group leaders and group members must read the instructions on the answer sheet for Task (a) thoroughly)

also explain to them that:

Everybody knows that there are very few students who would follow set guidelines for the progression of their sexual intimacy, because there are many factors which students take into account when deciding to become sexually intimate with someone or not. In Assignment 1, Task (b), the group members must compile a list of those factors which they think influence how sexually intimate different young people become before marriage with their romantic partners - for instance some are influenced by their religion, some by their upbringing and others perhaps by their

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personality, etc. ***The group must ask themselves : If young men/women are asked by their romantic partners to go on to a next stage of sexual intimacy, which factors do young people, and which factors should young people, take into account when they have to decide whether to become more sexually intimate or not?***

(Group leaders and group members must read the instructions on the answer sheet for Task (b) thoroughly)

4. Make sure that the group members understand the tasks before they start with the assignment.

5. When the groups have had sufficient time to complete the tasks, the two groups must give feedback on their answers and discussions:

The two groups must try, through joint discussion and debating, to evaluate critically each other's answers for Task (a) and Task (b). Each group must decide whether they think the other group's answers are realistic, whether they agree or disagree with the other group, and motivate why they then agree or not. During the joint discussions and debating the two groups must write down those answers and ideas about which they agree on a clean Answer sheet. In the end there will thus be a document that will reflect the viewpoints of the unified sexuality education group regarding young peoples' sexual intimacy in relationships.

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(ii) Answer sheet Assignment 1

(Each group must receive a copy of *Answer sheet assignment 1*)

Instructions for the group members Task (a)

NATIONAL HEALTH OFFICIALS HAVE IDENTIFIED THE FOLLOWING SUCCESSIVE LEVELS OF SEXUAL INTIMACY IN ROMANTIC RELATIONSHIPS:
Light embracing or fond holding of hands.
Casual goodnight kissing.
Intense (french) kissing.
Horizontal embrace with some petting but not undressed.
Petting of breast area from outside of clothing.
Petting of breast area without clothes intervening.
Petting below the waist from outside of clothing.
Petting below the waist without clothes intervening.
Nude embrace
Oral sexual stimulation
Sexual intercourse

Every young man/woman decides for him/herself when, where and how he/she is going to be sexually intimate with the romantic or sexual partner. Some young people will have sex on the first date, others wait months before they let their boyfriend/girlfriend give them an intense french kiss. ***Task (a), centres round the question: How sexually intimate could/may young people become with their romantic partners before marriage?, and how fast?".*** Study the levels of sexual intimacy as proposed by National Health. Then complete the following exercise by filling in, next to each level of physical intimacy, time spans or situations which reflect how far and how fast your group think young people could/may progress in terms of sexual intimacy before marriage.
For example: Light embracing and fond holding of hands - **first date;** Intense french kissing - **after two weeks casual dating,** etc.

Task (a)

How far and how fast could/may young people physically progress in relationships before marriage?

- Light embracing or fond holding of hands.

____

- Casual goodnight kissing.

____

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- Intense (french) kissing.

___

- Horizontal embrace with some petting but not undressed.

___

- Petting of breast area from outside of clothing.

___

- Petting of breast area without clothes intervening.

___

- Petting below the waist from outside of clothing.

___

- Petting below the waist without clothes intervening.

___

- Nude embrace

___

- Oral sexual stimulation

___

- Sexual intercourse

___

The group must be able to explain what their motivation was for the time spans and situations they decided on. General comments, opinions, ideas?

___

___

___

Are students on campus really so sexually involved/active as everybody says? Is it true that almost every student on campus will in their years at university have at least one one-night stand that involves, if not sexual intercourse, very intimate physical activity? If the group members take a look at their immediate circle of friends and their sexual activities, are the young people of today throwing themselves into sexual experiences without any serious considerations to the consequences? Which stage of the physical intimacy chart have most of the students on campus or the people in the immediate peer group of the group members reached? What are the group members' feelings concerning the physical/sexual activities of young people on campus? Are the group members positive or negative about the state of romantic relationships on campus? If negative - what is wrong with the relationships of students on campus? What is right?

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Instructions for the group members Task (b)

Why does the group think that the levels of intimacy should progress in the way you decided on in Task (a)? Which factors determined that you set up the time scheme for progression of levels of intimacy in Task (a) as you did? After all, there are several factors which influence young men's' and women's' decisions to go on to a next stage of physical intimacy or not. Some young people might feel that they are emotionally intimate enough to have sexual intercourse with their partner before marriage, while others, because of moral principles, might not go further than kissing before marriage. **In Task (b) the group must compile a list - firstly of all the factors which you think influence, and secondly all the factors which you think should have an influence on, how sexually intimate young people become with their romantic partners before marriage. Why is it that some wait and others do not?**
For example: Religious principles, length of relationship, shyness, emotional attachment to boy/girlfriend, etc.

Task (b)

If young men/women are asked by their romantic partners to go on to a next stage of sexual intimacy, which factors do young people, and which factors should young people, take into account when they have to decide whether to become more sexually intimate or not?

____

____

____

____

How easy is it to decide how sexually intimate you are going to be before marriage and then to stick to the decision? If not, what makes it difficult? Are there times when young people become more sexually intimate with their partners than they actually want to? If they do, why/when? If young peoples' romantic partners do sexual acts they do not like, how do the young people handle the situation? General comments, opinions, ideas?

____

____

____

____

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3.4 1.2 Assignment 2: Sex, Love and commitment

(i) Instructions for the group leaders

1. Divide the group into two smaller gender specific groups - men in one group and women in the other.

2. Give each group a copy of Answer sheet Assignment 2.

3. Explain to the group members that:

They will now be given an opportunity to get to learn more about the ideas and opinions which the opposite sex has concerning sex, love and commitment in romantic relationships.

and that:

In Assignment 2 each group has to compile a list of general problems, and then especially problems they have with the opposite sex in their romantic relationships. Each group must also compile a list of the ± ten most important prerequisites each gender has for their relationships and for potential girlfriends/boyfriends. Thus - what do they want from the opposite sex in a romantic relationship? What is it that they like about members of the opposite sex?

On the Answer sheet Assignment 2 there are a few questions and discussion topics that must be discussed by the group members and prepared for eventual feedback.

4. Make sure that the group members understand the assignment before they start.

5. When the groups have had sufficient time to complete the tasks, the two groups must give feedback on their answers and discussions:

What are the main problems men have with women in romantic situations? What do the women have to say about it? What do the women want to say about their problems with men and relationships? What can the men say to that? Can the opposite sexes in the group help each other with ideas for the problems they experience in romantic relationships? Maybe by telling each other what it is that they like of the opposite sex? and revealing what men and women want from each other?

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The two groups must also give feedback about their discussions of the questions and discussion topics on love and commitment that are given on Answer sheet Assignment 2. Do men and women differ in their perspectives on the importance of love and commitment in the relationships of young people? What are the differences? On which issues do men and women agree? Are the problems experienced by men and women in romantic relationships really so different? Are love and commitment still important to young people? Are love and commitment more important than physical sexual pleasure - or do these aspects go hand in hand? etc.

6. The group leaders should explain to the group members that they must feel free to share any thoughts or comments on the topic of sex, love and commitment with the group.

Through joint discussion and debating the group members must critically evaluate and give feedback on each other's opinions and comments. When this assignment has been completed the group members should know and understand something more of the needs and expectations that the opposite sex have for their romantic relationships.

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(ii) Answer sheet Assignment 2

(Each group must receive a copy of *Answer sheet assignment 2*)

Instructions for the group members

Assignment 2 involves that the two genders talk about sex, love and commitment within relationships, and then exchange ideas and opinions concerning this topic with the opposite gender.

The ***men*** should discuss in their group:

- Which problems do they have in general with their romantic relationships?
- Which problems do they have specifically with girlfriends in romantic relationships/situations?
- What do they want from women?
- Which characteristics of women do they like?
- What do they want in relationships at this stage of their lives?
- How does their ideal women look like?/ What is their ideal women like within a romantic relationship?

The ***women*** should discuss in their group:

- Which problems do they have in general with their romantic relationships?
- Which problems do they have specifically with boyfriends in romantic relationships/situations?
- What do they want from men?
- Which characteristics of men do they like?
- What do they want in relationships at this stage of their lives?
- How does their ideal man look like?/ What is their ideal man like within a romantic relationship?

Each group must, throughout the discussions, fill in their answers, ideas and opinions on the lists given below. Both groups should also discuss the questions concerning love and commitment that appear at the bottom of the Answer sheet, and prepare themselves for later feedback.

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Assignment

Problems with romantic relationships?

Problems with girlfriends/boyfriends?

What should your romantic partner look like/be like?

What do you want from your romantic relationships?

What do you want to say to the opposite sex?/ What do you want to ask the opposite sex?

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Questions for discussion: Love and Commitment

- Are relationships still important to young people - or are many of them open to physical intimacy without any commitment? Is love still important?
- Is the idea true about it being easier for men than for women to be sexually intimate without any sense of commitment or emotional attachment? Does this show on campus?
- Which of the factors listed in Assignment 1, Task (b), have the greatest impact on the sexual decision-making of young people on campus? Love, religion, personal beliefs, fear? Does love fall under the top/most important three?
- What is love? What is the difference between loving and being in-love? Is there a difference? Does it matter on campus whether you are in-love or whether you love someone?
- How does each gender group feel about the role of love and commitment in young peoples' romantic relationships?
- How important are love and commitment for men? and for women? in romantic relationships at this young age?
- Do love and commitment influence the level of sexual intimacy in the relationships of young people? How?
- Are there other reasons why young people on campus might have romantic relationships other than because they fell in love?
- If the group members look at the state of sexual activities - one night stands, 'jols' in public places, cheating on partners, etc. - do young people on campus still care about love and commitment? If not - why not?
- Why do men have one-night stands and casual 'jols'? Why do women have one-night stands and casual 'jols'?
- If young people are not yet sexually active - which factor usually keeps them from having sex? If they are already sexually active - what usually make them decide to have sex before marriage? Do young people often have to sacrifice some of the beliefs which usually have an important influence on their lives (as you listed in Assignment 1, Task (b)), to be sexually active?
- How does each gender group feel about marriage in this day and age. What about living together?
- If the group had to sum up the conclusion that most of the group members have come to about sex, love and commitment in relationships - short and sweet, what would it be?

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3.4.2 Homework for Group session 3

(Each group member must receive a copy of 3.4.2)

3.4.2.1 Instructions for group members

Dear group member

With reference to the Assignments which you completed in group session 3 in terms of young people in general, please complete the homework assignments as thoroughly and honestly as possible in terms of your personal feelings concerning sex, love and commitment. Remember that even though you have to hand it in at the next session, it will be anonymous and even so will not be revealed to anybody in the group.

N.B. You will not be expected to hand in homework assignment 1. For that very reason we request you to complete this assignment as thoroughly and honestly as possible so that you'll be able to get maximum personal benefit from it.

3.4.2.2 Homework assignments

(i) Homework assignment 1

How far and how fast would you physically progress in relationships before marriage? Decide for yourself how you feel about sexual intimacy before marriage. Focus on how you feel about it personally and not on what is generally expected of you, or what is socially acceptable. On the form below fill in time spans or situations that reflect when you would allow yourself to progress to each of the levels of physical intimacy with a man/woman:

- Light embracing or fond holding of hands.________________________________
- Casual goodnight kissing.____
- Intense (french) kissing.____
- Horizontal embrace with some petting but not undressed._____________________
- Petting of breast area from outside of clothing.___________________________
- Petting of breast area without clothes intervening._________________________
- Petting below the waist from outside of clothing.__________________________
- Petting below the waist without clothes intervening.________________________
- Nude embrace____
- Oral sexual stimulation____
- Sexual intercourse____

Do you think that you will be able to stick to a decision to let your sexual intimacy progress as you set it out above? If not - What could possibly make you change your mind; what could possibly make you move faster or slower in terms of sexual intimacy with a man/woman?

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(ii) Homework assignment 2

If your men/women are asked by your romantic partners to go on to a next stage of sexual intimacy, which factors influence your decision, when you have to decide whether to become more sexually intimate or not? Which factors had an influence on how you completed the list in Homework assignment 1?

____

____

____

____

____

____

Which of the factors that you mentioned above weigh more heavily than others? If you are not yet sexually active - which factor has kept you from having sex? If you are already sexually active - what made you decide to have sex before marriage? Did you have to sacrifice some of the factors that usually have an important influence on your life to be sexually active? Is it possible for you to take a decision always to take all the factors that are important to you into account before you go on to a further level of sexual intimacy?

Is it possible for you to decide now that you will always take your own needs and expectations into account when you are sexually intimate with a romantic partner, and that you will not allow yourself to do things with which you do not agree and which you do not feel comfortable with?

YES ☐ *NO* ☐ *UNSURE* ☐

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(iii) Homework assignment 3

What problems do you have with your romantic relationships / with you relationships with members of the opposite sex?

____

____

What problems do you have with girlfriends/boyfriends in relationships and romantic situations?

____

____

What do you think you can do about it?

____

____

What is good in your romantic relationships? in your relationships with members of the opposite sex?

____

____

What should your romantic partner look like/be like?

____

____

Does your romantic partner/ the persons with whom you have romantic interludes at present fit in your framework of needs and expectations for a romantic partner? Explain.

____

____

What do you want from your romantic relationships?

____

____

Are your romantic relationships at present within your expectations and needs you have for such relationships? Explain.

____

____

What would you like to say to yourself: any resolutions, decisions or convictions, of which you want to remind yourself, or want to stress, concerning your relationships with the opposite sex?

____

____

____

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GROUP SESSION 4:
SEXUALLY TRANSMITTED DISEASES

4.1 OBJECTIVES

- **To equip the group members with the knowledge which will enable them to recognize the symptoms of sexually transmitted diseases.**

- **To motivate the group leaders to practice sexual behaviour that promotes the prevention of the spread of sexually transmitted diseases by developing their insight into the serious consequences of these diseases.**

- **To introduce the group leaders to the support system available to them for the prevention and treatment of sexually transmitted diseases.**

Almost all sexually transmitted diseases can be controlled and cured with the correct medical treatment. Unfortunately it is precisely this fact that results in young people not being very worried about infection with and the transmission of sexually transmitted diseases. Young people are uninformed about the extensive consequences of these diseases. They do not realize that the effects of sexually transmitted diseases do not stop with an itch here and a rash there - *these diseases can cause blindness, infertility, heart problems, skin infections, insanity, abnormalities of the unborn fetus as well as death.*

Young people also do not possess sufficient knowledge of the symptoms of sexually transmitted diseases and are therefore unsuccessful in recognizing when they themselves, or their sexual partners, are infected with such a disease. Because of this the young people do not go for treatment soon enough thus spreading the disease and putting their own health at risk.

4.2 STRUCTURE OF THIS SESSION

4.2.1 Introduction to sexually transmitted diseases

Group participation is not a big part of this group session. The session mostly takes on the form of a lecture. It is important however to focus the group members' thoughts on the subject at hand before starting with the lecture. For this purpose the group leaders must start the session by facilitating a short discussion about the group members' possible experience with sexually transmitted diseases. In 4.4 a few questions are provided which are indicative of the type of questions that the group leaders can use to stimulate the discussion.

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4.2.2 Lecture

The group leader must convey the information about the transmission, symptoms, treatment and prevention of sexually transmitted diseases, as provided in Contents of Group session 4, to the group members in lecture format. The group leaders must use the medical photographs, provided in this session, to enhance the information given in the lecture. The following sexually transmitted diseases are discussed in this session: Gonorrhea, Syphilis, Genital Herpes, Trychomoniases, Chlamydia, Pubic lice, Genital warts and Moniliases. The lecture ends with some pertinent facts about sexually transmitted diseases.

4.2.3 Prevention and treatment

The group leaders must end the session with a combination lecture-discussion about the prevention and treatment of sexually transmitted diseases. Some information is provided for the group leader, but the group leader should first try to get the group members to share what they know about prevention and treatment of STD's before presenting the given information. In Contents of Group session 4 questions are provided which are indicative of the type of questions the group leaders can use to stimulate the group discussion.

4.3 GUIDELINES FOR THE GROUP LEADER

Group members generally find the subject of sexually transmitted diseases very sensitive and personal. The information that is conveyed to them, and especially the visual material, can cause unease. Most people feel more comfortable with the subject if it is handled in a highly professional manner. It will be necessary for the group leaders to present this session in a more clinical and serious way than they had done with previous more informal discussion sessions.

The group leaders should however still see to it that an atmosphere reigns in which the group members will feel free at any time to ask questions and offer opinions. Even though group activity and participation are not so important in this session, spontaneous participation should never be suppressed/discouraged.

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4.4 CONTENTS OF GROUPSESSION 4

4.4.1 Introduction to sexually transmitted diseases

The following questions are indicative of the type of questions the group leaders can ask to stimulate the introductory discussion (also see 4.2 for guidelines)*:*

- Name a few sexually transmitted diseases you already know of.
- How did you become knowledgeable about the sexually transmitted diseases you named above?
- What do you know about the diseases you named above?
- Are sexually transmitted diseases generally/often discussed? Why (not)?
- Are you ever concerned that you might be infected with such a disease? Do you think that the emphasis placed on AIDS results in not enough attention being given to sexually transmitted diseases?
- What do you think you should know about sexually transmitted diseases? What do you want to know about sexually transmitted diseases?

The group leader must get the introductory discussion going and then put the given, and new, questions to the group members according to the course the discussion follows. (Because of the extensive amount of information that has to be conveyed to the group members in this session, the introductory discussion should not take up too much time)

4.4.2 Sexually transmitted diseases

(Resources: Department of National Health and Population Development, 1991; Hyde, 1994)

Because there are a large number of sexually transmitted diseases, it is impossible to deal with all of them. The ones that will be discussed are those that occur most often within the general sexually active population.

4.4.2.1 Gonorrhea ("the clap")

How do you get it?

Most cases of gonorrhea result from penis-in-vagina intercourse. However, the gonorrhea virus can also be passed on by any other intimate sexual contact, for example oral or anal sex.

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How soon do the symptoms appear?

The symptoms usually appear within ten days after contact with the gonorrhea virus - it may even be the next day. It is necessary, however, that the infected person's partners of the past two months be examined and treated.

Symptoms and consequences

The early symptoms of gonorrhea in the male are painful and obvious, and therefore most men go for treatment immediately. A thick, creamy discharge, which can be white, yellow or yellow-green, comes from the opening at the tip of the penis. A painful, burning sensation is experienced when urinating, and the urine may contain blood or pus. The glands in the groin are swollen and the entire pelvic area may be tender. If the disease is not treated soon enough, the infection will spread to the man's internal reproductive organs. The pain during urination intensifies and is felt in the whole penis. The tissue of various organs becomes swollen. If the swelling also occurs in the testicles, scar tissue may form and leave the man sterile.

Approximately 60-80% of women with gonorrhea show no symptoms in the early stages of the disease. Because they do not realize that they need treatment, they can unwittingly spread the virus. It is very important, therefore, that the woman's sexual partner should inform her if the partner finds that he/she has been infected. When the woman's symptoms do start to appear, there is a yellow-green discharge that irritates the vulva of the vagina. As in the male, the infection can spread to the urethra and cause painful urination. If the infection is left unattended, it will spread to the uterus and the fallopian tubes. The woman usually experiences pelvic pain, and sometimes also irregular and painful menstruation. The swelling in the Fallopian tubes may leave scar tissue that can block the tubes and prevent sperm from passing through. Consequently the woman is sterile. Sometimes the tubes are only partially blocked, so that sperm is able to pass through; however, the woman's ovum is unable to move down. Conception may then take place in the tube, resulting in a so-called ectopic pregnancy. An ectopic pregnancy usually ends in one of two ways: the embryo is aborted spontaneously, or the embryo grows until it causes the surrounding internal structures to rupture and the embryo is then aborted. When a woman's internal reproductive organs burst open like this because of an ectopic pregnancy, there is heavy bleeding and the woman's body is in a severe state of shock. The risk of death is high.

The gonorrhea virus is spread from the sex organs. Anal sex can spread the virus from an infected person to the anus and the rectum of the person penetrated. Oral sex can transfer the virus to the mouth and throat structures. (The gonorrhea virus is very seldom spread by mouth-to-mouth kissing.) People who touch their eyes immediately after touching infected genitals spread the virus

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to the eyes. When the virus enters the bloodstream, infected mothers often transfer the virus to their unborn babies. These infants are then usually born with the infection in their eyes. If infected eyes are not treated soon enough, they become heavily swollen and very painful. Blindness may result. A gonorrhea virus in the bloodstream may affect the bone joints and cause gonorrheal arthritis, or it may have an effect on the heart valves.

How is gonorrhea treated?

Gonorrhea is treated with antibiotics. If the infected person receives medical attention soon enough, the virus can be totally destroyed.

4.4.2.2 Syphilis

How do you get it?

Syphilis is contracted through intimate sexual contact with an infected person.

How soon do the symptoms appear?

Syphilis has four phases. The first symptoms are usually those of primary-stage syphilis, and they appear 3-4 weeks after contact with the infected person. The symptoms of secondary-stage syphilis are more generalized and appear 3-6 months after contact. A latent stage follows, in which there are no noticeable symptoms, but the bacteria are spreading gradually within the body tissue. During late, or tertiary syphilis, which can develop many years after the first contact with the infected person, the person is usually very ill.

Symptoms and consequences

The main symptom during the first stage of syphilis is the chancre. The chancre is an ulcer-like lesion with a hard, raised edge that causes the structure to look like a crater. Although the chancre looks terrible, it is painless. It often appears on the glans of the penis. In the woman it may develop on the cervix, and the woman may be unaware of it. It also occurs on the labia and vulva of the vagina. If oral or anal sex took place the chancre may also appear on the mucous membranes of the mouth or rectum. Although it seldom happens, it is possible to contract syphilis from touching the exposed chancre of an infected person. The newly infected person will then develop a chancre on the hand/bodily part that touched the other person.

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The primary stage

The primary stage refers to the first few weeks of syphilis during which the chancre is present. Should the chancre not be treated, it nevertheless disappears after 1-5 weeks. This is, however, not an indication that the disease has cleared up.

The secondary stage

By the time the chancre has disappeared the syphilis bacteria have already entered the bloodstream and have traveled through the body. The appearance of a generalized body rash indicates the onset of the secondary stage. A distinctive feature of the rash is that the raised bumps do not itch or hurt at all. On white skins the rash is initially reddish, but later becomes a shade of brown. On a black skin it is grayish blue. On the moist areas of the body the bumps become larger and they burst open to release a thick fluid. This fluid is very dangerous, because it contains many syphilis bacteria. Other symptoms of this phase are hair loss, fever, swollen glands, a sore throat, loss of appetite, pains in the muscles, bones and joints, and headaches.

With the right treatment the disease can still be stopped at this stage without the sufferer having any permanent side effects.

The latent stage

The symptoms of the secondary stage disappear spontaneously after 2-5 weeks, just as the chancre disappeared. Most infected people believe that they are healthy again. However, the bacteria are still present in the body, and are penetrating the tissue throughout the body. This latent stage may last several years. After the first year of the latent stage the disease is no longer contagious, although a pregnant infected mother may transfer it to the foetus.

Late-stage (tertiary) syphilis

Approximately 50% of persons who are infected with syphilis and allow it to develop to the latent stage remain permanently in this stage and have no further complications from the bacteria. The other 50%, however, move into the dangerous last stage of the infection - tertiary syphilis. During this stage syphilis can attack the body in three ways:

- The bacteria may attack the internal organs, eyes, skin, muscles or endocrine glands. If treatment is given soon enough, the person can recover completely.
- The bacteria may attack the heart and the major blood vessels. This cardiovascular syphilis is often fatal - the person dies (usually 10-40 years after contracting the disease).

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- The bacteria may also attack the nervous system and brain, causing paralysis and insanity. This type may also be fatal (usually 10-20 years after infection).

How is syphilis treated?

Syphilis is treated with antibiotics (penicillin). Follow-up examinations are needed to ensure that the bacteria have been destroyed.

4.4.2.3 Genital herpes

How do you get it?

The genital herpes virus is transmitted by sexual intercourse, although there are people who have it whose only sexual partner does not. The sores and blisters of non-genital herpes may also spread to the genitals as a result of oral-genital sex.

How soon do the symptoms appear?

The first symptoms usually appear between two and twenty days after infection.

Symptoms and consequences

The symptoms are mainly the appearance of small, painful bumps or blisters. These may occur on the external male or female genitals. If anal sex took place, they may also be found around the anus. The blisters burst and cause painful sores. The blisters usually heal on their own within a few weeks, but the virus continues to live in the person's body and the symptoms may recur from time to time. A pregnant woman with herpes may transmit the disease to the foetus. Some babies recover, but others develop a brain infection that soon leads to death.

How is it treated?

There is no known drug that kills the genital herpes virus. Persons infected with this virus harbour it in their bodies for the rest of their lives.

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4.4.2.4 Trichomoniasis

How does one get it?

Trichomoniasis can be passed on by sexual contact between a man and a woman, but it can also be contracted from contaminated toilet seats or washcloths.

How soon do the symptoms appear?

The symptoms usually appear approximately seven days after contact with the contaminated object or person.

Symptoms and consequences

The woman who has been infected with trichomoniasis has a frothy, white or yellow vaginal discharge. The discharge irritates the vulva and also has an unpleasant smell. There are usually no symptoms in the male, but because men can pass the disease on to a woman. The partners should both be examined and treated if they were exposed to it. The disease can be treated the treatment should be given as soon as possible, for untreated trichomoniasis causes serious vaginal infections. It may also affect the cells of the cervix and make the woman more susceptible to cancer.

How is it treated?

Trichomoniasis is treated with Flagyl, an oral medication.

4.4.2.5 Chlamydia

How does one get it?

The disease is spread by sexual contact.

How soon do the symptoms appear?

The first symptoms can be detected after approximately 1-3 weeks.

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Symptoms and consequences

In the male the symptoms of chlamydia are very similar to those of gonorrhea. Because the urethra is infected, urination is painful. There is also a discharge from the penis. However, the pain when urinating is less severe than with gonorrhea, and the discharge is clearer and more fluid. An infected woman has an unusual vaginal discharge and may also experience pain when urinating. Pelvic pains may occur and there may be bleeding after intercourse. Often, though, the woman's symptoms are vague.

If the disease is not treated, the infection may spread to the surrounding reproductive organs, and may cause infertility in the infected person, male or female. A baby born to an infected woman may develop pneumonia or may have eye infections.

4.4.2.6 Pubic lice ("crabs")

How do you get them?

Pubic lice are easily spread from one person to another. They may be transmitted by sexual contact, by intimate bodily contact with an infected person or by contact with the same clothes, bedding, etc. as an infected person.

How soon do the symptoms appear?

The symptoms may be perceived immediately after infection.

Symptoms and consequences

Pubic lice are tiny lice - about the size of a pinhead - that attach themselves to the base of pubic hairs and then feed on the blood of their human host. The major symptom of this infection is an itching in the region of the pubic hair. As the eggs that have been laid in the pubic hairs hatch, the lice continue to multiply. If the lice and the eggs are not destroyed, an extreme irritation of the skin around the pubic area will result.

How is it treated?

The lice and the eggs are destroyed by washing the pubic hair with special shampoos and applying special creams. As the lice have a lifespan of only twenty-four hours, it is unnecessary to wash

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clothes and bedding that were used more than two days before. However, the eggs may live up to six days, so it is better to wash clothes and bedding in hot water.

4.4.2.7 Genital warts

How do you get them?

Genital warts are contracted through sexual intercourse with someone infected with the virus, but one may also get it from skin-to-skin contact with the warts.

How soon do the symptoms appear?

The warts usually appear 1-6 months after contact.

Symptoms and consequences

Genital warts are cauliflower-like warts that occur on male or female genitals. In the male they grow on the shaft or around the urethral opening or on the scrotum. In the woman they may appear on the vulva, on the vaginal walls or on the cervix. There is much concern over the incidence of genital warts, because it would appear that the presence of warts on the cervix is linked to an increased risk of cervical cancer. In fact, genital warts are now also associated with cancer of the vagina, vulva, penis, and anus. Another effect of the disease, if it is not treated in time, is that the warts multiply and spread, to the extent that they may cause discomfort during intercourse. Like many other sexually transmitted diseases the virus may also be passed on to an unborn baby.

How is the disease treated?

Carbon dioxide or alcohol is applied to the warts until they drop off. In extreme cases the warts may be removed surgically. Laser therapy is a modern way of removing the warts in extensive infections. Because of the association between genital warts and cervical cancer, it is advisable that women who frequently suffer from the warts should have a Pap smear at least every six months.

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4.4.2.8 Monilia (candida fungus/ yeast infection)

How do you get it?

Although monilia is not a sexually transmitted disease, it is dealt with here because it is a very common inflammation of the genitals and intercourse may aggravate it. However, it often also occurs in men and women who have not been involved in sexual relations. The fungus causing the disease is always present in the genital organs. If the delicate environmental balance in this region is disturbed (e.g. the pH changes) the growth of the fungus gets out of hand. This may happen during pregnancy or when someone has been on a prolonged course of antibiotics or oral contraceptives.

Symptoms and consequences

The major symptom of monilia is a thick, white discharge found on the walls of the vagina and the vaginal lips. The discharge causes irritation and itchiness of the vaginal tissue. In the man the penis becomes red, swollen and itchy. If left untreated, the infection can become painful and cause great discomfort.

How is it treated?

The infection is treated with creams that are applied to the genitals.

4.4.2.9 General information about sexually transmitted diseases

- A sexually transmitted disease may develop after only one sexual encounter with an infected person.
- Sexually transmitted diseases do not disappear without treatment.
- All sexual partners who may be involved must be treated for the sexually transmitted disease even if they do not reveal any symptoms yet.
- If you have already been treated for a sexually transmitted disease it does not mean that you cannot get it again.
- No one is immune to sexually transmitted diseases.
- No home cure will cause a sexually transmitted disease to disappear.
- The longer you postpone treatment of a sexually transmitted disease, the greater the risk will be of being left with permanent damage.
- IF YOU ARE INFECTED WITH A SEXUALLY TRANSMITTED DISEASE YOU ARE MORE SUSCEPTIBLE TO THE HIV VIRUS.

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4.4.3 Prevention and treatment of sexually transmitted diseases

4.4.3.1 Introductory discussion

The following questions are indicative of the type of questions that the group leader could ask to get the group members to participate in an introductory discussion about the prevention and treatment of sexually transmitted diseases (also see 4.2.3 for guidelines):

- What would you say to someone who wants to know how to prevent the transmission of sexually transmitted diseases?
- Do you know what to do if you should become infected with a sexually transmitted disease?
- Would you be embarrassed to go to a clinic or doctor to have a sexually- transmitted disease treated? Why (not)?
- What does a medical examination for sexually transmitted disease at a clinic or doctor entail?
- Etc.

4.4.3.2 Prevention of sexually transmitted diseases

The safest option is, of course, abstinence. After that, sexual activity with only one partner whom you know and are able to trust.

Use a condom. Girls using the Pill might feel they are safe: they may be safe in terms of pregnancy, but not against sexually transmitted diseases and AIDS.

Talk to your sexual partner about his/her previous sexual history even if it is a sensitive subject. People who are becoming sexually intimate should talk about these matters.

Some people who are sexually active and have sexual intercourse believe in washing their genitals before the intercourse takes place. Such a practice might sound unromantic, but many couples see it as part of foreplay to wash each other in a sensual manner, or to have a bath or a shower together. Contraceptive spermicides, jellies and creams also help to destroy the bacteria and viruses that cause sexually transmitted diseases.

In the final instance it is important for each person to realize that it is his/her social duty to use safe sexual practices, and to go for early examination and treatment if it should become necessary. When this happens, there is the further important responsibility - no matter how embarrassing it might be - of informing, as soon as possible, all sexual partners who might also be infected. If you suspect that you have a sexually transmitted disease, or if you are being treated for one, you

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should, of course, not be sexually active with other persons. Even if you are not too concerned about the consequences of the disease for yourself, it is selfish and unethical to expose others to the dangers.

4.4.3.3 Treatment

As soon as you suspect that you have a sexually transmitted disease, you must get to a family planning clinic or a doctor. You might feel embarrassed about consulting someone about such an infection. Do remember, however, that the medical staff are trained to treat such diseases, are used to dealing with them and do not feel embarrassed when talking about or treating them. Medical staff also treats these matters completely confidentially. However, if you are at all uncertain about a particular clinic or doctor's approach to such cases, phone them beforehand and find out. Medical staff will, of course, ask you many questions that sound rather personal, but it is necessary for them to know certain details of your intimate life so that they may diagnose your condition correctly and give the right treatment.

When you visit a doctor for treatment of a sexually transmitted disease, the consultation usually entails the following: a urine test, a blood test, the examination of a specimen of any discharge that you may have, and, for women, an internal examination which may include the taking of a tissue sample (scraping of the uterus). If you are pregnant you must inform the medical staff beforehand, as special procedures might then have to be followed during the examination and as for the treatment. It is possible to get the results of the examination and the tests immediately, but usually there is a waiting period for some of the test results. Remember that the clinic may do nothing to you and carry out no tests for which you have not given them permission.

Ultimately, you should realize that the hassle and possible embarrassment of the tests and the exposure of your personal life are worthwhile, when weighed against the well-being of yourself and those close to you.

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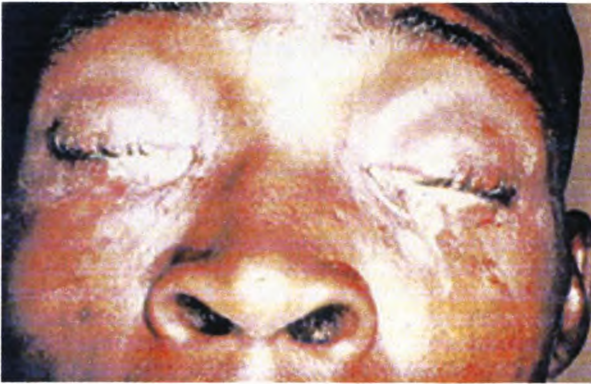
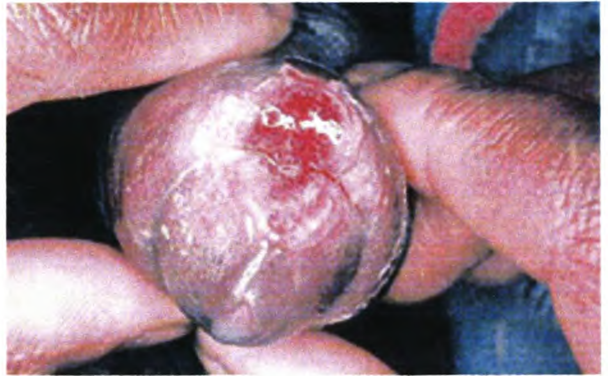
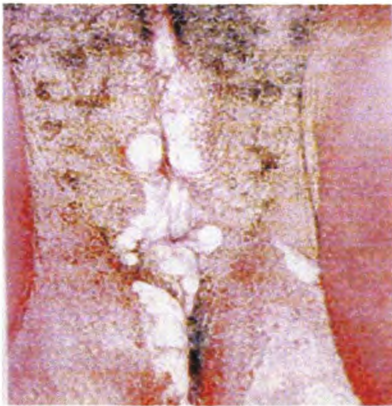
4.5 APPENDIX: VISUAL AIDES - SYMPTOMS AND SIGNS OF STD'S



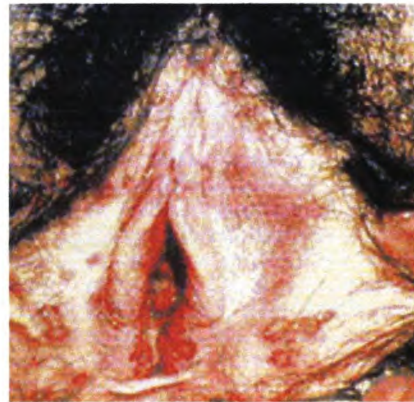
Photograph 1: Eye infection of an adult who has Gonorrhea



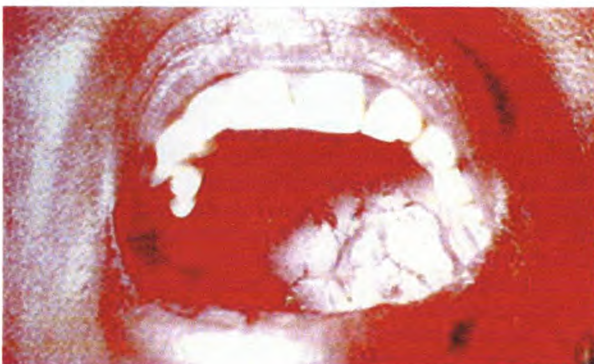
Photograph 2: A primary-stage Syphilis chancre on the glans of the penis



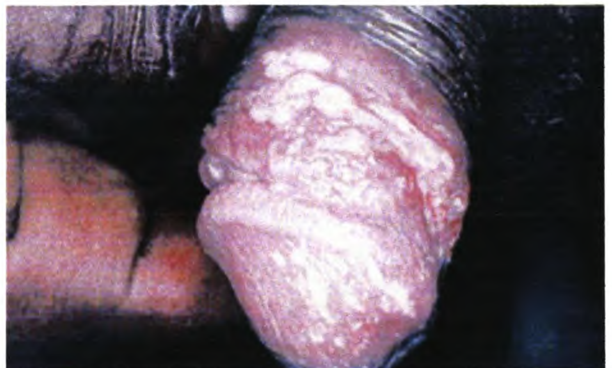
Photograph 3: Secondary Syphilis - swellings and lesions on the human anal area



Photograph 5: Ulcers of Genital Herpes on the genitals of a woman



Photograph 4: Sores in the mouth of a person who has Syphilis



Photograph 6: Ulcers of Genital Herpes on the genitals of a man

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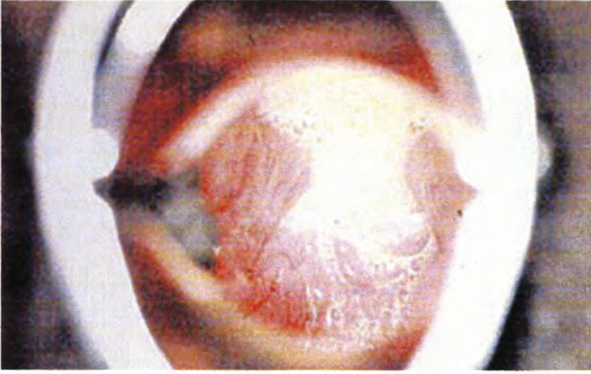
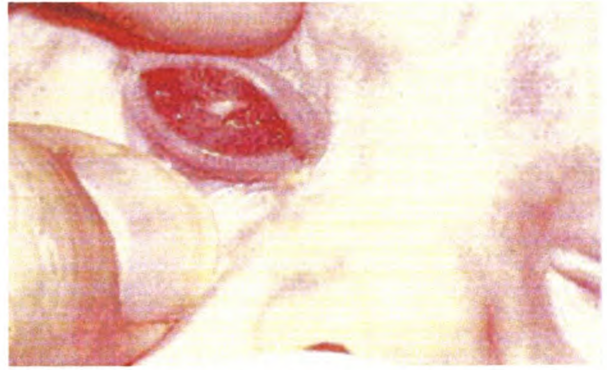
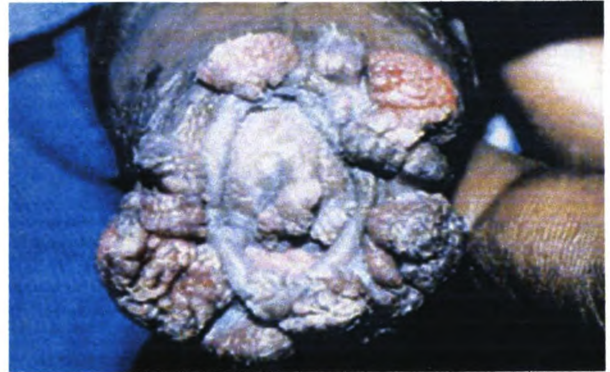


Photograph 7: Frothy vaginal discharge of woman who has Trichomoniasis



Photograph 8: Eye infection of newborn infected with Chlamydia

Photograph 9: Pubic lice on the human genital area



Photograph 10: Genital warts on the tip (glans) of the penis

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GROUPSESSION 5:
THE HIV AND AIDS

5.1 OBJECTIVES

The HIV is spreading fast through South Africa. Therefore it becomes increasingly more urgent to inform the general population of the realities concerning AIDS. GROUP SESSION 5 aims to equip students with the knowledge that they need to prevent the transmission of and infection with the HIV. By informing the group members of the true facts concerning the transmission and consequences of infection with the HIV, not only their ***skills*** for the prevention of AIDS are promoted, but also their ***motivation*** to participate actively in the prevention of AIDS, promoted. It is however not enough only to give the group members facts pertaining to the HIV - it is necessary that the group members are given the opportunity to talk to others about the HIV and AIDS issue. The group members then get a chance to form, clarify, reevaluate and possibly change attitudes and opinions regarding this subject. During the discussion there should be an attempt to nurture attitudes that will promote the group members' motivation for preventive behaviour. It is hoped that, as the group members become informed and are able to form more realistic attitudes toward the prevention, course and treatment of AIDS, any negative and destructive attitudes and feelings toward carriers of the HIV and people with AIDS, will become more positive.

Lastly the group members will get an opportunity to practise a skill which is central to the prevention of the transmission of sexually transmitted diseases and AIDS, namely the effective use of condoms. This does not involve only the correct application of the condom itself, but also the skills that will enable group members to successfully negotiate condom-use with sexual partners. The last objective of Group session 5 is then specifically to teach the group members those skills through exercises involving role-play.

5.2 STRUCTURE OF THE SESSION

5.2.1 Knowledge of the HIV and AIDS

The first part of the session comprises facts about AIDS that have to be passed on to the group members. To ensure more participation from the group members the information is presented in question-answer style: a question is given to the group members; the group members must first get a chance to give the correct answer to the question themselves; thereafter the group leader can correct or supplement the answer as needed. Presenting the information in this way ensures not only greater group participation, but also that time is not wasted on issues of which the group members know enough already.

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In this session visual material - medical photographs of AIDS patients - are provided. These visual aides should be used to create a realistic view of the serious nature of AIDS.

5.2.2 Attitudes and opinions concerning the HIV and AIDS

In the second part of Group session 5 some questions, covering a wide variety of topics concerning the HIV and AIDS, are provided. The group leaders must put the questions to the group members and then give the group members sufficient time in which to discuss the questions openly and honestly. The questions that are given serve as framework for the discussion and any other questions and issues that fall within the topic of this session can be tackled during this discussion.

5.2.3 Skills for the effective use of condoms

In the light of the important role which the effective use of condoms play in the prevention of sexually-transmitted diseases and AIDS, the group members are given a chance at the end of the session to practise their condom-use skills. This basically entails that they complete an exercise in which they learn to use a condom correctly, exchange ideas on how to initiate a discussion about the issue of condom-use within a sexual situation, and then actively practise how to convince their sexual partner to use a condom. (The group leaders must remember to get condoms for this exercise).

5.3 GUIDELINES FOR THE GROUP LEADER

Group session 5 should take the form of an ongoing, informal discussion of issues regarding the HIV and AIDS. The group leader must act as an initiator of discussions and then take the role of a participator, and act as a source of information by supplying correct facts only when he/she sees that the group members do not possess the correct facts or sufficient knowledge.

AIDS is still a topic that involves a number of sensitive issues. As in some of the discussions of previous group sessions, the group leaders have to look out for discussions that could lead to destructive debating. Such discussions should subtly be brought to a generally accepted conclusion or lead away from the sensitive issue. It is only in situations like these that the group leaders should intervene in the talks of the group members.

The nature of visual material included in this session is sensitive and should be handled in a formal manner. The group leaders should warn the group leaders about the nature of the visual material beforehand. No group member must be forced to look at the photographs.

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There are many unknown factors about AIDS and every day new theories and speculations about the HIV are published. Thus there will be questions from the group that the group leaders will not be able to answer with certainty. The group leaders must make sure that all questions that cannot clearly be answered in this session are written down. These questions must be researched to determine whether some answers might be available. Feedback must be given to the group members in the next session.

5.4 CONTENT OF GROUPSESSION 6

(Resources: Department of National Health and Population Development, 1991; Hyde, 1994; Several information pamphlets obtained from Family Planning Clinics)

5.4.1 Facts concerning the HIV and AIDS

(The group leaders must update data given below according to the statistics available for the period/year during which they present the program)

In South Africa more than 550 people who are carriers of the HIV are identified daily. At the beginning of 1992 the number of people infected (that we know of) was 446 000. The number doubles every 8.5 months.

<u>What is AIDS short for?</u>

AIDS - Acquired Immune - Deficiency Syndrome

<u>What is AIDS caused by?</u>

Aids is caused by a small virus or germ.

<u>Have scientists established where the AIDS virus comes from?</u>

No, they can only speculate.

<u>What is the name of the AIDS virus? What does each letter stand for?</u>

HIV - Human Immunodeficiency Virus

<u>What happens to the AIDS virus when it enters certain cells of the body?</u>

The virus enters the body through cuts or breaks in the skin, or through mucous membranes such as found in the reproductive organs. The virus becomes part of the T4 cells in the human body and uses it as a factory to reproduce itself. The T4 cells are needed to control the white blood cells that in turn fight infection and disease in the human body. As the virus enters more T4 cells the

functioning of the white blood cells become impaired - people eventually die from one ore more of the diseases which the body cannot fight in its vulnerable condition.

Figure 10: HIV and the white blood cells in the human body

The HIV itself does not directly cause the infected person's death, it merely makes the body more vulnerable and defenseless against other infections that take over and lead to chronic illness and eventual death.

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The AIDS virus stays in the cells of the body for many years

The AIDS virus can live in the body for many years before it grows and affects surrounding cells, damaging them also. When the virus starts to grow actively and affect the immune system of the body, it is said that the person has AIDS; before that time the person is merely a carrier of the HIV. The infected person can infect others with the HIV while being a mere carrier or while having full-blown AIDS. During the period between infection with the HIV and eventual AIDS, the infected person can feel completely healthy and nobody else will be able to detect that the person is HIV+. Because there are no external signs to show others, or even the carrier him/herself, that he/she is HIV+, this latent period makes it especially easy for the carrier to transmit the HIV to another person.

Who is at risk of getting AIDS?

White people, black people, brown people, yellow people, homosexuals and prostitutes - they are all at risk of getting AIDS. Of the number of people infected in South Africa 69% are black and 7% are homosexuals. Of the 7% homosexuals 94% are whites.

It is also very important to note that AIDS is spreading the fastest, not among homosexuals as most people think, but among young heterosexuals between the ages of 18-25.

How can the AIDS virus/HIV be passed on from person to person?

There are only four ways in which the virus can be passed on from one person to the other:

- sexual intercourse/contact with sexual fluids
- blood and blood products
- from mother to unborn child: through the placenta in the womb OR through contact between the blood of mother and child during the birth process
- from mother to child through breast feeding - the HIV can be present in the milk
- transplanted tissues

The AIDS virus cannot be transmitted through touching, kissing, sneezing, coughing or eating with a person who has AIDS. The HIV can be found in saliva, but the concentration is such that you would have to take in great amount of somebody else's saliva to be infected with the virus.

When are you then in danger of being infected with the HIV?

When you come in contact with the sexual fluids or blood of an infected person - this of course includes the sharing of instruments, like needles, which could pass on blood from the blood stream of one person to that of another.

Even though the virus can be present in saliva and sweat nobody has yet been infected by kissing someone or coming into contact with another person's sweat or saliva. On the other hand, any

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contact with a part of an infected person's body on which there are sores/open wounds, could put you at risk for infection with the HIV. This means that even though an ordinary kiss will not normally cause the transmission of the HIV, there could be a danger of the transmission of the HIV when either you have or the infected person has open sores in the mouths.

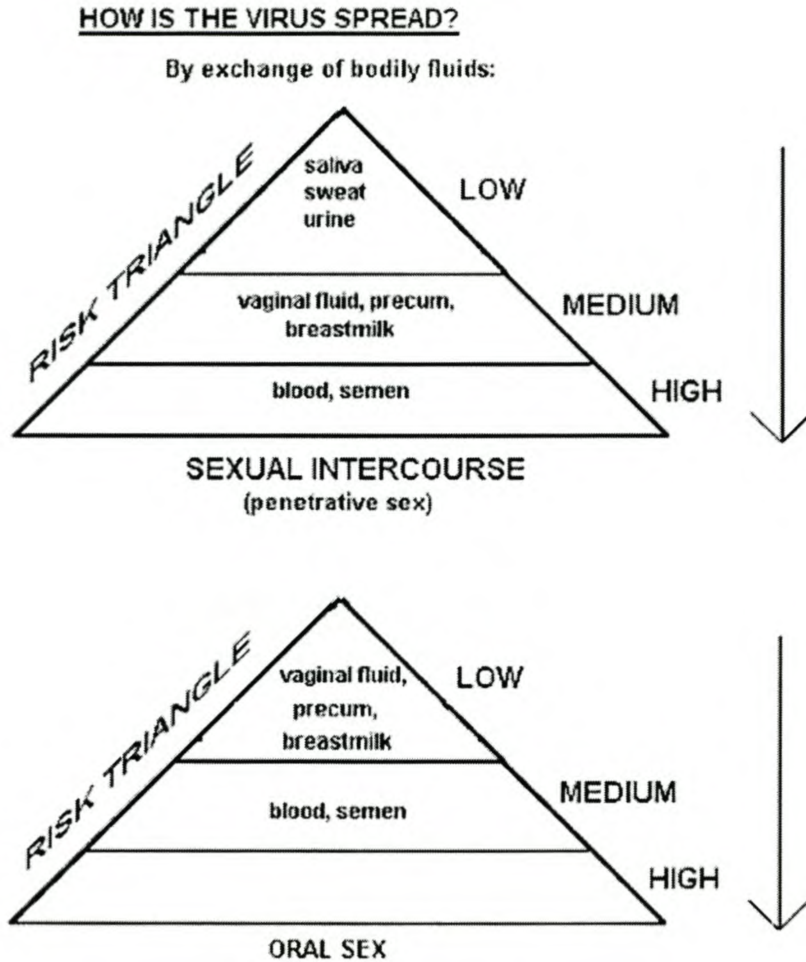

Figure 11: The transmission of the HIV

Any contact with sexual fluids of a HIV infected person can cause the transmission of the HIV. The correct use of condoms ensures that there is no contact between the sexual fluids of the infected person and the reproductive organs and fluids of his/her sexual partner.

AIDS can be passed on through oral sex. The AIDS virus cannot be passed on to humans by mosquitoes, insects or pets.

Which habits make it easier for people to get AIDS?

Excessive drinking of alcohol, smoking dagga and using intravenous drugs are all habits that put people at high risk for infection with the HIV. Why alcohol and dagga? Because it impairs peoples' judgment and thus increases the chances that they will take part in high-risk activities such as

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unsafe sex. The risk for infection with HIV also increases when a person is already infected with another sexually transmitted disease.

Can the AIDS virus live in animals like dogs and cats?

The AIDS virus can only live and grow in living cells of the human body, especially in cells of blood and sexual fluids.

What are the symptoms of someone who has AIDS?

Remember - someone who is infected with the HIV only has AIDS when the HIV becomes active and the symptoms as discussed below, the results of the activities of the HIV, become visible. With the initial activation of the virus the person has AIDS related complex: high fever, night sweats and abnormal tiredness. People lose weight rapidly, develop cancers, develop serious tuberculosis, and have several skin 'problems'.

How does a person with AIDS feel?

The person usually experiences disbelief, depression, anxiety, feelings of guilt and low self-esteem. They often show self-destructive tendencies. Family and friends often worsen emotional trauma because of rejection.

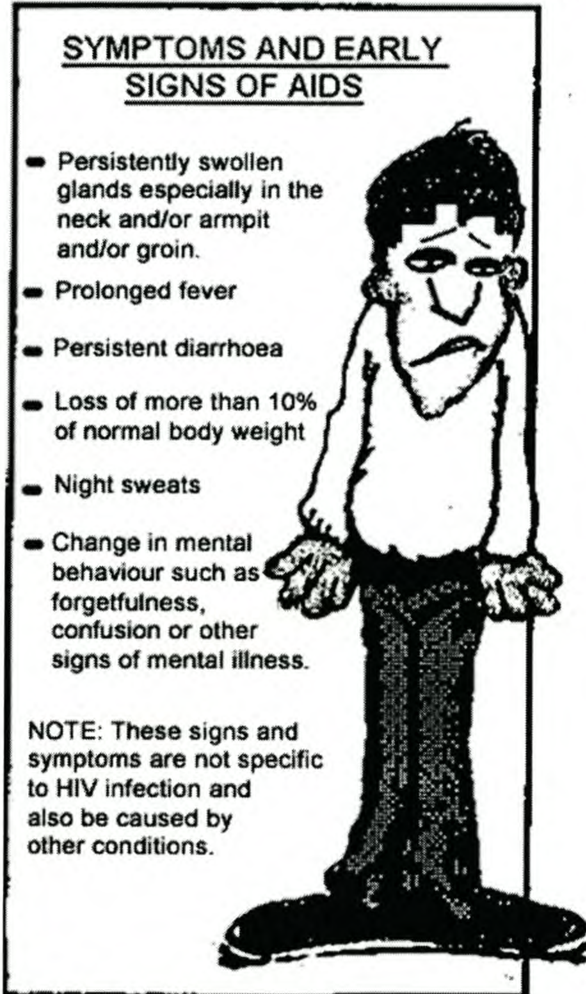

Figure 12: Symptoms and early signs of AIDS

What are the symptoms of a baby who is born with AIDS?

The babies look healthy at birth, but do not gain weight like healthy babies. They develop all kinds of illness and usually die before their second birthday.

Can people who have AIDS be cured?

No, scientists are working on a cure. 90% of all patients die within 18-24 months after the initial onset of AIDS.

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Is it safe to donate blood / to receive donated blood?

Yes, since 1985 all blood in South Africa is tested for HIV. Extra precautions are taken when people donate blood - no needle is used more than once, blood is sealed, and gloves are always used.

Can somebody get AIDS by having sex with an infected person only once?

Yes, once might just be one time too many.

What is the safest ways to avoid being infected with AIDS?

- Do not have sex at all.
- Keep to a long-term sexual partner whom you know is also faithful to you.
- Always use condoms.
- Find out about the previous sexual experiences of your potential sexual partner in order to ascertain whether you will be safe or not. Always use condoms.
- Ask your potential sexual partner to have him/herself tested for the HIV before you have sex. Always use condoms.

High-risk behaviour

Anal sex, several sexual partners, sex with a prostitute, sex under the influence of drugs or alcohol, sex with an HIV-infected person.

Do the following methods prevent that people become infected with the HIV?

- To wash after you have had sexual intercourse. NO
- To have unprotected sex with partners who say that they are not infected with AIDS or other sexually transmitted diseases. NO
- To avoid prostitutes and women from escort agencies. NO
- To choose very young people to have sex with NO
- To sexually stimulate partner's body without having sexual intercourse. YES
- To masturbate. YES
- To use condoms every time you have sexual intercourse. YES

Who is not at risk for infection with AIDS?

- people who don't have sex
- people who only kiss, cuddle and indulge in petting
- people who have one life-long sexual partner who have also not had any other sexual partners.
- people who use condoms every time they have sex

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How do you know whether you are infected with the HIV?

The virus can usually be detected in the body through medical tests 6-12 weeks after infection. Because of this latent period of approximately 3 months during which the HIV can be present in the body, but can still not be detected by tests, patients are tested twice - the second test usually 4-6 months after the first test. The test is very accurate and reliable. *However the test cannot tell you:* How you were infected, when you were infected, if you have AIDS, or when the AIDS will develop.

Figure 13: Safe sexual behaviour

How much does it cost do have yourself tested?

If you have the test done at a private doctor or hospital it can cost you anything from R70,00 to R300,00 depending on your medical insurance and/or the result of the test. (A test with a positive result, when the person is HIV+, costs more because more complicated tests have to be used than with a HIV- test).

There are Family Planning Clinics and organizations like ATICC where you can have the tests done free of charge. At the Student Health Clinic of the University of Stellenbosch HIV-testing can be done for a minimum amount of ± R30.

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5.4.2 Attitudes and opinions concerning the HIV and AIDS

5.4.2.1 Questions for discussion

(Group members do not have to be sexually active to answer the following questions. If some of them have problems taking part the group leaders should advise them to ask themselves: "If I were sexually active..." with the appropriate questions)

- Has the so-called "AIDS-scare" made you fearful of sex?
- Does the idea of AIDS scare you?
- Are you frequently worried that you might become infected with a sexually transmitted disease?
- Would you be more sexually active if you knew that there was no such thing as sexually transmitted diseases and AIDS
- What would your reaction be towards someone who wanted to postpone sex with you as a precaution against AIDS
- Do you think students who are infected with the HIV should be allowed to attend the university?
- And what about lecturers who are infected - should they be allowed on campus?
- Should there be compulsory HIV testing for everybody? For prospective mothers? For prospective fathers? For a marriage license?
- Should homosexuals who have the HIV/AIDS be treated with compassion?
- Do homosexuals deserve to get AIDS?
- Are homosexuals to blame for the AIDS epidemic?
- Should people with AIDS be quarantined?
- Should test results be shared with insurers? With public health officials (doctors, etc...)? With school officials? With employers? With sexual partners?
- Should the names of individuals with AIDS be kept confidential in order to protect them against discrimination?
- *"If it is meant to be that I get AIDS there is nothing I can do to prevent getting the disease."* Are there some of you who feel that way? What does the group think of this statement?
- People should avoid having contact with persons who have AIDS?
- Do you think it is normal to want to avoid having contact with persons who have AIDS?
- Should a doctor have the right to decide if he or she wants to treat patients with AIDS?
- How would you feel if one of your family members had AIDS?
- Is it important for you to exercise safety precautions in sex behaviour in order to prevent AIDS?
- Should there be separate facilities(toilets, etc) for people who have AIDS?
- Will knowing about AIDS cause less fear about AIDS? Is it a good or bad thing if fear lessens?

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- Do persons with AIDS deserve support from their family and friends? What do you think they go through? What kind of support do you think they need?
- Do you think there should be support for the family and friends of a person with AIDS?
- Do people who contract AIDS have only themselves to blame?
- Should people who have sex stop having sex altogether?
- Do you think AIDS is likely to become a fairly common heterosexual disease in South Africa?
- Any final opinions, ideas, comments?

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5.4.3 Skills for effective use of condoms

5.4.3.1 How to use a condom

Provide each group member with a copy of the above instructions and a condom. The group members should then practise how to put on a condom by using any available structure (chair-legs, fruit, glasses, etc.). The group leaders must go round to each group member to make sure that they are using the condom correctly.

Figure 14: What you should know about condoms

- Condoms are said to be 98% safe – if used correctly.
- Use condoms made of Latex rubber. Latex serves as a barrier to the viruses of AIDS and other sexually transmitted diseases.
- Use only SABS-approved condoms (don't trust the edible or "glow-in-the-dark" ones for e.g.)
- Condoms' efficiency relies much on factors such as the expiry date (last up to 5 years from date of manufacture if stored correctly) and storage (preferably in a cool dry place).
- Condom use is safer, and more comfortable, with a lubricant, BUT always use a water-based lubricant and not an oil base one (e.g. Baby oil, Vaseline). The oil-bases lubricants erode latex and the condom could break.
- A condom used with a spermicide may provide additional protection. Laboratory tests have proven that spermicides kill viruses which cause STDs and AIDS.
- 2 Condoms are not safer than one. On the contrary, the friction of 2 condoms rubbing together will promote breakage.
- Always put the condom on a erect penis, pinching the teat of the condom between your fingers as you put it on. There are two reasons why you do this: 1. It prevents an air bubble forming which is bound to burst during intercourse; 2. to retain some space for the collection of semen. Roll the condom right down to the base of the penis. When withdrawing the penis, hold on to the base of the condom so that no semen spills out. Carefully remove the condom from the penis. Tie a knot in the condom to prevent spillage and dispose of it in a bin wrapped in paper for e.g.
- Each condom should only be used once!!!!

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5.4.3.2 An exercise in "Condom-communication"

(I) Instructions for the group leaders

(The group leaders must give the same instructions to the group members as it is set out on the following pages)

Please Note: There might be some of the group members who could feel that because they are not yet sexually active, they cannot participate in this exercise. The group leader must instruct these members to think about what they would do if they should ever be in such a situation, or if it is still difficult, talk about how they think other people would/should act in such situations. Before starting the exercise the group leader should also remind the group members that "sexual partner" refers not only to somebody you have sex with, but also to the person/persons with whom you become involved on any of the different levels of sexual intimacy, thus ***sexual partners = sex partners as well as potential sex partners.***

1. Instruct each group member to think for a while about which factors really motivate them to use condoms if they should have sexual intercourse. Each group member should then write down on a piece of paper exactly when and how they would talk to their partner about the use of condoms: would they touch on the issue of condom-use before they even come close to sex in the relationships, would they talk about the issue only when already busy with sexual arousal, when and how would they do it, i.e. precisely what will they say, what will they use as motivation why they want to use a condom?

   Each group member must write down a ***direct response*** - a direct statement that they would use to initiate discussion of condom-use with their sexual partner, e.g. ' I think I would, just before we have sex, ask my sexual partner: "Don't you think we should start thinking about protection?"', etc.

2. When all the group members have had sufficient time to respond to the first instruction, they must one by one share their ideas on the how and when with the group. Each group member must give his/her direct response to the group the way he/she thinks it should be conveyed in order to promote effective condom-communication between sexual partners.

3. Before going on to the next group member's response, the group must give feedback to the previous group member about his/her response and ideas concerning condom-communication: whether they think his/her statement would effectively convince a sexual partner to use a condom, whether they agree with the time he/she would talk about the use of condoms with his/her sexual partner, and possibly give suggestions on how the group member could improve

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his/her condom-communication. The group members must be honest with each other and be open in sharing opinions and ideas. They must remember that the aim of the exercise is to give them the chance to practise effective use of and communication about condoms - they should therefore help each other to find the most effective responses and methods. (The group leaders should see to it, however, that group members stick to giving constructive criticism and that they do not become unpleasant and destructive.)

4. Researchers have found that there are six types of strategies that people frequently use to convince their sexual partner to use, or not to use, a condom. The six strategies are set out below.

   The group leader must read the **AVOID** statements to the group one at a time. The group must then discuss how they would react to such a strategy. How would they convince a sexual partner, who made use of such a strategy, to use a condom? What would they say in response to such a strategy? Some of the strategies are not what people say, but things people do to get their sexual partner not to use a condom. For each of these situations/behaviours the group must discuss how they would react if their sexual partner behaved in such a manner. How would they feel about such behaviour? What would they do to counteract such behaviour?

   The group members can also discuss reasons why some people do not want to use condoms. What do the group members think are the most commonly used reasons for not wanting to use a condom? What do the group members think of these reasons? Do they think there are some valid reasons? Do they have suggestions to solve the problems people have with condoms? Do people have misconceptions about condoms that could be rectified in order to promote the use of condoms?

5. When the group members have sufficiently discussed all the **AVOID** strategies the group leader must read the **USE** strategy of each category to them. Ask the group members to take a look at the responses they thought up at the beginning of the exercise and decide whether their own responses fit into one of the categories isolated by the researchers.

   Also explain to the group members that the USE strategies that are given here (except perhaps the DECEPTION strategy) are strategies that can be effectively used to encourage and convince sexual partners to use condoms.

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(ii) Condom-communication categories

Researchers have found that there are six main categories of strategies which people use to influence their sexual partners to use, or not to use, a condom (Chapman, Campbell & Peplau, 1994). The categories are:

*(The **Use** refers to ways that a person would use to convince his/her sexual partner to use a condom. The **Avoid** refers to the ways that a person would use to convince his/her sexual partner not to use a condom.)*

1. The **REWARD** strategy - the person promises positive consequences if the sexual partner (indicated by [________]) complies with his/her requests.

Use: " I would emphasize that [________]'s respect for my feelings about using a condom would really enhance our relationship."

Avoid: "I would stress how very happy and pleased I would be with [________] for not insisting on using a condom."

2. The **EMOTIONAL COERCION** strategy - the person threatens negative affective consequences if the sexual partner (indicated by [________]) does not comply with his/her requests.

Use: " I would let [________] know that I would be upset and angry at [________] for not wanting to use a condom."

Avoid: " I would say that if [________] pressured me about using a condom, then [________] does not care for me very much."

3. The **RISK INFORMATION** strategy - person presents information about the risks of sexually transmitted diseases and/or AIDS (or pregnancy) to the sexual partner (indicated by [________]) in an effort to persuade partner to comply with his/her wishes.

Use: " I would tell [________] that it is risky to have sex without a condom. We would both be safer from disease if we used a condom."

Avoid: " I would inform [________] that there have been very few cases of AIDS among heterosexual college students, so there is no need to use a condom."

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4. The **DECEPTION** strategy - the person uses false information or deception to gain the compliance of the sexual partner (indicated by [________]).
Use: " Even though I want to use a condom because I am worried about sexually transmitted diseases/AIDS, I'd make up a different reason to convince [________] that we should use a condom."
Avoid: " I would secretly hide the condoms from [________] so that when we were ready to make love, [________] could not find them.

5. The **SEDUCTION** strategy - the person uses sexual arousal to distract partner in order to gain compliance from the sexual partner (indicated by [________]).
Use: " Before [________] had a chance to object to the use of a condom, I would get [________] so 'turned' on that [________] would forget we were even using a condom."
Avoid: " If I thought [________] wanted to use a condom, I wouldn't say anything. I'd just get [________] really excited sexually and begin making love without a condom."

6. The **WITHHOLDING** strategy - the person threatens to withhold sexual activity if the sexual partner (indicated by [________]) does not comply with his/her demands.
Use: " I would just tell [________] that I will make love only if we use a condom."
Avoid: " I would just tell [________] that I will not make love if we had to use a condom."

End the exercise and this session with a short general discussion about the use of condoms. Are there some of the group members who think that using a condom is not enjoyable? Are there still some of them who feel that there are situations in which it is not necessary to use condoms? Do they think that there are situations in which even the most dedicated condom-user might not use a condom? Do most of the group members feel that it is necessary to use condoms at all times? What is the groups' final conclusion about condoms - do they say yes or no to the use of condoms, and condom-communication? When, according to the group, is the right time to talk to sexual partners or potential sexual partners about the use of condoms? Do the group members feel motivated, when they have sex, to talk to their sexual partners about the use of condoms, and to definitely use condoms?

Ask the group members whether there is anything they still want to say about sexually-transmitted diseases, AIDS or condoms.

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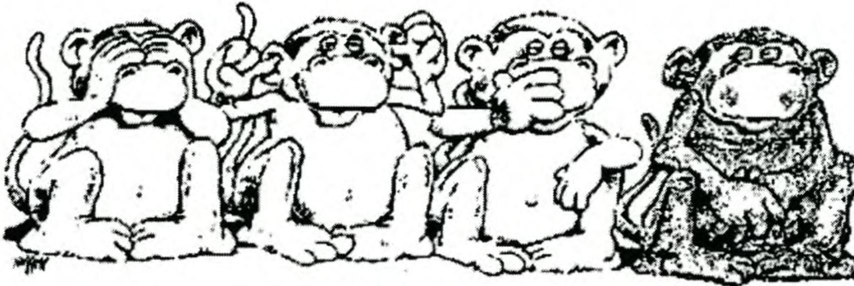
Give each group member a copy of the warning provided below so that they will have something to remind them of the important issues which have been discussed in the past two group sessions.

REMEMBER: AN EFFECTIVE RECIPE FOR SEXUAL PROTECTION IS CONDOMS + SELECTIVE SEXUAL RELATIONSHIPS. BUT THERE IS NO RECIPE SAFER THAN ABSTINENCE.



DON'T GET CAUGHT – BE LIKE THE FOURTH MONKEY

Figure 15: A warning: Don't get caught - be like the fourth monkey

5.4 PREPARATION FOR GROUP SESSION 6

First read through 6.2 and 6.3

At the end of Group session 5 the group leaders must present the group members with a variety of topics as proposed in Group session 6. The group members have to choose the topics that they wish to discuss in Group session 6 in order to enable the group leaders to prepare for the presentation in advance.

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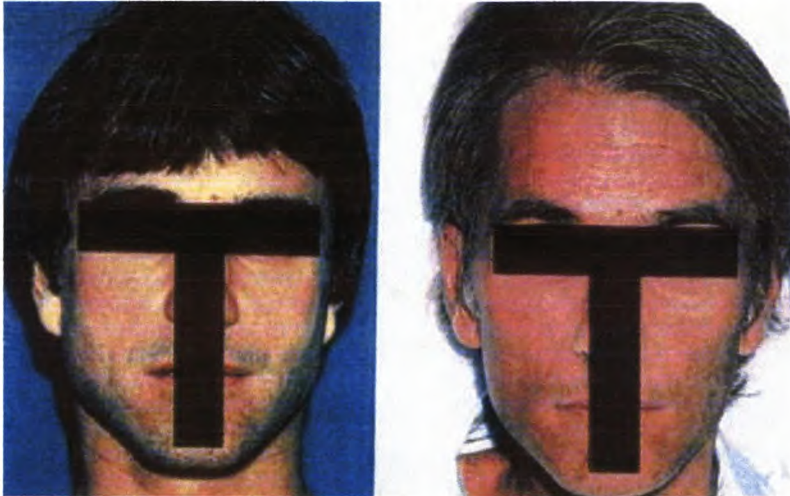
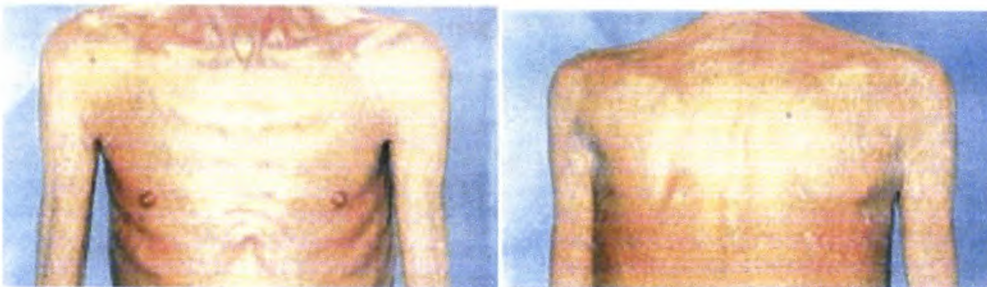
5.5 APPENDIX: VISUAL AIDES - SYMPTOMS AND SIGNS OF AIDS

The following pages contain medical photographs of people who were infected with the HIV and now have AIDS. These photographs must be shown to the group members in order to ensure that they form a realistic view of the serious and fatal nature of AIDS.

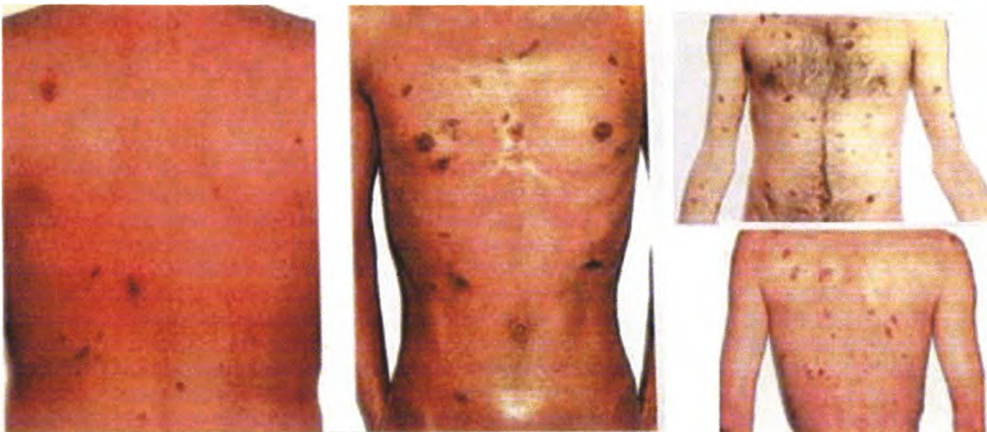


Photograph 11: Rapid ageing as a result of AIDS

These photographs were taken with an interval of two years. Premature graying, frontal recession and thinning of hair, loss of facial fat with hollowing of contour contribute to this appearance.



Photograph 12: Effects of AIDS on body weight and appearance



Photograph 13: Effect of AIDS on skin appearance

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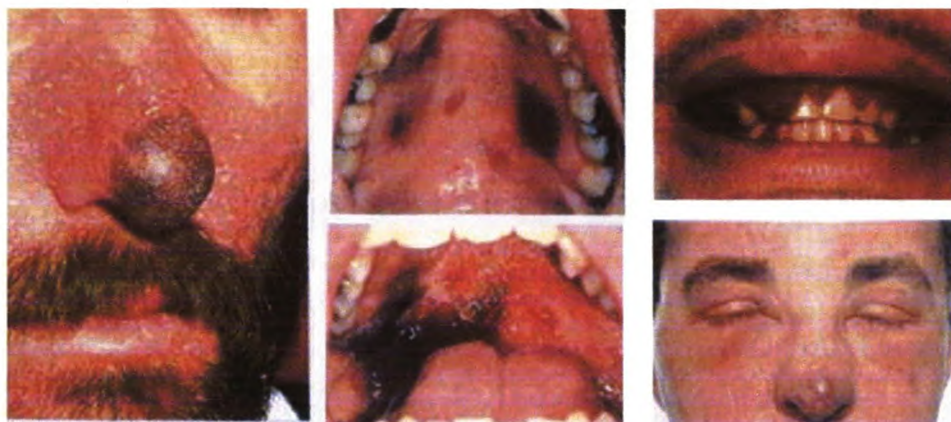
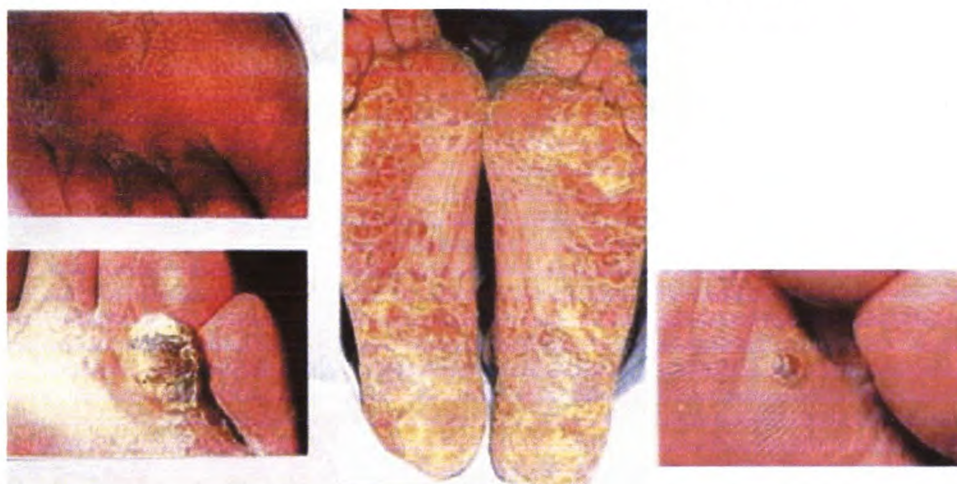
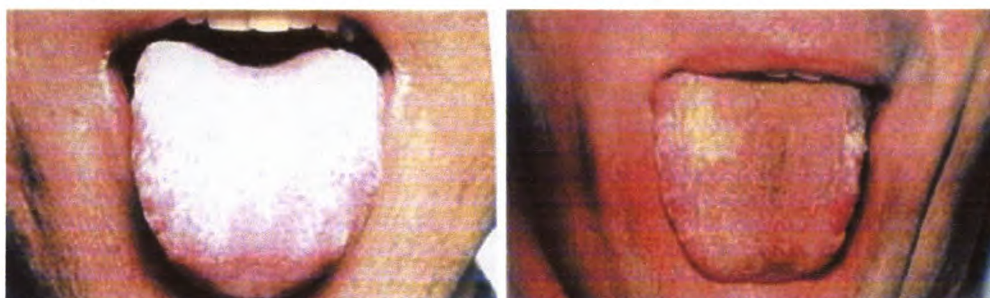


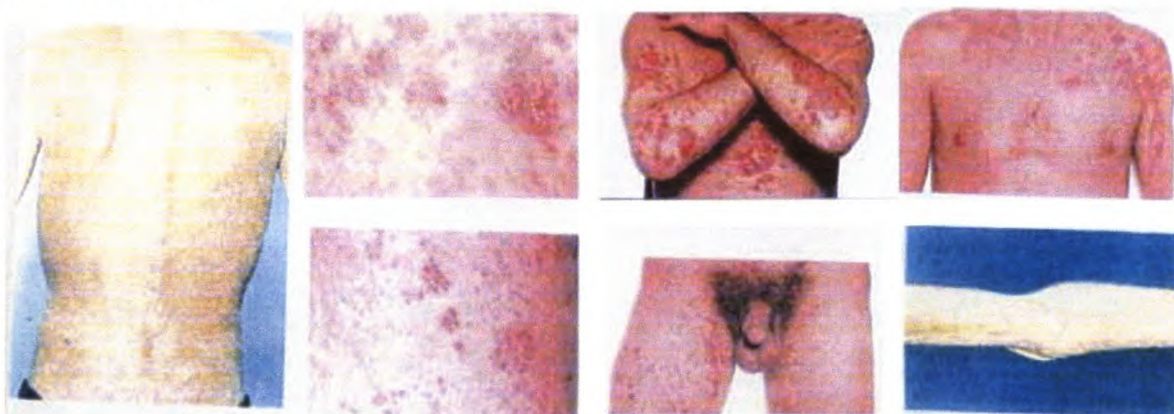
Photograph 14: Appearance of mouth and nose of person with AIDS



Photograph 15: Severe skin affectations on feet of person infected with AIDS



Photograph 16: Tongue infection as a result of AIDS



Photograph 17: General appearance of AIDS infected body

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GROUP SESSION 6:
SEXUALITY IN CONTROVERSY

6.1 OBJECTIVES

There are several controversial sexuality-related issues in the world of the young person that they rarely get the chance to discuss honestly and openly. Nevertheless they are expected to have clearly formed opinions about such issues and to act effectively when personally confronted with such situations. It is however unrealistic to expect them to make decisions concerning issues about which they have not yet had meaningful thoughts and/or discussion. Discussion, verbalization of and reflection on their true opinions and ideas, help young people to strengthen and clarify their attitudes and values concerning sexuality-related issues. These values and attitudes form a basis for decisions, concerning their behaviour in such controversial sexuality-related situations.

The objective of Group session 6 is therefore to create a relaxed atmosphere wherein the group members will have an opportunity to discuss their opinions openly concerning several sexuality-related issues like abortion, homosexuality, perversion, pornography, rape/molestation, masturbation, etc. Thus they get the chance to think about and verbalize their own opinions, and to hear other young peoples' ideas concerning controversial sexuality-related issues. Exposure to a variety of ideas, attitudes and convictions about sexuality and sexuality-related issues, contribute to the insight which young people need in order to make realistic and balanced decisions concerning their own attitudes toward and behaviour within controversial sexuality-related situations.

6.2 STRUCTURE OF THE SESSION

6.2.1 Discussion

Group session 6 has no preformatted exercises that have to be completed or information that has to be presented. The session basically entails informal discussion of controversial sexuality-related topics that are chosen by the group members (In Group session 5 the group leaders were told to ask the group members which topics they wish to discuss in Group session 6). In 6.3 some ideas are provided that the group leaders can use to stimulate group members' discussion of several topics. In 6.4 the group leaders will find case studies that they can use to initiate conversations between group members.

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6.2.2 Homework

In preparation for Group session 7 the group members are given a practical homework assignment.

6.3 GUIDELINES FOR THE GROUP LEADERS

Group session 6 is the sexuality psycho-education session requiring the most thorough preparation by the group leaders. Because this session consists mainly of discussion of topics chosen by the group members, it is not possible to provide the group leaders with preformatted material for the presentation of the session. Therefore it is the responsibility of the group leaders to collect their own material to stimulate conversations about the different topics that the group members choose to discuss.

The group leader must, as mentioned in Group session 5, ask the group members in the previous session what they wish to discuss in Group session 6. If the group leader did not do that in the previous session they should see to it that he/she is prepared for the presentation of a variety of topics in this session. The group leaders must remember to stick to the topics that are of controversial nature, e.g. abortion, homosexuality, perversion, pornography, rape/molestation, masturbation, transvestitism, prostitution, S&M (sadistic & masochistic) sexual activities, etc. Despite the choice that group members have in selecting specific topics for discussion, one topic, namely Abortion, is compulsory. In 6.4 there is a case study that can be used to stimulate a debate about Abortion. This case study is a good icebreaker to get the group members talking, and prepare them for further relaxed and open discussion of other subjects.

Any chosen topic can easily be converted into a discussion by creating a fictional case study (see examples of case studies about Homosexuality and Pornography in 6.4). Recent occurrences, books or films concerning these topics can also be used to initiate debates about these issues.

About **perversion** - talk about pedophiles and/or S&M sexual activities. For example, ask the group members how they would feel /what they would do if their sexual partner asks them to participate in S&M activities, and why they would react in that way?
About **transvestites** - ask them how they feel about people as depicted in films like "Priscilla, Queen of the desert"; what they would do if they found out their husband/wife is a 'cross-dresser'?
About **masturbation** - make a statement like "women masturbate less than men, and men masturbate every day" and then ask the group to talk about such a statement.
What about **prostitution**? - How would you feel if you found out your husband/wife had been to a prostitute?

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Rape - talk about the issue of rape on campus; what about the rape of men? What would the group members do if somebody attacks them? What would they do when their best friend comes to them and tells them that he/she has just been raped? (This, for instance, is a good topic with which to formulate case studies)

It should be clear that the group leaders could initiate successful discussion on almost any topic by making a controversial statement that stimulates reaction from the group members. I.e. asking their opinion on topic-related films, magazine articles and/or music, or presenting them with case studies for debate or discussions of possible reactions, or referring to recent occurrences. The group leaders can use the format of the case studies provided in this session to formulate their own case studies.

The discussions should be left to the group members. The group leaders should only intervene when the discussions stray too far from the topic, or when the group leaders see that the debate between two or more group members are becoming destructive/nasty. In both the above mentioned situations the group leaders must use the subtle presentation of a question or statement to divert the attention back to the topic at hand or away from the topic which is causing the problems between group members.

The group members must share their opinions, debate, agree, consult, laugh together, cry together, anything - as long as they get the chance to talk calmly about the issues, hear and share balanced opinions about the issues, think about it, and consequently be able to decide for themselves exactly what their attitudes toward these sexual issues are. It is important that the group members clarify their attitudes on values, because these attitudes and values will eventually determine their behaviour in controversial sexuality-related situations. I.e. are they comfortable in the company of homosexuals? What will they do if they become pregnant before marriage? Will they look at pornography? Will they reprimand their boyfriends/girlfriends if they look at pornography? Will they fight or give in if somebody tries to rape them? ***Will they be able to make effective decisions about such issues if they are confronted with them?***

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6.4 CONTENT OF GROUP SESSION 6

6.4.1 Examples of case studies

6.4.1.1 Unwanted pregnancy and Abortion

Jenny is a 22-year-old BA Law student. She has just found out that she is 3 weeks pregnant. She has been going out with the father of the child for 10 months. They have a normal relationship with the usual joys and problems. The father of the child is also a student. Both Jenny and the father still have more than two years of studying to complete before they get their degrees.

(i) Divide the group into two smaller groups.

Group 1: This group must justify/explain the reasons why Jenny should keep the child and how she would go about doing that.
Group 2: This group must investigate other options that Jenny has apart from keeping the child and then justify why and which of these options might be better than keeping the child.

(ii) Have a debate between the two groups. They must, ***among other things****, discuss:*

Which factors should Jenny take into account when she makes her decision?
Why must she keep the child?
Who is going to look after it?
What are her other options?
Why should she not follow one of the above-mentioned routes?
Should she marry the father of her child?
What are all the negative implications of abortion?
What about adoption?
Who is going to pay expenses for the child if she keeps it?
What emotional stress will all persons involved experience if she keeps the child? And if she has an abortion? Adoption?
What will happen to her student-life is she keeps the child? Will she lose friends?
How does she go about getting an abortion?
What about informal methods of abortion?
Are they safe?
Have you experienced anything like this/ or your friends perhaps?
Some more ideas?

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6.4.1.2 Homosexuality

Group leaders: Read the situation to the group members. Give each of them a chance to think about the situation. Then start asking the group members the questions that are provided. Give enough time for sufficient discussion of the previous question before going on to the next question.

You come home late one night to find your brother/sister in bed with a person of the same sex.

What is your immediate reaction?
The next morning your brother/sister confesses to you that he/she is a homosexual. What do you say to him/her?
Would your reaction have been the same if it had been your roommate?
What would you do if your same sex roommate made a pass at you?
What do you think of homosexuals and the way in which they are standing up for their rights? Do you think they are being discriminated against?
How does the group feel about homosexuals in general? Are you born that way? Is it abnormal?
Some more ideas, opinions?

6.4.1.3 Pornography

Group leaders: Read the situation to the group members. Give each of them a chance to think about the situation. Then start asking the group members the questions that are provided. Give enough time for sufficient discussion of the previous question before going on to the next question.

You walk into your boyfriend's/girlfriend's room to find him/her with his/her friends perversely discussing photographs of members of your sex that are in a pornographic magazine lying on the table in front of them.

How do you react? Do you feel violated at the sight of your boyfriend/girlfriend talking about naked members of your sex in that way? Do you join them? Are you against the publication of these materials? And pornographic films? Have you ever seen a real pornographic film? Do you think it is degrading? Do you find it stimulating? What else do you have to say about pornography?

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6.4.2 Homework assignment

Every group member must go to family planning clinics, shops, and pharmacists, and compile a list of the different contraceptive methods available (types of condoms, types of pills, other contraceptives, etc.). The list must include the type (name) of the contraceptive, brand names and prices. Each group member has to obtain at least one of the contraceptive products which are available free of charge at clinics. They should not spend money on products that they would not have bought anyway.

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GROUP SESSION 7: CONTRACEPTION

7.1 OBJECTIVES

Most of today's young people know by this stage of their lives what contraception and contraceptive devices are. There is however still a surprising number of young people who do not know about the variety of contraceptives available, where to get it and how to use it correctly. Many of these young people also find it difficult to acquire the contraceptives because of their ongoing unease with the idea of contraceptives, and because they are not motivated enough to go to clinics and pharmacies to obtain contraceptives despite the possible uncomfortableness it might cause. When they do obtain the contraceptives many of them still do not use it because they do not know how to talk to their sexual partners about the use of contraceptives, and they do not have the skills to encourage and convince their sexual partners to use contraceptives.

In Group session 5 an exercise about the use of condoms was used to address the latter problem of lack of communication about contraceptives.

In Group session 7 the objectives are to provide the group members with the correct knowledge and skills that will enable them to:

- **Choose the method of contraception which best suit their needs in light of the advantages and disadvantages associated with each contraceptive device/method;**
- **Correctly use several contraceptive devices/correctly apply contraceptive methods in order to ensure effective prevention;**
- **Know where and how to obtain contraceptives and be able to obtain these contraceptives without inhibition/discomfort.**

7.2 STRUCTURE OF THE SESSION

7.2.1 Feedback on Homework

In Group session 6 the group members received as homework a practical assignment. The group leaders should start Group session 7 by giving the group members a chance to provide feedback on their homework assignment. In 7.4.1 a few questions are provided which the group leaders can use to facilitate a short discussion about the homework assignment.

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7.2.2 Lecture

Group session 7 mainly comprises information about contraceptive devices and methods that have to be conveyed correctly to the group members. Information regarding contraceptives like the Pill, condoms, diaphragm, IUD, injection, spermicides, as well as information on several contraceptive methods is provided in 7.4.2. The group leaders must convey the information to the group members in lecture format, but should also get as much input from the group members as possible in order to promote group participation as well as group interest and attention.

7.2.3 Discussion

Group session 7 must be ended off with a short synoptic discussion about contraceptives. The aim of the discussion is to allow group members to ask or say anything they had not had the chance for during the session, and to make final conclusions and decisions about the topic at hand. Possible questions for the facilitation of the discussion are provided in 7.4.3.

7.3 GUIDELINES FOR THE GROUP LEADERS

Group session 7 is not a difficult session to present. Young people usually find the topic of contraception interesting and consequently show a great deal of enthusiasm for this session.

Despite the above-mentioned fact the information can become quite boring if the extensive information in this session is just rattled off by the group leader. The group leaders should try and find the most interesting way possible to convey the information to the group members. This topic need not be treated as clinically and as formal as Group session 4 (STD's) for instance. The group leaders can deviate from the lecture format by asking the group members questions and giving them a chance to reveal what they already know about certain contraceptives. Humour also works well as a diversion in this group session.

The group leaders must try to use visual material like examples of the contraceptive devices, magazine articles, posters and/or pictures of the devices, etc., to supplement the factual information. The group members usually understand the workings and instructions for using the devices better if they can actually see the contraceptives.

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7.4 CONTENT OF GROUP SESSION 7

7.4.1 Feedback on the homework

In Group session 6 the group members were given an assignment to compile a list of prices and names of the different contraceptives available in pharmacies and clinics. The group members also had to get some of the contraceptives that can be obtained free of charge from the clinics. The group members must now give feedback about this homework assignment:

What prices and names do they have on their lists?
Which contraceptives have they brought with them?
Was it easy to get the contraceptives?
Do they feel uncomfortable going into family planning clinics?
Do they feel uncomfortable when standing in front of the shelf with the contraceptives inside a pharmacy?
Will they be able to buy condoms in a pharmacy/store?
Have they possibly concluded from this exercise that it is not that uncomfortable buying contraceptives from a pharmacy, or going to a family planning clinic?
Will they be able to do it if necessary?
What is more important to them - to feel uncomfortable for five minutes, or to have trouble with an unplanned child and/or sexually-transmitted diseases for the rest of their lives?
Etc.

7.4.2 Contraceptive devices and methods

(Resources: Hyde, 1994; Pamphlets obtained from Family Planning Clinics)

7.4.2.1 The Pill

(Please note: The term "the pill" is used to refer to all oral contraceptive pills.)

General

The Pill is an oral contraceptive method. Many different brands are available - Triphasil, Diane, Ovral, and many more. These pills contain artificially produced estrogen and progesterone, the female hormones. Most contraceptive pills consist of both these hormones and are therefore called "combination" pills, but there are also oral contraceptives that contain only synthetic progesterone. (Some doctors maintain that the latter kind is not as effective as the combination pill, especially for use by young people.)

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How the Pill works

Contraceptive pills artificially increase a woman's levels of progesterone and/or estrogen at specific times during the menstrual cycle, causing bodily changes that make it difficult for her to fall pregnant.

- Contraceptive pills work mainly by repressing ovulation.
- In addition, the synthetic progesterone causes the cervical mucous to be very thick, thus making it difficult for male sperm to get through.
- The synthetic hormones also keep the lining of the uterus (endometrium) very thin, so that even if a fertilized egg should arrive in the uterus implantation in the endometrium would be unlikely.

The ova (eggs) that are released from the ovaries propel themselves by means of certain movements through the Fallopian tubes. Sperms also carry out movements that facilitate their progress through the Fallopian tubes to reach the ova for fertilization. Contraceptives obstruct movement inside these tubes, thus interfering with the propulsion and transportation of ova and sperms, and hampering fertilization.

Effectiveness

The use of oral contraceptive pills is the safest/most effective method of preventing pregnancy (excluding sterilization). The theoretical effectiveness of the Pill is virtually 100%, but effectiveness of use causes problems. By effectiveness of use is meant the degree to which the woman uses the contraceptive pill correctly. When women fall pregnant while on the Pill, it is usually because they have used the contraceptive wrongly or forgot to take it. If a woman forgets to take a pill for one day, she should just take two the next day. This does not seem to increase pregnancy risk significantly. If she forgets two days in succession, she should take two pills on each of the following two days, but the pregnancy risk will now be greater. The risk thus increases with every day on which the pill is not taken. It is recommended that a woman considers her contraceptive situation as unsafe as soon as more than one day has passed without her having taken the pill. This means that alternative contraception should be used for the rest of that cycle.

Many women are also not well enough informed regarding the influence of other substances on the effectiveness of the Pill. The working of the Pill can, for example, be obstructed by antibiotics. Women who need to take an antibiotic for an illness should realise, therefore, that sex might not be safe during that period. They need to carry on using their oral contraceptive as usual while they are taking the antibiotic. However, they will be protected against pregnancy again only when, after they

have finished the antibiotics, they have taken seven active contraceptive hormone pills on seven consecutive days. The above rule is relevant in any situation where the working of the Pill has been disrupted, such as when the woman has forgotten to take her pill, etc. Women whose oral contraceptive package includes placebos must remember that the placebos have no function other than to maintain the routine of taking a pill every day. Placebos are not hormone pills and women will not be "safe" after taking seven of them, or even, let's say, three of them and four hormone pills: it must be seven consecutive hormone (active) pills.

There are numerous substances as well as medical conditions (such as DIARRHEA) that can interfere with the effectiveness of oral contraceptives. It is extremely important, therefore, that your doctor knows that you are sexually active and are using an oral contraceptive. If you do not want to confide in him or cannot trust your doctor, it is of the utmost importance that you are continuously in touch with your family planning clinic about the correct use of your oral contraceptive.

Advantages

The Pill is an effective and convenient contraceptive. It is readily available and easy to use. It is one of the few methods of female contraception that is provided free of charge by family planning clinics. It is not a messy form of contraception and it also does not interfere with sexual intercourse. Furthermore, the Pill regulates menstruation and reduces the amount of menstrual flow. It often reduces premenstrual tension (PMS). Women who suffer from severe cramps during menstruation often use the pill to reduce the cramping. The Pill may also reduce/clear up acne. It has also been found that oral contraceptive pills may protect women against pelvic inflammations, and against cancer of the ovaries and the endometrium. The contraceptive effect of the Pill is easily reversible and it does not affect a women's fertility once she has stopped taking it.

Disadvantages

The Pill must be used correctly: one to be taken every day. Not everyone is capable of understanding the complicated instructions that explain how the Pill must be taken. Sometimes the Pill dries up a woman's milk, which makes it difficult for women who are breastfeeding. The working of the Pill is affected by interaction with certain prescribed drugs. Some women who use the Pill experience a degree of nausea, but this usually disappears after the first month. Many women complain that the Pill causes them to gain weight. The Pill does not directly cause the body to build up fat, but it may influence the hormones responsible for appetite. Thus many women going onto the Pill have an increased appetite, they eat more, and they gain weight. The increase

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in mass about which many women complain when they start using the Pill can, therefore, be controlled by them and is not an inevitable side-effect of the Pill.

Headaches and tenderness of the breasts are further possible side effects of the Pill. There are a few other medical conditions which can also be attributed to the Pill, but these occur in certain high risk cases, i.e. women who already have a tendency towards a certain illness or medical condition. In these cases the Pill usually made an already existing condition worse or activated illnesses that were latent. Examples of these conditions are blood clotting in the circulatory system, gall-bladder infection, and sexual diseases such as gonorrhea and vaginal infections. The Pill does not cause cancer, but can exacerbate an existing cancer. It is of the utmost importance that women consult their doctor or the medical staff at the clinics before they start taking certain contraceptives. Women who have been using contraceptive pills over a long period must also see to it that they have regular medical check-ups, specifically also of the reproductive organs.

It is important to bear in mind the negative effects mentioned above if women want to start using the Pill. It must be remembered, however, that the side effects are experienced only by a minority of persons, and that most women and almost all healthy young girls suffer no side effects when using the Pill.

7.4.2.2 The Injection

General

The injection is another form of contraception which can be obtained free of charge at family planning clinics. It contains only the hormone progesterone. There are two types of injections: one provides protection against pregnancy for eight weeks, and the other for twelve weeks.

How it works

The effect of the injection on the female body is the same as that of the Pill. It suppresses ovulation, changes the movement in the Fallopian tubes, alters the endometrium and thickens the cervical mucous. These changes occur within a week after the injection was given.

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Effectiveness

The injection is very effective and very few disruptions occur. Theoretically the injection is 100% effective, provided it is correctly administered.

Advantages

The injection is a safe and convenient method of contraception because it does not require daily attention. This method does not interfere with sexual intercourse. The main advantage of the injection is that it is not counteracted by other substances such as antibiotics. In contrast to the Pill the injection has a tendency to stimulate milk production and therefore assists breastfeeding. Because users of this contraceptive method have to return for their next injection every couple of months, they can be given continuous medical supervision to monitor the effects of the injection. The injection also reduces premenstrual tension and period pains.

Disadvantages

The injection is inclined to change the course of the menstrual cycle. Irregular bleeding as well as total absence of periods (amenorrhoea) may occur. The injection has the same effect on the appetite as the Pill. In exceptional cases a change in disposition (e.g. depression) and/or headaches occur. The injection causes a delayed return to fertility after prolonged use, so that women who stop having it sometimes struggle to fall pregnant quickly.
The injection is a convenient contraceptive method that requires little attention and motivation from the user. It is also very effective.

7.4.2.3 *The Intra-uterine Device (IUD)*

General

The IUD is a small plastic structure that is manufactured in a number of shapes. The plastic may be partly coated with metal or the device may contain hormones. The device is inserted into the uterus by a doctor or a nurse and remains there until the woman no longer wants to use it. One or two pieces of string attached to the device hang down through the cervix to enable a woman to check whether the device is still in place.

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How it works

The IUD prevents the implantation of fertilized ova into the uterus. The fertilised ova can, therefore, not grow into an embryo and are eliminated. Pregnancy is thus prevented.

Effectiveness

After the Pill and the injection the IUD is the most effective contraceptive method. The success rate is not 100%, however. From a group of 100 women using the UID at least two will become pregnant. Women who want to be absolutely certain that they will not fall pregnant should use an additional method at least during the ovulation phase of their menstrual cycle. The effectiveness of the IUD can be increased to 100% by using it in conjunction with a condom or a spermicide.

Advantages

The IUD has a continuous effect and daily attention to contraception is not required. The device does not interfere in the least with intercourse. Because the IUD's working is localised (in the uterus), it does not have an influence on the total hormonal system of the body as the Pill and the injection do. There can, thus, be no side effects causing discomfort in other parts of the body or bringing a change in disposition. Although it may not seem that way, the insertion of the device is simple, and causes hardly any inconvenience/discomfort. The contraceptive effect of the IUD is reversed as soon as the device is removed and a woman who wants to have a child should have no problem falling pregnant.

Disadvantages

The most important disadvantages that may be encountered are pelvic infections and perforation of the uterus. Uterine perforation of the uterus can be fatal. It is caused when the device is inserted incorrectly into the uterus. It is extremely important, therefore, that the device be put into place only by qualified doctors and nurses. Women with pelvic infections or those who have a history of such infections tend to experience aggravation or repetition of the condition. Pelvic inflammatory disease can block the Fallopian tubes, thus causing infertility.

The commonest side effects of the IUD are abdominal pains and cramps, and irregular or extended menstruation. Sometimes the IUD is rejected by a woman's body, so it is clearly not a contraceptive method that will suit everybody.

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7.4.2.4 Spermicides (sperm killers)

General

Contraceptive foams, jellies, and creams are all classified as spermicides. They are usually packaged in a tube or a canister together with a plastic applicator. The applicator is filled with the foam or jelly and inserted high into the vagina, where the spermicide is then released close to the cervix. The spermacide must not be inserted more than 20 minutes before intercourse and for eight hours afterwards it must not be washed out. New spermicide must be used for each act of coitus.

How it works

The spermicide contains an ingredient that destroys sperms or weakens them so much that fertilization is prevented. Another ingredient of the spermicide blocks the cervix, preventing sperm from entering the uterus.

Advantages

Spermicides have no side effects and are freely available without prescription or medical supervision. They are simple to use. The spermicides offer a measure of protection against sexually transmitted diseases. The presence of a spermicide facilitates intercourse with a condom and increases the effectiveness of condoms.

Disadvantages

The most significant disadvantage of spermicides is that they are not at all reliable: this contraceptive method has a high failure rate.

In order to apply the spermicide it is often necessary that sexual activity be interrupted. Many women dislike the leaking out of the spermicide afterwards and some find that it causes an irritation of the vaginal areas. Women need to be well motivated to continue using spermicides every time, and the spermicides must be used correctly. Because most people find the taste of spermicides very unpleasant, their use usually interferes with oral sex.

Spermicides should preferably not be used on their own for contraceptive purposes. They are, however, very useful in conjunction with condoms and the diaphragm, and they also give added protection against sexually transmitted diseases.

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7.4.2.5 The Cervical Diaphragm

General

The cervical diaphragm (better known as just "the diaphragm") is a dome-shaped structure of thin synthetic rubber with a rubber-covered rim of flexible metal. Before sexual intercourse the device is inserted into the vagina, where it fits snugly over the cervix. The cervical diaphragm must remain in position for at least eight hours after intercourse and may be inserted up to six hours before intercourse. The diaphragm may be left in the vagina for up to sixteen hours.

How it works

The cervical diaphragm blocks the entrance to the cervix and prevents sperms deposited in the vagina from entering the cervix. In order for the diaphragm to be really effective, a spermicide should be applied to the rim as well as to the upper surface (fitting against the cervix) of the device. The spermicide will ensure that any sperm that do slip past the diaphragm are destroyed or weakened. Any sperm remaining in the vagina will die after eight hours. This is why the diaphragm has to be kept in for eight hours after intercourse.

Effectiveness

The cervical diaphragm is a very effective contraceptive method provided the device is used correctly. It is not 100% safe. However, most failures occur because women do not position the diaphragm correctly in the vagina, or they do not use a spermicide along with it, or they do not keep it in long enough. Sometimes the device slips out of position during intercourse because of the expansion of the vagina. It is advisable, therefore, to insist that at least during the ovulation phase the man also uses a condom.

Advantages

The greatest advantage of the diaphragm is that it has no side effects. It is also very effective when it is used correctly. Women who are concerned about the side effects of the Pill, injection or IUD should perhaps consider the use of the cervical diaphragm as a contraceptive method. The contraceptive effect is, of course, easily reversible - a woman who wishes to become pregnant simply stops using the device.

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Disadvantages

Some people dislike using the diaphragm because it has to be inserted just before intercourse and they believe it spoils the atmosphere. Some couples, on the other hand, view the action of placing the diaphragm in position as part of their foreplay: the man puts it into the woman and both enjoy this necessary interruption.

Some women are averse to handling their own genitals and inserting their fingers into their vagina. Such women should rather not choose the diaphragm as a contraceptive method, because it will require too much motivation to use it every time.

The use of the cervical diaphragm demands energy and motivation from the woman. She must remember to use it and must always have some spermicide on hand as well. Women must also take care that they do not become so carried away during the sexual activity leading to intercourse that they forget to insert the diaphragm in time.

The cervical diaphragm requires a prescription from a doctor and is therefore not available free of charge like some of the other contraceptives. Furthermore, spermicides have to be purchased. However, if the diaphragm is well looked after it will last for at least two years.

7.4.2.6 The Contraceptive Sponge

The contraceptive sponge is a relatively new method of contraception. It is marketed under the trade name "Today". It is a little, rounded, disposable sponge made of polyurethane. The sponge is inserted into the vagina just like the cervical diaphragm. Its hollow side has to fit over the cervix. To facilitate removal there is a loop on the other side. The sponge is moistened with water before it is inserted and can be kept in the vagina for 24 hours. It is discarded once it has been removed form the vagina, but while it is in position it will protect the woman during more than one act of intercourse.

How it works

Firstly, the sponge contains a spermicide that destroys or weakens sperm. Secondly, it blocks the route of the sperm to the uterus. Thirdly, as a sponge, it soaks up the semen and traps the sperm inside it.

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Effectiveness

The success rate of the sponge is lower than that of the diaphragm. It is therefore not a worry-free contraceptive method.

Advantages

The greatest advantage of the contraceptive sponge is that it is easily obtainable without prescription. It is therefore a method women may use until they can get to a doctor for more reliable prescription contraceptives. (With contraceptive pills, injections and condoms freely available at family planning clinics nowadays, there is no need for a woman to take a risk - effective contraception can be obtained immediately.)

The sponge may be inserted long before intercourse and therefore does not have to interrupt the process. The spermicide provides some protection against sexually transmitted diseases.

Disadvantages

The sponge is not a very effective contraceptive. Some women are allergic to the spermicide that the sponge contains. Others find that the sponge absorbs their vaginal fluids. Reduced lubrication of the vagina can cause discomfort during intercourse. Because the sponge is not cheap, it can become quite an expensive method for women who have sex frequently.

7.4.2.7 Natural Methods

(I) Coitus interruptus

General

This is probably the oldest form of contraception. It is even mentioned in the Bible (Genesis 38:8-9) in the story of Onan. For this reason it is sometimes referred to as onanism.

How it works

The method entails the withdrawal of the man's penis from the woman's vagina just before the man has an orgasm. He therefore ejaculates outside the vagina.

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Effectiveness

Coitus interruptus (withdrawal) is not an effective contraceptive method. There are several reasons for this: drops of semen may be released from the penis during arousal and only one of these may contain enough sperm to cause pregnancy; if ejaculation takes place outside the vagina but still close to the vulva surrounding the vagina it is still possible for sperms to enter the vagina and swim to the uterus; it also happens quite frequently that the planned withdrawal by the man simply does not take place in time.

Advantages

The withdrawal method is the only last-minute method, i.e. it can be used when no other method is available. Of course, other options such as oral sex or mutual masturbation could rather be used in desperate situations where no contraceptives are available.
The withdrawal method is free, of course, and does not require a prescription.

Disadvantages

One of the greatest disadvantages that a man should be aware of is that men who often use this method may experience sexual dysfunction, such as uncontrolled ejaculation, later in life. Sexual dysfunction may also occur in women, because they often do not get full satisfaction from this method, and may struggle to attain orgasm later in life. Furthermore, the method is not at all effective: it often fails. It also inhibits the spontaneity of intercourse and the build up to maximum sexual pleasure. The method demands a great deal of motivation and concentration from the man, and also causes the woman to be worried throughout the act about whether the man will withdraw in time. When the parties are so occupied with the contraceptive method, maximum pleasure cannot be derived from the sexual intercourse.

(ii) Rhythm methods

The different rhythm methods basically entail the establishment of the most fertile days of a woman's cycle, either according to her menstrual cycle/uteral cycle (calendar method), her body temperature (temperature method), or a combination of the two. On these "fertile" days coitus will be avoided. The techniques for establishing the fertile time are very complicated and should preferably be worked out in consultation with a doctor or a nurse, and be regularly monitored by them.

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The methods are not very reliable because a variety of factors can influence the bodily cycles. (What do we call people who use the rhythm method? Answer: Parents!) The methods also require a fairly high degree of intellectual competency, as well as sexual discipline. Strict rules and routines have to be followed to try to keep the method effective. The cooperation of both parties is also a prerequisite.

The method is, of course, free of charge, and, with the exception of possible psychological stress, there are no side effects. The woman becomes aware of the workings of her own body. The method is easily reversible.

Disadvantages

There are periods of at least eight days during which the parties using this method of contraception may not have sexual intercourse. These times of abstinence often may place stress on relationships and/or individuals.

To ensure that the method is as effective as possible, there must be a period of about six months during which the woman's body temperature and cycles are monitored in order that a reliable contraceptive routine may be worked out. In other words, a couple cannot simply start using the method. It has also been found that when the method fails and a baby is born, there is an increased risk of the baby having some or other handicap. This is because such pregnancies are the result of sexual intercourse taking place late in the woman's cycle, and this could lead to an overripe egg being fertilised.

The rhythm method is the only method acceptable to the Roman Catholic Church.

(iii) Abstinence

Abstinence is undoubtedly the most effective and most reliable method of contraception. No evidence has yet been found that abstaining from intercourse, even for very long periods, has any physiological or psychological effects. To abstain from intercourse does, of course, not mean that one cannot be sexually active in other ways. The most erotic sexual arousal and satisfaction can be the result of non-penetrative sex.

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7.4.2.8 Douching

Some women believe that they can prevent pregnancy by flushing the vagina with certain liquids after sexual intercourse. A popular method with young women is to rinse their vaginas with a cola drink (coke) after intercourse. Unfortunately, although it is true that some acid-based solutions will kill sperms, it takes only a minute for sperms to enter the cervix and the uterus. Once the sperms are there, no douche can reach them. It is highly unlikely, then, that any women will be able to act fast enough to reach the sperms with a douching liquid. Moreover, douching can actually push some sperms up into the uterus.

7.4.2.9 Condoms

General

At present the condom is the only male contraceptive device. It is a thin rubber sheath that fits over the man's penis.

How it works

The condom catches the semen that is released during ejaculation and prevents it from entering the vagina. Condoms covered with a spermicide give extra protection because the sperm are killed or weakened. The condom also provides protection in that it limits the contact between the male and female sexual organs to a minimum, and in this way reduces the risk of sexually transmitted diseases and AIDS.

Effectiveness

Condoms are far more effective than most people believe. They are almost 100% reliable and can be made more effective if people use a spermicide along with a condom. Like all other contraceptive methods, however, condoms must be used correctly.

Advantages

Condoms have no side effects. They are readily available, free of charge, at family planning clinics. The condom is one of the few contraceptive methods that also provide protection against sexually transmitted diseases.

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Disadvantages

The greatest problem with the condom as a contraceptive again has to do with the disruption of the "spontaneity" of the process of sexual build-up. Because the condom may only be fitted to an erect penis, there must be an interruption to place it in position. This process can be very erotic if the woman unrolls it onto the man's penis or they do it together.

Some men complain that a condom reduces their sensation and therefore also their sexual pleasure. This can be a great problem. However, the more expensive condoms are designed to ensure that a man can still experience maximum sensation.

Most men play around with condoms from an early age and believe that they know exactly how to use them. A large number still do not put it on correctly, however, and therefore lessen the effectiveness of the condom.

The condom may break during sexual intercourse if it was not put on correctly or if it is of a poor quality.

7.4.2.10 The Female Condom

The female condom is a new contraceptive product that is not yet widely used. It is made of polyurethane and is an oblong bag. A sturdy circular section at the open end of the condom remains outside the vulva and keeps the condom in position. The sheath-like part of the device is pushed into the vagina. The closed end also has a thicker, sturdy structure that fits against the cervix. The condom should, preferably, also be covered with spermicide, and should be used only once.

The female condom has all the advantages and disadvantages of the male condom. It is, however, not available free of charge at family planning clinics. At pharmacies three Fendoms cost approximately R20. The condoms are available without prescription.

The female condom can be placed in position before the man has an erection. It must, of course, be in place before penetration. Here the interruption in the sexual activity to position the condom can therefore take place at an earlier, less intense stage.

There is not yet any information available regarding the extent to which the female condom affects the sensation and sexual pleasure of either the man or the woman. If they are always used during

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intercourse, and placed in position before penetration, they should have a high rate of effectiveness. They also provide protection against sexually transmitted diseases.

7.4.2.11 Emergency Contraception

Emergency contraceptive measures are applied only in exceptional circumstances, and should not be regarded as a method to be used regularly or to be relied upon. These methods are used when sexual intercourse has taken place and something went awry with the contraceptive method, or in single instances of unprotected intercourse. The methods are very effective but not guaranteed. These measures must be taken under the supervision of a doctor, nurse or pharmacist.

(i) The "morning-after" pill

High doses of hormones are taken by means of a course of birth-control pills within 72 hours after the unprotected intercourse. Two pills are taken as soon as possible within the 72-hour period and another two exactly twelve hours later.

(ii) The IUD

An IUD is inserted into the uterus as soon as possible after the unprotected intercourse. Implantation of the ovum in the uterus is thus prevented.

Please note: These emergency contraceptive measures must not be taken lightly. The "morning-after" pill is less effective each time it is used. The woman's hormone balance and consequently also her menstrual/uteral cycles are also disturbed by this high dosage pill. Moreover, both methods almost always have nausea and vomiting as side effects.

7.4.3. Discussion

Conclude the session with a discussion in which group members give their views on contraception and the various methods available. What would they choose? Why? What would they not use? Why? What further information would they like? Which unconventional contraceptive methods have they heard about or encountered? Do they think that they will now be able to make better decisions on which contraceptives to use? Are contraceptives more of a reality to them now than before?

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GROUP SESSION 8:
ASSERTIVENESS IN SEXUALITY

8.1 OBJECTIVES

It is the aim that the group members, throughout the sexuality education programme, develop their knowledge and attitudes related to sexuality. Such knowledge and attitudes promote decision-making skills as well as the group members' motivation to engage in effective sexual behaviour. The group members should, however, actually develop the skills they need to convert their knowledge, attitudes and decisions into effective behaviour. They need to know how to communicate their convictions to their sexual partners and should then practise what they know in order to strengthen and establish effective sexual behaviours.

The objectives of Group session 8 is thus to:

- **promote the group members' awareness of the sexual rights of every man and woman;**
- **provide the group members with an opportunity to develop and practise the communication and assertiveness skills that they might need in various sexual situations.**

8.2 STRUCTURE OF THE SESSION

8.2.1 Introductory Discussion

The session must be started with a short discussion about assertiveness and *being assertive.* The discussion includes a few specific questions (provided in 8.4.1) about personal assertiveness that each group member should answer. The group members' attention should be focused on the advantages associated with being assertive and to strengthen the group members' belief in their right to do so.

8.2.2 Practising assertiveness and communication skills

In 8.4.2 there are two exercises that the group members must complete. These exercises provide the group members with an opportunity to think about and practise their communication and assertiveness skills pertaining specifically to self-empowerment in sexuality-related situations.

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8.2.3 Feedback on Group session 8

End the session off with a very short discussion of the activities that were included in this session. (See 8.4.3)

8.3 GUIDELINES FOR THE GROUP LEADERS

Group session 8 should for the most part be placed in the hands of the group members. The group leaders' activity must be restricted to the clear explanation of the exercises and thereafter only the most necessary guidance of discussions in order to ensure the aims of the exercises are reached. The aim of the group session is to teach the group members assertiveness and effective communication - the group leaders must therefore let them get on with doing exactly that: communicating assertively.

The group leaders should see to it that Exercises 1 & 2 take up sufficient but not too much time, seeing that Exercise 3 is longer and more important than Exercises 1 & 2.

***A word of warning*:** even though the group leaders' participation in Group session 8 is small it is imperative that they study the group session thoroughly beforehand. The exercises can seem quite complicated at first and the group leaders should therefore know what they are about in order to be able to give effective guidance to the group members during the group session.

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8.4 CONTENT OF GROUP SESSION 8

8.4.1 Introductory discussion

Assertiveness = *the expression of thoughts, feelings, or beliefs in direct, appropriate ways which do not violate the rights of others. Assertive sexuality typically depends on the skills of negotiation and compromise.*

8.4.1.1 Instructions for the group leader:

(I) Initiate a discussion of the following questions:

- In which situations in their lives do the group members usually find it necessary to be assertive?
- In which specifically sexuality-related situations do the group members think it would be necessary to act assertively?

(ii) Each group member must identify situations/areas in their lives in which they wish they could be more assertive (It does not have to be related to sexuality - it could be any area: work, socially, handling problems, etc.). They should then answer the following questions:

- Why do they think they should be more assertive in those areas/situations?
- What are the possible disadvantages of non-assertive behaviour?
- What usually stops them/ people in general from being assertive?
- What would the advantages be to acting in a more assertive manner? Consider the following possibilities: independence, self-respect, being true to yourself, honesty in relationships, inner peace, clarity, etc.
- Do the group members feel that they actually have the right to be more assertive in the areas/situations they identified?

(iii)Each group member has to write out a response stating that they will make a conscious effort to act more assertively the next time they are in the above-mentioned situations/areas. They must each read the statement out loud to the group.

For example: "I am a considerate person. I do not push myself into the front of queues. I have the right to stand up for my place in a queue. I will be more assertive next time somebody shows disregard for my and other peoples' rights by pushing into the front of a queue. I will assert myself whenever my rights are being violated."

(iv) Inform the group of the following: “Assertive rights are basic human rights. The claim of this right is a statement we make of our ethical position, our view of freedom and the respect we have for ourselves and others.”

- Ask the group what they think some basic human rights are.

Provide each group member with a copy of the human rights as set out below:

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Human assertive rights

1. **The right to do anything that does not violate the rights of others.**
2. **The right to be assertive or non-assertive.**
3. **The right to make choices.**
4. **The right to change.**
5. **The right to control over body, time and possessions.**
6. **The right to express opinions and beliefs.**
7. **The right to think well of oneself.**
8. **The right to make requests.**
9. **The right to express sexuality.**
10. **The right to have needs and desires.**
11. **The right to fantasy.**
12. **The right to have information.**
13. **The right to have goods or services that have been paid for.**
14. **The right to be independent and to be left alone.**
15. **The right to say no.**
16. **The right to be treated with respect.**

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8.4.2 Practising assertiveness and communication skills

8.4.2.1 Exercise 1

(i) Instructions for the group leader

1. Each item (given below) describes a situation. The group leader must read out the situations one at a time. The group members must then be given sufficient time to respond to the situation. They must write down how they would react and what they would say if they were to be confronted with such a situation. They must write down (where appropriate) a direct response that they could use in such a situation.

For example:

Situation: When your date asks you if you agree to using a condom when you make love tonight, you think...

Response: I would be glad that he (she) brought this up; now we will both be protected.

Direct response: I would say: " I am glad that you feel the same way about safe sex as I do. Now we can both enjoy this to the full."

OR

Response This is a turn-off. I don't like using condoms.

Direct response: I would say: " I do not like using condoms and I don't want anybody to tell me what I should do when we make love."

They must try to answer the questions: What do I think? What do I do? What do I say? for each situation as appropriate to their natural response.

The group members must try to stay true to themselves by keeping their responses as close as possible to the way they think they would naturally respond if they were really in such situations.

2. Go through all the responses before asking the group members to read out their responses to the group. Take one situation at a time and have all the group members read their responses to that specific situation. For each response given the group must categorize it - they must decide whether it is an aggressive, assertive or nonassertive response. Let the group discuss each other's responses: do they agree with the way the other group members decide to react in different situations? What would they do differently? Can they give the other group members constructive feedback on how to handle the situation better? Do they agree with the others' responses? Why?
3. What does the group think would be an effective assertive reaction to each of these situations?

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(ii) Situations for exercise 1

(Adapted from The Intimate Relationships Questionnaire in Yesmont, 1992)

- During the past few weeks, your boyfriend/girlfriend seems less enthusiastic and caring about your relationship. What do you do?
- When your date says he/she will not have sex with you if you insist on using a condom, you think? You say?
- You are at a party with your boyfriend/girlfriend and notice that he/she is very attentive to someone of the opposite sex that you have never seen before. What do you think? What do you do? What do you say?
- You want to tell your date that you would like to use a condom when making love tonight. How do you tackle the issue? What do you say?
- Your boyfriend/girlfriend becomes silent instead of saying what is on her/his mind. You think? What do you do? What do you say?
- When you are asked by your date if you have any disease that you think you could transmit to him/her if you make love tonight, you think? You do? You say?
- Your boyfriend/girlfriend has criticized your appearance in front of your friends. What do you do? What do you say?
- When you suggest to your date that a condom be used for mutual protection when you make love tonight, your date teases you about being such a worrier. What do you do? What do you say?
- You want to ask your date if he/she has been tested for AIDS. How do you tackle the issue? And what do you say?
- If your date refuses to use a condom, you think...you say...
- When neither you nor your date has any condoms one evening, you say...
- You tell your date you would like to wait until you know each other a little better before having sex. When he/she gets annoyed you would do? /say? (Also reverse the situation - what would you say if he/she wanted to wait?)
- When you suggest to your date that a condom be used when you make love tonight, he/she says, "You don't trust me. I told you I have never been exposed to AIDS or Herpes, or any other disease." What do you do? And say?

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8.4.2.2 Exercise 2

The Case studies used in this exercise were adapted from similar examples in Franzini et al. (1990) and Crawford, Kippax and Waldby (1994).

(ii) Instructions for the group leaders

1. *See to it that each group member gets one of the case studies given below.*

The case studies must be given out randomly. Some of the case studies (case studies 1,2 & 8) differentiate between exercises for males and females. The other case studies (3,4,5,6 & 7) can be enacted by any group members irrespective of their sex - the group leaders should not try to give male roles to the men and female appropriate role-plays to the females. It is good to have some role-reversal in the role-play exercises.

2. *The group members must now be grouped together in pairs.*

Any method can be used to pair them off (let them turn to the one on their right/give them each a number and let them choose a number and thus a partner, etc), but it would be best not to let them choose their partners themselves.

3. *Each group member sets the scenario for role-play according to his/her case study.*

Each group member must be given enough time beforehand to prepare statements and possible responses. He/she must then start the role-play and the pair-partner must try to react to the situation as assertively as possible. This role-play must be done in front of the whole group.

4. *Discussion of each role-play can follow.*

Discuss why it is difficult to be assertive in such a situation. What might people be saying to themselves that could contribute to their non-assertive behaviour (negative self-talk)? What do the other group members think of the way in which the situation was handled? If they do not agree with the way in which the pair acted - how do they think people actually react in such situations?

5. *The group leaders are also allowed to confront the group members with different ideas after the role-play has been done* (don't interrupt):

They could ask the participant(s) what they would have said had the other one said "..." instead of "..." Group members are also allowed to ask for instance: If John had said this, what would your reaction have been? Etc. Although the feedback should focus primarily on the behaviour of the 'assertor', you will realize that in many of these role-plays the other pair-partner is also playing a role in which many of us will find ourselves one day, being responsible for some assertive

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behaviour. Where appropriate, focus should thus also be placed equally on the behaviour of both members involved in the role-play.

6. The group leaders can stop the role-play when they think the group members have had enough practise or if she/he sees that it is not working. However, don't stop it too soon.

(ii) Instructions for group members:

You will each be given a case study. You must use the case study as if you were a counsellor trying to help a client practise assertiveness skills. Your pair-partner will be the one who gets a chance to practise his/her assertiveness skills. Your function will be to provide realistic statements and responses befitting the given scenario that your pair-partner can then try and respond to in an assertive manner. (When it is your pair-partner's turn to use his/her case study you will get your chance to practise assertiveness skills within the scenario he/she will sketch and against the character he/she will portray) *Just follow the instructions given with each case study.*

(iii) Case studies for Exercise 2

The group leader must print out the case studies provided on the following pages and hand them to the group members.

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Case study 1

If your pair-partner is a female use (a). If your pair-partner is male use (b.)

(a) Stephen and Caren have just enjoyed a romantic dinner and have decided to take a long walk on a private secluded beach. They end up lying on a blanket and cuddling. They are both feeling quite intimate and sexual. They continue to touch and they both want to make love. They have been dating regularly for the past three months and have recently taken a weekend ski trip along with a group of friends. They are emotionally involved. Caren thinks that Stephen is very special. This will be their first time together sexually. Caren really wants to make love with Stephen but wishes to do it *safely*. Caren needs to communicate that she is interested in making love but that she is only interested in *safe* sex.

Instructions: You are Stephen. Your pair-partner is Caren. Prepare yourself - place yourself in Stephen's shoes; think of possible responses Stephen might use when confronted with Caren's feelings about safe sex. (Do not make it too easy for Caren to persuade you to take the trouble to have safe sex) Read the case study to your pair-partner (Caren). Tell her that you will play the part of Stephen and that she must play the part of Caren. Initiate a dialogue by indicating your willingness and need to make love to Caren.

(b) Stephen and Caren have just enjoyed a romantic dinner and have decided to take a long walk on a private secluded beach. They end up lying on a blanket and cuddling. They are both feeling quite intimate and sexual. They continue to touch and they both want to make love. They have been dating regularly for the past three months and have recently taken a weekend ski trip along with a group of friends. They are emotionally involved. Stephen thinks that Caren is very special. This will be their first time together sexually. Stephen really wants to make love with Caren but wishes to do it *safely*. Stephen needs to communicate that he is interested in making love but that he is only interested in *safe* sex.

Instructions: You are Caren. Your pair-partner is Stephen. Prepare yourself - place yourself in Caren's shoes; think of possible responses Caren might use when confronted with Stephen's feelings about safe sex. (Do not make it too easy for Stephen to persuade you to take the trouble to have safe sex). Read the case study to your pair-partner (Stephen). Tell him that you will play the part of Caren and that he must play the part of Stephen. Initiate a dialogue by indicating your willingness and need to make love to Stephen.

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Case study 2

If your pair-partner is male use (a) If your pair partner is female use (b)

(a) Julian has been dating Anna for the past three months and he really likes her. Anna has been over to Julian's place several times and his friends also think Anna is terrific. Julian feels that he is ready to have sexual relations with Anna. He invites Anna over to his place and after a romantic candlelight dinner, they are cuddling in front of a warm fire. Anna expresses the desire to make love. Julian would love to, but before he does, because of the AIDS issue, he wants to know something about Anna's sexual past. He will have to bring up the topic of Anna's sexual experiences.

Instructions: You are Anna. Your pair-partner is Julian. Prepare yourself - place yourself in Anna's shoes. Think of possible responses that Anna might use when confronted with the issue of her sexual past and AIDS. Show some resistance to conversation about AIDS. (Don't make it too easy for Julian to get the necessary information from you). Tell your pair-partner that he must play the role of Julian. Read the case study to him. Start the exercise by expressing your desire to have sex with Julian.

(b) Anna has been dating Julian for the past three months and she really likes him. Julian has been over to Anna's place several times and her friends also think Julian is terrific. Anna feels that she is ready to have sexual relations with Julian. She invites Julian over to her place and after a romantic candlelight dinner, they are cuddling in front of a warm fire. Julian expresses the desire to make love. Anna would love to, but before she does, because of the AIDS issue, she wants to know something about Julian's sexual past. She will have to bring up the topic of Julian's sexual experiences.

Instructions: You are Julian. Your pair-partner is Anna. Prepare yourself - place yourself in Julian's shoes. Think of possible responses that Julian might use when confronted with the issue of his sexual past and AIDS. Show some resistance to conversation about AIDS. (Don't make it too easy for Anna to get the necessary information from you). Tell your pair-partner that she must play the role of Anna. Read the case study to her. Start the exercise by expressing your desire to have sex with Anna.

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Case study 3

Ian and his friends were on the beach. It was broad daylight. He and two of his friends 'picked up three girls at the beach. Ian really wanted to be with the girl who was with his friend, but he was left with a strange looking person called Constance. As his friends wandered away the, turned to him and said: "Constance wants you to finger her." Ian thought: " Oh hell, how rude!" Constance then grabbed him and literally pushed Ian's hand down her pants.

Instructions: You are the Constance. Read the case study to your pair-partner and tell him/her to play the role of Ian. Initiate a dialogue by expressing Constance's wish to have a "jol".

Case study 4

Craig really repels Lee-Anne physically, but she can't say no when he invites her to the movies because he is her brother's best friend. They go to the movie and take their seats in the back row of the theater. As soon as the movies start Craig grabs Lee-Anne's hand with his clammy one and places it on his crotch. Lee-Anne can feel a huge erection through his trousers. She tries to pull away, but he holds it there very tightly before letting go, while simultaneously slobbering in her ear and trying to kiss her on the mouth.

Instructions: You are Craig. Read the case study to your pair-partner and tell him/her to play the role of Lee-Anne. Initiate a dialogue by expressing Craig's attraction to Lee-Anne. Don't make it too easy for Lee-Anne to get out of your clutches.

Case study 5

Lisa and Lee have been going out for three months and although taking it slowly, they've been getting closer to having sex. They're sitting on the sofa together. Romantic music is playing. They begin to get down to some serious kissing and touching. Lisa feels that she is not ready to become sexually involved with Lee yet. Lee really wants to take things further and hopes that tonight is the night.

Instructions: You are Lee. Read the case study to your pair-partner and tell him/her to play the role of Lisa. Initiate a dialogue by expressing your need for making love to Lisa. Remember that you really want to have sex with her tonight.

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Case study 6

Alex's boyfriend/girlfriend comes to her/his home to pick her/him up for a big party. Alex has been looking forward to this evening for a long time. They arrive at the party and start to mingle. Alex and her/his boyfriend/girlfriend find their group of best friends and they are soon involved in some enjoyable conversation. Somewhere during the conversation Alex's boyfriend/girlfriend criticizes her/his appearance. All Alex's friends heard this. Alex feels that she/he was unjustly embarrassed.

Give the following instructions to your pair-partner:
" *You are Alex. I am your boyfriend/girlfriend. Decide when and where, if not immediately you would confront me with the problem. Start the conversation by voicing your feelings.*"

Instructions: Play the role of the girlfriend/boyfriend in any manner you think appropriate. Try to react naturally to the way in which Alex (your pair-partner) confronts you. However try not to make it too easy for Alex to convince you to give in to her/his viewpoint(s).

Case study 7

Chris is at a party with her/his boyfriend/girlfriend. Chris notices that her/his boyfriend/girlfriend is very attentive to someone of the opposite sex. More attentive than Chris thinks a 'taken' man/woman should be. Chris has never seen this other person before.

Give the following instructions to your pair-partner:
" *You are Chris. I am your boyfriend/girlfriend. Decide when and where, if not immediately you would confront me with the problem. Start the conversation by voicing your feelings.*"

Instructions:
Play the role of the boyfriend/girlfriend in any manner you find appropriate. Try and react naturally to the way in which Chris (your pair-partner) confronts you. However try not to make it too easy for Chris to convince you to give in to his/her viewpoint(s).

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Case study 8

If your pair-partner is female use (a) If your pair-partner is male use (b)

(a) Pippa had met Martin at the beach the day before. She rang him up the next day and invited him to a party that night. This is Pippa's description of what happened at the party:
"...it was dark, very dark. There were about seven people on a bed. The others (on the bed) weren't really doing it - but somehow I remember him just lying on top of me on this guy's parents' bed - and for some reason - he just unzipped the old fly and pulled my panties to one side and went uh uh uh a couple of times and that was sort of it - I really didn't say anything, but I got scared and upset the next day when I had a chance really to think about what had happened, I didn't know anything about Martin - I decided that I had to talk to Martin about it the next day - but I didn't know if he would even remember..."

Instructions: You are Martin. Your pair-partner is Pippa. Read the case study to her so that she will understand the situation and the feelings of the character of Pippa that she has to portray. Ask her to start the exercise by confronting you with the problem. Prepare yourself for the role of Martin by thinking of the responses Martin might give when confronted with what he had done.

(b) Pippa had met Martin at the beach the day before. She rang him up the next day and invited him to a party that night. This is Martin's description of what happened at the party: "...it was dark, very dark. There were about seven people on a bed. The others (on the bed) weren't really doing it - but somehow I remember just lying on top of her on this guy's parents' bed - and for some reason - I just unzipped the old fly and pulled her panties to one side and went uh uh uh a couple of times and that was sort of it - she really didn't say anything, I didn't think she would even remember, but I got quite scared afterwards, I didn't really know anything about Pippa - I thought I should at least talk to her the next morning...".

Instructions: You are Pippa. Your pair-partner is Martin. Read the case study to him so that he will understand the situation and the feelings of the character of Martin that he has to portray. Ask him to start the exercise by confronting you with the problem. Prepare yourself for the role of Pippa by thinking of the responses Pippa might give when confronted with what had happened.

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8.4.3. Feedback on Group session 8

End off this session by asking the group members to provide opinions briefly about Group session 8 and assertiveness in sexuality. What did they think of the exercises? Do they think it might have helped in preparing them for future problematic sexuality-related situations? Do they think they will try to be assertive (when appropriate) in future? What did they get out of Group session 8?

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APPENDIX B: THE SEX KNOWLEDGE AND ATTITUDE TEST FOR ADOLESCENTS (SKAT-A)

Number ....

SEX KNOWLEDGE AND ATTITUDE TEST FOR ADOLESCENTS (SKAT-A)

SKAT ATTITUDE SECTION

DIRECTIONS: Below you will find a series of statements about sex. After reading each sentence decide the degree to which you agree or disagree. Check the box that closely applies to your answer.

	STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE
1. The decision about having an abortion should be made by the pregnant teenager and not by the teenager's parents or boyfriend.	☐	☐	☐	☐	☐
2. Boys who masturbate in a group will become homosexuals.	☐	☐	☐	☐	☐
3. Pornography should be banned.	☐	☐	☐	☐	☐
4. A woman should submit to a man's sexual demands.	☐	☐	☐	☐	☐
5. Abortion should be permitted whenever desired by the pregnant woman.	☐	☐	☐	☐	☐
6. Healthy sexually active people do not masturbate.	☐	☐	☐	☐	☐
7. Teenagers should have their parents permission before buying birth control.	☐	☐	☐	☐	☐
8. Only perverts look at pornography.	☐	☐	☐	☐	☐
9. Premarital sex is morally wrong.	☐	☐	☐	☐	☐
10. Parents should prevent their children from masturbating.	☐	☐	☐	☐	☐
Total	☐	☐	☐	☐	☐

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		STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE
11.	Homosexuals/lesbians should be allowed to be teachers in elementary and high schools.	☐	☐	☐	☐	☐
12.	Women should wait until they are married before having sex.	☐	☐	☐	☐	☐
13.	Abortion is murder.	☐	☐	☐	☐	☐
14.	It is OK for teen **females** to masturbate.	☐	☐	☐	☐	☐
15.	Adolescents who look at pornography are more likely to rape their sexual partners.	☐	☐	☐	☐	☐
16.	Masturbation is unhealthy.	☐	☐	☐	☐	☐
17.	Homosexuals/lesbians are sick.	☐	☐	☐	☐	☐
18.	Abortions should only be performed in cases of rape and incest.	☐	☐	☐	☐	☐
19.	It is OK for teen **males** to masturbate.	☐	☐	☐	☐	☐
20.	Sex education should be required in schools.	☐	☐	☐	☐	☐
21.	Children should not see their parents naked.	☐	☐	☐	☐	☐
22.	Sex between adolescents is not O.K.	☐	☐	☐	☐	☐
23.	It is a woman's fault if she gets raped.	☐	☐	☐	☐	☐
	Total	☐	☐	☐	☐	☐

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		STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE
24.	Abortion is a greater evil than bringing an unwanted child into the world.	☐	☐	☐	☐	☐
25.	Teenagers should be encouraged to remain virgins.	☐	☐	☐	☐	☐
26.	Sex education courses in high school should <u>only</u> teach teenagers about male and female anatomy (the parts of the body).	☐	☐	☐	☐	☐
27.	All kinds of pornography are degrading to women.	☐	☐	☐	☐	☐
28.	Teenage females who masturbate are queer.	☐	☐	☐	☐	☐
29.	Homosexuals should be allowed to marry each other.	☐	☐	☐	☐	☐
30.	The responsibility for using birth control should be shared by both the man and the woman.	☐	☐	☐	☐	☐
31.	Rape only occurs between strangers.	☐	☐	☐	☐	☐
32.	Birth control clinics should be located in high schools.	☐	☐	☐	☐	☐
33.	Teenagers who don't use birth control want to get pregnant.	☐	☐	☐	☐	☐
34.	Homosexuals/lesbians can be excellent parents.	☐	☐	☐	☐	☐
	Total	☐	☐	☐	☐	☐

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		STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE
35.	Parents should encourage their teenage sons to have sex.					
36.	Parents should encourage their teenage daughters to have sex.					
37.	A pregnant teenage girl should follow the decision of her parents regarding abortion.					
38.	It is O.K. to force a woman to have sex even when she has said she does not want to have sex.					
39.	Pornography should NOT be censored.					
40.	Parents should be responsible for teaching their children about sex.					
41.	It is impossible for a man to be raped.					
42.	Women should try to get as much sexual experience as they can before they get married.					
43.	A child is to blame when he or she has been sexually molested.					
	Total					

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SKAT A ACKNOWLEDGE SECTION

TRUE/FALSE QUESTIONS

DIRECTIONS: Below you will find a series of statements about sex. If you think the statement is **TRUE**, then circle the 'T'. If you think it is **FALSE**, then circle the 'F'. If there is any question you **DO NOT** understand, then circle the '?'.

No.	Statement			
1.	Feeling nervous can cause a man to have a quick orgasm and can cause a woman to have difficulty having an orgasm.	T	F	?
2.	A woman can only have an orgasm if her clitoris is touched.	T	F	?
3.	Teenagers are the only people who masturbate.	T	F	?
4.	A man may have trouble getting an erection when he feels nervous or scared.	T	F	?
5.	Male teenagers are more sexually active than female teenagers.	T	F	?
6.	It is rare for a teenage boy to have a sexual encounter with another boy.	T	F	?
7.	A woman who has not had an orgasm is frigid.	T	F	?
8.	A person who exposes himself or makes obscene phone calls will one day become a rapist.	T	F	?
9.	A person who masturbates is having sexual problems with his/her sexual partner.	T	F	?
10.	Many people dream at night about having sex with someone of the same sex.	T	F	?
11.	A person cannot like having sex with both men and women.	T	F	?
12.	Most parents want schools to offer classes in sex education.	T	F	?
13.	Men rape women because they want to control or humiliate them.	T	F	?
14.	During sex, using a condom (rubber) is the best way of avoiding STD's (sexually transmitted diseases).	T	F	?
15.	Dreaming about being raped means you want to be raped.	T	F	?
16.	Masturbating causes mental problems.	T	F	?
17.	A woman can't become pregnant during the months that she breast feeds her baby.	T	F	?
18.	The rhythm method (only having sex during the few days before and after a woman's period) is as safe as the pill in preventing pregnancy.	T	F	?
19.	Anyone who is sexually active can get a STD (sexually transmitted disease).	T	F	?
20.	When a child is raped or molested it is usually done by stranger.	T	F	?
21.	It is common for both men and women to masturbate.	T	F	?
22.	Taking cocaine increases a person's ability to have sex.	T	F	?
23.	Intercourse produces a stronger orgasm for women than does masturbation.	T	F	?
24.	Douching a few minutes after sex is likely to prevent pregnancy.	T	F	?
25.	A woman is not able to have as strong an orgasm as a man.	T	F	?
26.	More than half of all teenagers in America lose their virginity (have sex) by age 15.	T	F	?
27.	The youngest age at which most teenage girls can get pregnant is 12.	T	F	?
28.	A woman can ONLY get pregnant if she has an orgasm during sex.	T	F	?
29.	After having one orgasm, most woman have to wait 10-20 minutes until they can have another orgasm.	T	F	?
30.	You can get a sexually transmitted disease if you kiss a person who has a sexually transmitted disease.	T	F	?
31.	Rubbers/condoms is the form of birth control MOST WIDELY USED by teenagers who are sexually active.	T	F	?

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32.	When teenagers have sex (intercourse) FOR THE FIRST TIME, the majority of them use rubbers (condoms).	T	F	?
33.	Six out of ten teenage girls have sexual activity with another girl.	T	F	?
34.	The safest time to have an abortion is anytime up until the baby is born.	T	F	?
35.	Men who expose themselves in public are called exhibitionists.	T	F	?
36.	Men in their 30s have less interest in having sex compared to their interest when they were teenagers.	T	F	?
37.	A man who wears women's clothes is called a homosexual.	T	F	?

Total score ☐

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BEHAVIOR INVENTORY

1. How old were you when you went out on your first date? [ ]

2. From who(m) did you learn about sex? (Please check one or more)

   [ ] Friends
   [ ] Parent(s)
   [ ] Brother(s)/Sister(s)
   [ ] Other Relatives
   [ ] Books/Magazines
   [ ] Movies
   [ ] Television Shows
   [ ] Church
   [ ] Sex Education Classes
   [ ] Other ______________

3. How does your sexual experience compare to the experiences of your friends? (Please check one)

   [ ] I am less experienced.
   [ ] I have the same amount of experience.
   [ ] I am more experienced.

4. How does your knowledge about sex compare to the knowledge of your friends? (Please check one)

   [ ] I know less about sex.
   [ ] I know about the same.
   [ ] I know more about sex.

5. Have you ever had sexual intercourse?

   [ ] No
   [ ] Yes

6. How old were you when you had sex (intercourse) for the first time?

   [ ] Years old

7. Have you ever engaged in sexual activity with a person of the same sex as you?

   [ ] No
   [ ] Yes

8. Have you ever been forced to have sex when you didn't want to (been sexually abused)?

   [ ] No
   [ ] Yes

9. Have you ever forced someone else to have sex when he/she didn't want to?

   [ ] No
   [ ] Yes

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10. If you have never had sex (intercourse), why haven't you? (Please check one or more.)

- [ ] I don't want to.
- [ ] Religious beliefs.
- [ ] Nobody wants to have sex with me.
- [ ] I am not ready.
- [ ] I can't get birth control.
- [ ] Pressure from my parents to wait.
- [ ] Pressure from my friends to wait.
- [ ] Other ______________________________

11. If you have had sex (intercourse), what made you decide to have sex the first time? (Please check one or more.)

- [ ] I was ready.
- [ ] I was in love.
- [ ] All my friends were having sex.
- [ ] I was drunk or high.
- [ ] My girlfriend/boyfriend wanted to have sex.
- [ ] I was forced to have sex.
- [ ] I wanted to have a baby.
- [ ] Other ______________________________

12. How often do you use contraception, i.e., the pill, rubbers, etc.?

- [ ] Never
- [ ] Most of the time
- [ ] Sometimes
- [ ] Always

IF YOU ANSWERED NEVER, SOMETIMES, OR MOST OF THE TIME, why don't you use it every time? (Please check one or more.)

- [ ] Not important to me
- [ ] Can't afford it
- [ ] Don't want parents to find out
- [ ] Don't know where to get it
- [ ] Embarrassed to ask for it or buy it at the store
- [ ] Don't know how to talk about it with girlfriend/boyfriend
- [ ] Don't like to use it
- [ ] My girlfriend/boyfriend doesn't like to use it
- [ ] Against religious beliefs
- [ ] Sometimes I don't have it with me
- [ ] Don't know how to use it
- [ ] Don't know which one to use
- [ ] Don't want to interrupt sex
- [ ] Other ______________________________

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IF YOU ANSWERED SOMETIMES, MOST OF THE TIME, OR ALWAYS, why do you use contraception?

- [ ] Don't want pregnancy to happen
- [ ] Don't want to get a STD (sexually transmitted disease)
- [ ] Don't want to get AIDS
- [ ] My girlfriend/boyfriend wanted me to
- [ ] Someone told me to use it

13. How often do you use condoms (rubbers)?

- [ ] Never
- [ ] Sometimes
- [ ] Most of the time
- [ ] Always

IF YOU ANSWERED SOMETIMES, MOST OF THE TIME, OR ALWAYS, why do you use contraception?

- [ ] Don't want pregnancy to happen
- [ ] Don't want to get a STD (sexually transmitted disease)
- [ ] Don't want to get AIDS
- [ ] My girlfriend/boyfriend wanted me to
- [ ] Someone told me to use it

IF YOU ANSWERED SOMETIMES OR MOST OF THE TIME, why don't you use it every time?

- [ ] Not important to me
- [ ] I use other things
- [ ] Cannot afford it
- [ ] Don't want parents to find out
- [ ] Don't know where to get it
- [ ] Embarrassed to ask for it or buy it at the store
- [ ] Don't know how to talk about it with girlfriend/boyfriend
- [ ] Don't like to use it
- [ ] My girlfriend/boyfriend doesn't like to use it
- [ ] Against religious beliefs
- [ ] Sometimes I don't have it with me
- [ ] Don't know how to use it
- [ ] Don't know which one to use
- [ ] Don't want to interrupt sex
- [ ] Other ______________________________

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14. If you had a choice, what type of birth control method would you LIKE TO USE or have your girlfriend/boyfriend use? (Please check one or more.)

- [ ] I.U.D.
- [ ] Sponges
- [ ] The Pill
- [ ] Withdrawal
- [ ] Rhythm Method
- [ ] Condom (rubbers)
- [ ] Foam, jelly
- [ ] Douche
- [ ] Diaphragm
- [ ] Injection
- [ ] I don't like to use any form of birth control.

15. During the past month which of the following birth control methods have you or your girlfriend/boyfriend ACTUALLY USED? (Please check one or more.) (Please check one or more.)

- [ ] I.U.D.
- [ ] Sponges
- [ ] The Pill
- [ ] Withdrawal
- [ ] Rhythm Method
- [ ] Condom (rubbers)
- [ ] Foam, jelly
- [ ] Douche
- [ ] Diaphragm
- [ ] Injection
- [ ] None

QUESTIONS #16 AND #17
FEMALES ONLY -- PLEASE ANSWER
MALES SKIP TO QUESTION #18

16. How old were you when you had your first period? [ ]

17. Have you even been pregnant?

- [ ] No
- [ ] Yes

If you answered yes, how many times? [ ]

If you answered yes, what happened to the baby?

Did you
- [ ] keep the baby?
- [ ] have an abortion?
- [ ] give up the child for adoption?
- [ ] have a miscarriage?

QUESTION #18 IS FOR MALES ONLY

18. Have you ever gotten a girl pregnant?

- [ ] No
- [ ] Yes

If you answered yes, how many times [ ]

If you answered yes, what happened to the baby?

Did she
- [ ] keep the baby?
- [ ] have an abortion?
- [ ] give up the child for adoption?
- [ ] have a miscarriage?

19. Have you visited a health care professional or clinic for issues related to sexual activity?

- [ ] No
- [ ] Yes

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HOW OFTEN HAVE YOU HAD THE FOLLOWING EXPERIENCES <u>WITHIN THE LAST YEAR</u>? (Please check the box that closely applies to your answer.)

	NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY
20. Dating (going to dinner, movie, or party with boyfriend/girlfriend)	☐	☐	☐	☐	☐
21. Going home with a stranger you have met at a party or bar	☐	☐	☐	☐	☐
22. Go on a date with a group of friends	☐	☐	☐	☐	☐
23. Kissing while on a date	☐	☐	☐	☐	☐
24. Petting or fondling (not oral sex)	☐	☐	☐	☐	☐
25. Oral sex	☐	☐	☐	☐	☐
26. Sexual intercourse with a person of the **opposite sex**	☐	☐	☐	☐	☐
27. Sexual activity with a person of the **same sex**	☐	☐	☐	☐	☐
28. Masturbating alone	☐	☐	☐	☐	☐
29. Viewing a pornographic movie/video	☐	☐	☐	☐	☐
30. Reading a pornographic magazine	☐	☐	☐	☐	☐
31. Talking with your parents about sex	☐	☐	☐	☐	☐
32. Talking with your parents about contraception	☐	☐	☐	☐	☐
33. Talking with your boy-friend/girlfriend about sex	☐	☐	☐	☐	☐
34. Talking with your boy-friend/girlfriend about contraception	☐	☐	☐	☐	☐
35. Talking with friends about sex	☐	☐	☐	☐	☐
36. Talking with friends about contraception	☐	☐	☐	☐	☐
37. Forcing your sexual partner to have sex	☐	☐	☐	☐	☐
38. Being forced to have sex or being sexually abused	☐	☐	☐	☐	☐
39. Sexual fantasies	☐	☐	☐	☐	☐
Total	☐	☐	☐	☐	☐

40. During the past year, with how many different people have you had sex (intercourse)?

☐

41. Have you ever had a sexually transmitted disease (STD)?

☐ No

☐ Yes

If you have had a STD, please check those you have had.

☐ AIDS ☐ Chlamydia (NGU)

☐ Herpes ☐ Gonorrhea ("clap", "the drip")

☐ Lice ("crabs") ☐ Syphilis

☐ Other ______________________________

42. On a scale from 1 to 10 how would you rate your views on sex

1	2	3	4	5	6	7	8	9	10
Conservative				Middle of the road					Liberal

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APPENDIX C:
THE SEXUAL KNOWLEDGE TEST

Below you will find a series of statements about sex and sexuality.
If you think the statement is TRUE then circle the "TRUE".
If you think the statement is FALSE, then circle the "FALSE".
If you don't know the answer, or do not understand the question, please mark the "?".

1. For a woman to have an orgasm, her clitoris must be stimulated.	TRUE	FALSE	?
2. A woman cannot get pregnant by having intercourse while she is menstruating.	TRUE	FALSE	?
3. It is best to leave space at the closed end of a condom when putting it on the penis.	TRUE	FALSE	?
4. The contraceptive injection can protect a woman against pregnancy for as long as 12 weeks.	TRUE	FALSE	?
5. A person might test negative for HIV antibodies four weeks after an unsafe contact, when in fact he or she has been infected.	TRUE	FALSE	?
6. People who are clean and hygienic will not get infected with sexually transmitted diseases.	TRUE	FALSE	?
7. Erotic stimulation during foreplay enables the female organs to prepare for penetration by the penis.	TRUE	FALSE	?
8. Even after forgetting to take contraceptive pills for three days it will still prevent pregnancy.	TRUE	FALSE	?
9. During days 13-20 of the menstrual cycle, sperms will find it the most difficult to reach and fertilize the female ovum.	TRUE	FALSE	?
10. Spermicides can provide some protection against the transmission of sexually transmitted diseases.	TRUE	FALSE	?
11. There are scientific studies that demonstrate that the HIV is stopped by latex condoms.	TRUE	FALSE	?
12. The absence of a women's hymen indicates that she is definitely sexually active.	TRUE	FALSE	?
13. Symptoms of sexually transmitted diseases can include loss of hair, fever, pain throughout the body, blindness and sterility.	TRUE	FALSE	?
14. Men who wear only very tight underwear are at risk of becoming infertile.	TRUE	FALSE	?
15. A woman will be safe from pregnancy within one day after starting to take contraceptive pills.	TRUE	FALSE	?
16. To be effective the morning-after pill has to be taken within 72 hours after unsafe sexual contact.	TRUE	FALSE	?
17. Even if penetration of the penis occurs, without using contraception, a woman will still be safe against pregnancy as long as the man does not ejaculate within the woman.	TRUE	FALSE	?

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18. Young men can easily obtain free condoms from Family Planning clinics.	TRUE	FALSE	?
19. A person can control whether or not he/she gets AIDS/HIV infection.	TRUE	FALSE	?
20. A man with a small penis will not be able to effectively sexually stimulate a woman through penetration.	TRUE	FALSE	?
21. Contraceptive foams and spermicides can be put into the vagina hours before intercourse.	TRUE	FALSE	?
22. Antibiotics and appetite suppressants have the same detrimental influence on the effectiveness of the contraceptive injection, as they have on the effectiveness of contraceptive pills.	TRUE	FALSE	?
23. Feeling nervous can cause a man to have a quick orgasm and can cause a woman to have difficulty having an orgasm.	TRUE	FALSE	?
24. Although the IUD is a very comfortable method of contraception, more women using IUD's get pregnant than women who use other methods of contraception.	TRUE	FALSE	?
25. Body fluids like blood, semen, urine, saliva and tears have all been identified as important ways of transmitting the HIV.	TRUE	FALSE	?
26. Everyone with AIDS have the same symptoms.	TRUE	FALSE	?
27. It is unnecessary to prevent the spillage of semen by supporting the open end of a condom when the penis is withdrawn from the vagina after sexual intercourse.	TRUE	FALSE	?
28. A woman can only get pregnant if she has an orgasm during sex.	TRUE	FALSE	?
29. When young people want to buy condoms and other contraceptives from a chemist they have to produce proof of their name and age.	TRUE	FALSE	?
30. A man may have trouble getting an erection when he feels nervous or scared.	TRUE	FALSE	?
31. The use of condoms is the most effective way of preventing sexually transmitted diseases.	TRUE	FALSE	?
32. The HIV is transmitted as easily in oral as in anal intercourse.	TRUE	FALSE	?
33. A woman can't get pregnant the first time she has sex.	TRUE	FALSE	?
34. There are some sexually transmitted diseases that can heal naturally, without medical treatment.	TRUE	FALSE	?
35. Menstruation is a sure sign that a woman is not pregnant.	TRUE	FALSE	?
36. Women/Men can obtain the morning-after pill anonymously from chemists and family planning clinics.	TRUE	FALSE	?

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37. Ways in which sexually transmitted diseases can be transmitted include through contact with toilet-seats, bath cloths, saliva and through oral sex.	TRUE	FALSE	?
38. It is a human assertive right to be allowed to express your sexuality.	TRUE	FALSE	?
39. A woman who has not had an orgasm is frigid.	TRUE	FALSE	?
40. Contraceptives are just as effective as abstinence.	TRUE	FALSE	?

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APPENDIX D:

THE SEXUAL ATTITUDES TEST

The following pages ask about your attitudes towards a number of sexual issues.
Please decide to what extent these statements are true to what you believe and feel.
Then indicate your answer by circling the number that most correctly reflects your opinion.

1 = Strongly Disagree
2 = Disagree
3 = Don't Know
4 = Agree
5 = Strongly Agree

	Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
1. I don't think that there is anything wrong with having premarital sex just for the pleasure thereof.	1	2	3	4	5
2. I feel that having sexual intercourse before marriage would be acceptable to me, if I knew that there was a real love between my partner and me.	1	2	3	4	5
3. I think that my asking a potential sex partner about his/her previous sexual activities would be very unpleasant.	1	2	3	4	5
4. I believe that there should be a shared responsibility for birth control between my sexual partner and me.	1	2	3	4	5
5. I feel that I should learn to understand and fulfill my sexual needs and desires.	1	2	3	4	5
6. I think that it is inappropriate for me to engage in casual, everyday conversations about sex and sexuality	1	2	3	4	5
7. I believe that if I am sexually active I would always have a condom available/with me.	1	2	3	4	5
8. I believe that I have the right to ask for what I want in my romantic relationships.	1	2	3	4	5
9. I would sign a petition to legalize prostitution.	1	2	3	4	5
10. I believe that women should be allowed to have abortions if they are pregnant as a result of rape.	1	2	3	4	5
11. I believe that using condoms to prevent sexually transmitted diseases is not important if I have a steady partner	1	2	3	4	5

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	Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
12. I believe that AIDS can happen to me, like to anyone else, no matter what I do to prevent it.	1	2	3	4	5
13. I think that I should be concerned about whether others think I am sexy or not.	1	2	3	4	5
14. I feel that I should encourage my friends to carry condoms.	1	2	3	4	5
15. The possibility of AIDS frightens me, but I don't allow myself to worry about it.	1	2	3	4	5
16. I believe that sexually active people do not masturbate.	1	2	3	4	5
17. I believe that I shouldn't let the sexual attitudes and behaviour of the people around me influence my sexuality.	1	2	3	4	5
18. I believe that women should be allowed to have abortions whenever they feel it necessary to request one.	1	2	3	4	5
19. I believe that suggesting the use of a condom will ruin the intimate mood of me and my partner's sexual intercourse.	1	2	3	4	5
20. I hope that neither me nor my girlfriend/boyfriend will ever be so perverse as to look at pornography.	1	2	3	4	5
21. For me it is morally wrong to have premarital sex.	1	2	3	4	5
22. I do not need to be committed to a person to have sex with him/her.	1	2	3	4	5
23. I feel that family planning services should be located on this university campus.	1	2	3	4	5
24. To me the sexual acts that homosexuals engage in are totally perverted.	1	2	3	4	5
25. For me sex without love is meaningless.	1	2	3	4	5
26. I believe that sex education for university students is of little value.	1	2	3	4	5
27. The kind of people I mix with won't have AIDS.	1	2	3	4	5
28. In the heat of the moment I might have sex without using a condom.	1	2	3	4	5
29. I believe that masturbation is an effective way for me to learn about my sexual responses.	1	2	3	4	5

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	Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
30. I feel that my sexuality plays an important part in many areas of my life.	1	2	3	4	5
31. I believe that it is proper for me to be passive about expressing my sexual desires.	1	2	3	4	5
32. I think that it will be very awkward for me to tell my friends about using condoms correctly.	1	2	3	4	5
33. I believe that I can enjoy intercourse using condoms.	1	2	3	4	5
34. I believe that, like me, most university students prefer to have sex without using condoms.	1	2	3	4	5
35. I believe that I should avoid AIDS patients as far as possible.	1	2	3	4	5
36. I feel that if I try to talk with a potential partner about the prevention of AIDS and sexually transmitted diseases he/she will be suspicious of me.	1	2	3	4	5
37. I feel that, even if there is no pregnancy or disease having premarital sex can cause a lot of problems for me.	1	2	3	4	5

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APPENDIX E:

THE PERCEIVED SEXUAL BEHAVIOURAL SKILLS TEST

Please read through the following statements carefully and then:

(a) Circle the answer that best reflects how hard it would be for you to do each of the tasks.

(b) Circle the answer that best indicates how effectively you think you could do each of the tasks.

Please note: The term "sexual partner" refers not only to a partner you have sexual intercourse with (a sex partner), but also to a partner with which you are physically/sexually intimate.

---

1. Say "no" to having sex with someone very sexy whom you really like a lot.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

2. Encourage your sexually active friends to carry and use condoms.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

3. Tell a new sexual partner how far you are prepared to go physically.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

4. Ask a new sexual partner how many sex partners s/he has had.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

5. Ask a new sexual partner to have sex with only you.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

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6. Ask a new sexual partner if s/he has been exposed to HIV.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

7. Discuss using a condom before having sex.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

8. Buy a condom.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

9. When you don't think that you know a potential sexual partner well enough to become sexually involved, tell him/her so.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

10. Use a condom correctly.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

11. If you don't believe in having premarital sex, clearly explain to your sexual partner how you feel and what your reasons are.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

12. If no condom is available, find another pleasurable sexual activity where a condom isn't needed.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

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13. If no condom is available stop sexual activity while you or your partner go to get a condom.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

14. Ask a new sexual partner to be tested for HIV before having sex.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

15. Ask a new sexual partner whether s/he has ever had a sexually transmitted disease.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

16. (For men only) Ask to make sure that a new sexual partner is using contraceptives before having sex.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

(For women only) Ask your potential partner to wait till you have started taking contraceptives (like the Pill or injection) before having sex.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

17. If you have had sexually transmitted diseases, tell a new sexual partner about it.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

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18. Suggest and discuss other ways of fulfilling each others' sexual desires when you do not feel like going all the way with your sexual partner.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

19. Acquire whatever information you need to avoid falling pregnant/ making your sexual partner pregnant.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

20. Convince a sex partner to practice only safe sex.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

21. Refuse to have unsafe sex with a partner.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

22. Plan ahead to be sure you always have condoms on hand when you are going to be in situations where you are likely to have sex.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

23. Go to the campus health service for contraceptives.

(a) Very Hard To Do | Fairly Hard To Do | Fairly Easy To Do | Very Easy To Do

(b) Very Ineffectively | Somewhat Ineffectively | Neither effectively Nor Ineffectively | Somewhat Effectively | Very Effectively

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APPENDIX F:
CONTRACT OF RELIABILITY

I hereby declare that I, ..., on the .... day in the month ....of the year ....,
am completely dedicated to the sexuality psycho-education programme of the Psychology Department, University of Stellenbosch.

This dedication entails that I

make myself available to act as a peer group leader for my fellow students during the period ....;

commit myself to attend a training course of at least three hours in length;

accept responsibility for the recruitment and education of a gender mixed group of at least 16 fellow university students (experimental subjects);

will carefully protect the confidentiality of my group by not discussing group matters beyond the group;

am duty bound to present at least eight educational sessions, each of which are one to one and a half hours long, to eight of the above mentioned fellow students;

intend to present each educational session completely and with enthusiasm to the fellow students;

adhere to the research requirements of the associated with the education programme in a scientific and correct manner, in order to ensure that sexuality education on campus produces meaningful results on campus; and

take on this sexuality education programme with complete commitment - not only to ensure the successful completion of my academic course, **but also to contribute to the promotion of sexual health (physical and psychological) of my fellow students on campus.**

....	....	....	....
Signature of Group leader	Date	Signature of Co-ordinator	Date

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APPENDIX G:

INFORMED CONSENT FORM AND CONTRACT

I hereby declare that I, ..., on the .... day in the month .... of the year ...., dedicate myself to the sexuality psycho-education programme of the Psychology Department, University of Stellenbosch.

This dedication entails that I

understand and accept the nature of the sexuality psycho-education programme;

make myself available to be a peer group participant in sexuality psycho-education programme during the period ....;

am duty bound to attend at least eight educational sessions, each of which are one to one and a half hours long;

will complete all compulsory tests and homework assignments given to me by my group leader; and

adhere to the research requirements of the associated with the education programme in a scientific and correct manner, in order to ensure that sexuality education on campus produces meaningful results on campus.

....	....
Signature of Group Member	Date
....	....
Signature of Group leader	Signature of Co-ordinator