THE IMPORTANCE OF SEX EDUCATION FOR YOUTH IN BASSE, URR, THE GAMBIA

What are the challenges and opportunities in providing sex education to youth in Basse, Upper River Region (URR), The Gambia?

Name students:
Silke Colpaert and Caro Duvillers
Degree:
Applied Psychology - Clinical Psychology
Place:
Basse Santa Su, The Gambia

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School:
VIVES Campus Kortrijk
Bachelor Thesis Mentor:
Mrs. Rita Vancoillie

PREFACE

You are starting to read our bachelor thesis titled "The importance of sex education for youth in Basse URR, The Gambia: What are the challenges and opportunities?". The bachelor thesis was written to meet the graduation requirements of the Applied Psychology program at Vives Kortrijk. We have been working on this thesis from February till June 2025. During our time spent together in high school, we discovered a shared interest: “sexuality and sex education”.

In addition to our interest in sexuality and sex education, there was also a strong desire to contribute internationally. It was our childhood dream to go to Africa and work together with local professionals to create a positive impact. When we heard about the challenges in The Gambia, it quickly became clear that our mission was located there. Writing this thesis, not only challenged us academically, but it also taught us a lot about collaboration and networking to take concrete actions. We also learned how to respectfully deal with the cultural and religious influences that affect the theme of sexuality and sex education.

We would like to sincerely thank our parents for allowing us to seize this opportunity. Thanks to them, we were able to follow this program and fulfil our dream of going abroad. We would also like to thank Rita Vancoillie, president of the Contano Foundation, for guiding us during our process. She was not only a mentor from Contano Foundation and our school but also a listening ear and a helping hand. During our stay in The Gambia, we received much support from the organization Basse Got Talent. The organization showed us the way in Basse, allowing us to reach many people with our sessions. We are also very grateful for the Gambian Red Cross Society and SOS Training centre that gave us the opportunity to hold our sessions and develop within this experience. Within Basse, we also received support from the local organization The Gambia Family Planning Association. This organization made sure that we had practice material to work with during the sessions, for example condoms and other contraceptives. We would like to express our gratitude to VIVES Kortrijk for offering us this opportunity and connecting us with Contano Foundation. Finally, we would like to thank Noor De Doncker, an English teacher and Bart Colpaert for proofreading our bachelor’s thesis and checking it for errors.

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1. INTRODUCTION

1.1 GENERAL PROJECT DESCRIPTION

The overall theme of our project is sex education. We have been given the opportunity to develop this project on behalf of Contano Foundation. This is an organisation that works with local professionals to fight all forms of violence and exploitation of woman and children. One of those local professionals is Basse Got Talent, an organisation that believes every child has a talent. They guide young people in their search for their strengths, contributing to their personal well-being and development.

Sex education is a very broad theme that can be divided into different topics. To visualise this, we built a house. The roof represents our overall theme: 'sex education.' The building blocks are the different topics we will discuss in our sessions that all fall under this main theme.

We plan to give a total of 15 sessions at SOS Training Centre, the management of Basse Got Talent and the Gambian Red Cross Society. The first session is an introduction session to explain what sex education and sexuality mean and how the following sessions will be structured. In the following sessions, we will discuss the topics represented by the building blocks of our house: biology and reproduction, puberty and menstruation, STI's (sexually transmitted infections) and STD's (sexually transmitted diseases), contraception, FGM (female genital mutilation), consent and boundaries.

The house represents the statement: 'building qualitative knowledge together.' After each session, we let participants decorate the house with a piece of fabric, this is how we want to bring this statement to life. We also chose a house because it protects you from external influences, such as violence and exploitation. A house is strong and symbolises that good education and knowledge makes you more resilient and stronger as a person.

1.2 GENERAL CONTEXT AND POSITIONING WITHIN THE CURRENT SOCIETAL CONTEXT AND IN RELATION TO EXISTING SCIENTIFIC KNOWLEDGE

Sex education in The Gambia happens in a complex social context influenced by traditional norms, religious beliefs and cultural taboos. While young people are increasingly exposed to modern media and global information about sexuality, formal sex education remains limited and often inadequately tailored to their needs.

Scientific research has shown that comprehensive sexuality education (CSE) is an effective way to inform young people and help them make healthy choices. Studies indicate that adolescents who receive comprehensive sex education are better protected against STD's and unplanned pregnancies. They have more knowledge about sex education and develop greater strength in life, such as critical thinking, resilience, responsibility, self-awareness, communication skills, respect for others and empowerment (Sensoa, Waarom seksuele vorming, 2025).

Despite these scientific insights, this topic is not systematically included in the Gambian school curriculum. Lessons are often limited to basic information about biology and menstruation, without any deep discussions on topics such as contraception, STI's, mutual consent and gender equality.

NGO's and international organizations such as the UNFPA (United Nations Population Fund), UNESCO (United Nations Educational Scientific and Cultural Organization) and UNAIDS (Joint United Nations Programme on HIV/AIDS) therefore advocate for the implementation of CSE (comprehensive sexuality education) in the educational curriculum. To achieve this, they collaborate with the government and local organizations, including Contano Foundation, Basse Got Talent, The Gambia Red Cross Society and Social Welfare to launch initiatives that raise community awareness about the importance of sex education. However, structural changes remain slow due to resistance from cultural and religious sectors.

1.3 LINKS TO AND COMPARISONS WITH THE INTERNATIONAL CONTEXT

The Self-Determination Theory by Deci and Ryan, states that people have three psychological basic needs: autonomy, relatedness and competence. When these needs are fulfilled, this promotes intrinsic motivation, well-being and personal growth (Deci & Ryan, 2000).

In the context of our sex education in The Gambia we find it important to link this theory to international perspectives. Sex education is researched worldwide. By looking at it through an international lens we can adapt the effective methods from other countries to the cultural and religious sensitivities of The Gambia. We especially want to prevent that sex education becomes too top-down and normative, which makes the students less motivated. Additionally, we find it important as students of applied psychology to use scientifically substantiated and proven approaches in our sessions instead of intuition-based methods.

A report from UNESCO from 2018 emphasizes that effective sex education must be based on autonomy through participation of the students and the strengthening of skills in a safe environment, through which young people feel competent and are motivated to make healthy choices (UNESCO, 2018).

In many Western countries the focus lies on a holistic and open approach of sex education, where young people are actively involved and stimulated to ask questions. This is different in more traditional or culture-bound approaches, such as in The Gambia where sex education and conversations about sexuality are more sensitive. Yet international research shows that supporting autonomy (for example by letting young people express their own opinion and actively participate), relatedness (creating a safe and confidential learning environment) and competence (providing them with scientific and practical knowledge that helps them make healthier and safer choices) are universal key factors for successful sex education.

If we look at international research, we see several interesting things that we can link to The Gambia and the abstinence culture. Abstinence is choosing not to have sex until a certain moment, such as marriage. The American abstinence program ‘Silver Ring Thing’ tries to convince young people in the United States of America, the United Kingdom and Ireland to have no sex until marriage. Although there is a positive response in the short term, research from the University of Columbia shows that young people often relapse into sexual behaviour without using contraception (Irish Family Planning Association, 2004).

Supporters of such abstinence programs claim that comprehensive sex education and access to contraception contribute to high teenage pregnancies and STI rates. However, figures from the UNFPA show that countries with broad sex education actually have the lowest percentages (United Nations Population Fund, 2003).

In The Gambia sex education is often limited and abstinence is strongly encouraged from cultural, religious and traditional viewpoints. This has led to a lack of knowledge about sexual health and limited access to contraception. This can, according to previously discussed research, contribute to higher percentages of teenage pregnancies and sexually transmitted infections.

We also looked at sex education in Belgium. There we see that sex education is integrated into the school curriculum. They start with lessons in primary education. In Belgium, they focus on both biological and relational aspects of sexuality (Sensoa, 2025).

The content of sex education in Belgium varies depending on the age group but covers topics such as physical changes, emotions, relationships, gender, sexual diversity and reproductive health. Attention is also given to the use of contraception, the prevention of sexually transmitted infections and respect for boundaries within relationships.

The Belgian government and various NGO’s, such as Sensoa, work together to develop curricula and teaching materials that are scientifically based and adapted to the sexual development of young people (Sensoa, 2025). The goal of sex education in Belgium is not only to increase knowledge about sexuality but also to promote healthy and respectful relationships, strengthen sexual resilience and ensure the rights of young people to information and care.

1.4 GET TO KNOW BASSE GOT TALENT

Contano Foundation has several partner organisations they work with. We were put in touch with the organisation Basse Got Talent. They are committed to developing young talent and raising awareness of important social issues, such as FGM (female genital mutilation) and gender-based violence. In this introduction, we want to take you through the mission, vision and work of Basse Got Talent.

Since 2020, Basse Got Talent's mission is focused on recruiting and supporting young talents. The organisation started with a specific focus on acting, later they added other talents. Basse Got Talent focusses on personal development and wellbeing. They provide an environment where young people get the opportunity to grow and further develop their skills.

The original vision was to make movies of a professional standard by 2025. While their goal has not been fully achieved, they have made progress. The organisation remains committed to improvement and growth. Their ultimate goal is to make a lasting impact within the community.

Basse Got Talent targets students from level 7 to level 11. Those levels benefits most from their programmes and activities. In the school system of The Gambia, progression is not based on age but on levels. A child moves to a higher level once they have met the required qualifications. Furthermore, the management of Basse Got Talent thinks that students in level 12 will be less involved in the organisation because they are often completing their high school and then attending education in Kombo. Therefore, they focus on younger students who are developing fully and can grow within the organisation's initiatives.

The organization offers workshops and programmes on specific topics such as FGM, gender based violence and human rights. After covering a particular topic, they ask participants to create a short play highlighting that topic. This role-play approach helps them to better understand what it is about and convey the message to the community in a creative way. This helps to sensitise the community on important issues.

In addition to their own initiatives, they also collaborate with other organisations and associations within Basse. Working together allows them to increase their impact and support them in achieving their goals on specific social issues. These social issues can involve child marriages, forms of violence, or violations of human rights.

Basse Got Talent also engages the workshops and programmes in community outreach by going to remote communities that are harder to reach. They visit these communities to make them aware of important issues affecting their lives and well-being. Recently, they implemented an FGM project and went to remote communities to discuss and sensitise those communities on this important issue.

2. LITERATURE STUDY

2.1 SEX EDUCATION

WHAT IS SEX EDUCATION?

Sensoa describes the concept of sex education as follows: "All children in the world go through sexual development. It is therefore important that involved caregivers such as parents and school guide the children through this. These caregivers do this by answering questions that children or young people have about their bodies, sexuality and relationships. They also do this by talking to teenagers about safe sex, contraception, sexually transmitted infections and by discussing consent and boundaries" (Sensoa, Seksuele opvoeding, 2025).

WHAT IS THE PURPOSE OF SEX EDUCATION?

"All children and young people, regardless of background or issues, have the right to healthy and safe sexual development and education as part of their overall development." (Universal Declaration of Human Rights; Convention on the Rights of the Child; WHO Regional Office for Europe, 2010). The right described here shows that it is a universal human right to be supported during sexual development (Richtlijnenjeugdhulp, 2020).

To further clarify the value of sex education, we would like to emphasize that there is a difference between children and adolescents. This means that these target groups have different needs (weten.site, 2025).

According to Freud, children go through five psychosexual stages. In the phallic stage (ages 3–6), they begin to explore the physical differences between men and women and often feel attracted to the parent of the opposite sex (the Oedipus complex in boys, the Electra complex in girls). At the same time, they experience rivalry with the same-sex parent. By eventually identifying with that parent, they learn socially acceptable behaviour and begin to shape their identity (weten.site, 2025).

In the latency stage (ages 6–12), sexual interest decreases and the focus shifts to school, friendships and moral development. Children build social skills and learn to cooperate with others. This phase forms an important foundation for their further growth (weten.site, 2025).

In the genital stage (from around age 12), sexual development becomes more prominent again. Adolescents develop sexual interest in others, usually peers and may begin to have their first sexual experiences. Libido becomes more active and sexuality starts to play a larger role in their lives (weten.site, 2025).

Children are naturally curious and ask questions about themselves and the world around them. By answering these questions honestly, adults support their identity development. For adolescents, it is crucial to receive accurate information about topics such as contraception, STI's, and reproduction. This helps them make healthy and responsible choices in their sexual relationships (Sensoa, Waarom seksuele opvoeding, 2025).

Positive consequences of sex education:

- Strengthening sexual resilience of children and young adults against exposure to misogynistic and on-sided stereotypical views on sexuality.
- Increased resilience by making young people feel positive about their bodies and providing them the opportunity to talk about sexuality.
- They are prepared to have safe sex.
- They dare to react when faced with inappropriate behaviour.
- Schools can offer students different views on relationships and sexuality without undermining the perspectives of the student or the parents.
- (Richtlijnenjeugdhulp, 2020)

Furthermore, quality sex education leads to:

- Fewer unintended pregnancies and sexually transmitted infections
- A more considered first sexual intercourse
- More respect and empathy, better communication skills, better emotional regulation and healthier relationships
- Increased resilience and less sexual boundary-crossing behaviour
- Less discrimination based on gender and sexual orientation
- Better self-image and body image and a critical view of the influence of media
- Less fear of seeking help
- Better communication between parents and their children
- (Richtlijnenjeugdhulp, 2020)

DOMAINS OF SEX EDUCATION:

- Biological and physical development: Growth of the genitals and primary and secondary sexual characteristics, physical changes during puberty, body and self-image, body care, (cosmetic) surgery and physical disorders.
- Psychosocial development: Sexual behaviour, sexual feelings (infatuation, desire, arousal, orgasm, addiction and dysfunctions), gender identity and gender disorders, (sexual) relationships, body and self-image (attitude, emotions) and handling media images.
- Others: Fertility, reproduction, contraception and family formation.
- (Seksueleopvoeding.info, sd)

WHAT IS SEXUALITY?

Sexuality encompasses all feelings, thoughts, beliefs, desires and behaviours that are sexually oriented. It is a broad and dynamic concept. Sexuality is connected with intimacy, pleasure and reproduction. People give their own meaning to sexuality under the influence of interaction with their social and cultural environment.

When adolescents become sexually mature, which is from puberty onwards, they begin to engage in more relational and sexual interactions. For this, they need information and skills to deal with their sexuality in a positive and responsible way. This means that their choices are safe, voluntary, equal and informed, with respect for the health and well-being of themselves and others. (Richtlijnenjeugdhulp, 2020).

When is somebody ready for sex?

Being ready for sex is something very personal and it means something different to everyone. It's not just about physical maturity, but also about emotional maturity and being able to handle responsibility. You are only ready for sex if you want it yourself. You need to feel ready for sex based on your own beliefs and not because others are already doing it.

When we look at the Islam, this happens after marriage. The Quran emphasizes that sexual relations are only appropriate within marriage, between a man and a woman and that it should occur with mutual consent and respect. As stated in Surah Ar-Rum (30:21): 'And among His signs is that He created wives for you from your own, that you might find peace and tranquillity with them and has placed between your affection and mercy.' This verse highlights the importance of a loving and respectful relationship within marriage." (Quran.com, Surah Ar-Rum 30:21, sd)

Also, the word 'must' does not apply when it comes to your readiness for sex. Your partner or your environment cannot force you to have sex. It's important to give yourself the time to discover what you enjoy, what your boundaries are and with whom you feel safe enough to share that intimacy. There is no set age at which you are 'ready' and there is no rush. The most important thing is that the moment feels right for you and that you are sure it is out of your own free will. (Allesoverseks.be, Wanneer ben ik klaar voor de eerste keer?, sd) Finally, it is also important to look at the legislation around having sex. For example, having sex in The Gambia is legal from the age of 18 (Ageofconsent, sd).

2.2 BIOLOGY AND REPRODUCTION

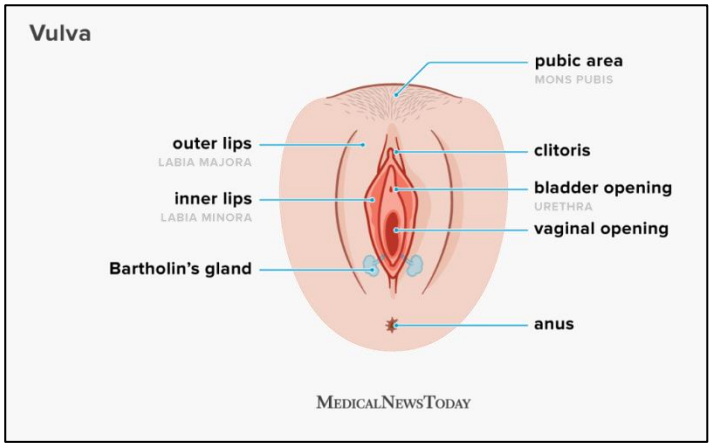
BIOLOGY OF THE GENITAL AREAS

Female (outer structure)	**Male (outer structure)**	**Female (inner structure)**	**Male (inner structure)**
Vulva	Foreskin	Vagina	Swelling bodies
Large (outer) labia	Glans of the penis	Cervix	Urethra
Small (inner) labia	Opening of the urethra	Uterus	Testes
Clitoris	Shaft	Ovaries	Epididymis
Urethal opening	Scrotum	Fallopian tubes	Vas deferens
Vaginal opening	Pubic hair		Prostate
Pubic hair			Cowper's glands

Female

- Vulva: This is the outer female genitalia that consists of the large (outer) labia, small (inner) labia, clitoris, urethral opening and vaginal opening. It not only plays a role in sexual arousal, but also helps protect the internal genital organs from infection and injury. It is the visible part of the female reproductive system.
- Large (outer) labia: These are the larger folds of skin on the outside. They protect the inner parts from dirt and infections and often contain hair.
- Small (inner) labia: These are the smaller folds of skin that lie between the outer labia. They protect the inner parts from dirt and infections and keep everything hydrated.
- Clitoris: The clitoris is a sensitive organ with thousands of nerve endings and is the main source of sexual arousal for many women. It is located at the top of the vulva, where the inner labia come together. Although the small visible part at the top of the vulva is only a small part of the entire organ, the clitoris has internal structures that extend along the vagina and around the urethra. It is entirely dedicated to sexual pleasure and has no other reproductive function.
- Urethral opening: This is where urine comes out of your body. It is just below the clitoris and above the vaginal opening. Its only function is urination.
- Vaginal opening: This is the entrance to the vagina. It is located below the urethral opening and leads to the internal reproductive organs.
- Vagina: Connects the outside of the body to the uterus, receives sperm and acts as a birth canal.

- Cervix: This the lower, narrow part of the uterus that acts as a gateway to the uterus. During menstruation, the cervix allows the uterine lining to be shed. During labour, the cervix opens to allow the baby to pass through the birth canal.
- Uterus: The uterus is a hollow, muscular organ that plays a central role in the female reproductive system. It houses and nourishes a developing foetus during pregnancy, sheds its lining during menstruation if no pregnancy occurs and contracts during labour to help deliver the baby.
- Ovaries: The ovaries produce eggs and release hormones such as oestrogen and progesterone, which regulate the menstrual cycle and support pregnancy.
- Fallopian tubes: The fallopian tubes are the channels that connect the ovaries to the uterus. Each fallopian tube has an opening near the ovary that catches the egg once it is released during ovulation. They are the typical site where fertilization occurs when a sperm cell meets an egg. The fallopian tubes also help transport the fertilized egg (embryo) to the uterus.
- (Zanzu, Zichtbare geslachtsdelen van de vrouw, sd)
- (Zanzu, Inwendige geslachtsdelen van de vrouw, sd)



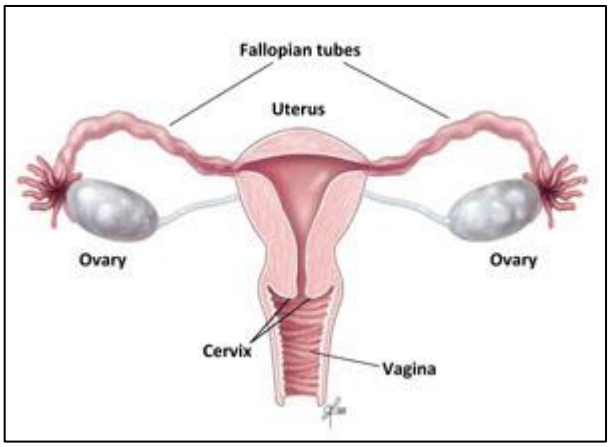
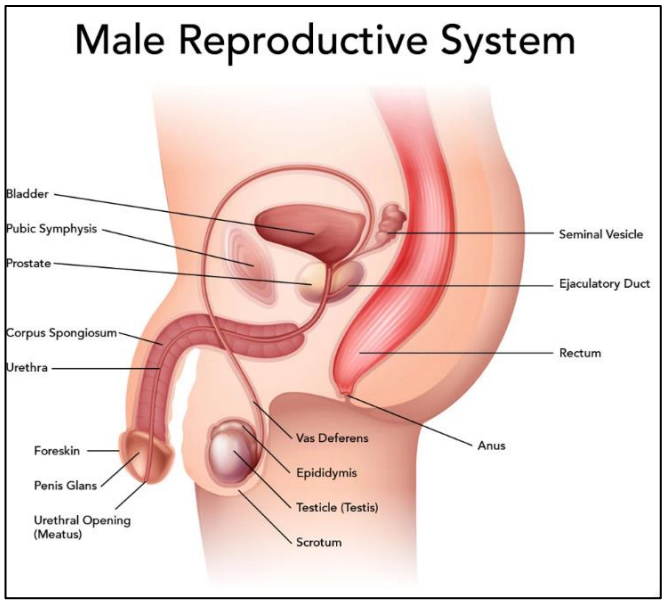


Image source 1: (Morenjoy)

Image source 2: (Cleveland Clinic, Female Reproductive Organs)

Male



- Penis: It serves both for sexual intercourse and urination. It also plays a role in sexual arousal, with numerous nerve endings in both the glans and shaft.
- Glans of the penis: The glans is the rounded tip of the penis. It is highly sensitive and plays a major role in sexual arousal. In uncircumcised men, the glans is covered by a piece of skin called the foreskin, which can be pulled back to expose the glans.
- Shaft: The shaft is the long, cylindrical part of the penis between the base and the glans. It contains swelling bodies that fill with blood during sexual arousal, making the penis stiff. The shaft also contains nerve endings and plays a role in sexual stimulation.
- Swelling glands: Swelling glands refer to the corpora cavernosa and corpus spongiosum. These are spongy tissues in the penis that fill with blood during an erection, making the penis stiff. The corpora cavernosa are two cylinders of tissue that run along the top of the penis, while the corpus spongiosum runs along the bottom of the penis and around the urethra.
- Scrotum: It is a sack of skin and muscle tissue in which the testes are located. It regulates the temperature of the testes, keeping it slightly lower than the rest of the body to optimise sperm production. The scrotum can contract or relax to maintain the ideal temperature for sperm production.
- Testes: The testes are the male reproductive organs that produce sperm cells and the hormone testosterone. They are located in the scrotum and are responsible for the production of sperm in the testes, as well as the secretion of testosterone, which regulates male sexual characteristics and fertility.
- Epididymis: The epididymis is a rolled-up tube located at the back of each testicle. It serves as a storage place for sperm cells. After sperm cells are produced in the testicles, they move to the epididymis where they mature and develop the ability to swim and fertilise an egg.
- Vas deferens: The vas deferens are long tubes that transport mature sperm cells from the epididymis to the urethra during ejaculation. Through the vas deferens, the sperm cells can travel to the prostate and seminal vesicles to mix with the seminal fluid before ejaculation.
- Seminal vesicles: The seminal vesicles are two small glands located behind the bladder. They produce a fluid rich in sugars and other substances that energise the sperm cells and help them survive. This fluid forms a large part of the semen and mixes with the sperm during ejaculation.

- Cowper's Glands: The Cowper's glands, also known as bulbourethral glands, produce a clear and slimy fluid that prepares the urethra for ejaculation. This fluid helps neutralise the acidic residue of previous urination in the urethra and provides lubrication during intercourse.
- Prostate: The prostate is a small gland located under the bladder. The prostate produces a fluid that nourishes and protects sperm cells. This fluid, together with sperm cells from the testicles and fluid from the seminal vesicles, forms the sperm. The prostate also plays a role in the contraction of the urethra during ejaculation.
- Urethra: The urethra is a tube that transports urine from the bladder and sperm from the reproductive system outside the body through the penis. It has two functions: to excrete urine and to transport sperm during ejaculation. The urethra runs through the penis and is surrounded by the corpus spongiosum.
- (Sensoa, Hoe ziet de penis eruit?, 2025)

Image source: (Jpmedicalcoding)

An erection

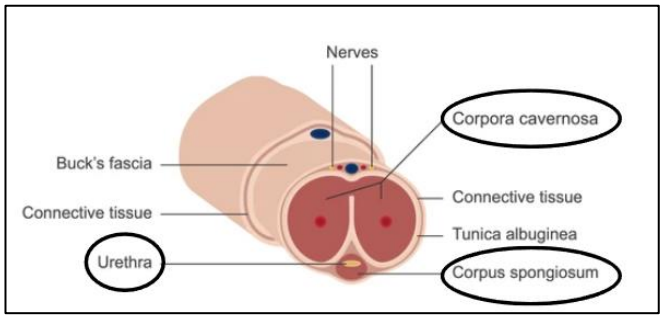
An erection in men is the process where the penis becomes stiff and erect. This happens through a combination of physical and neurological factors (Seksualiteit.nl, 2025). How it works:

1. Stimuli: An erection can be triggered by physical or psychological stimuli, such as sexual arousal, touch or even thoughts or dreams.

2. Nerve signals: When the brain receives signals indicating sexual arousal, nerve signals are sent to the penis. These signals cause the blood vessels in the penis to expand.

3. Increased blood flow: The increased blood flow occurs because the arteries bringing blood to the penis widen. At the same time, the veins that carry blood away from the penis narrow, so the blood stays in the penis longer.

4. Filling of the corpora cavernosa (swelling bodies) : The penis consists of two corpora cavernosa (erectile tissue) and a third corpus spongiosum, which surrounds the urethra. When blood flows into the corpora cavernosa, they enlarge and harden, causing the erection.



5. Reduction of the erection: When sexual arousal decreases or after orgasm, the blood flow to the penis reduces. The blood vessels constrict and the blood is drained away, causing the erection to subside.

6. (Seksualiteit.nl, 2025)

An erection can therefore be influenced by both physical and psychological factors and is a normal physiological process essential for reproduction and sexual activity (Seksualiteit.nl, 2025).

Image source: (Med Mastery)

REPRODUCTION

When people feel like having sex, the man's penis gets bigger and stiffer and the woman's vagina becomes moist. When the penis goes into the vagina, it gives a good feeling. When the penis repeatedly goes in and out of the vagina, an orgasm will occur in the man. An orgasm can also take place in the woman, but this is not always the case. It is therefore completely okay not to experience an orgasm during penetration. The fluid that the man discharges during orgasm is called semen. It is a white, sticky liquid containing millions of sperm cells. These sperm cells enters the woman after male orgasm. The man's sperm then swim into the vagina to the uterus and fallopian tubes in search of an egg. Once an egg has been released from the ovary in the woman, it can be fertilised. When the sperm cells reach the egg, they all try to get through the egg's wall. However, only one sperm cell can enter the egg cell; this is called fertilisation. The egg and sperm fuse to form a new cell, this new cell grows further in the woman's womb to form a new baby. The process takes about nine months. In the first month, the baby is the size of a grain of rice and at the end, the baby is about 50 centimetres (Schooltv.nl, 2002).

When the baby is fully grown in the belly, it is time for labour. During labour, contractions are triggered. A contraction happens when the muscles of your uterus squeeze and then let go. It’s your body’s natural way of preparing for actual childbirth (Cleveland Clinic, Braxton Hicks Contractions, 2022). There are different types of contractions that happen in the run-up, at the time of birth and after birth:

- Braxton Hicks contractions
- Prodromal labour contractions
- Early labour contractions (first stage of labour)
- Active labour contractions (first stage of labour)
- Pushing contractions (second stage of labour)
- Afterbirth contractions (third stage of labour)
- Postpartum contractions

Before real labour starts the mother will experience false labour contractions, called **Braxton Hicks contractions**. They cause the cervix to soften and relax. These uneven contractions of the uterus are completely normal and can start during the second or third trimester. This is around 20 or 30 weeks. (Cleveland Clinic, Braxton Hicks Contractions, 2022).

Prodromal contractions are a form of false contractions that can occur during pregnancy. They are often mistaken for real contractions and usually appear in the weeks before the due date. These contractions can be painful, return regularly every five minutes and last for about a minute. During this phase, the baby often already starts to descend. The head sinks deeper into the pelvis. Prodromal contractions are very similar to Braxton Hicks contractions. Both are types of false or practice contractions that can occur weeks to months before the actual delivery. They are called false contractions because they do not initiate real labour (Cleveland Clinic, Prodromal Labor, 2022).

The first stage of labour has two parts: early and active labour contractions. At first, contractions are mild and irregular, but over time they become more powerful and regular during the active phase. In the **early labour**, contractions usually last 20 to 30 seconds and come every 30 to 60 minutes. They feel like mild pain or pressure. This stage is the start of uterine dilation. In the **active labour**, contractions become longer, up to 40 to 70 seconds and come every three to five minutes. They are then so intense that talking or moving becomes difficult. In this phase, there is an increase in dilation to 10 cm (Cleveland Clinic, Contractions, 2024).

The pushing phase is the second stage of labour. It begins once the cervix has fully opened and is no longer an obstacle to the baby's head. There is now a free passage, allowing the mum to push her baby out from the womb through the birth canal. How long this phase takes depends on the position and size of the baby and how well the mum can push during the contractions. In a first birth, pushing usually takes between one and two hours. Normally, a baby is born facing the mother's back (anterior position). But some babies lie facing the mother's belly (posterior position). In such a case, it may be more difficult for the baby to pass through the pelvis, so the pushing may be heavier or longer (Sutter Health, sd).

When the baby is out of the belly, the child will start weeping due to the cold and light it experiences. The mother can then comfort her new baby and hold it very close to her. The latter is very important for the child's **bonding**. After birth, there are also contractions to get the placenta out and the uterus back in place (Schooltv.nl, 2002).

Bonding or attachment: This is the strong affective bond we have with specific people in our lives and the degree of trust in their care. Attachment acts as a system for affect and stress regulation. In this process, the helpless baby cries to attract the mother’s attention. It is a kind of survival instinct of the baby. Furthermore, the mother produces the hormone oxytocin (attachment hormone) when hearing the crying, which makes the mother want to provide care. The goal of attachment is to create proximity with a caregiver as a base to explore the world (Hannon Dewi, 2023-2024).

The afterbirth is the third and shortest stage of labour. It usually lasts no longer than 20 minutes. The mother pushes out the placenta (afterbirth). This is the organ that develops in the uterus during pregnancy. The placenta provides oxygen, nutrition and removes waste products from the baby's blood. Contractions in this stage are less painful than in the earlier stages. Sometimes the mother has to push, or the doctor presses on the abdomen to help the placenta out. It is normal to have some heavy bleeding during or after delivery of the placenta. In caesarean section, the placenta is removed when the doctor removes the baby from the womb (Cleveland Clinic, Stages of Labor, 2022).

Postpartum (or postnatal) refers to the period after giving birth. It usually lasts six to eight weeks, or until your body is back to its pre-pregnancy state. During this time, major changes happen in both your body and your life. Some changes are physical, such as breast enlargement and vaginal bleeding. Other changes are caused by hormonal fluctuations. Giving birth is a big physical and emotional challenge. The postpartum contractions you may feel are the shrinking of the uterus to its normal size. This causes cramps and vaginal bleeding. Your healthcare provider can massage the uterus through the abdomen to make it smaller (Cleveland Clinic, Postpartum, 2024).

PSYCHOLOGICAL FACTORS DURING PREGNANCY

Psychological factors are important to discuss because they greatly influence the mother and the child during pregnancy and birth.

According to the APA (American pregnancy association), mood changes during pregnancy are caused by physical stresses, fatigue, changes in your metabolism or by the hormones oestrogen and progesterone. Significant changes in your hormone levels can affect your level of neurotransmitters, which are brain chemicals that regulate mood. Mood swings are mostly experienced during the first trimester between 6 to 10 weeks and then again in the third trimester as your body prepares for birth. (Americanpregnancyassociation, 2025) These hormones and the general changes in the woman's body can, in addition to happiness, also cause a lot of uncertainties. Therefore, it is important to surround the expectant mother with calmness and tranquillity. Furthermore, it is also important to support the new mother well after birth. "Baby blues" or "Postpartum depression" can occur. These phenomena are psychological in nature but have a significant impact on life after birth. Baby blues are mood swings that occur after childbirth. These mood swings are caused by hormonal changes following delivery (Babyboom, sd).

Furthermore, the subject psychopathology describes postpartum depression as a mood disorder in which persistent and severe mood changes occur after childbirth. This begins within four weeks after delivery. One in three women continues to struggle with depressive feelings during the first three years. Women with a history of depression or fear of pregnancy have an increased risk of developing the disorder. Genetic factors can also play a role. Postpartum depression increases the risk for the woman to experience depressive episodes later in life (Jeffrey S. Nevid, 2021). According to PubMed Central, it is a global issue. Recent figures show that in countries such as Burkina Faso and Ghana, 44 percent of women are at risk of developing this. (PubMed, 2020)

2.3 PUBERTY AND MENSTRUATION

WHAT IS PUBERTY:

Adolescence is the transition period between childhood and adulthood, which runs from 10 to 19 years. This stage is a special period in human development and plays a crucial role in forming a healthy foundation for the future (World Health Organization, Adolescentengezondheid, 2025). During adolescence, children develop into adults. Puberty is an important part of adolescence, which usually takes place between the ages of 10 and 16 (Nederlands Jeugdinstituut, 2025).

Puberty is a natural phase in life in which the body develops from child to an adult. This process is driven by hormones and happens at different ages for boys or girls. Hormones are the chemicals in your body that control all kinds of body processes. During puberty, hormones help your body develop into a more mature version of itself (JouwGGD.nl, 2025).

During puberty, young people experience a fast growth phase. In a few weeks, pants can become too small and dresses too tight (Jellinek, 2025). Physical, emotional and social changes take place during this period. This is a sign that the body is preparing for adulthood.

In Europe, puberty usually starts for girls between the ages of 9.8 and 10.8 years. For girls in Africa, this phase starts later on average, between 10.1 and 13.1 years. In general, girls enter puberty about one to two years earlier than boys (Kras, 2020).

Gender characteristics are the visible differences between male and female bodies. There are two types of gender characteristics. Primary gender characteristics are already present at birth. For men, these include the penis and testicles, while women have the clitoris and labia. Secondary gender characteristics do not develop until puberty (Wikipedia, sd).

PHYSICAL CHANGES DURING PUBERTY:

Changes during puberty for girls:

- Breast development
- Hair on the legs
- Hair in the armpits
- Hair in the genital area (pubic hair)
- Accelerated growth
- Hips grow wider
- First menstruation
- (Office of Population Affairs, sd)

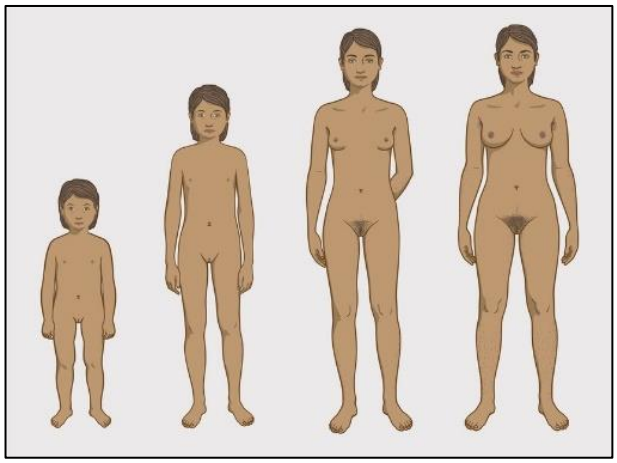


Image source: (Gerard, Tussen de lakens)

Changes during puberty for boys:

- Penis and testicles start growing
- Beard growth
- Hair in the armpits
- Hair in the genital area (pubic hair)
- Voice changes
- Accelerated growth
- Shoulders become broader
- Muscles get bigger
- First ejaculation
- (Office of Population Affairs, sd)

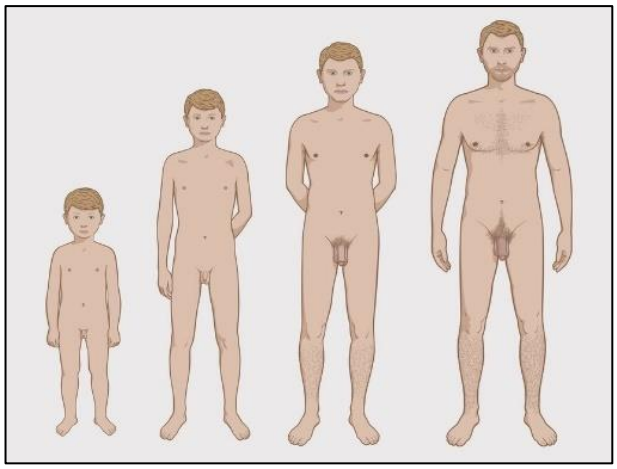


Image source: (Gerard, Tussen de lakens)

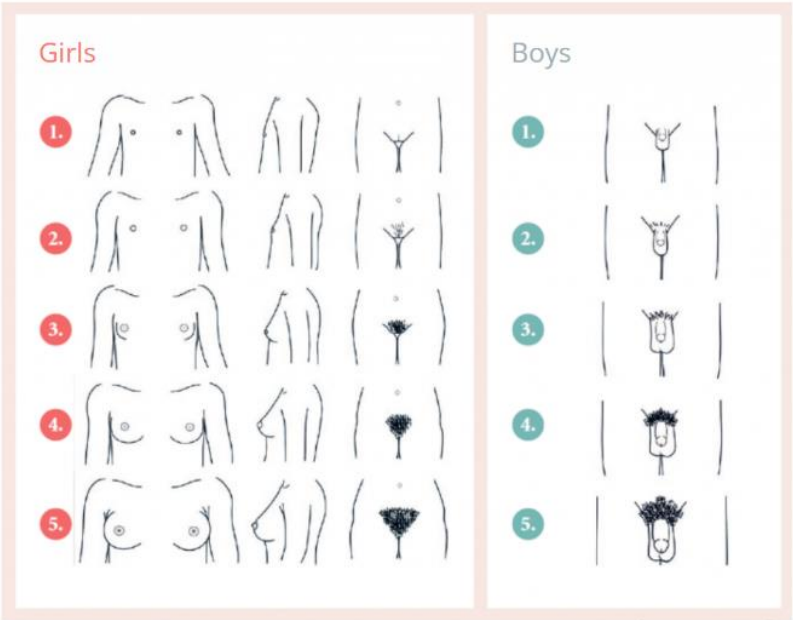


Image source: (Tannerstadia)

MENSTRUATION AND THE FEMALE REPRODUCTIVE SYSTEM

What is menstruation?

Menstruation is the monthly shedding of the lining of the uterus. This process is also known as the menstrual period, menstrual cycle or simply menstruation. Menstrual blood, which consists of a combination of blood and tissue from the inner wall of the uterus, leaves the body through the cervix and vagina (Cleveland Clinic, Menstrual Cycle, sd).

Hormones play an essential role in menstruation. These are chemical messengers in the body. The pituitary gland in the brain and the ovaries produce and release certain hormones at specific times during the menstrual cycle (Cleveland Clinic, Menstrual Cycle, sd).

These hormones stimulate ovulation, in which an egg emerges from the ovaries and travels through the fallopian tubes to the uterus. It also causes the lining of the uterus to thicken, allowing a possibly fertilised egg to implant if impregnation by a sperm cell occurs during its journey in the fallopian tubes. If the egg is not fertilised by a sperm cell, pregnancy does not occur. The lining of the uterus is then broken down and shed, resulting in menstruation (Cleveland Clinic, Menstrual Cycle, sd).

A menstruation is considered normal when it lasts between three and seven days (Cleveland Clinic, Menstrual Cycle, sd).

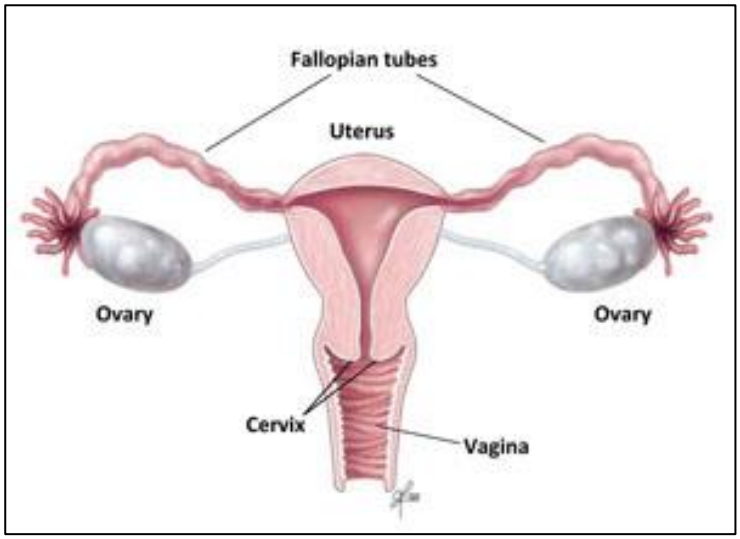
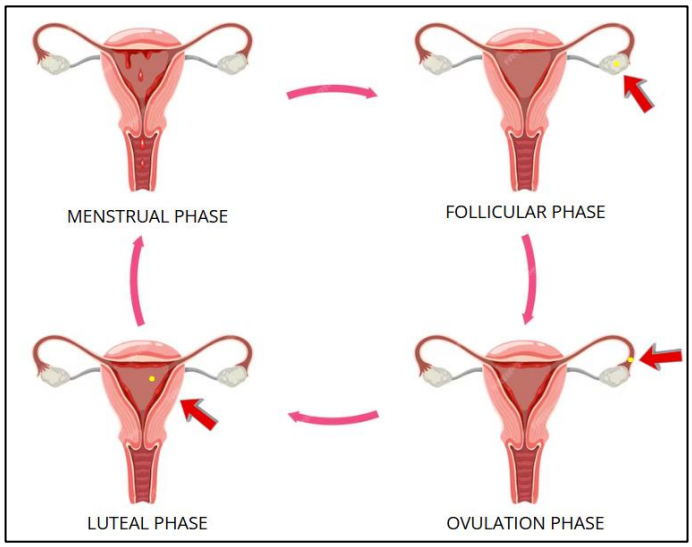


Image source: (Cleveland Clinic, Female Reproductive Organs)

What is a menstrual cycle?

The menstrual cycle refers to the series of biological processes that take place in the female body each month in preparation for a possible pregnancy. The cycle starts on the first day of menstruation and runs until the first day of the next period. Although the length of the cycle can vary from person to person, the process occurs in the same way for everyone (Cleveland Clinic, Menstrual Cycle, sd).

What are the four phases of the menstrual cycle?



The menstrual cycle consists of four phases, which are influenced by fluctuations in hormone levels. These hormones control the functioning of the reproductive organs and cause specific processes to take place in the body (Cleveland Clinic, Menstrual Cycle, sd). The four phases are:

1. Menstrual phase: This phase starts on the first day of menstruation. When no impregnation has taken place, the lining of the uterus is shed and discharged through the vagina. Usually, this bleeding lasts three to five days, but a duration between three and seven days is also considered normal (Cleveland Clinic, Menstrual Cycle, sd).

2. Follicular phase: This phase also starts on the first day of menstruation and continues until ovulation. Although the lining of the uterus is shed and discharged through the vagina, the body starts preparing for a new cycle at the same time. During this phase, oestrogen levels gradually rise. This stimulates the building of a new lining in the uterus in preparation for a possible pregnancy. At the same time, follicle-stimulating hormone (FSH) stimulates the maturation of several follicles in the ovaries. Around day 10 to 14, one of these follicles develops into a mature egg (Cleveland Clinic, Menstrual Cycle, sd).

3. Ovulation: Around day 14 of an average 28-day cycle, ovulation occurs. A sudden rise in luteinising hormone (LH) causes the ovary to release an egg, marking the moment of ovulation (Cleveland Clinic, Menstrual Cycle, sd).

4. Luteal phase: This phase runs from about day 15 to day 28. The egg leaves the ovary and travels through the fallopian tubes to the uterus. Progesterone levels rise to prepare the lining of the uterus for possible implantation. If the egg is fertilised and attaches to the lining of the uterus, pregnancy occurs. If fertilisation does not occur, oestrogen and progesterone levels drop, causing the lining of the uterus to be shed and menstruation to begin (Cleveland Clinic, Menstrual Cycle, sd).

Image source: (brgfx)

MYTHS AND MISCONCEPTIONS ABOUT MENSTRUATION

Myths	Facts
You can't get pregnant during your period (Penn Medicine, 2019).	Don't ditch the condoms just because you're on your period. Your chances of getting pregnant while on your period are slim, but they're still there (Penn Medicine, 2019).
Your period should last exactly one week each month (Penn Medicine, 2019).	For most women, periods last about 5 days and happen every 4 to 5 weeks. But periods can be shorter or longer and more or less frequent and they can change each month. Even if your period is normally on time, that doesn't mean every period will be. Your body is unique and so is your monthly cycle (Penn Medicine, 2019).
Girls having their periods should sleep in a separate shed or a different bed (Unicef, 2018).	Menstruation is not contagious and causes no harm to anyone else in the same room (Unicef, 2018).
Any form of physical activity can disturb the menstrual flow (Unicef, 2018).	Exercise and sports can actually help relieve pain (Unicef, 2018).

SELF-CARE

Change your menstrual products regularly. Trapped moisture creates an ideal environment for bacteria and fungi to multiply. Wearing the same menstrual underwear, pads or cotton cloths for too long can cause skin irritation or infection (U.S. Centers For Disease Control and Prevention, sd).

Keep your genital area clean by washing the outside of your vagina (vulva) and buttock area daily. Always wipe from front of your vagina to back after going to the toilet to avoid infections. Wash your vagina with water only, as the vagina cleans itself naturally. Using soap or other cleaning products in the vagina can disturb the natural pH balance, which can lead to infections such as fungal infection or bacterial vaginosis (U.S. Centers For Disease Control and Prevention, sd).

Make sure you drink enough water. This helps flush out your urinary tract and can reduce the risk of infections, such as a fungal infection (U.S. Centers For Disease Control and Prevention, sd).

Wear light, breathable clothing, such as cotton underwear. Tight fabrics can trap moisture and heat, which encourages bacterial growth (U.S. Centers For Disease Control and Prevention, sd).

Use unscented sanitary products. Perfumed hygiene products can irritate the skin and upset your natural pH balance (U.S. Centers For Disease Control and Prevention, sd).

Wash your hands both before and after using the toilet and before and after changing a menstrual product (U.S. Centers For Disease Control and Prevention, sd).

Throw away used disposable menstrual products properly or wash the reusable ones: Wrap the disposable menstrual products in toilet paper, a tissue or other material and then throw them in the bin. Do not flush menstrual products down the toilet. Or wash the reusable ones, such as menstrual underwear or cotton cloths (U.S. Centers For Disease Control and Prevention, sd).

Keep track of your periods and monitor your cycle. Your period can be an important indicator of your overall health. Irregular periods can indicate conditions such as diabetes, thyroid problems or celiac disease. You can track your period on a calendar or with a special app on your phone (U.S. Centers For Disease Control and Prevention, sd).

Heat therapy can provide relief from menstrual cramps and muscle tension. Place a heat pad or a bottle of hot water on your lower belly to relax your muscles and promote blood circulation (Sharfin, 2023).

If you feel unsure about your period, talk about it with someone you trust. Menstruation is a natural process that every woman worldwide has to deal with and it is important to know that you are not alone. (Silke and Caro, 2025)

FIRST EJACULATION

First ejaculation:

Most boys experience their first ejaculation between the ages of 11 and 16. The time at which this happens depends on the functioning of their hormones (Jeugdgezondheidszorg Utrecht, sd). Hormones are the chemicals in your body that control all kinds of body processes (JouwGGD.nl, 2025).

Ejaculation:

Ejaculation can occur either during masturbation or in your sleep. If it happens during sleep, it is called a wet dream. It is not necessary for a boy to have dreamt about sex. The sperm may simply need to come out of the body. Not all boys experience wet dreams (Jeugdgezondheidszorg Utrecht, sd). During ejaculation, millions of sperm cells are released. From his first ejaculation, the boy is fertile. If he has sex with a girl, it is possible for her to become pregnant (Jeugdgezondheidszorg Utrecht, sd).

EMOTIONAL AND PSYCHOLOGICAL CHANGES DURING PUBERTY

Experiencing hypersensitivity:

During puberty, your body experiences all kinds of changes. This can make you feel uncomfortable and become extra sensitive about your appearance. This can cause you to become irritable more quickly, have mood swings or feel sombre. It can help to be aware of these behavioural changes and talk about them with someone you feel comfortable with (Menstrupedia, sd).

In search of your own identity:

During the transition to adulthood, you are probably busy discovering what makes you unique as an individual. You often spend more time with friends than family during this period, as they are in a similar stage of life. You may be busy exploring your own character, how you stand out from others and what place you fill in the world (Menstrupedia, sd).

Feeling insecure:

Puberty is a transitional period when you are no longer a child, but also not yet fully mature. This can lead to feelings of uncertainty. You start thinking about new aspects of life, such as your future, career and relationships, which can be confusing (Menstrupedia, sd).

This uncertainty can become stronger as the expectations of those around you change. You are expected to take on more responsibilities than when you were younger. Although this can be overwhelming at first, over time you will grow into these new roles and develop more self-confidence. How quickly this happens depends on how you handle these changes (Menstrupedia, sd).

Peer pressure:

During puberty, you are more likely to engage with your friends and like them, be influenced by trends in the media and the culture around you. You unconsciously adopt what is considered popular, such as clothing style, language and behaviour. This can sometimes feel uncomfortable and even influence your likes and dislikes. In addition, the urge to fit in with your peers can make you conflict with your parents' expectations, which can lead to tensions (Menstrupedia, sd).

Inner contradictions:

During puberty, you are in a transition phase between child and adult. This can lead to conflicting feelings, as you are stuck between how you were as a child and how you want to be as an adult. You may want more independence, but at the same time still want support from your parents. You may also doubt whether you should let go of your old interests to fit in better with your friends. This can cause inner conflicts, leading you to seek more clarity about who you are and what you want (Menstrupedia, sd).

Mood swings:

During puberty, you may experience strong and fluctuating emotions. Which can intensify your insecurity and inner conflicts. You might feel confident and happy at one moment and irritable or sombre shortly afterwards. These sudden changes in your feelings are called mood swings. They are often caused by fluctuations in your hormone levels and other physical and mental changes that occur during this phase (Menstrupedia, sd).

Getting interested in sexuality:

Puberty is also the phase when your sexual maturity develops. One aspect of sexual maturity is being curious about sex. With the start of puberty, it is normal for a boy or girl to be sexually attracted to people with whom they want to be more than 'just friends' (Menstrupedia, sd).

2.4 STI'S AND STD'S

WHAT IS AN STI/D?

Prof J. Van Damme and Prof G.G.M. Essed, define sexually transmitted infection as an infection that can be transmitted through sexual contact. Although the term 'sexually transmitted disease' (STD) is also frequently used, 'STI' is more accurate because a person can be infected with an infection without already showing symptoms. Once the infection leads to symptoms or signs of illness, it is referred to as an STD (Prof.dr. J. Van Damme, 2013).

The previously mentioned professors also say that having an STI increases the chances of contracting another one. This is because some STI's affect the immune system of the genitals or cause irritation and damage, making it easier for other germs to enter. STI's are transmitted through blood, semen, vaginal fluids and through contact with mucous membranes. In case of suspected STI, partner notification and contact tracing play an important role in preventing further spread of the infection (Prof.dr. J. Van Damme, 2013).

Pregnant women can also transmit an STI to their child. This is called vertical transmission. It can occur in three ways: through the placenta during pregnancy, during childbirth or through breastfeeding, depending on the type of infection. Examples of STI's that can be transmitted this way include syphilis and HIV. The bacteria that causes syphilis (Treponema pallidum) can cross the placenta and cause serious harm to the unborn child. HIV can also be passed through the mother's blood and may affect the baby's immune system. In some cases, hepatitis B can already have an impact during pregnancy (Cleveland Clinic, Vertical Transmission, 2025).

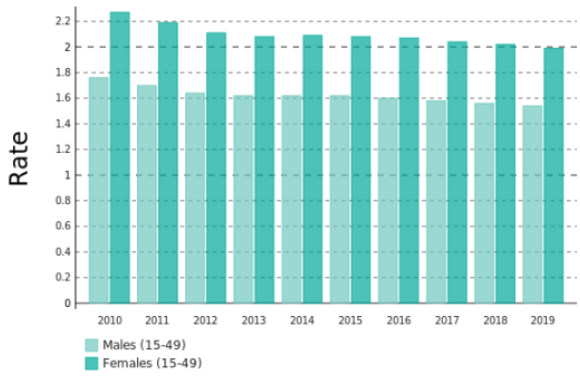
During delivery, the baby is again at risk. During birth, the child comes into contact with the mother's vaginal discharge, blood and mucous membranes. If pathogens are present in it, the baby may become infected. For example, STI's such as chlamydia and gonorrhea can cause eye inflammation when the baby passes through the birth canal. Genital herpes is another example. If the mother has active blisters during childbirth, the virus can be transferred to the baby, which can cause serious complications. HIV and hepatitis B can also be passed on through blood at birth (Cleveland Clinic, Vertical Transmission, 2025).

To reduce these risks, it is important that STI's are detected in pregnant women early. In many countries, routine testing during pregnancy is part of standard prenatal care. If necessary, preventive measures can be taken, such as medication, a c-section, or vaccination of the baby immediately after birth (Cleveland Clinic, Vertical Transmission, 2025).

The most common STI is Chlamydia. It is known to affect fertility. For women, the infection often leads to symptoms. However, if left untreated, it often leads to blockage of the fallopian tubes. Other known STI's in The Gambia are Gonorrhoea, Syphilis, Herpes, HPV (Human Papillomavirus) and HIV (Dimbayaa, sd).

3.1 HIV incidence rate per 1000, Gambia (Republic of The) (2010-2019)

New HIV-infections in the reporting period per 1000 uninfected population (Adults, ages 15-49)



Source: Spectrum file

The prevalence of HIV in The Gambia is estimated to be about 1.9% among adults aged 15-49 years in 2019. A higher prevalence is also observed among female sex workers, reaching 11%. By 2022, UNAIDS reported 1500 new HIV infections in The Gambia. In total, an estimated 14,000 people are living with HIV there. (UNAIDS, 2020). Furthermore, there are few to no statistics available on STI's at national level. The Gambia Bureau of Statistics (GBoS) publishes general health statistics, but no specific figures on STI's.

Image source: (UNAIDS, 2020)

HIV (HUMAN IMMUNO DEFICIENCY VIRUS) AND AIDS (ACQUIRED IMMUNE DEFICIENCY SYNDROME):

According to the Aidsfonds, HIV is the virus that causes AIDS. HIV gradually breaks down the immune system that protects a person against diseases. As this protective layer is damaged, symptoms and complaints may appear. When the body becomes so weakened that it can no longer protect itself, this is called AIDS. On average, it takes 8 to 10 years for someone to develop AIDS. However, it can also happen after 2 years or much later. It is difficult to predict (Aidsfonds, sd).

What does HIV?

When HIV enters the body, it seeks out special immune cells. The virus enters these cells and embeds itself in the cell's DNA. This process transforms the cell into a sort of factory that produces new HIV particles. The new HIV particles then enter other special immune cells and the process repeats itself. More and more cells begin to produce HIV particles. The more cells infected with HIV, the weaker the immune system becomes (Aidsfonds, sd).

Treatment?

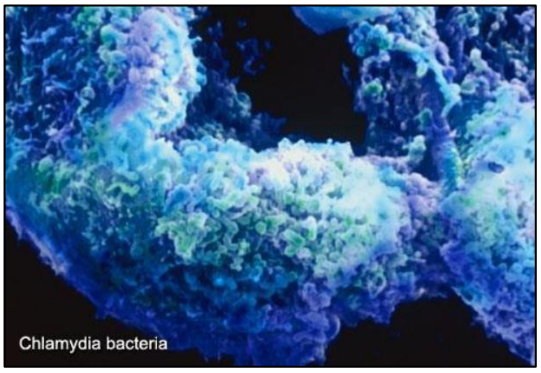
HIV can be treated with medication. The virus will no longer cause damage to the cells due to the medication and AIDS will therefore not be developed. HIV is also no longer contagious while taking the medication. There is still no cure for HIV so the medication must be taken for life.

However, access to medication is not a given for everyone. About 75 percent (28.7 million people on treatment) have access to medication. The other 25 percent do not have access to it. Looking at figures from West and Central Africa, 78 percent of people with HIV had access to HIV medication (in 2021) (Aidsfonds, sd).

Symptoms?
Complaints of acute HIV infection: flu-like symptoms such as fever, swollen glands, rash, weight loss, vomiting, nausea and sore throat. During the acute phase, the risk of transmission is highest.

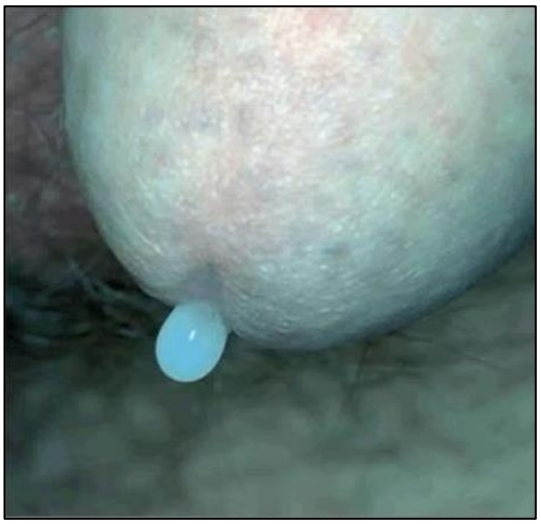
Long-term complaints: extreme fatigue, night sweats, weight loss, fever, shortness of breath and diarrhea.
After the acute phase, someone may feel healthy again for the long term. However, the immune system is being damaged by the virus in the meantime. As a result, the body becomes less and less able to fight diseases and infections (Aidsfonds, sd).

CHLAMYDIA


Chlamydia bacteria

The RIVM (Rijksinstituut voor Volksgezondheid en Milieu) reports that Chlamydia is caused by the bacterium Chlamydia trachomatis. This bacterium usually causes no symptoms and often goes away on its own. If symptoms occur, it can be treated with antibiotics. Chlamydia can be prevented with a condom (RIVM, Chlamydia-trachomatis, 2024).

Symptoms?



Men: Pain or burning sensation when urinating, discharge from the urethra, pain in the scrotum, itching or pain around the anus, diarrhea or other bloody discharge from the anus.

Women: Pain or burning sensation when urinating, more or different discharge than usual, bleeding between periods, pain or bleeding during sex, lower abdominal pain, itching or pain around the anus, diarrhea or other bloody discharge from the anus.

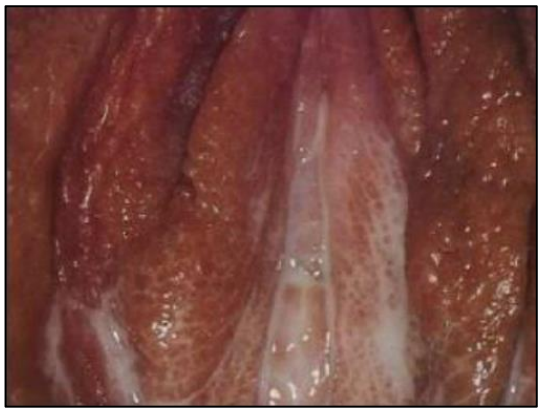
Research from the RIVM shows that women can also experience severe symptoms such as pelvic inflammation. A woman who gets Chlamydia multiple times is at higher risk for severe complications from the STI. Additionally, there may be a reduction in fertility after a Chlamydia infection. However, this chance is very small (RIVM, Chlamydia-trachomatis, 2024).

Chlamydia during pregnancy?

A pregnant woman with Chlamydia can pass the bacteria to the baby during delivery. The pregnant woman herself has a higher risk of an infection of the uterine lining after delivery due to Chlamydia. Without treatment, there is a risk of premature labour, early rupture of membranes, preterm birth and low birth weight. During delivery, the baby can acquire Chlamydia, which can cause eye infections and respiratory infections (RIVM, Chlamydia-trachomatis, 2024).

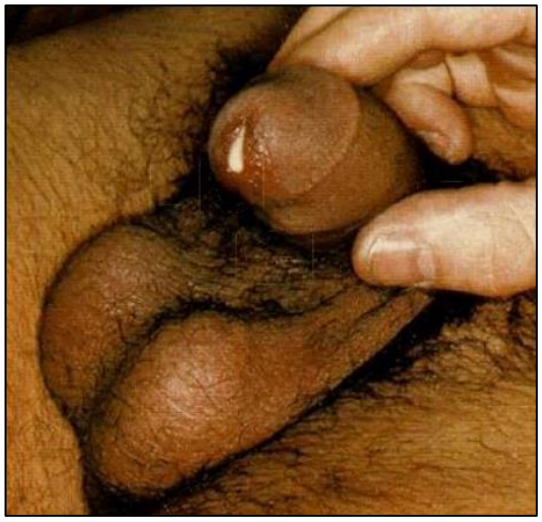
Images source: (Thestdproject)

GONORRHEA



The RIVM states that Gonorrhea is an STI caused by a bacterium (*Neisseria gonorrhoeae*). The bacterium can cause infections in men's urethra, rectum, throat and testicles. Women can get infections in the urethra, cervix, fallopian tubes, throat and rectum. Gonorrhea can be treated with antibiotics. The STI is also commonly referred to as "the clap" (RIVM, Gonorroe, 2024).

Symptoms?



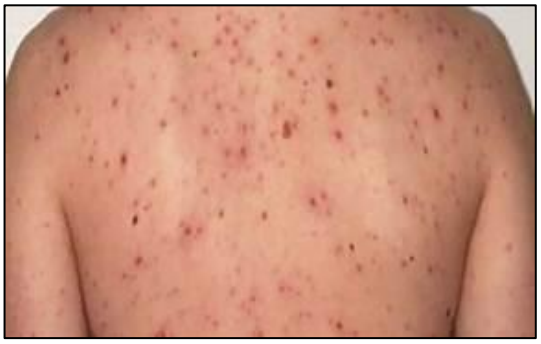
Men: Pain when urinating, burning sensation when urinating, discharge from the penis, itching around the anus, blood or mucus from the anus, pain in the testicles.

Women: Pain when urinating, burning sensation when urinating, vaginal bleeding, more discharge than usual, itching around the anus, blood or mucus from the anus, severe abdominal pain.

The symptoms can appear in the vagina, penis, anus, eyes and throat (Soaaids, Gonorroe-symptomen, sd).

Images source: (Thestdproject)

SYPHILIS



Syphilis is an STI caused by a bacterium (Treponema pallidum). The bacterium causes infections in almost all organs, including the brain. Syphilis can be treated with antibiotics (RIVM, Syfilis , 2024).

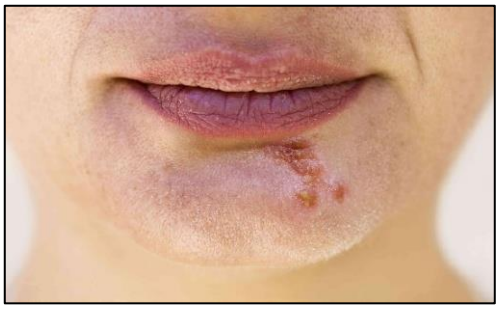
Symptoms?

The disease progresses in different stages.

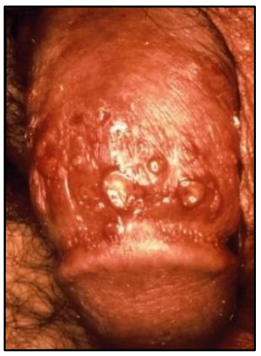
- First stage: A sore appears on the penis, around the vagina, anus or mouth.
- Second stage: A non-itchy rash appears on the torso, arms and legs, or bumps around the penis or vagina. Additionally, fever, a general feeling of illness, muscle aches and hair loss may occur. Sometimes the symptoms are more severe: liver and kidney dysfunction or cranial nerve failure.
- Third stage: After the second stage, the symptoms often disappear. However, if syphilis is not treated, the infection can remain in the body silently for years. Eventually, it may progress to the third stage, which can cause serious damage to organs such as the brain (neurosyphilis) or the heart. (RIVM, Syfilis , 2024).

Image source: (mednl.net)

HERPES SIMPLEX VIRUS



The herpes simplex virus, abbreviated as HSV, is an infection that causes herpes. Herpes can appear in various parts of the body, usually on the genitals or mouth. There are two types of herpes simplex virus, type 1 and type 2. HSV-1 is also known as oral herpes. It is the most common cause of cold sores around the mouth and herpes simplex eye infection. HSV-2 is generally responsible for genital herpes outbreaks. Although there is no cure for herpes, antiviral treatments can alleviate symptoms. Medication can reduce pain and shorten healing time. It can also reduce the total number of outbreaks. HSV-1 infection can occur through general interactions such as eating with the same utensils, sharing lip balm, or kissing. HSV-2 is transmitted through unprotected sexual acts (Gezondheid, 2024).

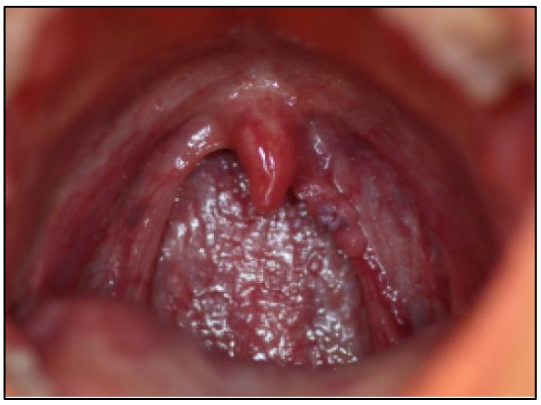


Symptoms?

There may not always be symptoms, but the symptoms that can occur include: Sores and blisters around the mouth or genitals, pain during urination, itching, fever, swollen glands, headache, loss of appetite, fatigue. Herpes in the eyes (type 1) is an inflammation of the cornea, causing eye pain, eye discharge and a heavy feeling in the eye (Gezondheid, 2024).

Images source : (mednl.net)

HPV (HUMAAN PAPILOMA VIRUS)



HPV stands for human papillomavirus. The virus can cause cervical cancer and genital warts. It can also cause cancer in the penis, anus, vulva, vagina and the mouth and throat. You get HPV (human papillomavirus) through sexual or intimate contact. Nearly everyone will get an HPV infection at some point, both men and women (about 80 to 90 percent of the population). Most of the time, the body clears this virus on its own, but it can also lead to (precursors of) cancer. The HPV vaccine provides good protection against HPV infections (RIVM, HPV humaan papillomavirus, 2024).

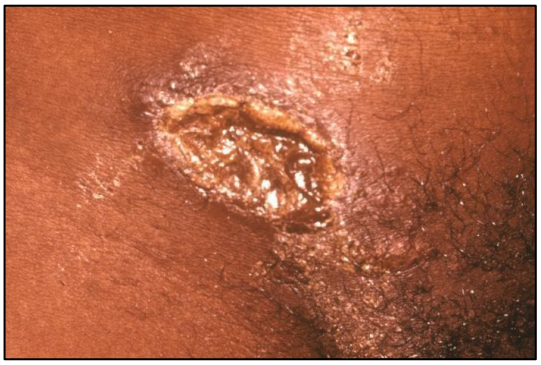
Symptoms?

Pre-cancer symptoms of HPV: bleeding, discharge, or visible changes in the skin or mucous membranes (RIVM, HPV humaan papillomavirus, 2024)**.**

Image source 1: (Libraries, Human Papillomavirus (HPV))

Image source 2: (Libraries, Human Papillomavirus (HPV))

CHANCROID



Chancroid (also called soft chancre) is a bacterial infection caused by *Haemophilus ducreyi (H. ducreyi)*. Chancroid is considered a sexually transmitted disease (STD). You might also hear of diseases that are spread through sex called sexually transmitted infections (STI's). Even though chancroid is very contagious, it's curable (Cleveland Clinic, Chancroid soft chancre, 2020).

Symptoms?

The incubation period (the time between when you've been exposed and when you develop symptoms) for chancroid is about three to seven days. The signs and symptoms of chancroid include (Cleveland Clinic, Chancroid soft chancre, 2020):

- Raised and painful bumps on the skin of your genitals.
- Ulcers with ragged soft edges that develop from these bumps.
- Reddened and shiny skin on the sores.
- Leakage of pus and infectious fluid.
- Spreading and connecting of these sores into larger areas
- (Cleveland Clinic, Chancroid soft chancre, 2020)

Women may not be aware of the sores, but they can be painful in men (Cleveland Clinic, Chancroid soft chancre, 2020).

Image source: (mednl.net)

PARTNER NOTIFICATION

If you have an STD, it is important to inform your sexual partners. They can then get tested and if necessary, receive treatment. And they should also inform their sexual partners. This way, STD's will not be further spread (Soaaids, E-learning basiskennis soa's , 2025).

FGM AND STD/I'S

Research in The Gambia has shown that women who have undergone FGM have an increased risk of contracting certain STD's. A study from 1999 found that women with FGM had a significantly higher prevalence of herpes simplex virus type 2 (HSV-2), an indicator of an increased risk of HIV infection. The odds ratio for HSV-2 was 4.71, suggesting that women with FGM are nearly five times more likely to have this infection than women without FGM (L Morison, sd).

Additionally, the physical complications of FGM, such as scarring, infections and reduced hygiene, can increase the likelihood of contracting other STD's (Lee, 2025). The combination of FGM and the increased risk of STD's, including HIV, highlights the need for ongoing education, law enforcement and healthcare initiatives in The Gambia. It is essential that both the medical and social aspects of FGM are addressed to protect the health and well-being of women and girls.

PSYCHOLOGICAL IMPACT

The psychological consequences of an STI diagnosis in Gambia often manifest in feelings of fear, sadness, guilt and depression. The fear of being rejected by a partner or by the community is significant and many people struggle with the idea that their future and relationships are permanently damaged. This sometimes leads people to keep their diagnosis a secret, causing them to avoid seeking help or delay treatment. The shame can be paralyzing and has a negative impact on self-image. Especially among young people and women, this can lead to social isolation, loss of self-confidence and even suicidal thoughts. (Surg, 2023).

INTERVIEW WITH THE IMAM ALPHA SIDIBEH

To gain a better understanding of the religious perspective on sexually transmitted infections (STI's), we had a conversation with an imam. We wanted to know how Islam views the origin of these diseases and how to deal with them. When asked whether contracting a disease such as an STI is seen as the will of God, he responded:

"That is not true. Not everything is the will of God. For example: on the highway, cars are driving at high speed. If you lie down there and get hit, that is not God's will, then you have taken your own life. Also, if you smoke and become ill as a result, that cannot be linked to God. But if I am just sitting here talking and a coconut unexpectedly falls on my head, then you could consider that the will of God. I have no control over that. What we do have control over lies within our responsibility. God has given us a brain and reason." (Sidibeh, 2025)

Regarding the recognition of STI's within Islam, he confirmed that they are indeed acknowledged:

"Yes, Islam recognizes the existence of these diseases. That is why Islam teaches that when you have a contagious disease, you must isolate yourself."

We also asked whether the use of contraception is accepted in cases where one of the partners has an STI but still wants to have sexual intercourse. To this, the imam responded:

"That is a medical issue. If it is harmful, Islam will tell you to stay away from it. The loss of one life is better than the loss of two. That's also why we closed our mosques during COVID-19." (Sidibeh, 2025)

According to Imam Alpha Sidibeh, Islam acknowledge the existence of STI's and places the responsibility on the individual. It is the individual's duty to isolate themselves in order not to infect others. Islam also states that one must stay away from something that harms you, which means having sex while having an STI is not justified, even with the use of a condom (Sidibeh, 2025).

2.5 CONTRACEPTION

WHAT IS CONTRACEPTION?

Contraception is a general term for methods and tools that prevent pregnancy. It is used when people have sex and do not want to become pregnant (temporarily). Some also protects users against sexually transmitted infections and -diseases. Contraception has no lasting impact on a woman's fertility. When she stops using contraception, she can have children again (Zanzu, Wat is anticonceptie?, 2025).

During our interview with the Executive Director of the Family Planning Association, we learned a lot about contraception in The Gambia. Family Planning is an NGO, which is a non-governmental organisation. This means that the organisation works independently of the government and has no commercial goals, but works for the common good. According to them, there are different types of contraception that they use in The Gambia, such as: a condom, a women's condom, the pill, a contraceptive injection and a hormonal implant. It is available for free at the NGO and at the hospital. It can also be bought from the pharmacy under payment (Gambia Family Planning Association, 2025).

MAN CONDOM

What is it?

A condom is a thin cover that you put over your stiff penis before having sex. It catches the man's sperm during ejaculation (Zanzu, Condoom, 2025). It provides protection against sexually transmitted infections (STI's) and also helps prevent an unwanted pregnancy. Condoms come in a variety of sizes, depending on the thickness of the penis. Make sure the condom is neither too tight nor too loose (Zanzu, Condoom, 2025).

Image source: (Gerard, Tussen de lakens)

How do you use it?

- Make sure the expiry date has not passed.
- Tear open the package at the notch. Avoid using scissors, knives, teeth or sharp nails to prevent tearing.
- Pinch the top of the condom flat to leave room for the sperm. Place the condom on the tip of the erect penis (erection).
- Check that the rolled-up edge is on the outside. Then roll the condom all the way down over the penis to ensure it stays in place during intercourse.
- The condom is ready for use.
- After ejaculation, pull the penis back while it is still stiff.
- Hold the condom tightly by the edge to prevent sperm from leaking out.
- Tie a knot in the condom to prevent leaks and then throw it in the bin. Do not use it again.

- (Zanzu, Condoom, 2025)

Tips:

- Always use a condom only once.
- Never put on two condoms on top of each other because this increases the risk of tearing.
- It is best to store a condom in a cool place.
- Do not put the condom in your wallet, because this may damage the condom. Put it in your handbag or the pocket of your jacket or shirt, for example.
- (Zanzu, Condoom, 2025)

Reliability:

When used properly, the condom is a very reliable form of contraception. If it is not used correctly, the condom is less reliable. About 18 out of 100 women become pregnant after a year of using the condom during sexual intercourse (Zanzu, Condoom, 2025).

Protection against STI's and STD's:

The male and female condom are the only contraceptives that offer protection against HIV and reduce the risk of getting a sexually transmitted infection (STI). If left untreated, an STI can develop into a sexually transmitted disease (STD) (Zanzu, Condoom, 2025).

WOMEN'S CONDOM

What is it?

A female condom is a soft, thin pouch that you insert into the vagina before sex. The pouch has a flexible ring on both sides: a thin outer ring and a thicker inner ring. It catches the man's sperm during ejaculation (Zanzu, Vrouwencondoom, 2025). It forms a protective barrier and provides effective protection against sexually transmitted infections (STI's) and unwanted pregnancy.

Image source: (Gerard, Tussen de lakens)

How do you use it?

Apply the female condom before penetration. Follow these steps:

- Check that the expiry date is still valid.
- Apply lubricant both on the inside and outside of the condom.
- Press the inner ring together.
- Insert the condom into the vagina.
- Insert one finger into the condom and push the inner ring in as far as possible. Make sure the condom does not twist and that the penis stays inside the condom during penetration.

- The outer ring ensures that the condom stays in place during sex. This ring stays outside the body and covers the area around the vagina.
- After sex, grab the outer ring, turn it slightly and gently pull the condom out. Make sure no sperm leaks on the vagina.
- Throw the used condom in the bin.
- (Zanzu, Vrouwencondoom, 2025)

Reliability:

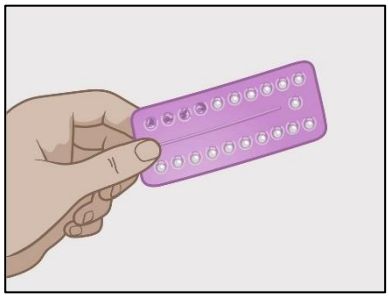
When used correctly, the female condom is a very effective form of contraception. However, if it is not applied properly, its reliability is lower. About 21 out of 100 women become pregnant after a year of using the female condom during sexual intercourse (Zanzu, Vrouwencondoom, 2025)

Protection against STI's and STD's:

The male and female condom are the only contraceptives that offer protection against HIV and reduce the risk of getting a sexually transmitted infection (STI). If left untreated, an STI can develop into a sexually transmitted disease (STD) (Zanzu, Vrouwencondoom, 2025).

THE PILL

What is it?

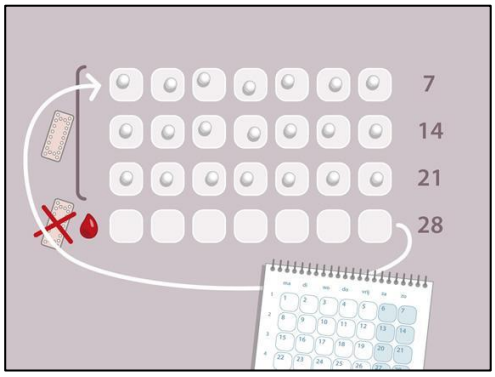


The pill is a contraceptive. It usually consists of a strip of 21 or 22 pills, but sometimes it contains 24 or 28 pills. There are many different packages (different colours, rectangular, round,...) (Zanzu, De pil, 2025).

The pill contains 2 hormones. These hormones prevent ovulation. The hormones also make it harder for sperm to enter the uterus (Zanzu, De pil, 2025).

Image source: (Gerard, Tussen de lakens)

How do you use it?



- A strip of 21 pills should be used as follows: Take 1 pill at the same hour every day. The days of the week are usually on the back of the strip. This way you can check that you haven't forgotten to take a pill.
- After 21 days (3 weeks), the strip runs out.
- In the next 7 days (1 week), you will not take a pill. This week your menstruation will start. You are also protected this week.
- After 7 days (1 week), start a new strip of pills, even if you are still bleeding.
- Now repeat the previous steps.
- (Zanzu, De pil, 2025)

Image source: (Zanzu, De pil)

Menstruation:

A withdrawal bleeding occurs when you stop or pause hormonal contraceptives, such as the pill. Although this bleeding looks like a menstrual bleeding, it is not the same as a natural menstrual bleeding (Seksediversiteit.nl, sd).

Most birth control pills contain the hormones oestrogen and progestogen. These hormones interfere with the natural cycle and prevent ovulation from happening. When you temporarily stop taking these hormones, for example during the stop week, the hormone level in your body drops. This hormone drop causes bleeding. This bleeding is often less intense and last for a shorter time than a regular menstrual period (Seksediversiteit.nl, sd).

The difference with a real menstruation is that in a natural cycle, an egg is released and the lining of the uterus prepares for a possible pregnancy. When fertilisation does not occur, the built-up lining of the uterus breaks down and a menstrual bleeding occurs. Hormonal contraception prevents ovulation, so the withdrawal bleeding occurs because of a rapid decrease in hormones and not because the thickened lining of the uterus is shed (Seksediversiteit.nl, sd).

Reliability

The pill is reliable. About 9 in 100 women become pregnant when taking the pill for 1 year. The pill may be less reliable if:

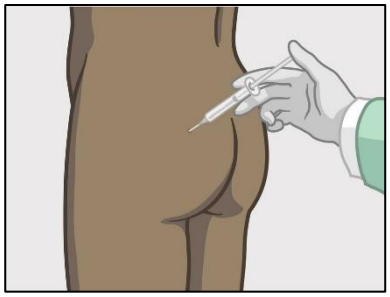
- You do not always take the pill at the same time (especially if you take it more than 12 hours later than usual)
- You vomit within 2 hours of taking the pill
- You take certain medicines. Tell your doctor you are taking the pill. Then he/she can take this into account when prescribing medicines.
- You forget to take a pill.
- Taking a pill only on the days you have sexual intercourse is absolutely not reliable.
- (Zanzu, De pil, 2025)

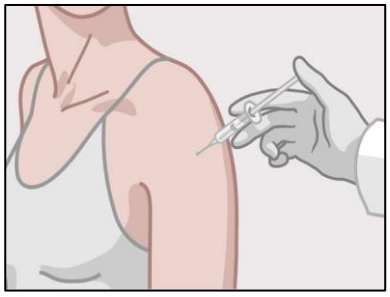
Protection against STI’s and STD’s:

The pill does not protect against STI’s or HIV. The male and female condom are the only contraceptives that offer protection against HIV and reduce the risk of getting a sexually transmitted infection (STI). If left untreated, an STI can develop into a sexually transmitted disease (STD) (Zanzu, De pil, 2025).

CONTRACEPTIVE INJECTION

What is it?





A contraceptive injection is an injection of a hormone into the arm or buttock to prevent pregnancy. After the injection a woman cannot get pregnant for the next 3 months. The injection is given by a health professional (Zanzu, De prikpil, 2025).

The injection contains 1 hormone that prevents ovulation. It also makes it harder for sperm to reach the uterus and reduces the chances of a fertilised egg implanting (Zanzu, De prikpil, 2025).

Image source 1: (Gerard, Tussen de lakens)

Image source 2 : (Zanzu, De prikpil)

How do you use it?

- Within the first five days of your menstrual cycle a health professional gives you an injection in your upper arm or buttock.
- You then have to come back every three months (12 weeks) for another injection.
- (Zanzu, De prikpil, 2025)

Menstruation:

The injection can affect your menstrual periods. Some women have less frequent periods or no periods at all, especially after multiple injections. This is because the contraceptive injection continuously releases hormones that suppress ovulation and maintain a thin lining of the uterus. Other women may experience irregular or frequent, light bleeding, which some find annoying. The absence or irregularity of menstruation due to this method is not harmful to your health. However, frequent or heavy bleeding, especially for women with poor nutritional status or low iron levels, can lead to anaemia (Irisch Family Planning Association, sd).

Reliability:

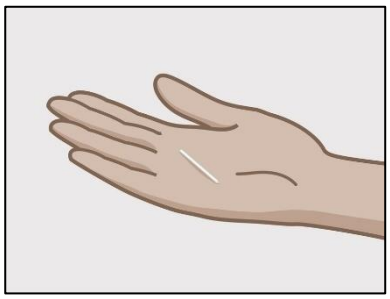
The contraceptive injection is reliable if you have a new injection every 3 months. Around 6 in 100 women get pregnant when they use the contraceptive injection for 1 year (Zanzu, De prikpil, 2025).

Protection against STD's:

The contraceptive injection does not protect against STI's or HIV. The male and female condom are the only contraceptives that offer protection against HIV and reduce the risk of getting a sexually transmitted infection (STI). If left untreated, an STI can develop into a sexually transmitted disease (STD) (Zanzu, De prikpil, 2025).

HORMONAL IMPLANT

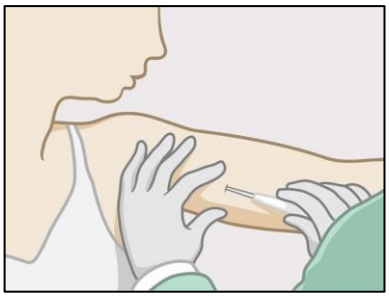
What is it?



The hormonal implant is a flexible plastic stick, the size of a lucifer. It contains one hormone that prevents ovulation. It also makes it harder for sperm to enter the uterus and reach the egg (Zanzu, Hormonaal implantaat, 2025).

Image source: (Gerard, Tussen de lakens)

How do you use it?



A health professional will place the implant. You will be given a local anaesthetic and the bar will be inserted with a needle just under the skin on the inside of your upper arm. This is practically painless. The hormonal implant remains effective for three years. After three years, it must be replaced (Zanzu, Hormonaal implantaat, 2025).

Image source: (Zanzu, Hormonaal implantaat)

Menstruation:

Menstruation can change under the influence of hormonal injection. Women may experience changes in the regularity of their bleeding. Bleeding may become more irregular or there may be intermittent bleeding. The duration and amount of bleeding may also vary. These changes are usually temporary. After a period of use and adaptation of about six months, 80-90% of women find the new bleeding pattern acceptable (Allesoverseks.be, Het hormonaal implantaat, sd).

Reliability:

The hormonal implant is very effective when used properly. The chance of pregnancy is about 1 in 2000 (Zanzu, Hormonaal implantaat, 2025).

Protection against STD's:

The hormonal implant does not protect against STI's or HIV. The male and female condom are the only contraceptives that offer protection against HIV and reduce the risk of getting a sexually transmitted infection (STI). If left untreated, an STI can develop into a sexually transmitted disease (STD) (Zanzu, Hormonaal implantaat, 2025).

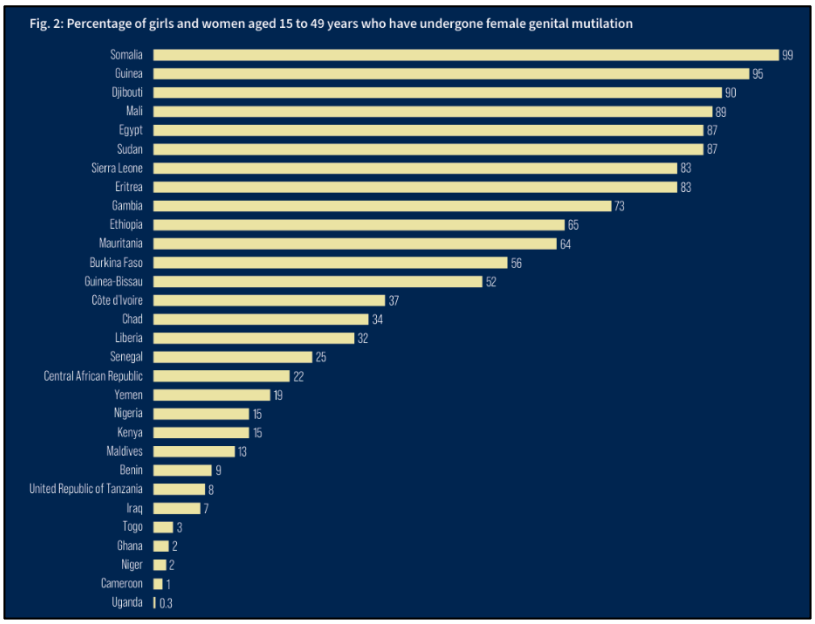
2.6 FGM

WHAT IS FGM:

The World Health Organisation (WHO) defines female genital mutilation (FGM) as 'all procedures in which the external female genital organs are partially or completely removed or the female genital organs are otherwise damaged for non-medical reasons' (World Health Organization, Female genital mutilation, 2025). It has both physical and psychological consequences. Nevertheless, it remains deeply rooted in the cultural and traditional beliefs of many communities (UNICEF, 2025).

Female genital mutilation is a serious violation of several articles of the Universal Declaration of Human Rights, including Article 3: right to life, liberty and security, Article 5: torture is forbidden, Article 7: the law is equal for all.

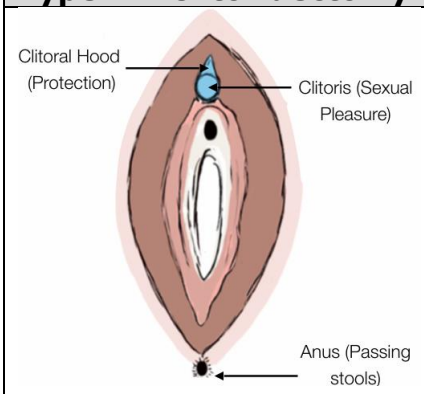
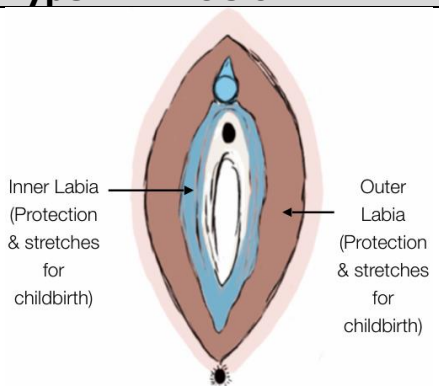
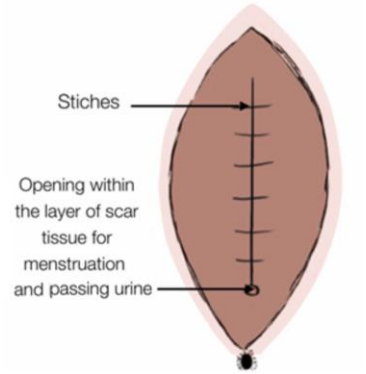
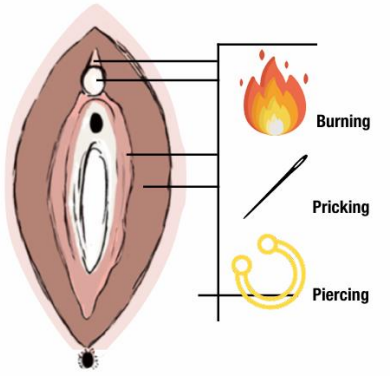
Female genital mutilation is a practice that happens worldwide, but is particularly widespread in various parts of Africa, including The Gambia. In 2024, more than 144 million girls and women in Africa, more than 80 million in Asia and more than 6 million in the Middle East have undergone this practice (United Nations Children's Fund, 2024).



UNICEF statistics from 2024 show that The Gambia ranks 9th among countries where this practice is most common, with 73%. This represents the percentage of girls and women between the ages of 15 and 49 who have undergone FGM. Somalia, Guinea and Djibouti rank 1st, 2nd and 3rd with 99%, 95% and 90% respectively (United Nations Children's Fund, 2024).

Image source: (United Nations Children's Fund, 2024)

DIFFERENT TYPES OF FGM:

Type 1 – Clitoridectomy	**Type 2 – Excision**
 Image source: (National FGM Centre, Types of FGM)	 Image source: (National FGM Centre, Types of FGM)
Type 1: Partial or total removal of the clitoral hood and/or clitoral glans (National FGM Centre, Types of FGM, 2025).	**Type 2**: Partial or total removal of the clitoral glans and inner labia with or without excision of the outer labia (National FGM Centre, Types of FGM, 2025).
Type 3 – Infibulation	**Type 4 – Other harmful procedures**
 Image source: (National FGM Centre, Types of FGM)	 Image source: (National FGM Centre, Types of FGM)
Type 3: Usually includes partial or total removal of the clitoral glans and inner labia and/or outer labia, with inner and/or outer labia sewn/fused together leaving a small hole (National FGM Centre, Types of FGM, 2025).	**Type 4**: Any other injury to the genitalia including piercing, scraping, burning, stretching or pricking for non-medical purposes (National FGM Centre, Types of FGM, 2025).

FGM BAN IN THE GAMBIA:

In 2015, The Gambia took an important step in the fight against female genital mutilation (FGM) by passing a law banning the practice. The proposal is part of the Women's (Amendment) Act and was seen as a historic milestone for the rights of women and girls in the country.

The introduction of the law was partly made possible by years of efforts by activists, human rights organisations and health workers who created awareness about the harmful effects of FGM (Touray & Mohamed, 2024).

In 2024, The Gambia proposed a law to repeal the ban on female genital mutilation (FGM). This caused much debate in the country and international concerns (Al Jazeera, 2024).

The proposal intended to decriminalise female genital mutilation, which would mean no jail time or fines. In March, it was approved at a second reading, with only five out of 53 parliamentarians voting against it. Human rights groups were concerned that The Gambia would become the first country to overturn such a ban (Al Jazeera, 2024).

Parliamentarians voted again on different parts of the proposal. In the last vote on 24 July 2024, a majority of the members of parliament voted against all parts of the proposal, leaving the ban on FGM in place (Al Jazeera, 2024).

During our research on FGM, we became aware of the complexity of this topic. It is not only about legislation, but also about deeply rooted beliefs, social pressure and a lack of awareness about the consequences. Amnesty International rightly highlights that criminalisation is only a first step. Without structural education and community-based initiatives, FGM is likely to continue in silence (Amnesty International, 2024).

CONSEQUENCES OF FGM:

Short term consequences:

- Severe pain
- Excessive bleeding (haemorrhage)
- Distension of the genital tissue
- Fever
- Infections e.g., tetanus
- Urinary problems
- Wound healing problems
- Injury to surrounding genital tissue
- Shock
- Death
- (World Health Organization, Female genital mutilation, 2025)

Long term consequences:

- Urinary problems: Painful urination, urinary tract infections
- Vaginal problems: Discharge, itching, bacterial vaginosis and other infections
- Menstrual problems: Painful menstruations, difficulty in passing menstrual blood, etc.
- Scar tissue and keloid
- Sexual problems: Pain during intercourse, decreased satisfaction, etc.
- Increased risk of childbirth complications and newborn deaths: Difficult delivery, excessive bleeding, caesarean section, need to resuscitate the baby, etc.
- Women with type 3 (infibulation) may require de-infibulation. This is the opening of the infibulated scar to allow sexual intercourse and childbirth. This can happen in several ways: through surgery, by going back to the circumciser to unseal the woman by opening her vagina with a knife, after which her husband will have sex with her for three days to prevent the opening from closing again or through penetration of the man (Koita, 2025).
- Psychological problems: Depression, anxiety, post-traumatic stress disorder, low self-esteem, etc.
- (World Health Organization, Female genital mutilation, 2025)

A prick in the genitals, as can happen in type 4, may not be visible after many years. But it is important to realise that a women may still be able to remember the physical or emotional trauma.

When FGM is performed at a young age, such as with an infant or toddler, the woman may not have a conscious memory of it. But she may become more and more aware of it later in life. It is also possible that some women may not make a connection between their health problems and FGM, while others may not seem to experience any direct effects of it (National FGM Centre & Albert, FGM Medical Examination: Good Practice, 2025).

Psychological consequences:

Female genital mutilation can have a lasting impact on a woman. The traumatic experience may initially be suppressed by the child, but may surface years later and manifest itself in various ways (GAMS België, Wat is VGV?, 2025).

- Loss of trust in family
- Behavioural problems
- Anxiety, panic (flashbacks, nightmares)
- Depression - PTSD (Post-traumatic Stress Disorder)
- (GAMS België, Wat is VGV?, 2025)

CAUSES OF FGM:

Social reasons:

In communities where FGM is a standard, the practice is often seen as a requirement for social acceptance. Girls and their families experience frequent social pressure to continue the tradition to avoid exclusion or stigma (GAMS België, Wat is VGV?, 2025).

FGM is sometimes used to ensure girls' virginity and control sexual behaviour. It is a way to protect the honour of the family and ensures that the girl is considered 'honourable' (GAMS België, Wat is VGV?, 2025).

In some cultures, FGM is associated with increased chances of marriage and dowry. Uncircumcised girls are sometimes considered unclean or unfit for marriage. This leads to economic and social disadvantages for their families (GAMS België, Wat is VGV?, 2025).

Looking in the context of polygamous marriages where a man may not be able to satisfy all his wives sexually, women may experience feelings of frustration and be tempted by non-marital relationships. In such situations, female genital mutilation is sometimes seen as a way of protecting the husband's honour, because FGM is supposed to ensure that the woman does not have these desires (GAMS België, Wat is VGV?, 2025).

Cultural reasons:

FGM is often justified as a cultural heritage passed down from generation to generation. Proponents of the practice see it as an essential part of their identity and cultural continuity. It has always been done, it happens, that's all (GAMS België, Wat is VGV?, 2025).

In some cultures, female sexual organs are considered unclean or ugly. FGM is then performed to 'purify' the body or meet beauty ideals (GAMS België, Wat is VGV?, 2025).

Religious reasons:

The practice of FGM is an ancient cultural tradition that existed before the introduction of monotheistic religions. FGM is still performed in some communities under the misconception that it would be a religious obligation. Although neither the Bible, the Torah or the Quran prescribe the practice (GAMS België & GBV & ASYLUM, Vrouwelijke genitale verminking en internationale bescherming, 2019).

Within the Islam, high-level Sunni scholars have spoken out against FGM. At an international meeting at Al-Azhar University in Cairo in 2006, a fatwa was issued declaring that FGM has no basis in Islamic law (Démographiques, 2007). A fatwa is a legal advice or statement given by an Islamic scholar on an issue related to Islamic law (sharia) (Britannica, 2025).

This message was further clarified in Rotterdam on 10 December 2007. Here, the Islamic University of Rotterdam, Pharos and the Federation of Somali Associations Netherlands organised a meeting to discuss it. Islamic scholars from all over the Netherlands at the time confirmed the validity of the fatwa and highlighted the need to follow it (GAMS België, (Vrouwelijke genitale verminking) Een aantal mythes onder de loep, 2020).

The Islam even highlights in the Qur'an the protection of the body and the avoiding of harm, as shown in Surah Al-Baqarah (2:195): 'And do not throw yourself into destruction with your own hands.' (Quran.com, Surah Al-Baqarah 2:195, n.d.)

Although the Quran does not directly name FGM as good or bad, several verses point out that harming the body, altering Allah's creation and causing oppression and suffering are against Islamic principles. You can read this in Surah At-Tin (95:4): 'Verily, We have created man in the best form.' (Quran.com, Surah At-Tin 95:4, n.d.), Surah Al-Ahzab (33:58): 'And those who harm believing men and women without reason, burden themselves with slander and a clear sin.' (Quran.com, Surah Al-Ahzab 33:58, n.d.) and Surah Ar-Rum (30:30): 'Therefore, focus with all your being on religion as a true believer. This is the nature (fitrah) Allah has imparted to human beings. There is no change in Allah's creation.' (Quran.com, Surah Ar-Rum 30:30, n.d.).

We can conclude that the practice of female genital mutilation (FGM) has no basis in Islamic law, as confirmed by prominent scholars and fatwas. The Quran highlights the protection of the body and avoidance of harm. This brings FGM into conflict with Islamic principles. In other words, FGM is not supported by Islam.

Economic reasons:

An economic motivation for FGM is marriage. In many communities, FGM is seen as a requirement for marriage. When women are strongly dependent on men, this may encourage them to perform the practice for economic benefits. In some cultures, FGM is even required for getting an inheritance. Also, performing FGM can be an important source of income for practitioners (GAMS België, Wat is VGV?, 2025)

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2.7 CONSENT AND BOUNDARIES

WHAT IS CONSENT AND BOUNDARIES?

According to Rutgers expertise centre in sexuality, consent is mutual consent or mutual agreement. Anyone who participates in sexual acts has indicated their desire and is not being forced (seksualiteit, sd).

Stevens quotes the following about boundaries: 'Relationally, people are always dealing with boundaries. It is between one person and the other. A boundary is a limitation, a demarcation of what belongs to one and what belongs to the other. You also have a personal boundary. This boundary relates only to the person himself. A personal boundary can be about what the person's capabilities are or what the person wants and doesn't want, where a person wants to invest time in and where not.' (Stevens, sd).

From the subjects 'Social psychology' and 'clinical reasoning', we found a lot of psychological frameworks, which allowed us to look at boundaries and consent in a larger framework. This allowed us to state that the basic principle of boundaries and consent is autonomy. People find it important to communicate their own boundaries clearly and exercise control over them themselves (Stijn Meuleman, 2023). It is also important to understand that boundaries are changeable over time due to the context. We take the basic principle from Ryan and Deci's self-determination theory. What this theory also describes is that consent is an implementation of that autonomy that people value so much (Hannon Dewi, 2023-2024).

On the other hand, when we talk about consent, we should also talk about compulsion. A person may feel compelled to say yes out of fear of negative consequences. For instance, Icek Ajzen's Theory of planned behaviour says that people are influenced by three things: attitudes, subjective norms and perception of control. Attitudes describe the person's morality, what does the person think is right or wrong. Subjective norms are about, what the person thinks others expect of him or her. The perception of control is about the extent to which a person feels able to perform the actions (Boom, sd).

We can link this theory to compulsion, because in cases of compulsion, a person's attitudes (morality) can play a significant role. For instance, a person may feel obliged to agree in order not to disappoint the other person. A person may thus go beyond their own limits to keep the other person positively interested. Subjective norms can also have an impact. A person may put his autonomy aside to get the other person's approval (Boom, sd).

In the last aspect, power also plays a role. A power differential may cause one to consent or overstep one's own boundaries. Besides the above theory, it may also be that a person experiences cognitive dissonance during compulsion. When someone has not experienced consent or autonomy for a long time due to external influences, the person starts trying to convince himself that agreeing was the right choice. Even if it was not in line with your own boundaries (psycholoog.nl, sd).

Finally, from the subject of clinical concepts, Albert Bandura's social cognitive theory links well with boundaries and consent. This theory describes how people learn through observation, imitation and modelling. According to Bandura, people learn socially acceptable behaviour by watching and imitating others in the close environment. When we start looking at this theory on a social level, it can explain how norms around consent and boundaries develop (Hannon Dewi, 2023-2024).

THE FLAGGING SYSTEM

The flagging system is a methodology developed in Flanders for educators of children, adolescents and adults to make sexual (boundary-crossing) behaviour discussable, assess it correctly and respond appropriately. The flagging system that we apply during the session is adapted to the context within The Gambia (Sensoa, Vlaggensysteem: hoe reageren op seksueel grensoverschrijdend gedrag, 2025).

With the flagging system, you can:

- Objectively assess the sexual behaviour of children, adolescents and adults
- Discuss sexual behaviour with the individual involved and other professionals
- Better align within the professional team on the pedagogical steps to be followed
- As a leader, develop a vision and policy on sexual health within the organization
- (Sensoa, Vlaggensysteem: hoe reageren op seksueel grensoverschrijdend gedrag, 2025)

The flagging system helps to formulate a well-considered response after applying the 6 criteria to a concrete situation. This acts as a counterbalance to emotional or panicked reactions, or indifference (Sensoa, Vlaggensysteem: hoe reageren op seksueel grensoverschrijdend gedrag, 2025).

What are the criteria of the flagging system?

Using 6 criteria, you can categorize sexual behaviour into 4 categories of severity, indicated by different coloured flags. For each flag colour, an appropriate response is suggested (Sensoa, Vlaggensysteem: hoe reageren op seksueel grensoverschrijdend gedrag, 2025).

6 criteria:

- Mutual Consent
  Consent can be explicit (e.g., through verbal agreement) or implicit (e.g., through flirting back). It is important that everyone understands what is being proposed and what the consequences are. Consent can only be given in a voluntary situation.
  So, consent:
  - *Can be withdrawn at any time*
  - *Can not to be given when the action comes as a surprise*
  - *Is difficult to assess in people with limited language comprehension or language ability*
  - *Can not be non-verbal*

  Nuance: *from the Quran, a married couple has duties towards each other. The man has duties towards the woman (e.g., bringing money into the household). The woman also has duties towards the man (e.g., managing the household). There are also sexual duties. A woman should fulfil her husband's sexual needs and vice versa. If the woman desires sex, the man must provide for her as well. However, just because one partner wants sex does not mean it must happen. A conversation can still take place about consent. A man or woman should never feel force to have sex, as that is absolutely not okay.*

  Relevant quotes from the Quran that support this explanation:

  Surah AI-Baqarah (2:223):

  "Your wives are a tilth for you, so go to your tilth as you will, but do so in a good manner. And fear Allah, through whom you ask one another and the wombs (that bore you)." (Quran.com, Surah Al-Baqarah 2:223, sd)

  Surah An-Nisa (4:19):

  "O you who have believed, it is not lawful for you to inherit women against their will. And do not make difficulties for them in order to take [a part] of what you gave them, unless they commit a clear immoral act. And live with them in kindness." (Quran.com, Surah An-Nisa 4:19, sd)

- Voluntariness
  Voluntariness means that no one is forced, persuaded or pressured..

  Nuance: even if your partner wants to be satisfied, it is still a human right to not want that. It should be okay to discuss this with the partner involved.
  Human right supporting this text:
  Article 3 of The UDHR:

  "Everyone has the right to life, liberty and security of person." This right means that people have the right to protect their body and sexuality. Neither partner should be forced to engage in sexual acts without their consent.

The right to say 'no' is a fundamental human right and communication about this subject is crucial.
(Amnesty, n.d)

- Equality
  We speak of equality when all parties involved are equal. There is no large difference in number (between the parties), authority, power, (work) experience, intelligence, age, physical, cognitive, or emotional development. When there is an unequal power relationship, abuse can occur.
  E.g. an older family member to a younger child in the family
- Developmental or functional level
  Sexual behaviour is okay when it fits a certain age or developmental phase. Sex is only okay when you are of legal age (+18).
- Context
  Healthy sexual behaviour always happens in an acceptable context, e.g., not in public or at work, with privacy for all involved.
- Impact
  Sexual behaviour is okay if it does not cause harm to the involved parties physically, psychologically, or emotionally. Someone may experience severe anxiety if the sexual behaviour is not acceptable. When unwanted contact is intimate and/or frequent, it can also be traumatizing.
- (Sensoa, Vlaggensysteem: hoe reageren op seksueel grensoverschrijdend gedrag, 2025)

What are the flags?

- Green flag: acceptable sexual behaviour
- Yellow flag: slightly boundary-crossing sexual behaviour
- Red flag: seriously boundary-crossing sexual behaviour
- Black flag: severely boundary-crossing sexual behaviour
- (Sensoa, Vlaggensysteem: hoe reageren op seksueel grensoverschrijdend gedrag, 2025)

How do you assess the criteria in a situation?

1. What do you see?
2. Who is doing this?
3. Go through and argue each criterion
4. Give a score for each criterion:
    - +: oké
    - +/-: questionable, slightly crossing boundaries, okay for some, not for others
    - -: criterium is not oké
    - ?: insufficient information
    - D.N.M: does not matter
5. Based on the evaluation of the criteria, assign a flag to the situation or behaviour:
    - A situation gets a **green flag** if all criteria are okay. The behaviour is assessed as normal sexual behaviour.
    - You speak of mildly sexually transgressive behaviour with the **yellow flag**. This is referred to when there is no clear mutual consent, slight compulsion is used, secrecy is enforced, there is a slight inequality, the behaviour does not match the level of functioning/age level and the behaviour is mildly harmful.
    - A **red flag** is used to indicate seriously sexually transgressive behaviour. This is referred to when there is no clear mutual consent and the behaviour is clearly unacceptable, compulsion, manipulation, violence and power are used, the person involved cannot walk away, there is an inequality and the behaviour causes physical, emotional and psychological harm. Mildly sexually transgressive behaviour can also receive a **red flag** if it is frequently repeated.
    - **Black flag** is when there is a case of severely boundary-crossing sexual behaviour. We speak of a **black flag** when there is no clear mutual consent and the behaviour is clearly unacceptable, compulsion, aggression, violence and power are used, the person involved cannot walk away, there is a severe inequality and the behaviour causes physical, emotional and psychological harm. The **black flag** is also assigned if there has previously been a case of seriously transgressive sexual behaviour and it was appropriately addressed at the time. The person involved should therefore know that this is seriously transgressive behaviour.
    - (Sensoa, Vlaggensysteem: hoe reageren op seksueel grensoverschrijdend gedrag, 2025)

THE FLAG SYSTEM IN THE GAMBIAN CONTEXT

The flag system assesses sexual behaviour of children, young people and adults based on six criteria. It is a methodology that can be used in education to assess the sexual behaviour of children and young people in an objective and pedagogically responsible way. The system uses four flag colours: green, yellow, red and black. These colours indicate the degree of (un)acceptable sexual behaviour. This provides teachers and other school staff with a clear framework to correctly interpret sexual behaviour and respond appropriately.

Instead of relying on personal feelings or cultural beliefs, the flag system is based on six objective criteria: consent, equality, age and developmental level, context, self-respect and the impact on others.

In educational practice, the flag system can be applied in various ways. It helps in identifying and assessing sexual behaviour between students. Teachers can distinguish between normal, exploratory behaviour and behaviour that crosses boundaries, by analysing behaviour according to the criteria. This helps prevent both overreaction and underestimation of the seriousness of certain situations.

The flag system is also valuable in sex education lessons. By discussing and assessing different scenarios and behaviour together, students learn what healthy boundaries are and how to interact respectfully with one another. In this way, the system contributes preventively to a safe school environment.

Finally, the flag system can play an important role in creating a school policy. By using it as a guideline when developing or evaluating school policy related to inappropriate or boundary-crossing behaviour, the school ensures that all staff members act according to the same principles. The system can also serve as a foundation for reflection and professional development during team meetings.

INFORMATION FROM THE INTERVIEWS (SEE ATTACHMENTS):

Mr. Kelepha Koita

Mr. Koita mentions that The Gambia has laws in place to protect people against sexual violence, including the Women's Act of 2010, the Children's Act of 2005, the Sexual Offences Act and the Trafficking Act. These laws are meant to provide legal protection for victims of sexual violence. Unfortunately, there is a cultural challenge: the culture of silence. When a sex related crime occurs, it is often not reported. This is because such crimes frequently take place within families and the family tries to preserve its honour by remaining silent (Koita, 2025).

They also take into consideration that a man imprisoned for his crimes cannot take care of his family. Within Islam and Gambian culture, a man has a dominant role. The man is expected to take care of the family. When a man is in prison, this cannot happen (Koita, 2025).

Looking further at religious and cultural influences, Mr. Koita tells us that religious and cultural influences have a strong influence on consent, especially within marriage. He explains that according to religious beliefs, a wife should not refuse her husband's sexual advances and vice versa. However, this should be supported by mutual respect and care for each other. The concept of 'rape' does not exist within marriage in The Gambia. This is why many crimes go unreported because they are not supported by the law (Koita, 2025).

What we definitely take away from the interview is that religion and culture are often mixed. Many people are using religious interpretations to justify actions or practices. Female genital mutilation (FGM), for example, is culturally practised in some areas but not supported by religion. While some try to justify it with religion. The way people interpret religion can determine what they consider acceptable in terms of consent and sexual rights (Koita, 2025).

Mr. Koita clarifies that regardless of the weapon used in an assault (knife, razor blade, etc.), anything causing physical harm should be reported to the police (Koita, 2025).

The last thing Mr. Koita points out is that many girls in The Gambia lack knowledge about their own bodies, particularly concerning pregnancy and menstruation. This lack of education can prevent them from understanding their own boundaries and asserting consent in relationships (Koita, 2025).

2.8 TRAINING OF GROUPS

To ensure our sessions run smoothly, we referred back to our course on 'training groups'. In this course, we were taught how, as support workers, we can work with groups and train them effectively. Below, we share some elements from that course which enabled us to design and deliver a successful session.

GROUP DEVELOPMENT ACCORDING TO LEVINE

The first theory we can link is Levine's theory. This theory describes group development based on two central concepts: 'intimacy' and 'authority'. In the theory of Levine, intimacy refers to the degree of connectedness, openness and trust between group members. It concerns how safe individuals feel to show themselves, share personal experiences and be vulnerable within the group. The concept of authority refers to the position, influence and role of the leader within the group and how the group members relate to that authority (De Galan, 2021).

Because we must deliver several sessions to different groups in a short amount of time, there is little opportunity for the group to fully develop. As a result, we often remain stuck in the initial phase, also called the parallel phase of group development. The parallel phase is described as a stage where intimacy is low, people do not yet know each other very well. The participants also don't yet know the trainers, which causes the trainer to receive a high level of authority from the group. The other phases are the acceptance phase, the reciprocity phase and the farewell phase (De Galan, 2021).

This theory offered us tools to handle groups effectively. First of all, as trainers, it is important to establish contact with the group. In the parallel phase, a trainer should not be perceived as authoritarian or forceful. If this happens, it can lead to so-called kicking behaviour from the group in which participants test the trainer's boundaries. To prevent this, it's crucial to start the session off well. From this theory, we received several practical tips (De Galan, 2021):

- **Always arrive well in advance to the training room**
  Make sure you have time to arrange the space the way you want. Greet the participants and put them at ease by chatting with them (De Galan, 2021).
- **Start with the participants' experience**
  Be as concrete as possible about what the participants will learn and what it will bring them. This shows that you've invested in understanding their context, which is motivating (De Galan, 2021).
- **Prefer flip charts to PowerPoint or a beamer**
  Use methods that allow participants to write or draw. This helps you gauge their opinions and feelings (De Galan, 2021).
- **Switch on your professional compassion**
  Do you find someone irritating, difficult, or intimidating? Work on it! Try speaking to that person individually before the session begins (De Galan, 2021).
- **Be curious about their practice**
  When people respond, ask follow-up questions. This shows you're genuinely interested in their experience. Don't ignore interruptions, reward them instead (De Galan, 2021).

We also received tools for handling resistance from participants during a session. In such moments, a participant tests the trainer's authority. Here are some concrete strategies we were given:

- **Giving away authority**
  You do this by fully connecting to the participant's experience. As a trainer, you temporarily let go of your own agenda and focus on how it is for them. The key is to remain warm and curious in the face of a challenge to your authority. Stay calm and first reflect back what the other person is trying to say. Be careful! The group might expect you to put the opponent in their place, but if you act too harshly, the group may feel unsafe (De Galan, 2021).
- **Adding authority**
  The trainer first sets aside their own agenda and connects with what the participant wants. Only after that, the trainer states what is important for him namely, that the participant learns. The next step is to propose a way forward. When the participant says "yes," the trainer gains authority. Make sure the proposal is realistic (De Galan, 2021).
- **Giving away authority again**
  After making a proposal, it's important to check whether the participant agrees with it. You again shift toward giving away authority. If there is still major resistance, it's important to acknowledge that (De Galan, 2021).

The theory of Levine in a intercultural context

When applying Levine's theory of group development in an intercultural setting such as Gambia, it is essential to consider cultural and religious influences. The concepts of intimacy and authority take on different meanings and implications than they do in a western context.

We observed that norms and beliefs regarding hierarchy, gender and communication had a clear impact on group dynamics. In mixed-gender groups female participants were often more reserved when discussing topics related to sexuality, especially in the presence of male participants. This made it harder to build trust and often kept the group in the parallel phase of Levine's model.

Our own role as female and foreign trainers also influenced group dynamics. The information we presented was at times challenged by participants, indicating that gaining credibility and trust was not always straightforward. Traditional gender roles also played a part. As women discussing topics often seen as 'male' in this context, our input was sometimes perceived as less authoritative.

We noticed several signs of cultural sensitive topics: nervous laughter, long silences, and participants, especially women, looking to male group members or the trainer for approval before speaking. These reactions indicated discomfort or uncertainty when engaging in open discussion.

To respond appropriately, we adjusted our approach. We took a neutral and inclusive stance during our sessions, allowing space for diverse opinions and perspectives. Working in smaller groups helped create a safer atmosphere and allowed intimacy to develop more quickly. We also applied key communication skills, guided by three core attitudes: empathy, authenticity and unconditional acceptance.

Rather than directly correcting beliefs, we invited participants to reflect through questions, stories or anonymous case studies. We presented ourselves not as authority figures but as facilitators of dialogue. This helped reduce the power distance and foster greater engagement among participants.

S.P.E.L- METHOD

The Dutch acronym **S.P.E.L** stands for: Playful, Process-oriented and Experiential Learning. This approach is based on the idea that people learn most effectively by doing, experiencing and actively reflecting, rather than just absorbing knowledge through theory or instruction. This method provides a framework that justifies the creative elements in the sessions (such as the quiz, memory game, etc.) (De Galan, 2021).

- **Playful**: Through play, people connect with each other. This increases motivation and contributes to psychosocial development. A game can also be used to simulate reality, for example, a case study in which participants are given space to make mistakes. Play also helps participants connect with their own experiences, which increases their reflective capacity (De Galan, 2021).
- **Process-oriented**: It is important to be flexible and follow what arises in the group here and now. Respond to what is happening at that moment in your training. Process-oriented work is always a balancing act between following the group's dynamic and ensuring safety for both yourself and the group by keeping solid ground under everyone's feet (De Galan, 2021).
- **Experiential learning**: Luk Mulder, founder of the SPEL-method, describes this using the trio: Head (thinking) – Heart (feeling) – Hands (doing). Instead of focusing on knowledge transfer, experiential learning emphasizes: actively participating in tasks or situations, feeling what it does to you, reflecting on the experience and drawing lessons from what you went through (De Galan, 2021).

INTRODUCTION WITH INTROD

The INTROD-method is useful at the beginning of a training session because it provides a structured and thoughtful way to help a group get off to a good start. It ensures that, as a trainer, you immediately work on safety, clarity and engagement. These are three crucial elements for building a successful session or training (De Galan, 2021).

- I = Interest – Spark interest by starting with an anecdote or real-life example
- N = Need – Explain why the topic is important and relevant
- T = Time – Clarify how long your part will take
- R = Response – Indicate what kind of interaction or feedback you appreciate
- O = Outline – Share what topics will be covered and what comes next
- D = Destination (Goal) – Explain what participants will learn or gain from this part (De Galan, 2021)

3. SUSTAINABLE DEVELOPMENT GOALS

3.1 SDG 3: GOOD HEALTH AND WELL-BEING FOR ALL

Sex education directly contributes to achieving this goal by providing both young people and adults with the knowledge and skills needed to make informed choices about their bodies, relationships and sexual health. This has various positive effects on the overall health and well-being of individuals and communities. (Sensoa, Waarom seksuele opvoeding, 2025)

Sex education helps people become aware of the risks of sexually transmitted infections (STI's), such as HIV, chlamydia, gonorrhoea and syphilis. STI's are infections that are passed through sexual contact and they can develop into sexually transmitted diseases (STD's) if left untreated. Sex education provides information on how to prevent these infections, including the use of condoms and other forms of contraception. It also promotes safe sex practices and highlights the importance of preventing STI's. By raising awareness and knowledge about STI's, sex education can help reduce their prevalence within communities.

Another important aspect of sex education is providing knowledge about contraception and family planning. Informing young people about the different contraceptive methods enables them to make informed choices. This can prevent unintended pregnancies. This has important health benefits for women, as it reduces the risk of complications during pregnancy or the need for harmful abortions. There is also an economic advantage. When women have control over when they want to have children, there is a possibility that the child will be born in better conditions. It provides women with many opportunities to continue their education or grow in their careers when they have control over it. This contributes to a better socio-economic equality between men and women. It offers women the chance to step into leadership positions.

Sex education also promotes reproductive health by teaching people about menstruation and pregnancy. It helps them to be better informed about their bodies and the changes they undergo. It also informs them about their reproductive rights.

Sex education is essential for preventing sexual violence and abuse. It teaches young people about the values of mutual respect in relationships, the importance of consent and how they can protect themselves from sexual harassment or violence. It contributes to the protection of both the physical and mental health of individuals.

Sex education plays an important role in enhancing mental well-being. It helps young people and adults develop a healthy self-image and become aware of healthy relationships. By openly discussing sexuality, relationships and sexual preferences, people can feel less ashamed and better cope with their own feelings. This reduces anxiety and uncertainty about sexuality.

3.2 SDG 4: QUALITY EDUCATION

Education is not just about reading and writing. It is also about knowledge that empowers young people and helps them shape their future (The Global Goals, 2025). In The Gambia, we saw first-hand the need and demand for sex education. SDG 4, quality education, is about equal access to knowledge and skills that contribute to a better life (The Global Goals, 2025). Our project aligns perfectly with this, as sex education is essential for young people's health, safety and self-determination.

We knew that knowledge about sexuality would be limited, but it was only when we talked to students that we realised how big the information gap really is. Many had never learned about puberty, menstruation, STD's or contraception, etc. One girl asked us after a session: 'What is sex education anyway?' Other girls told us how grateful they were that we wanted to give them the knowledge about their own bodies. This really made us reflect on the fact that while this information may seem obvious to us, it is completely new to them. Realising that boys and girls hardly have access to basic knowledge about their own bodies made it clear how great the need for sex education is in The Gambia. This moment reminded us why our project is so important: education is not only about textbooks, but also about knowledge that empowers young people to make confident and healthy choices.

What we are experiencing in The Gambia is that sex education has a direct impact on the well-being and opportunities of young people. This is seen in the rising numbers of STD's and the statistics of FGM. The Gambia is in the top 10 countries where this practice is most common. By giving them the right knowledge, we are not only empowering individuals but also the community. It is the key to prosperity and opens up a world of possibilities, making it possible for each of us to contribute to a progressive, healthy society (The Global Goals, 2025).

3.3 SDG 5: EQUALITY

SDG 5 focuses on promoting gender equality and empowering women and girls. SDG 5 encompasses ending violence against women, improving access to economic opportunities and promoting equal opportunities in leadership. Sex education plays a crucial role in achieving SDG 5 because it contributes to promoting gender equality, preventing gender-based violence and promoting sexual and reproductive rights (SDGnederland, 2025).

Sex education provides girls with the knowledge and skills they need to make well-informed choices about their bodies and relationships. It strengthens their position and ensures they stand firm in a world framed by men. In addition, sexual education ensures that both girls and boys have equal access to important information about sexual health, rights and respectful relationships. It contributes to raising awareness of gender norms and the importance of mutual consent.

We notice that there are many religious and cultural influences within this SDG. For example, a girl told us during a session that she must ask for permission from her husband. In Islam, men are often seen as the head of the family and are expected to take responsibility for the well-being, protection and financial support of their household. Sex education goes beyond these influences. It offers women and young girls perspectives that go beyond their religion and culture, which contributes to their autonomy.

It helps young people learn about the importance of respectful relationships and combating sexual violence, which is an important aspect of SDG 5. It strengthens the sexual and reproductive rights of young people by making them aware about access to contraception, correct information about STI’s, STD’s and the right to make their own choices about their bodies. Essentially, sex education contributes to achieving gender equality by teaching young people about respect, equality and the protection of their rights. It not only helps prevent discrimination and violence but also provides the knowledge needed to create a safe environment where a young person can develop.

3.4 SDG 17: PARTNERSHIPS FOR THE GOALS

Sex education can be linked to SDG 17 in several ways. The impact of sex education is highly dependent on collaboration between various partners, such as governments, local schools, healthcare and local organizations. By focusing on these partnerships, we can reach many people and provide greater accessibility.

One important partner is Basse Got Talent. Basse Got Talent is an organization dedicated to young adults in Basse. This organization has strong connections with local schools, allowing us to reach many students, both boys and girls. Also very important is our collaboration with The Gambian Red Cross Society. They have a very different target group then schools: migrants, people in need and volunteers. This organization provides us the opportunity to work more at the community level. This way, we can reach young people who do not attend school and the older generations.

Partnerships are important to obtain information that is tailored to the local culture and religion. Through our partners, we have gained valuable information. 'Family Planning' informed us on what contraceptive methods are used locally and they gave materials to integrate in our sessions. This way, we also know where contraception is available and where to take tests.

When we further reflect on the partners who were also of great value to the development of the project, we must certainly mention the Catholic University of Applied Sciences, VIVES and the Contano Foundation. Thanks to VIVES, we were given the opportunity to embark on this adventure. By supporting students in international internships and projects, VIVES directly contributes to SDG 17: Partnerships to achieve goals. Through these sustainable collaborations, VIVES promotes knowledge exchange between Belgian students, international partners and local communities. In this way, the university college plays an active role in promoting global connectedness and shared learning experiences.

The collaboration with Contano Foundation was also of great value. As both a Belgian and local partner, Contano Foundation acted as a bridge between us as foreign students and the community of Basse. They supported us not only in practical matters but also helped us establish connections with local stakeholders, understand cultural sensitivities and organize our sessions.

In addition to their student-related roles, Contano Foundation also carries out sustainable and broad social work in the region. The organization is committed to improving the quality of life in The Gambia, with a particular focus on children and women. The organization supports the local hospital with the aim of developing the maternity ward into a place where high-quality and safe care can be ensured for both mother and child.

Through effective collaboration between governments, schools, healthcare, local organizations and communities, sex education can be improved and made more accessible. The collective effort ensures that sexual health is promoted and that hard-to-reach target groups can also be included. Strengthening these partnerships is key to increasing the impact of sexual education.

4. DEVELOPMENT OF THE PROJECT

4.1 SESSION 1: INTRODUCTION OF SEX EDUCATION

Preparation

Before our session, we visited schools such as Nassir, Saint-Georges and Saint-Joseph to get to know our target group better. The conversations with girls aged 13 to 20 clearly showed that their knowledge about sex education was very limited. We could deduce this from the responses we received to our questions. For example, many girls didn't know what sexual education was. That's why we decided to start the first session with an introduction that focuses on the questions: What is sex education? Why is it important? How does it work? We also realized that, as Western students, we needed to deepen our understanding of local customs and views. Finally, we based the session content on literature about sexuality, sex education and its associated positive effects.

Development

For the first session, we created a guide for teachers in which everything is described step by step. This is a separate document in which we will include all sessions. We also took into account that there might not be a projector available in the classrooms. To address this, we made a poster (see attachment) that served as a guide for the students during the session.

The aim of the first session was to introduce the participants to the topic of sex education and the benefits of it. In addition to providing information, the session also created space to explore the participants' perspectives. We did this using a statement game that we developed ourselves. Based on their answers and accompanying explanations, we were able to understand their views and learn from them. The game was also designed to be played outdoors, since young people often spend the whole day inside the classroom.

Finally, we wanted to use a clear visual as a recurring theme throughout the sessions. The visual was a house, with sex education as the roof and building blocks such as female genital mutilation, biology and reproduction, menstruation and puberty, STDs, contraception, and consent and boundaries. Each session corresponds to one building block and in this way, we wanted to emphasize our metaphor: together, we build solid knowledge around the theme.

Evaluation:

Saint-Georges

- *Approximately 30 participants, exclusively girls*
- *12 to 16 years old*

It was the first session we gave in The Gambia, which made us very curious. We wondered what the interaction would be like and how they would respond to the material. Would they participate actively or be more reserved? Would they understand the content as we intended it and does our approach align with their perspective? At the same time, we were curious about what we could learn from this group ourselves.

We found ourselves in a completely different cultural context than we are used to in Western Europe, especially when it comes to topics like sexuality. The way sex is interpreted and viewed differs greatly from our Western perspective. In our Western context, openness and individuality are often taken for granted, while in The Gambia, other norms and values apply based on tradition, religion and collectivity.

This reality led us to take a more cautious approach during the first workshop. We tried to place the answers with the participants rather than with ourselves. We did this through a game that included various statements. The following responses emerged:

The results of this session show a general acceptance of sex education, but also some confusion about its meaning. Both groups agreed that sex education can help prevent teenage pregnancies and sexually transmitted infections such as HIV/AIDS. However, they could not clearly explain why this is the case. This suggests that participants recognize the positive effects but have limited concrete knowledge about the content of such education. Their views seem based more on assumptions than on their own understanding.

There was division regarding the statement that young people have the right to know about their bodies and sexual health regardless of their religion or culture. One group found it enriching to learn perspectives beyond their own upbringing. The other group stated that religion and culture cannot be separated from upbringing and that it is unacceptable to explain sex to young children. The other group did not argue this point.

Both groups agreed on the importance of consent and setting boundaries but initially did not fully understand these concepts. Only after further explanation did understanding improve. A striking comment was that women within marriage are expected to obey their husbands and that consent is not always relevant. This shows how deeply ingrained certain gender roles are and emphasizes the importance of continued attention to this theme in future sessions.

There was strong agreement on the statement that education about menstruation and reproduction makes girls healthier and more confident. Participants said that women are often afraid of reproduction due to lack of communication. Often, sex education is only given shortly before marriage, which they consider too late. At that point, there is little room for questions or gradual knowledge building. Knowledge about menstruation was also limited.

Participants also believe that by receiving education about the consequences of FGM, girls gain more insight into the risks and will consequently be less likely to undergo it. At the same time, it was acknowledged that girls often have no choice, as parents or the community already decide for them. Still, there was a belief that education will eventually lead to change.

Regarding gender equality, both groups recognized that sex education can play an important role. By educating boys about topics such as menstruation, greater understanding and respect for girls can develop.

Notably, the statement that sex education encourages young people to become sexually active earlier was clearly rejected. According to participants, sex education helps better understand the risks.

Participants further indicated that sex education might conflict with cultural and religious values but remains necessary. It was acknowledged that culture makes the topic difficult but this was not seen as a reason to completely avoid it.

Opinions differed on whether parents or schools are responsible for sex education. Some felt it is the parents' job, while others emphasized that many parents prefer to avoid the topic, so schools must intervene. This discussion shows a need for cooperation between parents and schools.

Finally, the statement that sex education imposes Western norms was rejected. Sexuality is universal, it was said, and the fact that it is less openly discussed in some cultures does not mean it should not be addressed. However, it was emphasized that the content of lessons must be adapted to the local context.

From these answers, we can conclude that our understanding of the religious and cultural impact on sex education needs to be strengthened. We also learned from the statements that there is a different perception of consent within marriage. Finally, we consider this session a success because we gained a lot of new information on the subject.

SOS training centre – ICT class

- *Approximately 15 participants, both men and women*
- *18 years old and above*

At the start of the session, we quickly noticed that the group showed little to no interaction. It was therefore very difficult to gain their attention for the session. During the theoretical part, where we focused on the positive outcomes, domains and meaning of sex education, the response remained minimal. There was little reaction to questions and eye contact was often avoided. It was also noticeable that the participants spent a lot of time on their phones. We take away from this, the importance of setting clear agreements about phone use at the beginning.

When we went outside to play the game, we saw more participants showing interest. However, the start of the game was challenging because the participants did not fully understand the concept. Once the game was understood, a sense of competition developed, which we really enjoyed. The game had the following results:

The results of both groups are comparable to the results of the previous session. Once again, it is clear that sex education is seen as an important tool to reduce teenage pregnancies and sexually transmitted diseases such as HIV/AIDS. However, the participants in this session were able to explain well why that is. The reason for this may be the fact that this group includes older participants who are already sexually experienced.

Unlike the previous session, all participants agreed that young people have the right to learn about their bodies and sexual health. However, children must be at least 12 years old. Anything younger was considered unacceptable by this group.

The importance of learning about consent and setting boundaries was acknowledged by both groups. Participants emphasized that young people must know what constitutes acceptable behaviour and where they can turn if something happens. During the discussion on consent within marriage, a notable difference of opinion arose: a male participant claimed that a man does not need to ask his wife for consent, which was strongly opposed by a female participant. This illustrates how deeply rooted certain gender roles are and highlights the importance of continued attention to this topic in future sessions.

Both groups agreed that making sexuality negotiable in schools can help counter harmful practices such as child marriage and female genital mutilation (FGM). Despite this consensus, the same male participant mentioned earlier stated that FGM is necessary to control women. We decided to end this discussion, as there was no longer room for nuance and misogynistic comments were being made.

Regarding gender equality, opinions were divided. Some participants found it valuable to involve boys in topics such as menstruation and pregnancy so that they better understand what these involve. Others did not consider this necessary because they believed these topics do not concern boys directly. However, both groups unanimously rejected the idea that sex education encourages young people to become sexually active earlier. Instead, they stated that it helps to better understand the risks. This response was surprising to us, as we expected a more conservative attitude among older participants.

These groups also indicated that sex education in schools might conflict with moral and religious values in Gambia. However, the necessity of such education was again acknowledged.

On the question of who is responsible for sex education, opinions differed: some believed that parents should do this, especially to prepare girls for their first menstruation, while others emphasized that many parents prefer to avoid the topic and that schools therefore must play an important role. Additionally, it was mentioned that sex education at home is often separated by gender, which can be detrimental to gender equality as boys learn little about female issues and vice versa.

On the statement that sex education should focus primarily on abstinence rather than contraception, the participants disagreed. They were aware that pregnancy can also occur from pre-ejaculate, although the boys were initially unaware of this until the girls explained it during the sessions.

Finally, the concern that sex education imposes Western norms was not shared. The participants believed that sex education remains important, regardless of who provides it.

This session was successful in terms of gathering information. We received a lot of input and nuances were added to the statements. However, we had to strongly encourage the group to respond.

SESSION 1: GAME

The game in which the class is divided into two teams with the goal of collecting as many statements as possible for their team, can be described as a success. The game stimulates discussion and reflection on the importance of sex education and the influencing factors. At the same time, it provides us with valuable insights into the opinions, doubts and questions that exist within the group, which helps tailor future sessions to their world.

The game format was well received because it generated a sense of competition among the participants. Because there was a chance to win, the participants were extrinsically motivated, which led to an increase in interaction. The participants are difficult to motivate intrinsically, so an extrinsic factor was needed. In this case, this factor was provided by incorporating a sense of competition. We will also consider this in future sessions, incorporating competition into the games. The concept of the game was clear. The participants quickly understood what was expected of them and were able to provide strong and well-founded arguments for the statements.

4.2 SESSION 2: BIOLOGY AND REPRODUCTION

Preparation:

In preparation for this session, we reviewed the literature study and incorporated it into the PowerPoint presentation used during the session. We also consulted local people, such as Mr. Kelepha Koita, to determine whether it was appropriate to show photos of genitalia. Additionally, we used material from the Psychopathology course, which explains what postpartum depression entails. We found it relevant to address this topic because it is a global issue.

We would also like to explain why we chose to use a 2002 source from 'SchoolTV'. We find it important to mention this as it is an older source. We consciously decided to include it because it explains the process of human reproduction in an accessible and understandable way. Especially with topics like reproduction, which can be complex or sensitive for certain audiences, it is crucial that the information is presented clearly, visually, and in a low-threshold manner. Moreover, the basic knowledge about human reproduction has hardly changed since 2002, making the content still relevant and accurate.

Finally, we also involved midwifery students in developing the theory about contractions during childbirth.

Development:

We deliberately scheduled this session as the second one, as many of the upcoming sessions refer to genitalia and reproductive organs. We focused on anatomy, functioning (such as erection), and the process from sex to childbirth. We also addressed the psychological impact of childbirth, including baby blues and postpartum depression, supported with statistics to increase credibility.

In the section on childbirth, we discussed the different types of contractions and their mental impact, such as anxiety or panic. This helps prepare mothers for what is happening in their bodies.

The goal of the session was to create clarity about genitalia, their function, and appearance. We deliberately chose to use drawings instead of real photos, out of respect for culture and religion. This helps young people better understand their bodies, develop a healthy body image, and reduce shame. In a context where FGM is still practiced, scientifically accurate illustrations provide an alternative image and encourage critical thinking and reflection.

We also addressed reproduction, as young people in The Gambia often only learn about pregnancy shortly before marriage. By informing them earlier, we aim to increase their knowledge and help them make more conscious decisions regarding sex and reproduction.

We integrated quizzes into the PowerPoint to keep the session interactive. The presentation contained clear visuals of genitalia and provided structure throughout. For

the wording of the questions, we consulted ChatGPT, and we tested the participants' knowledge using images and quiz questions.

Finally, we assessed participants' prior knowledge and associations by writing the words 'sex education', 'biology', and 'reproduction' on the board at the start of the session.

Evaluation:

The Gambia Red Cross Society camp in Numuyel

- *Approximately 70 volunteers, both men and women*
- *16 to 21 years old*

We can describe this session as a valuable learning experience. At the beginning, we were quite nervous, as we had heard that instead of 25 participants, there would be 70 present. Throughout the session, we gained meaningful insights into what motivates the participants. Initially, there was little interaction, but thanks to the efforts of a facilitator from the Gambia Red Cross Society, who introduced rewards, engagement quickly increased. This showed that the participants mainly respond to external stimuli such as money or sweets—a form of controlled motivation. While this approach proved effective in the short term, it raises concerns about its long-term sustainability. It encourages behaviour driven by external rewards, leaving little room for autonomy or intrinsic motivation. The focus shifts toward earning a reward rather than developing genuine interest or understanding.

Before discussing the quizzes, we would like to briefly reflect on the initial ideas written on the board by the participants:

- Sex can also be seen as the biological appearance of an individual.
- Biology is the scientific study of living organisms.
- Reproduction is the process by which an organism gives life to offspring of its kind.
- Sex education is the teaching and learning about how a man penetrates a woman to have children.

These answers are limited to scientific definitions and lack personal opinions or feelings. This suggests that participants are used to receiving factual information in education. Additionally, topics such as sexuality and reproduction may be considered sensitive or taboo, making participants feel safer giving neutral, objective answers rather than sharing personal experiences or viewpoints.

From the first photo quiz, we concluded that terms like "prostate" and "epididymis" (testicular appendage in the scrotum) were particularly difficult to remember. This could be because students had never encountered these terms before. Therefore, we should give these more attention in the future.

The main quiz was divided into four categories. Questions about male erection were often answered correctly, especially by boys, although many participants had trouble recognizing terms such as corpus spongiosum and corpora cavernosa. Most participants were able to answer the questions about reproduction, though the difference between "ovary" and "fallopian tube" was not always clear. The questions about childbirth and contractions proved challenging and were frequently answered incorrectly, requiring repetition and clear explanation. In the final category, dealing with psychological influences after birth, we assumed participants were familiar with the term "mood swings," but this turned out not to be the case. This taught us not to make assumptions about participants' prior knowledge.

The Gambia Red Cross Society camp in Sarealpha

- *Approximately 70 volunteers, both men and women*
- *16 to 21 years old*

During the first session, we gained valuable insight into the participants' motivation. In this second session on biology and reproduction, we consciously tried to apply the knowledge we had acquired. Although we do not fully support the principle of reward and punishment, we chose to extrinsically reward the participants. Changing the motivational framework in such a short time seemed too ambitious. An additional reason for this choice was that we needed the students' responses for our thesis.

When using rewards, we observed that the level of interaction increased more quickly and remained stable throughout the session. Toward the end, attention decreased, but we attributed this more to fatigue than to a drop in motivation.

Once again, only definitions appeared on the board, no feelings or opinions despite us explicitly asking for them. Examples of the answers included:

- Biology is the scientific study of life.
- Reproduction is the process by which an organism gives life to an offspring of its kind.
- Sex can also be seen as the biological appearance of an individual.

When comparing these answers to those from the session in Numuyel, we see many similarities. This may indicate that different schools place the same emphasis on a scientific approach to these topics.

During the knowledge test, it was again noticeable that the word "prostate" was difficult, while "ovary" posed no problem. Interestingly, one boy with a lot of prior knowledge on the topic often helped guide the group.

The answers from the main quiz aligned with our expectations. We deliberately spent more time on complex topics, such as explaining contractions and spontaneously clarifying the term "mood swings." We also provided more feedback to check whether participants understood the information, which appeared to be effective. The group had less difficulty recognizing terms, for instance, most participants correctly identified corpus spongiosum and corpora cavernosa.

Additionally, it stood out that boys responded more often than girls. This likely reflects the cultural context in The Gambia, where traditional values remain strong. Unmarried girls are expected to remain virgins until marriage and therefore often avoid sensitive topics such as sex, reproduction, and erection. Girls also tend to be more reserved in mixed-gender groups. The dominant role of men in Gambian society clearly influences the openness and participation of girls.

SESSION 2: GAME

A quiz was used as an interactive method to engage with the learning material. Again, a sense of competition was created, which led to a lot of interaction. The participants found it difficult to understand how the answers should be formulated. The quiz consisted of questions with four possible answers (a, b, c, or d). We explained that the answers should consist of the question number followed by the corresponding letter. It was only after repeating the instructions several times and demonstrating on the board that the participants understood. We could tell that they initially didn’t understand because they were writing out the full questions and answers on their paper.

4.3 SESSION 3: PUBERTY AND MENSTRUATION

Preparation:

Our preparation began with a literature study on puberty and menstruation. We used different sources, such as the World Health Organization (WHO) to provide a general explanation of what puberty means. The U.S. Centre for Disease Control and Prevention (CDC) provided tips on self-care during menstruation. We also used 'Menstrupedia' to gain insight into the emotional and psychological changes that young people can experience in this phase of life. The Cleveland Clinic provided clear information about menstruation. We have also read an article about an overview study by the University of Copenhagen. This study examines whether there are differences when puberty starts for girls in Europe and Africa.

In order to demonstrate the changes during puberty, we requested and received permission to use the Sensoa photo bank. They have photos in which this development is clearly shown using drawings of both women and men.

Development:

For our session on puberty and menstruation, we deliberately chose to give it to both boys and girls, and to young adults who have already passed this stage of life. During our first visits to schools in Basse, a girl told us that lessons on menstruation are often taught only to girls, while boys are sent out. Although this is done with the intention of protecting girls or because menstruation is seen as a 'girl thing', it can unintentionally contribute to shame, misunderstanding and taboo. Boys are denied the opportunity to obtain correct information, which maintains ridicule or rejection of girls on there periods.

With our session, we wanted to change this by informing both genders together, working towards more openness and mutual understanding. That way, boys learn that menstruation is something natural and girls can feel more supported rather than excluded. We tried to do this in a culturally sensitive and respectful way, but we deliberately chose to show scientifically correct drawings of how changes happen during puberty. Training on puberty and menstruation is also relevant to young adults, because they often act as role models or points of contact for adolescents within their communities. By involving them, we also hope to encourage the transmission of accurate information.

To develop this session, we used the literature study we conducted on puberty and menstruation as a basis. We started by refreshing our knowledge on the physical, emotional and psychological changes young people go through during this phase. We looked not only for medical information, but also for insights that highlight the importance of self-care.

We paid specific attention to how puberty can differ depending on geographical context and what this means for young people in The Gambia. Visual material helped us convey physical changes in a respectful and accessible way, especially in an environment where language or accents can be a barrier.

We developed a PowerPoint presentation in which we gave clear and visually supported information. We added text to bridge any language barriers. After the informative part, we organised a quiz with questions on the discussed topics. This served as a knowledge check and also gave us the opportunity to repeat or explain certain things in an interactive and playful way if there was any confusion.

Evaluation:

SOS training centre – ICT class

- *Approximately 20 participants, both men and women*
- *18 years old and above*

We first focused on the theoretical part in which we shared knowledge about puberty and menstruation. We noticed that this approach suited the participants well, despite expecting the ICT class to be less interactive. The group turned out to be much more open and enthusiastic than in previous sessions we held. Especially a newcomer in the class, a more mature woman, contributed strongly to the dynamic by actively participating, answering questions and providing additional information. This created a positive and lively atmosphere, which benefited the flow of the session.

Next, we implemented a quiz as a creative activity, in which participants could test and repeat the knowledge gained in teams. The quiz brought competition and playfulness, which resulted in high engagement. The scores were high. This confirms that most participants understood the material well.

From our experience, setting and enforcing clear rules proved essential to create a structured and calm learning environment. This was an improvement compared to previous sessions, where there was sometimes distraction because participants stayed seated, watched films or did not pay attention. By explicitly agreeing on rules at the beginning of the session and consistently enforcing them, we had to intervene less and the group was better focused.

Regarding group dynamics and motivation, we noticed that using humour is a powerful tool to connect and actively engage participants. Using funny remarks, for example about some boys 'probably being too old for their first ejaculation,' caused many moments of laughter and made it easier to especially get boys to loosen up. Additionally, we saw that the role of the quizmaster is decisive for the enthusiasm of the participants. The more fun we had ourselves, the more enthusiastic the group became. We often laughed and applauded the groups that gave a correct answer.

In summary, a combination of a clear theoretical framework, a playful and competitive creative activity and setting and enforcing clear rules with a touch of humour makes for a successful session. For future sessions, we recommend continuing to use this approach and embracing the role of facilitator as an energetic quizmaster with enthusiasm.

The Gambia Red Cross Society in Basse

- *Approximately 20 volunteers, both men and women*
- *16 to 21 years old*

This session started difficult. The projector was not working and we had to wait a while until they got it running. When we finally could start, it shut down a few times during the informative part. We noticed that this did not benefit the concentration of some participants.

Still, we tried to remain calm and continue with the session as consistently as possible. Because of projector issues a bit of the text and clarifying diagrams and photos from the supporting presentation was missed. Because of that we thought the participants would have learned less than in the previous session, but when we moved on to the quiz, we saw that the scores of these groups were quite high. So we can state that their scores were similar to those of the ICT class.

During the quiz, the projector completely failed, so we had to do the quiz without the screen. We felt this lowered the enthusiasm a bit, because it was harder to build tension without showing the answer on the screen.

To continue the quiz, one of us sat among the participants to read out the questions and possible answers, while the other stood at the scoreboard to try to create some excitement. The participants said they still enjoyed it, but we did notice a difference in enthusiasm between the first group (the ICT class) and this group at the Red Cross. Overall, we can say that their scores were good, so they learned a lot from the informative part. Making the quiz more difficult may be a working point for us.

SESSION 3: GAME

For this session, we chose to develop a quiz. This gave us the opportunity to test the participants' knowledge, but also to repeat or explain certain things in an interactive and playful way when there was confusion.

We noticed that the concept of a quiz works well when there is enough competition between the different teams and that external motivation helps to make the participants more enthusiastic. We also noticed that it helps for the quizmaster to be enthusiastic. For example, we made it exciting when revealing the answer and applauded the groups who gave a correct answer. This also increased the level of competition, which created a fun group atmosphere. When we evaluate this quiz, we can say that the questions were too easy for some groups. So, there definitely should have been some more difficult questions.

4.4 SESSION 4: STI'S AND STD'S

Preparation:

To prepare for this session, we conducted literature research to identify which STI's (sexually transmitted infections) are common in The Gambia. Additionally, we visited Family Planning, the hospital, and a pharmacy to gain insight into the available care and options for people with an STI. At Family Planning, individuals can get tested for STI's, receive medication, and obtain guidance. The hospital also offers STI tests and corresponding treatments. Pharmacies do not provide testing, but antibiotics can be collected there to start treatment.

Besides gathering factual information, we were also curious about the religious perspective on STI's. Therefore, we spoke with Imam Alpha Sidibeh, who explained that STI's are recognized as illnesses within Islam. While some diseases are considered tests from God, this is not the case for STI's. The Quran places great emphasis on maintaining health and permits doing whatever is necessary to save a life. The imam gave an example: if someone is starving, they may eat pork, even though it is normally regarded as impure in Islam. This example highlights that protecting health is a priority, even in the context of STI's. Consequently, treatment and education are seen as very important within this framework.

Development:

We chose to give lessons about STIs because they are essential for the health and well-being of both young people and adults. Many people have limited knowledge about STI's, which often leads to misunderstandings. In some cultures, the topic is taboo and rarely discussed. Clear education raises awareness, prevents misunderstandings and has a preventive effect by informing about safe sex practices, such as condom use and the importance of testing. This can reduce the spread of STI's. Additionally, such sessions help break the taboo, making it easier to talk about STI''s and seek help. They also support young people in making informed choices, such as using condoms.

To make the session interactive, we integrated a game and a case study. The game created an informal atmosphere and helped make STI's discussable. The case study focused on Mariama, a 14-year-old girl who had dropped out of school and worked at the market. She had unprotected sex and showed symptoms of an STI. She asked a friend for advice and participants were asked to put themselves in the friend's shoes.

The goal was to introduce participants to STI's in an interactive and light-hearted way, including information about where to get help and partner notification. Partner notification is important for prevention: (former) partners are informed that they may have been exposed and should get tested.

Evaluation:

SOS training centre – ICT class

- *Approximately 70 participants, both men and women*
- *18 years old and above*

At the start of the session, we could observe that there was no interaction at all. Many participants were lying on their benches or staring into space. We tried to engage with them by asking how their morning was going, but only received a few responses. We therefore decided to dive straight into the session. We began the session by going over which STI's the participants were familiar with. The participants mentioned the following STI's: HIV, Gonorrhea and Syphilis. The other STI's we planned to discuss during the session were unfamiliar to them.

When we started explaining HIV, we first asked whether the participants knew the difference between HIV and AIDS. To our surprise, the participants could not answer this question. This surprised us because we had already seen many awareness posters about HIV and AIDS in the schools. Participants from previous sessions also indicated that they had already learned about HIV and AIDS.

When we moved on to the memory game, there was noticeably more engagement from the group. We relocated outside and noticed a positive shift in the group's dynamics and atmosphere. As we began explaining the game, it quickly became clear that the participants had never heard of the concept before. We therefore decided to demonstrate and explain it visually. From our course on 'training groups', we knew that demonstration is the most effective way to convey new information.

During the game, it quickly became clear that a strong sense of competition existed within the group. We noticed this because the participants shuffled all the cards in every round, even though this was not the intention.

After playing the game, we took some time to explain what 'partner notification' is and where one can go in case of an STI or suspected infection. We decided not to continue with the case study, as four of the fifteen participants had already left due to the session running over time.

Finally, we would like to mention that the women clearly took the lead during the session. The men remained more in the background, which required us to actively encourage their participation. We did this by directing questions specifically to them or involving them in the memory game.

SOS training centre – Catering class

- *Approximately 30 participants, both men and women*
- *18 years old and above*

It was very busy in the classroom, which made it difficult to get the participants to pay attention to the session. The cause of this may have been the fact that it had just been lunch break.

When we started the theoretical part, we first asked which STI's were known by the group. They knew HIV, Syphilis and Gonorrhea. These results correspond with the first group, which allows us to state that these STI's are included in education In The Gambia. However, when we asked this group what HIV is, the participants could also not answer.

With this group, we chose to leave out the memory game because it was almost time to end the school day. Some participants also mentioned that they wanted to go home. We chose to work only with the case of Mariama. Throughout the case, three questions were asked and the participants had to answer them on an sheet of paper. The following answers emerged:

<u>What advice would you give to Mariama?</u>

- The advice we would give to Mariama is to go to the hospital to get medication and to keep the baby.
- I will advise her to go to the hospital and Family Planning to be tested.

<u>What are the contributing factors to the situation?</u>

- She has a lack of sex education and financial support.
- She has a lack of education and advice from her parents.
- She and the boy were young and naïve.
- They had unprotected sex.

<u>What could Mariama have done to protect herself?</u>

- Use a condom

What stood out in the answers was that several participants indicated that Mariama might be pregnant. However, we had only mentioned the possibility of an STI, without saying anything about a pregnancy. This interpretation may come from the idea that sex is primarily intended for reproduction and is not necessarily associated with pleasure.

Answers often referred to the assumption that young people are still naive and therefore less able to take responsibility when it comes to sex. The role of parents was also mentioned. They were said to not have informed Mariama enough. This view seems to originate from the idea that primary caregivers play a crucial role in providing sex education. When we delved deeper into the possible reasons why her parents had not given this information, the following points emerged:

- In Islam, sex before marriage is not allowed. So why would parents provide education about it before marriage?
- Parents themselves did not receive quality education, which means they lacked the tools to properly inform their children.

We found it striking that religion strongly influences views on sex, with marriage seen as the only acceptable context. This leads parents to avoid discussing sex before marriage, fearing it might encourage it. As a result, a cycle continues where generations lack open sexual education, passing down these social patterns.

The Gambia Red Cross Society office in Basse:

- *Approximately 20 volunteers, both men and women*
- *16 to 21 years old*

We can describe this session as successful. We were able to convey the theoretical information effectively and carry out all the exercises. At the beginning of the theory, we asked about prior knowledge about STI's. We received similar answers as in the previous groups. Within the group, syphilis, HIV and gonorrhoea were known. We also asked what the difference was between HIV and AIDS, but the group did not answer. We find this a remarkable result as the Gambia Red Cross Society runs many preventive campaigns against HIV and AIDS.

We continued with the memory game. One of the participants had previously attended this session at the SOS Training Centre, which sped up the game considerably. Thanks to her explanation in Fula, a language often spoken as a mother tongue in The Gambia, the group understood the rules of the game much faster. Using the native language led to a higher level of language comprehension, which made it much easier to explain the instructions. After playing the game, we continued with the Mariama case. The following answers emerged:

<u>What advice would you give to Mariama?</u>

- To go to the hospital and Family Planning.
- To go get medication.
- Talk to your parents and go to the hospital.

<u>What are the contributing factors to the situation?</u>

- Mariama didn't use protection.
- There is a culture of silence.
- There is a lack of education.
- Availability: At the hospital, they do not provide condoms to underage youth. Having sex is only allowed from the age of 18. If you are younger, it is not permitted and you will not receive condoms. Other forms of contraception are also not provided.
- People get caught up in the pleasure of sex, which leads to negligence when it comes to protection.
- Young people are curious and want to explore e.g. sex without a condom.

What could Mariama have done to protect herself?

- She must use a condom.

Comparing the results of these questions with those of the previous groups, we can conclude that we get similar results. For the first question, the hospital and Family Planning are recommended by the students as places to go in case of an STI. This information was given during the theoretical part of the session, so it is clear that the information is understood. We also see the parental role reflected in the responses.

The answers to the second question gave us a lot of information about the factors involved in the case study. We hear that young people do not get contraception because the law does not allow them to have sex. Which doesn't mean it doesn't happen. Young people therefore do not have access to contraception, which has consequences. This leads to risks such as unwanted pregnancies and the spread of sexually transmitted infections (STI's).

SESSION 4: GAME

The concept of **the memory game** was unclear to many participants. The idea of flipping matching cards was likely something they had never encountered before. This became evident when, after each round, they shuffled the cards around. The goal of the game is for participants to remember where the correct cards are located. By constantly mixing the cards, this memory strategy becomes ineffective. We also had the impression that the participants were relying on recognition rather than knowledge of the content. For example, they focused on the bold titles and images that slightly showed through the paper.

There was a sense of competition among the participants, which led to a lot of interaction. But there was also a lot of cheating, with participants shuffling the cards again or flipping more than four cards.

4.5 SESSION 5: CONTRACEPTION

Preparation:

Our preparation began with a literature study on contraception. One of the sources we used was Zanzu. This is a website developed by Sensoa, which provides information on sexual health in a visually and linguistically accessible way. This resource provided us with a solid content base to shape the session scientifically correct. We also requested and received access to Sensoa's photo database. This visual support allowed us to illustrate contraceptive methods and their use in a clear and respectful way.

To know more about which contraceptive are being used in The Gambia we had an interview with the Family Planning Association. During this interview we received practice materials that complemented what we had already provided ourselves. We were given extra male condoms, female condoms and the birth control pill. This allowed us to make the sessions extra interactive. Not only could we demonstrate the material ourselves, but we could also let the participants practice. This tangible material was a valuable addition to make the topic interactive for the participants and provoke questions.

Development:

While developing our project about sex education, we consciously chose to add this theme to our building blocks. We chose this because of its great importance for the health and well-being of both young people and adults. Incorrect use of contraception can lead to unwanted pregnancies and STI’s, causing further consequences. Such as long-term health complications, dropping out of school, financial difficulties, social stigma, unsafe abortions,…

Through visits to several schools in Basse, such as Nassir, Saint-Georges and Saint-Josephs, we noticed a lack of correct information around contraception. This regularly leads to misunderstandings, wrong assumptions or complete avoidance of contraceptives. For example, the male condom is a reliable form of contraception when used properly. Lack of knowledge significantly reduces its effectiveness. When used correctly, about 2% of women become pregnant within a year; with typical use, this number increases to 18% (Zanzu, Condoom, 2025).

By discussing this topic in an approachable and respectful way, we aimed to clear up misunderstandings and spread accurate information. The session content was based on an interview with the Family Planning Association in Basse. We focused on the most commonly used and available methods in the region: the male condom, the female condom, the contraceptive pill, the hormonal injection and the hormonal implant. These were supported by visual materials from Zanzu and Sensoa.

We wanted the session to not only pass on information and clear up misunderstandings, but also to normalize the conversation around contraception. We aimed to create a safe environment where questions could be asked. In The Gambia, talking about sex or sex education is not always easy among locals, as the topic is often considered taboo. Cultural and religious beliefs play a big role in this.

To achieve this, we developed two working formats: a PowerPoint presentation and a board game. The presentation offered structured explanation and helped bridge language barriers. The board game allowed repetition, active participation and made the topic easier to discuss in small groups. We also created posters explaining step-by-step how to correctly use male and female condoms.

Evaluation:

The Gambia Red Cross Society office in Basse

- *Approximately 20 volunteers, both men and women*
- *16 to 21 years old*

To start the session in an interactive way, we used a series of statements on contraception. These were deliberately chosen to see how good the knowledge around contraception was and to reveal common misconceptions. Some statements were simple and meant to build the group's self-confidence, while others contained incorrect assumptions that often circulate in youth groups. Several participants for example believed the statement that you cannot get pregnant from the first time you have sex. Another misconception was that using two condoms provides extra protection, while in reality, this increases the risk of breakage due to friction. These myths are a result of a lack of sex education, as well as wishful thinking and the idea that once can't hurt. We can also link this to optimism bias, where people tend to believe that risks apply to others but not to themselves.

Participants asked several questions throughout the session. One asked whether freezing eggs could be considered contraception, revealing confusion between fertility preservation and contraceptive methods. Others expressed concern about the safety of implants or assumed that taking one contraceptive pill was enough. These questions reflect how fear or misinformation spreads when reliable information is lacking. A typical example is the availability heuristic, where people overestimate the risk of something based on memorable or dramatic stories.

At the end of the session, we used a board game with questions and tasks, played in small groups. It allowed us to repeat key information and correct misunderstandings in a more approachable way. While the group was responsive, some participants still missed essential points, especially those who were less engaged during the informative part.

SOS training centre – Catering class

- *Approximately 15 participants, both men and women*
- *18 years old and above*

As in the previous session, we opened with a set of statements about contraception, which revealed similar misconceptions, such as the belief that two condoms offer more protection or that pregnancy can't occur the first time having sex.

At the beginning of the session, we had made some agreements together to keep things on track: no mobile phone use, be attentive, raise your finger if you want to ask questions and listen to each other. During the session, we noticed that these rules were not followed. Despite reminding the group several times of the agreements made, there continued to be a lot of chatter at the back of the room. When we suggested splitting the chatters and putting them at the front, things calmed down a little, but it remained challenging. We decided to walk in between the group and continue to give the informative part from there. We also repeated the importance of this session, which helped to regain their attention.

During the contraceptive demonstration, we noticed that the group was more engaged. Several participants showed interest and wanted to actively participate by trying out some of the actions from the demonstration themselves.

During the board game, participants were enthusiastic and actively involved.
However, we occasionally had to remind them to answer each question carefully, as some tended to skip questions or give incomplete answers. What we noticed was that certain key information, despite being repeated several times during the session, had still not stuck with some participants. These were often the participants who had been less attentive or engaged during the informative part of the session.

Basse Got Talent management

- *Approximately 10 participants, both men and women*
- *16 to 25 years old*

This smaller group was more knowledgeable and critical in their thinking. Stil,

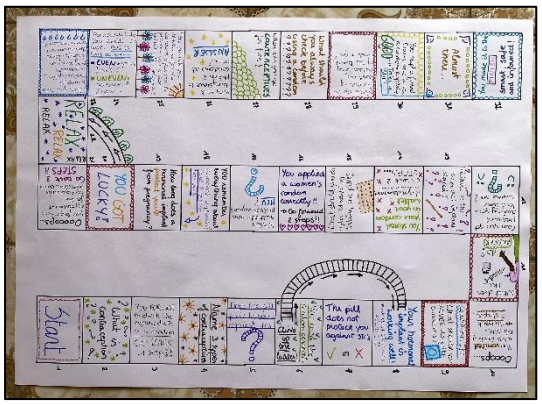
It was noticeable that this group generally gave more correct answers than other groups, possibly indicating a higher level of prior knowledge or critical thinking. Yet they too fell into the well-known trap. This shows that critical minded young people are still exposed to persistent misinformation.

The group asked numerous in-depth questions, demonstrating a strong sense of intrinsic motivation. For example, participants wanted to know what happens once hormonal contraception wears off or what steps to take if a pill is taken incorrectly. Cultural context also discussed during the discussion. One participant shared that the use of contraception is often kept secret due to religious or societal disapproval. This observation was also confirmed in our interview with Imam Alpha Sidibeh, who explained that contraception is only permitted for medical reasons or within the context of family planning.

One participant shared that some girls secretly travel to other regions to receive contraceptive implants, fearing their families or communities would disapprove. When complications arise afterward, they often deal with them alone, afraid of being recognised or exposed. This example highlights deep psychological tensions. One of these is cognitive dissonance, which refers to the inner conflict between personal autonomy and the expectations of the community. Another is strong social control, where individuals feel pressured to conform to prevailing norms. These dynamics underline how complex and sensitive the topic of contraception is within this cultural context.

After the informative part, the group played the board game in pairs of two, as they were only ten participants. The game was well received and ran smoothly, although some needed occasional reminders to answer each question properly. After the session, we handed over the game and posters to the management for further use.

SESSION 5: GAME



For this session, we chose a board game. On the squares were questions and tasks that had to be answered or carried out. Participants were only allowed to stay on the square if they had answered the question correctly, otherwise they had to go back to the square they came from. This way, we wanted to check whether they understood the information from the session and we could eliminate any mistakes. The participants were very enthusiastic about the game, but it was necessary to repeat each time that they really had to answer all the questions in order to be allowed to stay.

The questions are based on the information from our literature study, while for the action tasks we made use of ChatGPT. For example, it gave us tasks like: 'You help a friend learn how to use a condom properly, take 1 step' or 'Oooops, you forgot your appointment for the contraceptive injection… uh-ooh, go back 3 steps'. These tasks give participants the opportunity to empathise better with the theme, through the use of concrete situations.

During the board game, we deliberately used B.F. Skinner's principles of operant conditioning, in which behaviour is influenced by rewards and punishments. Correct answers or safe actions provided a step forward, while incorrect answers or unsafe choices meant a step backwards. This way, participants received feedback in a playful way, which reinforced their knowledge and taught them what behaviour is desirable.

4.6 SESSION 6: FGM

Preparation:

Our preparation for session 6 started with an extensive literature study. We wanted to get a good understanding of female genital mutilation and use reliable sources, because this is a topic we are never faced with in Belgium. For figures and statistics, we used sources from UNICEF and the United Nations Children's Fund. The World Health Organization (WHO) gave us a clear definition of FGM, which provided a good starting point for our literature study. To better explain the different types of FGM, we used illustrations and information from the National FGM Centre of the United Kingdom. These helped us explain the topic in a visual and understandable way. From the organisation GAMS Belgium, we got further information on the causes and consequences of FGM. They offer very accessible and practical explanations.

Since religion is often mentioned in connection with FGM, we quoted fragments from the Quran and interviewed Imam Alpha Sidibeh to understand how Islam really views this. In this way, we wanted to avoid misunderstandings and frame the religious aspect correctly. It soon became clear that culture and tradition play a bigger role than religion and that there are different opinions within Islam. FGM is not explicitly forbidden or prescribed in Islam. As Imam Sidibeh said, "If you want to do FGM, you can, but nobody can force you to do it. Female genital mutilation doesn't prevent you from being a Muslim. So, it's like a choice and part of culture" (Sidibeh, 2025). This religious position contrasts with Gambian law, which prohibits FGM.

It is important to note here that one imam cannot speak for the entire Islam. Everyone has their own way of interpreting religion, which explains why there are so many different views, even within the same religious community. Imam Sidibeh's opinion offers valuable insight, but is only one of many possible perspectives.

We also interviewed local assistant social worker Mr Kelepha Koita about de-infibulation on women with type III FGM. Type III is the most invasive form of female genital mutilation and is also known as infibulation. This involves cutting away the labia (usually the small ones, sometimes the large ones) and sewing them together, leaving only a small opening for urine and menstrual blood.

De-infibulation is the opening of this sealed opening to allow sexual contact or childbirth. Mr Koita explained that this can be done in several ways: through surgery in the hospital, by going back to the circumciser who opens the vagina with a knife, after which the husband has sex for three days to prevent the opening from growing closed again or through forced penetration by the man himself (Koita, 2025). These insights were very valuable in deepening our knowledge and aligning it with local realities.

Development

During the development of our project, we were instructed to include female genital mutilation (FGM) as a theme, given its high impact on women's sexual health in The Gambia. Despite the legal ban, FGM is still widespread. We therefore wanted to understand why this practice persists and what social, cultural, religious and economic factors are involved.

To shape the session, we developed a PowerPoint presentation and a role-play based on 'Bono's hats'. Also called 'thinking with the six hats of Edward de Bono'. It is a method for looking at a topic or problem from different angles (De Schryver, Ernalsteen, Oyen, & Vandewalle, 2024-2025). We used different roles and a storyline in line with local realities.

With the different approaches in the game, we wanted to demonstrate the complexity of this topic. We clearly emphasised that it was about the view-point of the role and not their personal opinion. In doing so, we wanted to create a safe environment in which different ideas could be expressed, without judgement or pressure. Then we highlighted the importance of de-rolling and taking emotional distance from the role played and returning to their own identity (De Schrijver & Delabie).

Evaluation:

The Gambia Red Cross Society office in Basse

- *Approximately 20 volunteers, both men and women*
- *15 to 21 years old*

During our session on female genital mutilation (FGM), we noticed that the participants were initially somewhat reserved, but gradually showed more openness and commitment. Thanks to the interactive approach, deeper conversations and more trust emerged.

In groups, young people discussed why they think FGM is still prevalent, categorising their answers into four factors: social, cultural, economic and religious.

- Social: FGM is seen as a way to protect family honour. Circumcised girls are said to get more respect, while uncircumcised girls are excluded or considered less chaste.
- Cultural: FGM is often seen as an important tradition and essential for education and preparation for marriage.
- Economic: Women who perform FGM earn money through it. For some families, this is an important source of income. FGM is also seen as a step towards marriage and therefore financial security.

- Religious: These arguments caused the most confusion and division, both for the participants, but especially for ourselves. Some participants were convinced that FGM is religiously acceptable within Islam, partly because it would reduce women's sexual desires or "cleanse" them. Others argued that it is permissible as long as only a small part or 25% is removed. At the same time, there were also participants who clearly stated that FGM has nothing to do with religion.

We noticed during the sessions that religion was often mentioned by the participants as a reason to pursue FGM, which made us suspect that religion and culture are strongly intertwined in their perceptions, which was also confirmed by the imam. This led to us having to constantly deliberate on how best to discuss these diverse and sometimes conflicting views, without imposing our own views, but rather providing space for open dialogue and sharing different perspectives.

From a psychological perspective, we saw that social pressure plays a major role in perpetuating FGM. For instance, participants indicated that girls who are not circumcised are often excluded or seen as less chaste, which leads to following out of fear of rejection. Groupthink was also found to be present: young people often blindly adopt beliefs of their community. Through intergenerational transmission of norms, these beliefs are passed on from generation to generation. And finally, the discussion about religion and culture raised questions about identity formation: We are confused by the different narratives and opinions on this discussion, but how do local adolescents deal with contradictory information that conflicts with what they have been taught as truth from an early age?

The role-play on FGM went smoothly. Some participants were enthusiastically empathised with their roles, while others were rather quiet. We always emphasised that it was about a role and not their personal opinions.

After the game, we also took time to de-roll so that everyone could consciously return to their own identity. We felt this was important to avoid any personal confusion and to ensure that participants did not feel personally attacked or responsible for the views they expressed in their roles.

SESSION 6: GAME

The game was based on De Bono's hat method, adapted with roles that matched local realities. We created a story around a girl, Awa, where participants were assigned a role with a specific opinion on FGM. Each role was given three questions: “What do you think about FGM?”, “What is your reason (cultural, religious, social, economic...)?” and 'What do you say to Awa?'

We discussed the answers in group, revealing the multiplicity of views within the group. We scrapped the planned second part with dilemmas on the spot, as we found that it was difficult to keep everyone's attention.

We did conclude with a final reflection and the so-called ‘ de-rolling’. This required everyone to describe in one word how their character felt towards Awa. We then had participants consciously distance themselves from their roles. This technique, which we learned in the Counselling and Coaching course, proved very valuable here too, given the sensitivity and complexity of the subject in this context.

4.7 SESSION 7: CONSENT AND BOUNDARIES

Preparation:

In preparation for this session, we delved into the meaning of the concepts of consent and boundaries. What do these concepts actually entail and how are they related to each other? We then consulted our course materials to explore which psychological theories support these topics. We discovered links with the Self-Determination Theory by Ryan and Deci, the Theory of Planned Behaviour by Icek Ajzen and the Social Cognitive Theory by Albert Bandura.

The interview with Mr. Kelepha Koita also gave us new insights. We learned how sexual violence is viewed in The Gambia and how the concept of consent is approached within marriage. Mr. Koita also spoke about various challenges in the country, such as the prevailing culture of silence, the lack of education and the use of religion as justification for harmful practices such as female genital mutilation (FGM). Thanks to this interview, we were able to place the concepts of consent and boundaries in a broader perspective, taking into account cultural, religious and legal factors (Koita, 2025).

It was important to further investigate the applied methodologies in Belgium. The goal was to strengthen the knowledge exchange between us, as Belgian students and the local partners. This enabled us to better understand the differences in approach between Belgium and Gambia. These are mainly situated in the fields of religion and culture, which lead to different perspectives on issues such as sexual violence within marriage, boundaries and consent.

Development:

The reason why we want to dedicate a session to the concepts of consent and boundaries is because these elements are essential within sexual education. Before sex can even be considered, attention must first be given to consent and the involved boundaries. In this way, healthy and respectful relationships can be built. By understanding these topics, people can clearly and honestly express their own boundaries while also respecting those of others. This applies not only to romantic relationships but also to platonic friendships.

We also discussed compulsion because it is clearly linked to sexually transgressive behaviour. Consent must be given without someone feeling forced. We discussed compulsion in the literature study based on the Theory of Planned Behaviour by Icek Ajzen, which describes how people are influenced by three aspects: attitudes, subjective norms, and perceived behavioural control. This theory explains how a person’s beliefs and behaviour are strongly dependent on the social context, the prevailing norms in their environment and how much influence they believe they have over their own choices. By gaining these insights about compulsion, we can better understand how it arises and how it relates to sexually transgressive behaviour. Moreover, understanding compulsion offers a different perspective on consent and boundaries.

It is important to talk about situations in which consent and boundaries are not respected because this raises participants' awareness of the negative impact on both the individuals involved and society. It not only helps participants understand what is and isn't okay, but also enables them to set clear boundaries. A session like this also provides resistance against the culture of silence, in which people are afraid to speak about boundary-crossing behaviour.

Finally, is talking to young people about this important, because they are in a phase of life in which the development of intimate relationships plays a central role. By talking about consent, boundaries and sexually transgressive behaviour, young people become more aware of their own boundaries and those of others. It helps them build healthy and respectful relationships, based on mutual consent and trust.

We chose to give this session using interactive games. By literally letting them feel their boundaries, they are enabled to recognize and protect them. Games also support a high level of interaction, which is very important for this session. Consent and boundaries are very personal topics, which is why we need a lot of input from the group. Through games, we address statements and myths about sexually transgressive behaviour. Because it is presented in a game format, a light and safe atmosphere is created in which young people feel freer to share their opinions, ask questions and break taboos.

Evaluation:

The Gambia Red Cross Society office in Basse

- *Approximately 20 volunteers, both men and women*
- *16 to 21 years old*

On the day we conducted this session at the Gambia Red Cross Society, two sessions were scheduled: one on "Female Genital Mutilation (FGM)" and another on "Consent and Boundaries." We chose to present the session on consent and boundaries second, as we quickly realized that the group had not yet established sufficient safety. The FGM session primarily consisted of theory with only one activity, making it a safer starting point. This approach aligns with Peter Levine's theoretical insights, which suggest that participants lacking mutual trust tend to focus primarily on the trainer, which is easy with a lot of theory integrated in the session.

Reflecting on the day, we are confident that this sequence was the right choice. By the time the second session began, participants were more at ease with each other.

At the beginning of the training, we introduced the concept of consent using a simple visualization: offering baobab juice to a person. By staying close to a familiar and everyday situation, the concept became quickly clear, and we observed that participants understood the idea of consent well.

After completing the visualizations, we proceeded with an exercise focused on expressing consent: the body carousel, that we explain after the evaluation of this session. Notably, boys often took the initiative in performing the actions. We observed many mixed-gender pairs, consisting of a boy and a girl, actively participating. Contrary to our expectations, it was primarily these mixed-gender pairs who performed the exercises. Actions related to kissing were generally not performed by the majority. Other actions, such as belly-to-belly or stroking the face, were predominantly performed.

For the myth-busting task, the group was divided into four. It was noticeable that boys often assumed a more dominant role during the group process. This may be influenced by cultural factors, where men traditionally hold more leading positions than women in the Gambian context. Regarding most myths, the group agreed with the PowerPoint presentation. Only the myth "If you don't resist, you're not a victim" led to discussion. One participant believed that mutual clarity is essential: without resistance, it's challenging for the other person to gauge what is desired. This prompted us to reflect on the flag system: with minors, there is no debate due to power imbalance, but with equals, grey areas can arise, even if someone feels like a victim.

In the first exercise on the flag system, it was evident that all groups agreed that a married couple may kiss each other publicly. However, one group also believed that a 20-year-old girl could be forced to have sex with her husband, highlighting how complex sexual misconduct within marriage is perceived. In Gambia, marital rape is not criminalized.

When ranking situations from completely okay to completely not okay, groups had different orders. However, one situation was clearly considered completely okay: "A married couple kisses each other in the market." From second place onwards, opinions varied. For instance, one group found it absolutely inappropriate for two boys to show each other's genitals during a football training, while another group considered the situation with the family member more problematic.

For the final task on the flag system, participants had to link the six situations to the six criteria of the flag system. The situations "a stranger gives a kiss on the cheek in the youth centre" and "a 20-year-old girl is forced to have sex with her husband" were linked to consent because neither situation can involve mutual consent. Consent cannot be given in a situation where coercion is used or when the person is surprised.

Under "voluntariness," the situation was mentioned where a 16-year-old boy looks at a naked 18-year-old girl. Some participants explained that the girl was obligated to be seen naked. However, one group member disagreed, stating that the 16-year-old boy is still young and naive. This fact can then be linked to the criterion of functioning, as the boy, according to that group member, is still too young to understand what is happening.

The criterion "equality" focused on minority and majority age. Here, groups indicated that an adult should know better and thus bear responsibility towards a minor. A situation related to this was: "A family member touches the breasts of a 14-year-old girl in the compound."

Under "context," the situation was mentioned of two boys showing their erection during football training. One found it okay because it can happen among all boys. The other said that homosexuality is not acceptable within Gambian culture.

For the final criterion, "impact," it was indicated that sexual misconduct can lead to emotional, physical, or psychological harm. When we asked for concrete examples of such possible harm, participants couldn't immediately provide answers. They likely based their answers on information they had previously heard during the presentation. We see this as an area for growth, so we can focus more on concrete examples in the future.

Finally, we conclude that the group may have never consciously reflected on "consent" and "boundaries," as evidenced by their difficulty in fully understanding these concepts. In Gambian culture, where tradition sets the norm, such topics are rarely discussed. The reason for this may be that it deviates from that norm. For instance, consent within marriage is a challenging issue.

SOS training centre – Catering class

- *Approximately 20 participants, both men and women*
- *18 years old and above*

If we compare this session with the one described above, we can conclude that this session was very chaotic. Unlike the Gambia Red Cross Society, this group had known each other for much longer, which led to strong mutual trust. Unlike in Levine's parallel phase, the group no longer needs the trainer as a catalyst to interact with one another, which puts the trainer's authority to the test. As a result, it was often difficult to get the participants' attention or to start an exercise.

The visualisation exercise around boundaries had to be explained several times before it was understood. During the exercise, participants looked at each other instead of sensing their own boundaries. Instead of following their own feelings, they took each other as reference. Possible causes for this are a lack of clarity about the aim of the exercise and the collective nature of Gambian culture, in which group cohesion and mutual alignment are important. Individual boundaries may be experienced differently in Gambia than in the West, where autonomy is central. This aligns with differences in needs according to Maslow's pyramid.

Although the levels of Maslow's needs remain the same, their interpretation differs per culture. Physiological needs and safety are the basic needs in both Europe and West Africa. When it comes to social needs, the focus in Europe is on individual relationships, personal space, and autonomy, with smaller networks. In West Africa, the focus is more on collective connection with family, village, and religious groups. Social status also depends on someone's role within the community (Cherry, 2024).

Image source: (Indeed & Herrity)

Regarding self-esteem, in West Africa it mainly comes from recognition by the group and contributing to the community. In Europe, self-esteem is more linked to personal achievements, such as diplomas and career (Cherry, 2024).

Self-actualisation in West Africa often takes place within the boundaries of the community or religion. In Europe, self-actualisation is an individual pursuit of freedom, study, travel, and self-reflection, separate from group pressure or expectations (Cherry, 2024).

After the boundaries exercise, we continued with the body carousel. It was remarkable that all the assignments testing individual boundaries in the group were carried out. The likely reason is that all participants were women and knew each other very well. To see how far participants would go and provoke a reaction, we gave an uncomfortable task: licking each other's feet. Here, boundaries were indicated and accepted.

During the first exercises with the flag system, the reactions were striking. As in the previous session, a kiss between a married couple in the market was seen as "okay". Forcing a woman to have sex within marriage was also accepted by some, again indicating that consent within marriage remains a difficult topic. Peeking was often considered acceptable, especially within the same compound. Opinions varied on a kiss from a stranger: some saw it as normal in nightlife contexts, others emphasised the importance of consent. The remaining situations were judged as "not okay".

There were significant differences between groups when ranking the situations. Some saw forced sex within marriage as very harmful, others as acceptable. This shows a divide between traditional and more progressive views on consent. It was also notable that the distinction between minors and adults was barely discussed. This may be explained by the fact that these young people are often confronted with adult responsibilities and situations from an early age in daily life.

In the final flag system assignment, we observed that the concept of "consent" was well understood, as every group linked it to a situation. The link with "voluntariness" was made with the situation: "A 20-year-old girl is forced to have sex with her husband," indicating that it could not be considered voluntary.

"Equality" was not mentioned spontaneously by any group and always had to be introduced by us. Traditional patterns are still strongly present today, with men often seen as the head of the household and women taking a more subordinate role. This inequality between men and women is often considered self-evident, which is why the idea of equal rights and mutual respect does not arise automatically.

SESSION 7: GAMES

The body carousel was experienced as very enjoyable. Participants were asked to form an inner and an outer circle, so that each person had a partner. Although it was a non-competitive exercise, it can still be described as a success in terms of interaction. The activity focused on performing unusual tasks with a partner, but only if both parties gave consent. Because the tasks were sometimes intimate or unusual, a light-hearted atmosphere was created in which participants could explore and better understand their own boundaries and the importance of giving and receiving consent.

Also **the flagging system exercise** was a non-competitive exercise. Unlike the body carousel, we had to make an extra effort to motivate the participants to start the group discussions about the six situations. It turned out to be a very interesting exercise because it required discussion and consultation within the groups about dilemmas that do not have a straightforward answer. This led to the sharing of diverse and thought-provoking perspectives on the situations. Additionally, the activity provided valuable insights into how consent and boundaries are understood and applied within the Gambian context.

6. GENERAL CONCLUSION

6.1 RESEARCH QUESTION: WHAT ARE THE CHALLENGES AND OPPERTUNITIES IN PROVIDING SEX EDUCATION TO YOUTH IN BASSE, UPPER RIVER REGION (URR), THE GAMBIA?

We start with a brief summary of the research question: 'What are the opportunities and challenges in delivering sex education to youth in Basse, URR, The Gambia?' We began by researching prevailing beliefs, cultural sensitivities and levels of knowledge about sexuality, reproduction and personal boundaries. We based our development of the educational sessions on these valuable insights. We gained a better understanding of how young people experience these topics, what questions and concerns they have and how open or reserved they are in discussing them.

It became clear what role parents, religious leaders, schools and local partners play in promoting or hindering sex education. Sexual education offers opportunities to collaborate with religious and local leaders. During our project, we established connections with an imam and local organizations, such as the Gambian Red Cross Society and Basse Got Talent. These partnerships enabled us to deliver culturally sensitive sessions while also addressing misconceptions around topics like STI’s, STD’s and contraception.

Sex education also contributes to gender equality. By involving both boys and girls and exposing them to diverse perspectives, participants were encouraged to think critically about gender roles. Stereotypes such as “boys always want sex” or “women belong in the household” were openly discussed. While some participants agreed with these views, others disagreed, indicating the presence of both traditional and progressive mindsets. Sensitive topics such as consent within marriage were also addressed in a safe environment.

Scientific research shows that sexual education not only promotes sexual health, but also supports the personal development of young people. They learn to set and respect boundaries and develop essential life skills such as critical thinking, communication, self-awareness and responsibility (Sensoa, Seksuele opvoeding, 2025).

One major challenge is the influence of traditional beliefs and religion. During our sessions, we noticed that certain norms are deeply rooted. Some women mentioned they had to use contraception in secret or that consent within marriage is not always seen as necessary. Additionally, we encountered widespread misinformation on topics such as sex, menstruation and contraception. For example, some participants believed that one cannot get pregnant the first time having sex or during menstruation. Other misconceptions included the belief that birth control pills cause infertility or that using two condoms offers better protection. While these inaccuracies pose challenges, they also present opportunities by highlighting where educational support is most needed.

An unexpected challenge was the motivation of the participants, that was often extrinsic. Many young people engaged mainly in hopes of receiving a reward. As a result, their focus was less consistent and information was less likely to be retained. Cheating during games was common, indicating that winning sometimes took precedence over learning. The competitive element helped to increase engagement, something that was harder to achieve without interactive activities.

Our experience in Basse taught us to focus on possibilities rather than limitations. While infrastructure and comfort are often prioritized in Belgium, we saw in The Gambia that community spirit, creativity and flexibility are more highly valued. Volunteers played a key role in this. They were trained to spread information themselves, helping to create a community based change.

We also observed that social workers in The Gambia are more proactive in seeking out people in need, whereas in Belgium, individuals are generally expected to ask for help themselves. Working on a sensitive topic like sexuality required cultural understanding. We actively explored local customs, religious views and values, which significantly deepened our understanding of the context.

This experience was both intellectually enriching and personally meaningful. We expanded our knowledge of sexual education and look forward to seeing future students further develop and refine this important topic.

Building qualitative knowledge together

After each session, we let participants decorate the house with a piece of fabric, this is how we want to bring this statement to life.

We also chose a house because it protects you from external influences, such as violence and exploitation. A house is strong and symbolises that good education and knowledge makes you more resilient and stronger as a person.

6.2 CRITICAL REFLECTIONS

MOTIVATION

During our project in Basse, we noticed that the motivation of young people was often extrinsic in nature. In contrast to the Belgian education system, where intrinsic motivation is actively promoted through the self-determination theory (autonomy, competence and relatedness), we saw that this form of motivation was less developed in The Gambia.

We applied the self-determination theory in our sessions. We stimulated autonomy by creating space for personal opinions, competence through playful methods in which young people could experience success and relatedness through group assignments. This proved to be insufficient. Young people responded hesitantly, were often distracted, chatted among themselves, used their phones or walked in and out of the classroom. Even clear agreements at the start of the sessions had only limited effect.

A possible explanation for this lies in the education system. Many young people are used to a traditional, hierarchical form of education in which knowledge is mainly transferred in a top down structure. There is little room for self-expression, freedom of choice or critical thinking. This became evident when we asked participants to write their opinion on the board, but only saw definitions and no personal viewpoints. The literal repetition of questions and answers points to a learning style focused on memorization rather than reflection.

Cultural factors reinforce this pattern. In the Gambian context, there is a strong emphasis on respect for parents, elders and authority figures. Obedience is valued and openly expressing your opinion, especially on sensitive topics such as sexuality, is often seen as inappropriate or even disrespectful. These values can inhibit the development of autonomy and critical reflection, important building blocks of intrinsic motivation.

In search of a solution, we took inspiration from the approach of the manager of The Gambia Red Cross Society. He managed to capture the attention of young people with simple tools, such as a reward system and group-oriented motivation techniques. We decided to hand out lollipops during quiz questions. This turned out to be surprisingly effective. We saw that engagement increased, young people raised their hands and there was much more enthusiasm, even for questions without rewards.

This raises questions: do young people also learn more as a result? And does the acquired knowledge remain when the reward disappears? We realized that extrinsic motivation can be a useful entry point, especially in a context where intrinsic motivation is not yet self-evident, but it is not a sustainable solution in itself. The goal remains to intrinsically motivate young people so that they continue to learn and grow out of personal interest and curiosity.

Our experience showed that motivation is complex, especially in intercultural contexts. A one-sided approach rarely works. Effective motivation requires a combination of strategies and a good understanding of the cultural and educational background of the target group.

SAFETY IN THE GROUP

During our sex education sessions in Basse, we deliberately chose to work with mixed groups of boys and girls. Our aim was to foster dialogue, promote mutual understanding and emphasize that sexual health is a shared responsibility. While this setup had clear benefits, it also raised questions about the psychological safety of participants, particularly when discussing sensitive topics.

According to Deci and Ryan's self-determination theory, intrinsic motivation is supported by autonomy, competence and connectedness. Although safety is not one of the three pillars, it plays an indirect but essential role, especially in creating a sense of connectedness within the group. Feeling psychologically safe encourages participants to share personal thoughts and ask questions, key elements for meaningful learning.

In The Gambia, traditional gender roles still influence group dynamics. Men are often seen as authority figures, while women are expected to be more modest and obedient. This can create an environment where girls feel less free to speak, especially in mixed settings. However, our observations painted a nuanced picture. Some girls expressed themselves confidently, even on taboo subjects, while some boys remained silent or hesitant. This points to changes, young people are increasingly exposed to diverse role models and perspectives through globalisation and social media.

We must remain culturally sensitive. Change is gradual and must be rooted in respect for local traditions and values. Pushing change too quickly or without context risks rejection or resistance. True transformation begins with listening, building trust and creating space for open dialogue.

We also saw that psychological safety does not only depend on group composition. The facilitators play a crucial role. Through clear agreements, empathetic responses, humour and small human gestures, like eye contact, using names and showing genuine interest, we noticed greater engagement and openness from participants. Our enthusiasm during sessions often sparked similar energy among the group.

While some participants withdrew or remained silent, especially on sensitive topics, others just felt encouraged to speak out. Mixed sessions are valuable, as long as facilitators consciously work to create a safe and respectful atmosphere. Involving both sexes in these discussions helps break down stereotypes and promotes empathy. For instance, one girl pointed out how boys often dismiss or misunderstand the effects of menstruation, something that only becomes visible when both sides are part of the conversation.

In conclusion, working with mixed groups can enhance understanding and encourage critical thinking, as long as the psychological safety of participants is prioritized. Facilitators play a key role in this process. Through a respectful presence, responsiveness to group dynamics and cultural awareness, even sensitive topics can be discussed openly and constructively.

CULTURAL SENSITIVITY

During our project in Gambia, we were confronted with a tension between cultural sensitivity and universal human rights. On the one hand, respect for local norms is essential for sustainable international cooperation. On the other, fundamental rights, such as sexual health and bodily integrity, should never be in question. This brought us to the question: What role can and should we, as outsiders, take within a context unknown to us?

We noticed that sexuality is a taboo in many Gambian communities, especially for young people who are not yet ready to marry. This taboo is deeply rooted in culture and religion and contributes to a lack of sex education, teenage pregnancies, sexually transmitted infections such as HIV, and the continuation of female genital mutilation (FGM).

Although we stayed in Gambia for four months, we quickly realized that this period was too short to fully understand the complex social, cultural and religious context. That is why we deliberately chose a cautious approach: gathering information, listening actively and observing before engaging in conversation. We spoke with an imam, a assistant social worker and young people themselves. This taught us, for example, that FGM is more of a cultural than a religious practice. In the future, we would like to complement this with the perspective of a pastor, in order to better understand the Christian point of view as well.

The question remained whether we, as outsiders, had enough insight to discuss the topic of sex education in a respectful and culturally sensitive way. We grew up in a Western context in which openness about sexuality is taken for granted, but is four months enough to understand what sexual education should mean in The Gambia?

We concluded that the answer is not straightforward. Thanks to the knowledge we gained and our open, non-judgemental attitude, we managed to take a first step: starting the conversation and creating space for dialogue. In collaboration with local organisations, we were able to help raise awareness and give young people the opportunity to voice their opinions, something that strengthened their involvement and sense of ownership.

At the same time, we realize that four months is not enough to achieve lasting change. Building trust, understanding cultural sensitivities and truly integrating into the local context requires more time. Awareness is a gradual process that requires integration of the topic, repetition and cooperation in order to be truly sustainable.

SUSTAINABILITY

In this critical reflection, we consider sustainability as an essential principle within our project. Our goal was to build something that would continue to exist after our departure. We explicitly did not want to launch an initiative that would come to a halt as soon as we left. Therefore, the focus was on four pillars: local involvement, cultural sensitivity, equality and achievable goals.

Local involvement and ownership are crucial. Sustainability requires that local partners and communities are not only involved in the implementation, but also in the preparation and design of the project. This creates understanding and responsibility for the content. In our case, we mostly managed to achieve this. Through thorough analysis of the resources available on site, such as the presence of a projector at The Gambia Red Cross Society and the SOS Training Centre, we developed materials that were well suited to the context. We also prepared a manual explaining the sessions step by step. Still, we should have involved Basse Got Talent more actively in the development: their limited involvement could put pressure on continuity.

Cultural sensitivity is a necessary condition for sustainability. In order for the project not to appear as a Western intervention, it had to be aligned with local norms, values and customs. Sexuality remains a taboo subject in The Gambia, which made this particularly challenging. Through conversations with an imam and a assistant social worker, we learned to distinguish between religious and cultural factors. We incorporated these insights into the project design, for example by referencing the Quran and using recognizable local examples, such as the baobab instead of coffee. Still, we acknowledge that four months is insufficient to fully understand a culture: our sensitivity was sincere, but there is certainly room for improvement.

The project had to be able to continue independently. Therefore, we set achievable goals and provided clear support through the manual. We took into account the available resources as well as the motivation and capacities of those involved.

We pause to consider a reality we observed on-site: even when resources and opportunities are present, projects are not always continued. Local partners may have other priorities or struggle with time limitations or unclear roles. However, the goal of sustainability was not an afterthought, but a fundamental motivation from the beginning to the end of our project.

SOCIALLY DESIRABLE ANSWERS

Social desirability is an important factor to consider, something we noticed several times during our project in Basse, Gambia. Particularly during evaluation moments, we noticed that partners often gave exclusively positive feedback. While this initially gave us the feeling that our work was appreciated, the question soon arose as to what extent these reactions were sincere. Partners were possibly holding back out of politeness, or out of respect for our efforts as guests in their communities. This behaviour did not seem limited to evaluations, but could also be present during interviews, sessions and other forms of collaboration.

A possible explanation for this lies in the unequal power dynamic between Western and local actors. As European students, we have access to resources and international networks, which despite our intention of equality, automatically creates a certain power dynamic. This dynamic can lead local partners to behave cautiously or diplomatically, out of concern for jeopardising future collaborations or out of a sense of responsibility toward us as temporary visitors of their community.

The colonial history of the continent also plays a role. The traces of the colonial past are sometimes still noticeable in ideas about knowledge, authority and social relations. Some people may subconsciously have the impression that Western methods are superior, which can manifest itself in affirming ideas or avoiding criticism. In the past, showing socially desirable behaviour was a way of feeling secure within an unequal system. Although that context has changed, such patterns can live on, sometimes without being aware of it.

To approach this carefully, we deliberately adopted a critically reflective attitude towards our own role. We realised that our presence could never be completely neutral and tried to create as open and safe a space as possible, in which conversation partners felt free to share their opinions. Specifically, we did this by actively listening, using neutral language, not expressing judgements on sensitive topics, such as female genital mutilation (FGM), and emphasising that honest feedback is welcome and valuable, even when it differs from our own ideas.

We also experienced moments of genuine openness and authenticity. Some participants expressed clear and at times critical viewpoints, even if these did not align with what they might have thought we wanted to hear. Others held firmly to their own traditions and beliefs. This shows that social desirability may have been there, but no longer as a dominant attitude. In that diversity of voices, we found valuable insights that deepened and enriched our project.

FEMALE GENITAL MUTILATION (FGM)

An important reflection during our session on female genital mutilation (FGM) was the complex intertwining of religion and culture. Although literature and our conversation with a local imam indicated that FGM is primarily a cultural practice, we saw that many young people in Basse actually experienced it as a religious obligation. Interpretations varied widely: from young people who believed it to be fully religiously supported, to others who found it acceptable only in certain forms and again others who rejected any religious justification. This variety of perspectives showed that religion and culture are strongly intertwined in young people's perceptions and not easily distinguishable.

That complexity also emerged during the session itself. We had prepared a PowerPoint listing four common motives for FGM: social, cultural, economic and religious reasons. These were based on our literature study and the conversation with the imam. The participants' opinions did not always correspond with this, especially regarding religion. That brought a certain discomfort with it: we did not want to undermine their experiences or impose anything on anyone during this session.

We noticed that religious topics require particular sensitivity. For example, the participants spoke about the prophet with great reverence and never used his name literally. We followed that example, out of respect. Such subtle cultural signals reminded us how important it is to use language carefully, especially when dealing with sensitive topics.

Because of the differing viewpoints, we had to regularly consult and align with each other on the spot, searching for words that allowed space for the experiences of the young people without pushing our own perspective too strongly to the forefront. That required flexibility, mutual coordination and a lot of attention to group dynamics.

The discussion also touched on broader psychological themes, such as identity and cognitive dissonance. For some young people, it can be confronting to hear viewpoints during such a session that contradict what they have been taught from a young age. We were confused by the different stories and opinions in this discussion, but how do local adolescents deal with contradictory information that clashes with what they have been taught as truth from an early age? This is not something that was caused by our presence, but rather a dynamic that already existed within the community itself.

The diversity of opinions made it clear that even within one community there is no uniform view on FGM. That led us to a critical reflection on our role as external facilitators. How can we create space for multiple perspectives without coming across as normative? How can we contribute to awareness without giving the impression that we bring the 'right' answer?

This experience highlighted for us how important it is to work with modesty, openness and continuous self-reflection in intercultural contexts.

6.3 SUGGESTIONS FOR IMPROVEMENT, DEEPENING AND POSSIBILITIES FOR A FOLLOW-UP PROJECT

Here we illustrate suggestions, elaborations and improvements in function of the further development of the project: sex education. First of all, we propose to further invest in local community initiatives. An example of this is Basse Got Talent, which can act as a valuable bridge to different communities. By utilizing their network and creative approach, we can reach young people and other target groups in an accessible way.

In the development of this bachelor thesis, we involved Basse Got Talent to a lesser extent, which led to the loss of useful networks and information. At the same time, we see potential in continued collaboration with the organization The Gambian Red Cross Society and new collaborations with the organization Family Planning. Through them, we can not only obtain materials such as condoms, but also gain access to additional locations to organize sessions.

We would like to indicate that aiming to reach more locations, with the ambition to cover multiple themes per session, is highly recommended to increase the reach of the project. In this way, we can spread a wide range of information without having to return to the same community repeatedly. This more efficient approach makes it possible to reach a larger group of people with limited resources. However, we do want to emphasize that, as with our thesis, it is interesting to ensure that all themes are presented to the same group, so that they get a complete picture of the project.

We see the involvement of religious leaders and the older generation as an important next step in the project. By engaging in dialogue with different generations, we create a broad picture of how sexual education takes shape in Basse, where tradition and renewal can reinforce each other. Reaching the older generation and religious leaders is important to get the community on board with the project. Religious leaders are active within both Islam and Christianity. In our project, the emphasis was mainly on Islam, as the majority of our participants were Muslim, and Islam is the dominant religion in Basse. However, we recommend that in a next phase of the project, more attention be paid to Christianity as well, in order to create broader support within the community.

When designing the sessions, active and visual work methods must continue to be used. Games, visualizations and metaphors increase engagement, but there must also be strict attention to purposefulness. Playing should not lead to carelessness but should stimulate knowledge and understanding. For example, the board game, in which participants needed substantive knowledge to move forward, proved to be particularly effective. Game forms that rely purely on guessing, such as the memory game, we would avoid in the future. An metaphor (like our house-system) can be used to help participants make connections and better understand and remember the content.

Another powerful element we would recommend is the use of testimonials and personal stories. By sharing cases in which sexual education had a positive impact, we make the content relatable and tangible. This not only enhances the learning process but also strengthens emotional engagement with the theme.

Furthermore, we suggest to introduce sexual education within healthcare institutions. By working together with the hospital, for example with social workers in the hospital, we gain access to a target group already engaged with care and recovery. This offers a unique opportunity to give sexual education a place within a broader healthcare context.

Finally, we would like to further introduce the Flag System as a framework to evaluate sexually transgressive behaviour and formulate appropriate responses. Collaborations with partners such as Mr. Kelepha Koita, assistant social worker and the involvement of schools are essential. By implementing this framework in education, we can not only identify behaviour but also think about concrete follow-up steps and appropriate support after an incident has been observed.

7. FINAL REFLECTIONS

7.1 SILKE COLPAERT

What a four months... So much learned, so much experienced, so many unforgettable memories made. My stay in The Gambia as part of a MOW project on sex education was an intense and educational period. In this reflection, I look back at the path I took in writing my bachelor's thesis. I reflect on the obstacles I encountered, the personal growth I experienced and the way this project broadened my perspective on professional healthcare.

One of the most important skills I strengthened during this project is my communicative ability within international collaboration. I learned to communicate clearly and respectfully about complex topics, taking into account language barriers, cultural differences and diverse values. Through this project, I developed my planning and organizational skills, especially as we often had to adapt to feedback and unexpected changes. This constant need for flexibility also impacted my personal work habits. I used to postpone tasks and work late into the night, but I've now found a more balanced rhythm: starting earlier, working consistently and finishing on time. I've come to realize how much clarity and calm good planning can bring and that's something I definitely want to take with me into my future academic and professional career.

We had to stand our ground and this made my self-confidence grow: I dare to take initiative more quickly, make decisions in uncertain situations and make my voice heard in group settings. Finally, I learned to work together in a multidisciplinary and intercultural team, an experience that has made me professionally stronger.

While giving sessions around sex education, I soon noticed that feeling the group was crucial. I developed more sensitivity to group dynamics, as this was really needed. Especially as we brought up topics that were sensitive or considered taboo. I learned to listen more attentively, read more between the lines and pick up on non-verbal signals. Learning to switch between group levels, ages and gender relations also required flexibility and a high degree of empathy. I learned to adjust my language and tone to the comfort level of the group and to leave room for questions, doubts and silence.

I learned that sensitivity and respect are essential when working in a different cultural context. We addressed topics such as female genital mutilation and contraception. These are subjects that, in some Gambian communities, are considered very sensitive or taboo. I learned to listen with curiosity rather than speak from my own frame of reference. We worked together with local partners who helped us shape our sessions in a culturally appropriate way. Sometimes that meant avoiding certain words, sometimes it meant taking more time to first build trust before discussing difficult topics.

My future plan before I left was to study Clinical Psychology at UGent and that has not changed, but I have started to look at the possibilities for my future with a much broader perspective. There has always been something in me that is deeply interested in the international, in collaboration and in getting to know other cultures, frames of reference and countries. I've started to realize that this doesn't only have to remain an interest, but that I can absolutely do something with it. There are so many different ways to engage in international collaboration in a professional context and I hope that I can truly integrate this passion into my career in the future. This experience made me realize that working in a multicultural context not only challenges me, but also inspires and energizes me.

7.2 CARO DUVILLERS

In this reflection, I look back on the process of writing my thesis on sex education. I reflect on the challenges I encountered along the way, the insights I gained and how all of this has influenced my professional development.

During the research, I learned to place theoretical information within a broader, international framework. Also, how important it is to include religious and cultural influences in the development of sensitive topics, such as contraception or FGM. I learned to work flexibly and to always take possible obstacles into account. I made sure that alternatives were available, such as using a poster instead of a PowerPoint presentation, when that better suited the context or target group. This flexible mindset helped me deal with unexpected situations while still ensuring the quality of my work.

Throughout the process, I gained a deeper understanding of sustainability. I realized that my work should not only be efficient but also have a long-term effect. This insight taught me to evaluate my decisions more critically. By thoroughly researching the target group and learning level, I learned how to tailor my work more effectively.

Working in an international context was particularly enriching. Dealing with cultural differences, adjusting communication and collaborating with people from different backgrounds broadened my perspective and strengthened my intercultural competencies. I learned to be open to other worldviews, to reflect on them in a neutral and clear way and to remain flexible in my working methods.

I also encountered some concrete difficulties during this project. The first challenge was dealing with the sensitivity of the topic of sex education. In Gambia, this remains a taboo subject, which made it difficult to gather objective and reliable information. Therefore, integrating various cultural and religious perspectives was not a simple task. It required a great deal of effort to represent conflicting views accurately, without falling into judgments or generalizations. It was sometimes challenging to distance myself from my own frame of reference and to listen to new opinions without bias.

While giving the sessions, I also experienced that it was sometimes difficult to keep the group quiet and to clearly take on my role as a facilitator. My natural tendency to be flexible led me to not set my boundaries clearly enough. Fortunately, I could count on the support of my fellow student. We formed a good team and thanks to her regular, honest feedback, I was able to adjust my attitude towards the group. She encouraged me to show more self-confidence and to set my boundaries more clearly. This collaboration helped me to stand stronger in my shoes and to improve my communication skills.

Although my future plan to study Clinical Psychology at UGent has not changed, this project has made me reflect on other possibilities. I have started to consider the idea of working with migrants in the future or participating in international projects. The contact with different lifestyles, cultures and religions showed me how valuable it is to keep learning, not only about the world around me but also about myself. By challenging yourself to function in a new context, you continuously rediscover who you are and how you grow as a person.

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9. ATTACHMENTS

ATTACHMENT 1: SESSION - SEX EDUCATION

POSTER – SEX EDUCATION

INTRODUCTION ON SEX EDUCATION

What is sex education?

- It is literally education about sex.
- Young people go through a sexual development.
- Parents or other educators, such as teachers, have the responsibility to guide the young person in this process.
- The educator does this by:
  - Answering questions
  - Teaching young people to recognize and accept their boundaries
  - Teaching people how to have safe sex, use contaception and about sexually transmitted disease (STD's).

What is sexuality?

- Sexuality is your feelings, thoughts, beliefs, desires, and behaviors that are sexually related.
- Sexuality is a very broad concept. It is tied to your gender, reproduction, intimacy, and more.
- During puberty, young people start to show more and more interest in sexual activities, such as a first kiss.

What is the purpose?

- Young people who have a positive feeling about their bodies and can talk about sexuality are more resilient. They are able to stand up for themselves.
- A safe environment is created for the young person because they have knowledge about contraception, STDs and know where to go with any questions they might have.
- Parents may not talk about this to their children. Therefore, space is made in education for discussing these topics. Different perspectives on sexuality are also presented.
- Young people often come into contact with stereotypical, misogynistic and one-sided images of sexuality. By offering a counterbalance to this, their resilience is strengthened.

Positive outcomes

- Fewer unplanned pregnancies
- Fewer sexually transmitted infections
- Increased resilience
- Better self-esteem and body image
- A critical view on perspectives of sexuality
- Less fear/taboo about seeking help
- Better communication on the topic

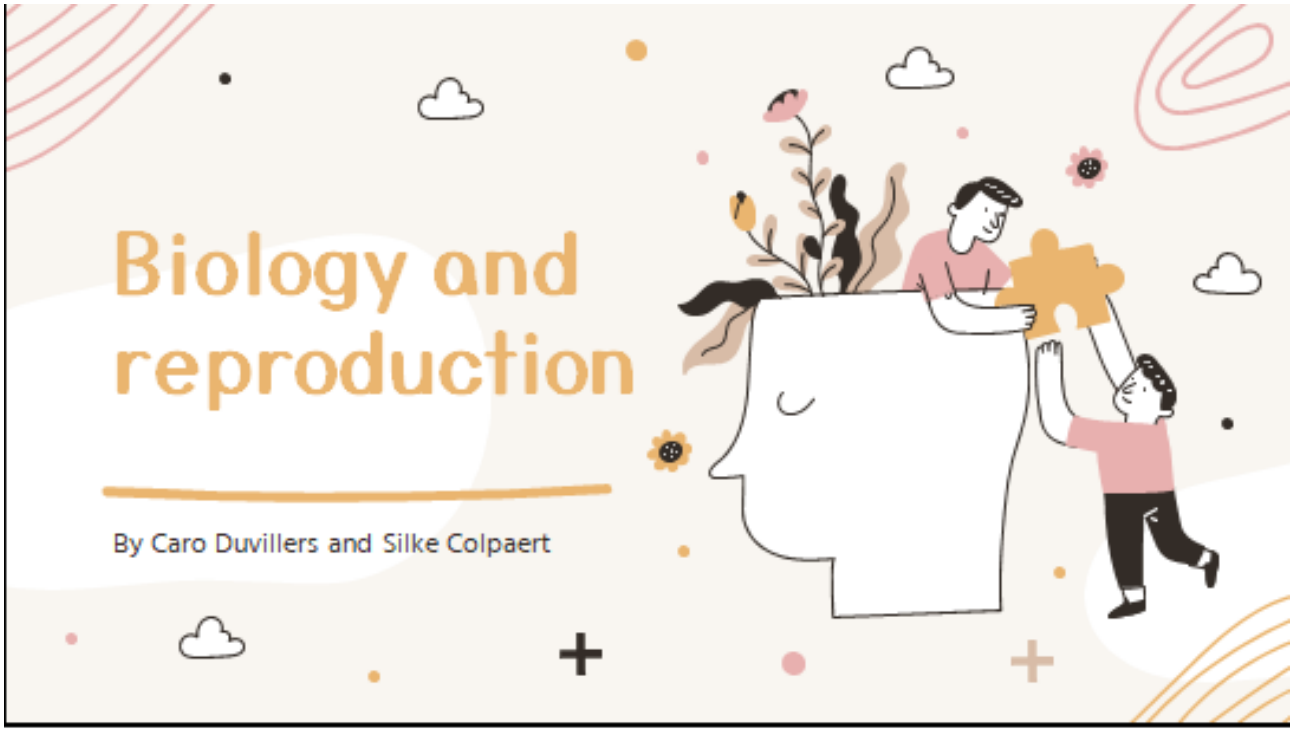
Domains of sexuality?

- The biological and physical development: Growth of the genitals and primary and secondary sexual characteristics, physical changes at puberty, body and self-image, body care and physical disorders.
- Psychosocial development, including: sexual behavior, sexual feelings (desire, arousal, (sexual) relationships and dealing with images in the media.
- Fertility, reproduction, contraception and family formation

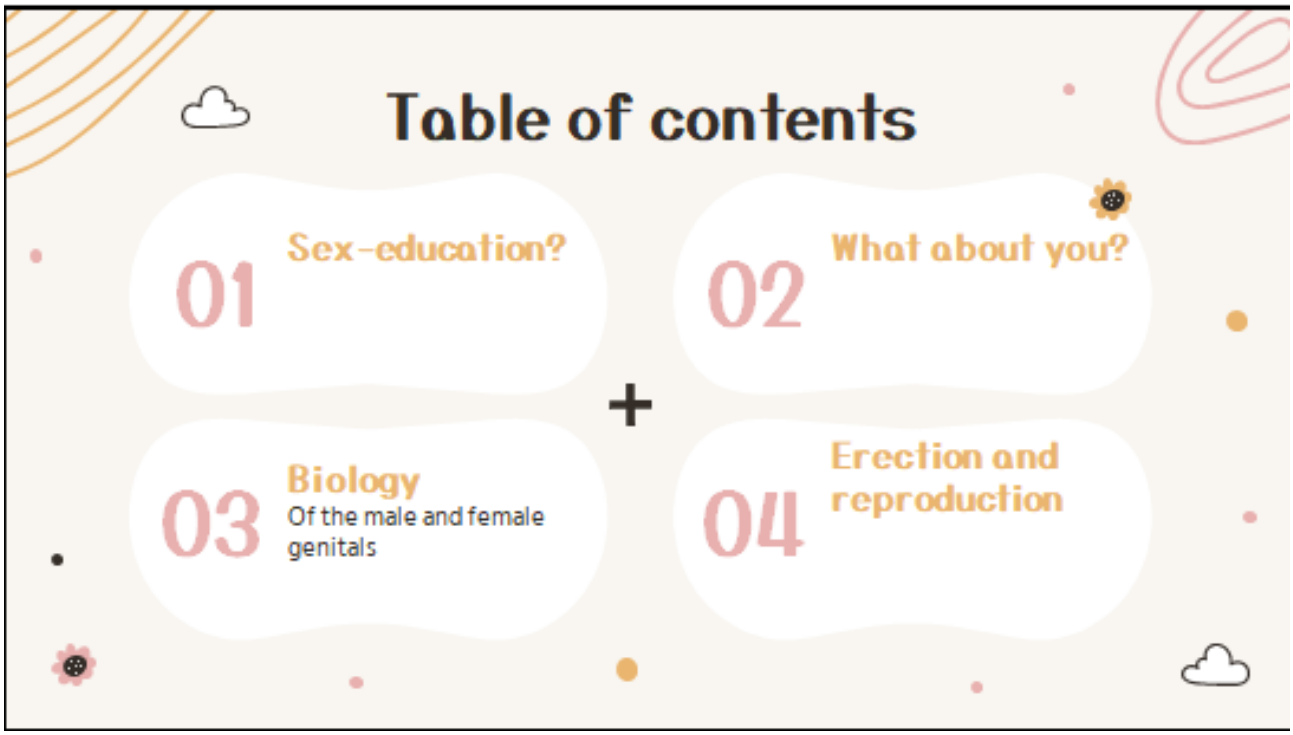

SEX EDUCATION
BIOLOGY AND REPRODUCTION
PUBERTY AND MENSTRUATION
STD's
CONTRACEPTION
FGM
CONSENT AND BOUNDARIES

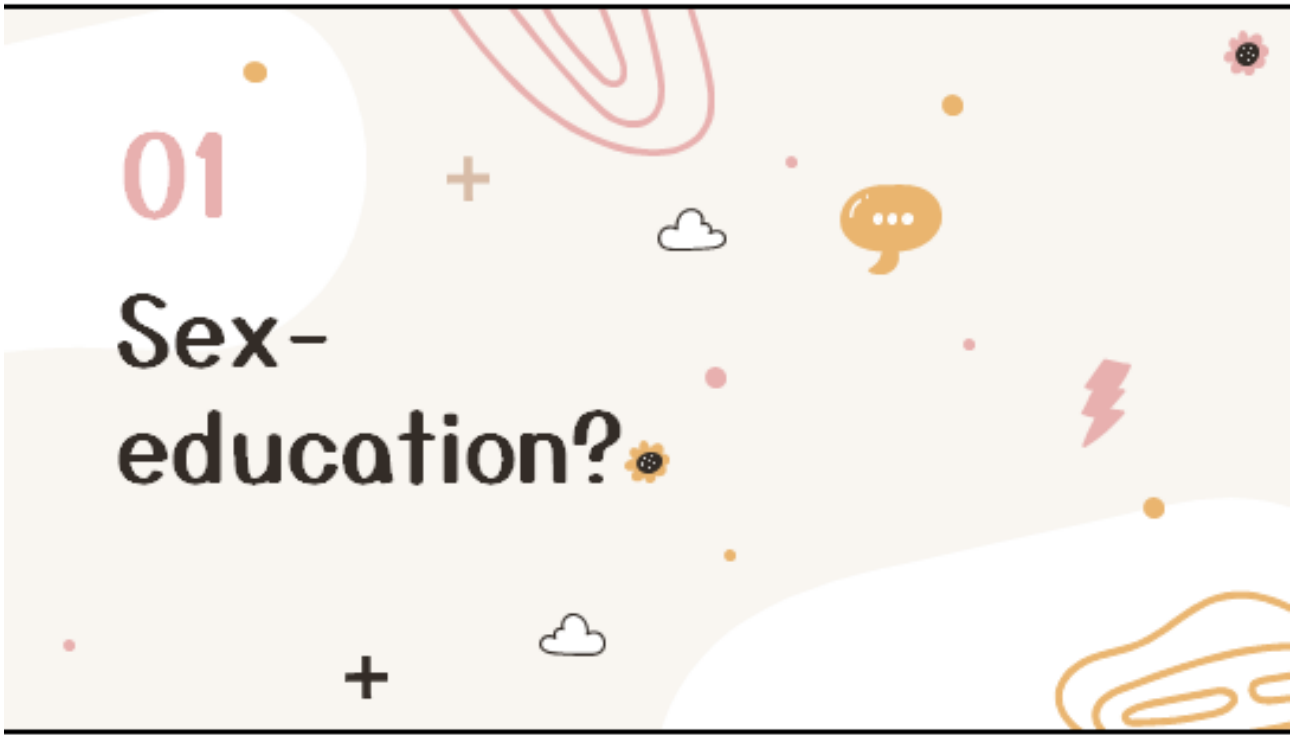
ATTACHMENT 2: SESSION - BIOLOGY AND REPRODUCTION

POWERPOINT 1 – BIOLOGY AND REPRODUCTION

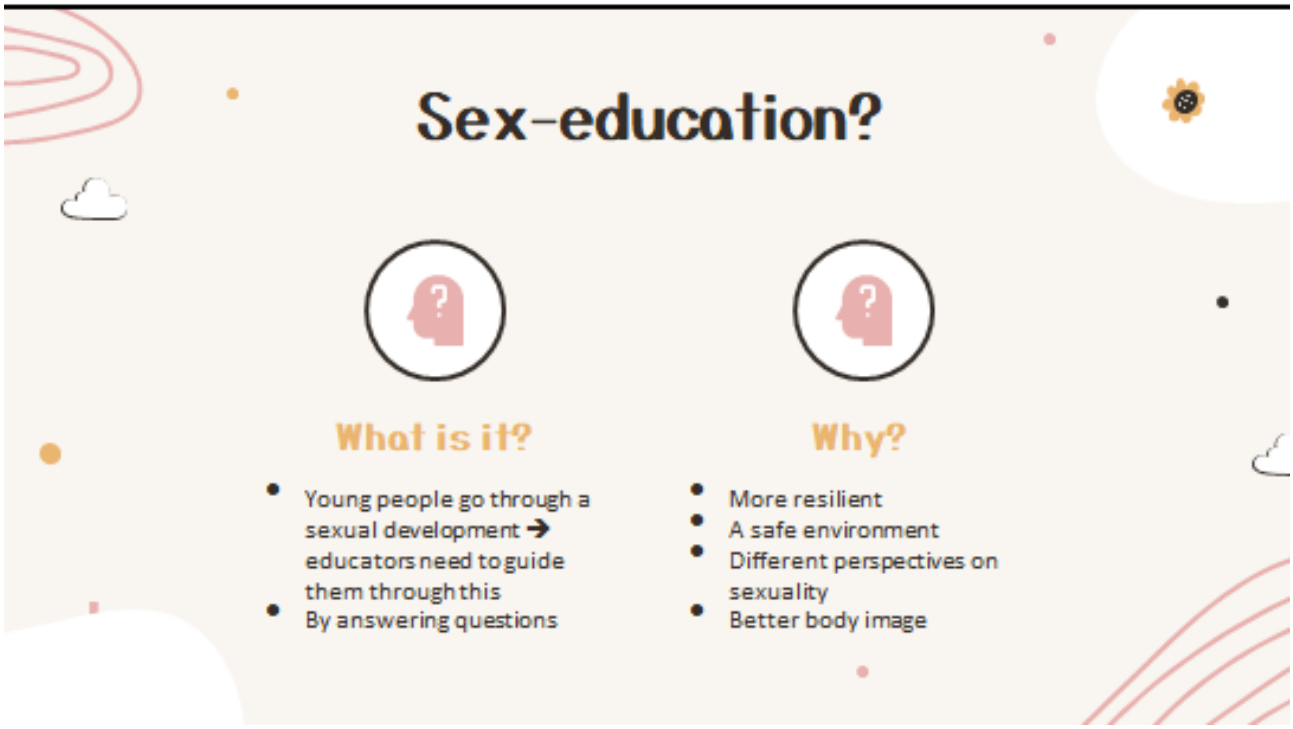


1

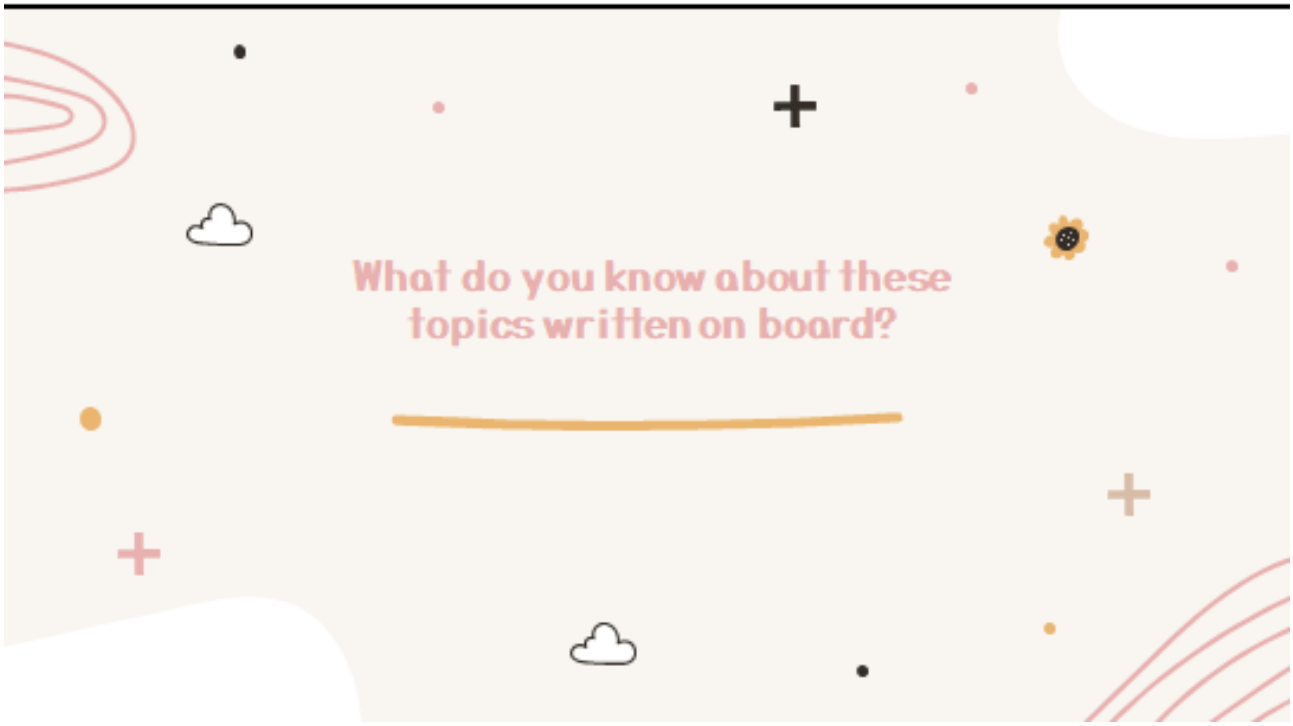



01
Sex-education?

3


Sex-education?
What is it?
Young people go through a sexual development → educators need to guide them through this
By answering questions
Why?
More resilient
A safe environment
Different perspectives on sexuality
Better body image

5



The topics written on board were: Sex education and reproduction

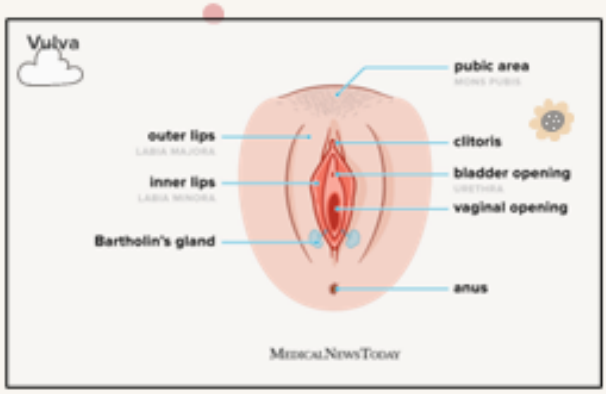
03

Biology

7

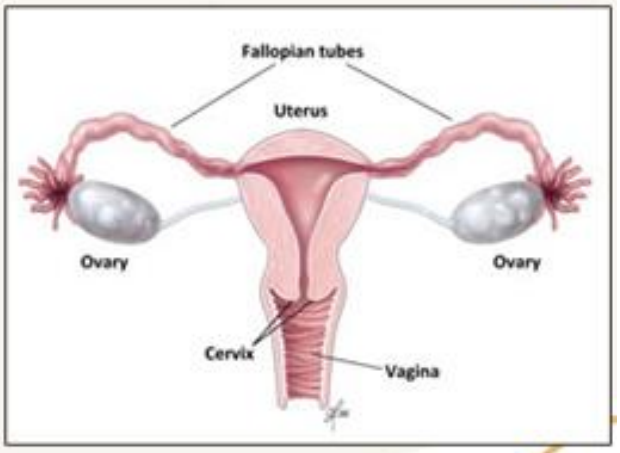
Biology of the female genitals (outer parts)

- **Vulva**: Outsite parts of the female genitals. It protects the internal genital organs.
- **Large (outer) labia**: They protect the vagina and bladder opening for dirt and infections
- **Small (inner) labia**: They protect the vaginal opening, clitoris and the bladder opening and keep everything hydrated and flexible.
- **Clitoris**: Is a small sensitive organ that plays an important role in women's sexual pleasure.
- **Pubic hair**: hair that grows on the genital area
- **Bladder opening**: Only for urination
- **Vaginal opening**: Opening to the vagina



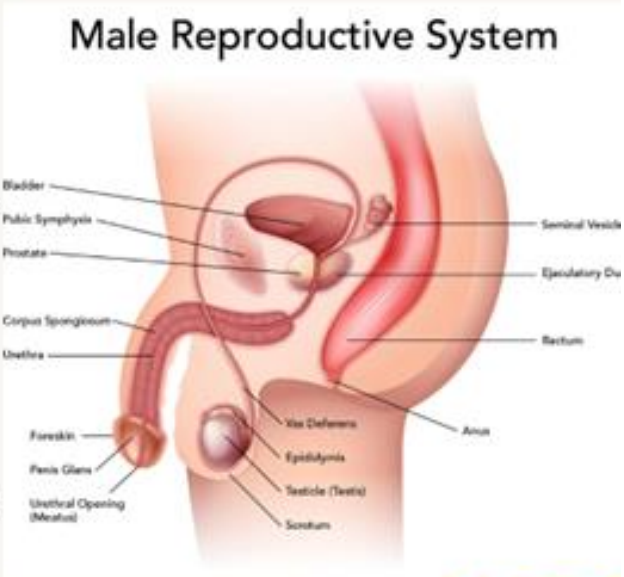
Biology of the female genitals (Inner parts)

- Vagina: Connects the outside of the body to the uterus
- Uterus: Houses and nourishes the developing foetus during pregnancy
- Cervix: Separates the uterus from the vagina and regulates the passage of menstrual blood and sperm
- Ovaries: Produce eggs and hormones such as oestrogen and progesterone
- Fallopian tubes: Catch the eggs and are the place of fertilisation



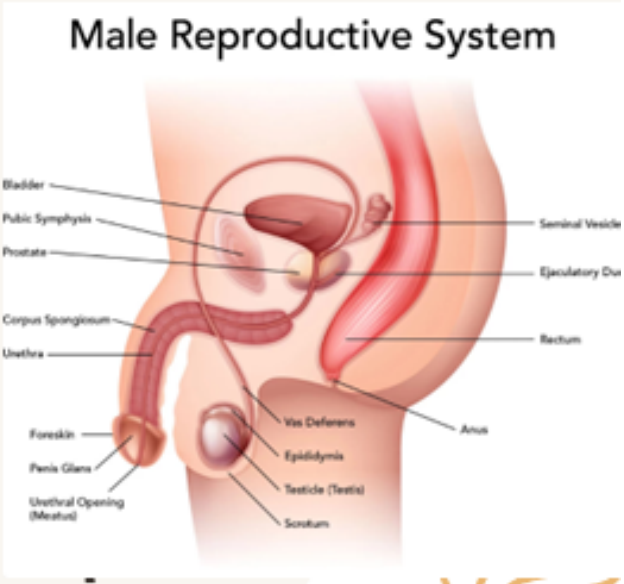
Biology of the male genitals

- Penis: Serves for sexual activity and excretion of urine.
- Glans of the penis: The glans is the rounded tip of the penis. It is highly sensitive and plays a major role in sexual arousal
- Shaft: the long, cylindrical part of the penis between the base and the glans
- Scrotum: Contains the testes and regulates their temperature for sperm production
- Testes: Produce sperm cells and the hormone testosterone
- Epididymis: Stores and matures sperm cells.
- Prostate: Produces fluid that forms part of sperm and supports sperm
- Urethra: Directs urine and semen out of the body through the penis

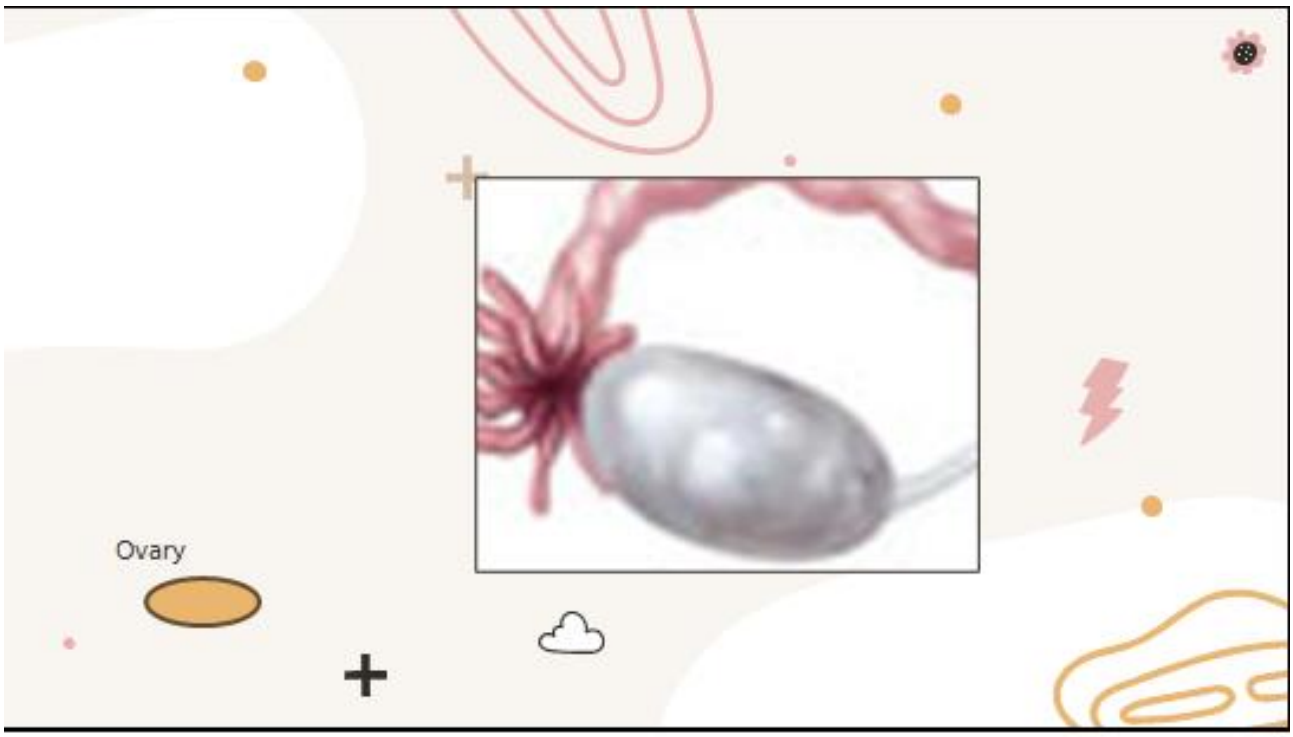


Biology of the male genitals

- **Swelling glands:** Swelling glands refer to the corpora cavernosa and corpus spongiosum. These are spongy tissues in the penis that fill with blood during an erection, making the penis stiff.
- **Vas deferens:** The vas deferens are long tubes that transport mature sperm cells from the epididymis to the urethra during ejaculation.
- **Seminal vesicles**: The seminal vesicles are two small glands located behind the bladder. They produce a fluid rich in sugars and other substances that energise the sperm cells and help them survive.
- **Cowper's Glands**: The Cowper's glands, also known as bulbourethral glands, produce a clear and slimy fluid that prepares the urethra for ejaculation.



GAME 1 – BIOLOGY AND REPRODUCTION



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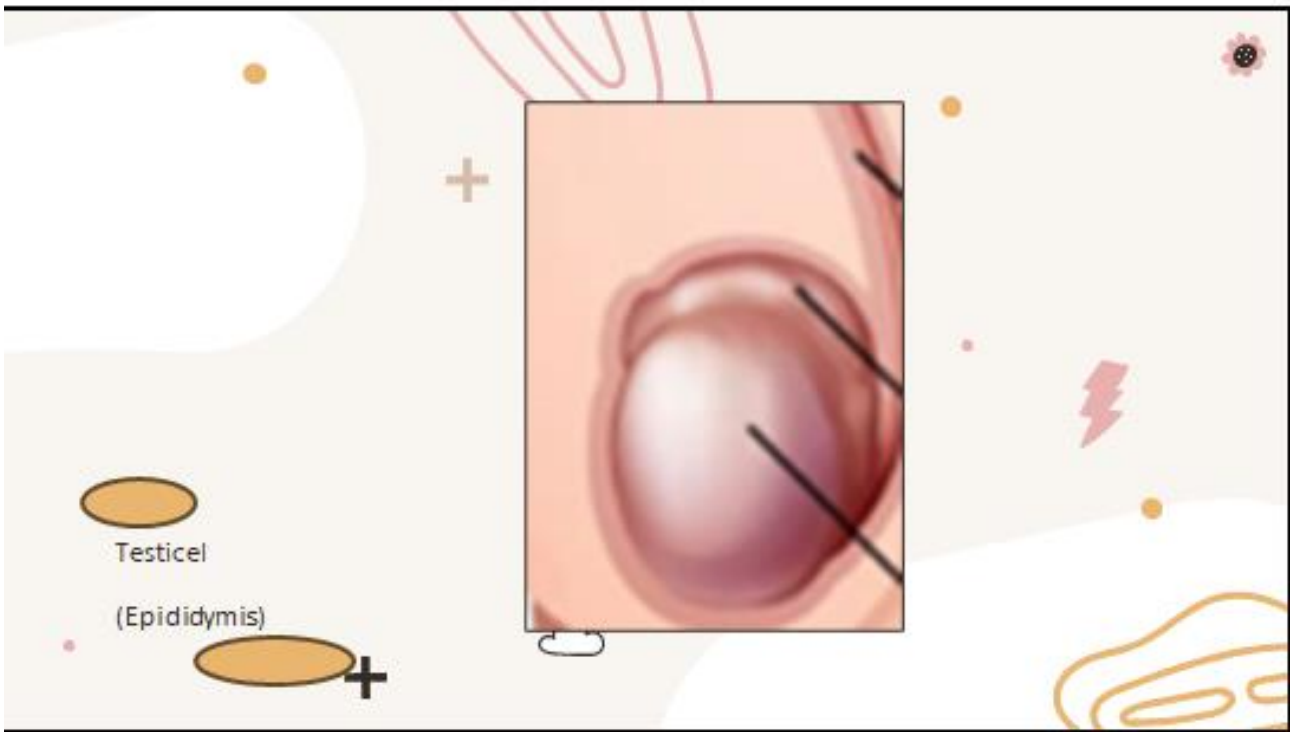

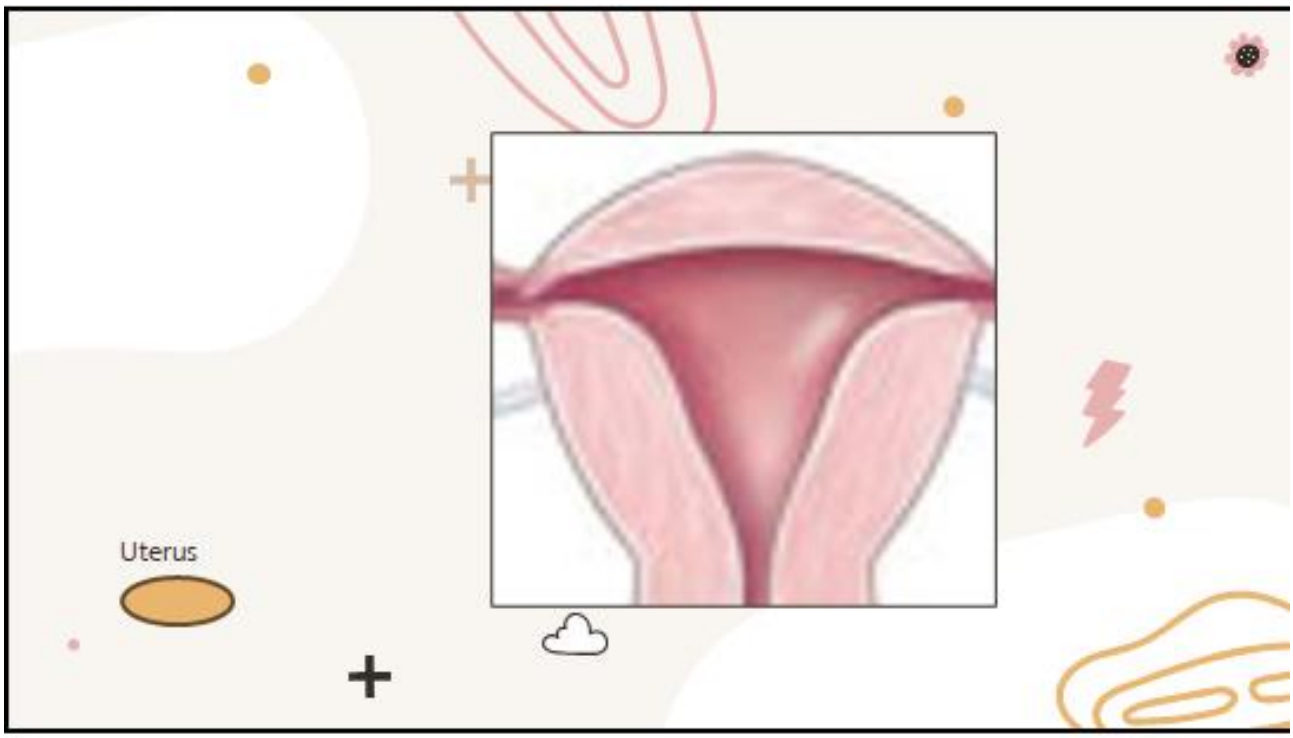

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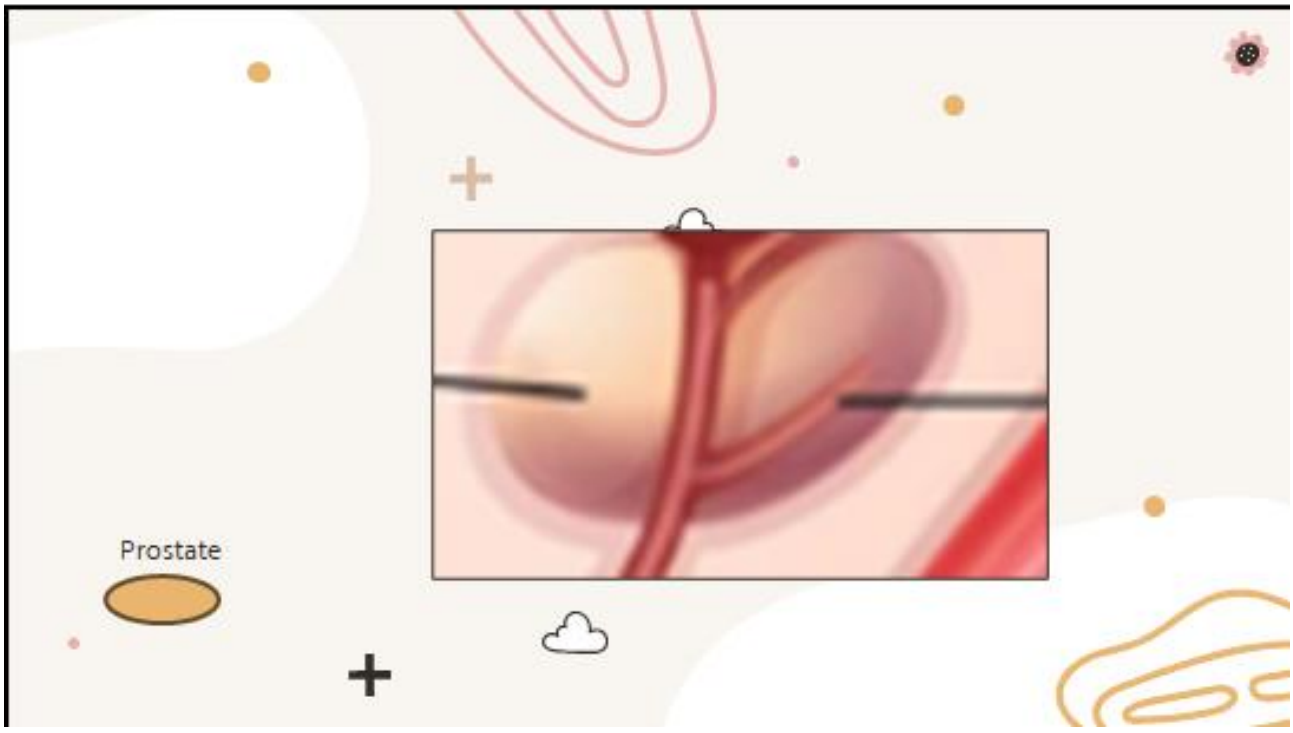

POWERPOINT 2 – BIOLOGY AND REPRODUCTION

04

Erection and reproduction

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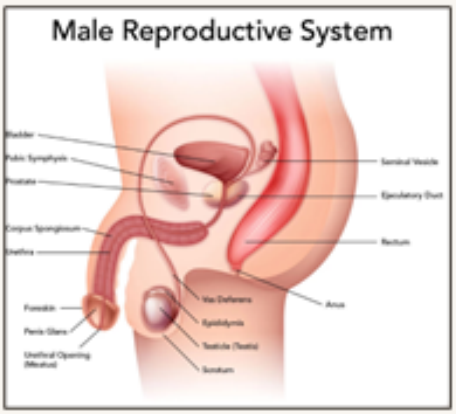
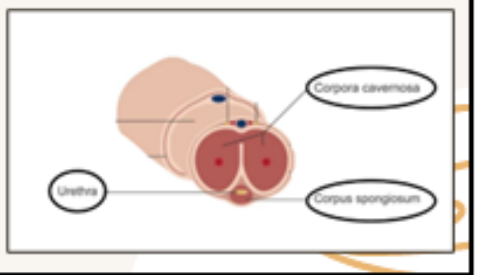
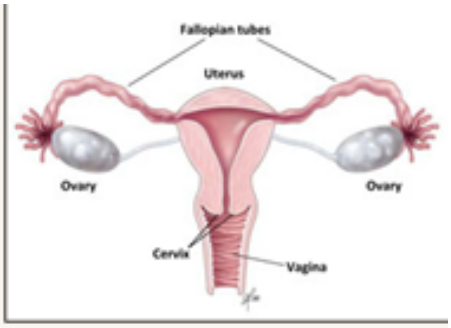
Erection

- An erection in a men is the process where the penis becomes hard and erect → combination of physical, psychological and neurological factors
- How it works:
- 1) STIMULI = An erection van be triggered → by physical or psychological stimuli, such as sexual arousal, touch, thoughts or dreams.
- 2) NERVE SIGNALS = The brain receives signals indicating a sexual arousal → nerve signals send to the penis → signals cause blood vessels to expand
- 3) INCEASED BLOOD FLOW = Occurs because the arteries bringing blood to the penis widens → the veins that carry blood away from the penis narrow → blood stays longer in the penis
- 4) FILLING OF THE SWELLING BODIES = The penis consists of two corpora cavernosa and a third corpus spongiosum → blood flows into the corpora cavernosa → they become larger and harder → causing the erection
- 5) REDUCTION OF THE PENIS = Blood flow to the penis reduces → blood vessels tighten and blood is drained → reduction





Reproduction



- Erection and moist vagina
- Orgasm will occur (sometimes in women)
- Semen → spermcells produced from testes
- Enter the women through the orgasm of the man
- Spermcell swims into the vagina → uterus and fallopian tubes in search of an egg
- Once an egg has been released from the ovary in the woman, it can be fertilised
- Only one sperm cell may enter the egg cell = fertilisation
- The egg and sperm fuse to form a new cell, this new cell grows further in the woman's womb to form a new baby
- 9 months

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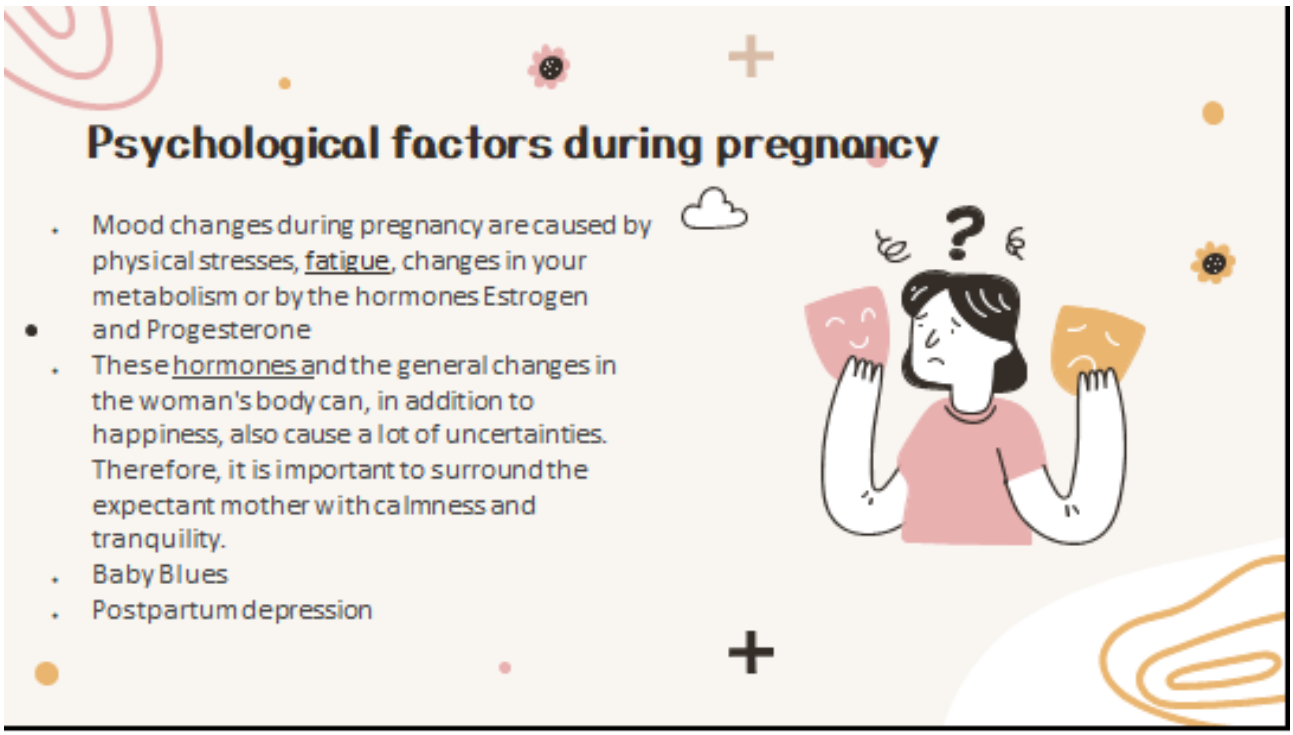
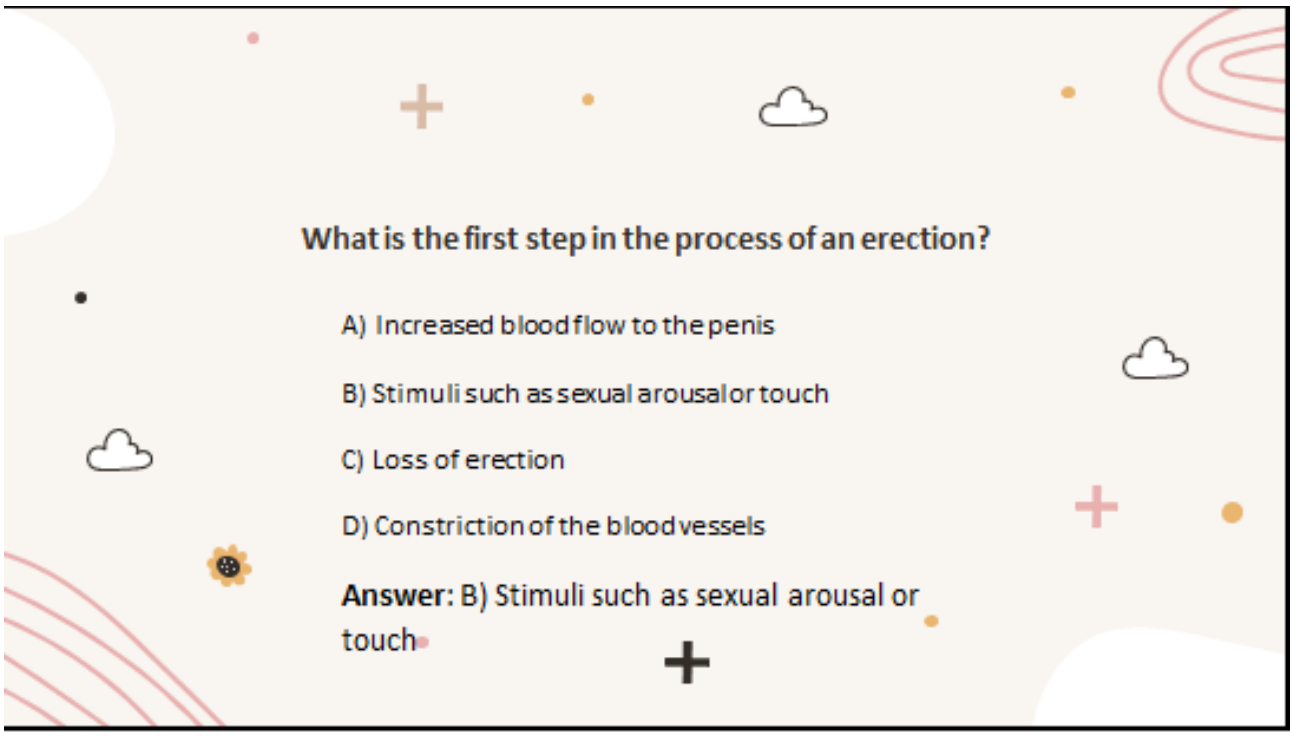
Labour

- When the baby is fully grown, it's time for labour
- Contractions are triggered = contractions of the uterus
- False labour contractions = Preparation for labour, but don't put it in motion. (Braxton Hicks contractions and prodromal contractions)
- Early labour = In this stage contractions usually last 20 to 30 seconds and come every 30 to 60 minutes. They feel like mild pain or pressure. This stage is the start of uterine dilation.
- Active labour = In this stage contractions become longer and come very 3 to 5 minutes. They are then so intense that talking or moving becomes difficult. In this stage there is an increase in dilation to 10 cm.
- Pushing contractions = When the cervix has fully opened there is a free passage, allowing the mother to push her baby out.
- Afterbirth contractions = After the baby is born, the mum still has to push out her placenta. This is an organ that develops in the uterus during pregnancy. This organ provides the baby with oxygen, nutritions and removes waste products from the baby's blood.
- After birth the baby will start crying. The mother can comfort her baby and hold it very close. This is very important for the baby's bonding


Psychological factors during pregnancy
Mood changes during pregnancy are caused by physical stresses, fatigue, changes in your metabolism or by the hormones Estrogen and Progesterone
These hormones and the general changes in the woman's body can, in addition to happiness, also cause a lot of uncertainties. Therefore, it is important to surround the expectant mother with calmness and tranquility.
Baby Blues
Postpartum depression

GAME 2 – BIOLOGY AND REPRODUCTION


What is the first step in the process of an erection?
A) Increased blood flow to the penis
B) Stimuli such as sexual arousal or touch
C) Loss of erection
D) Constriction of the blood vessels
Answer: B) Stimuli such as sexual arousal or touch

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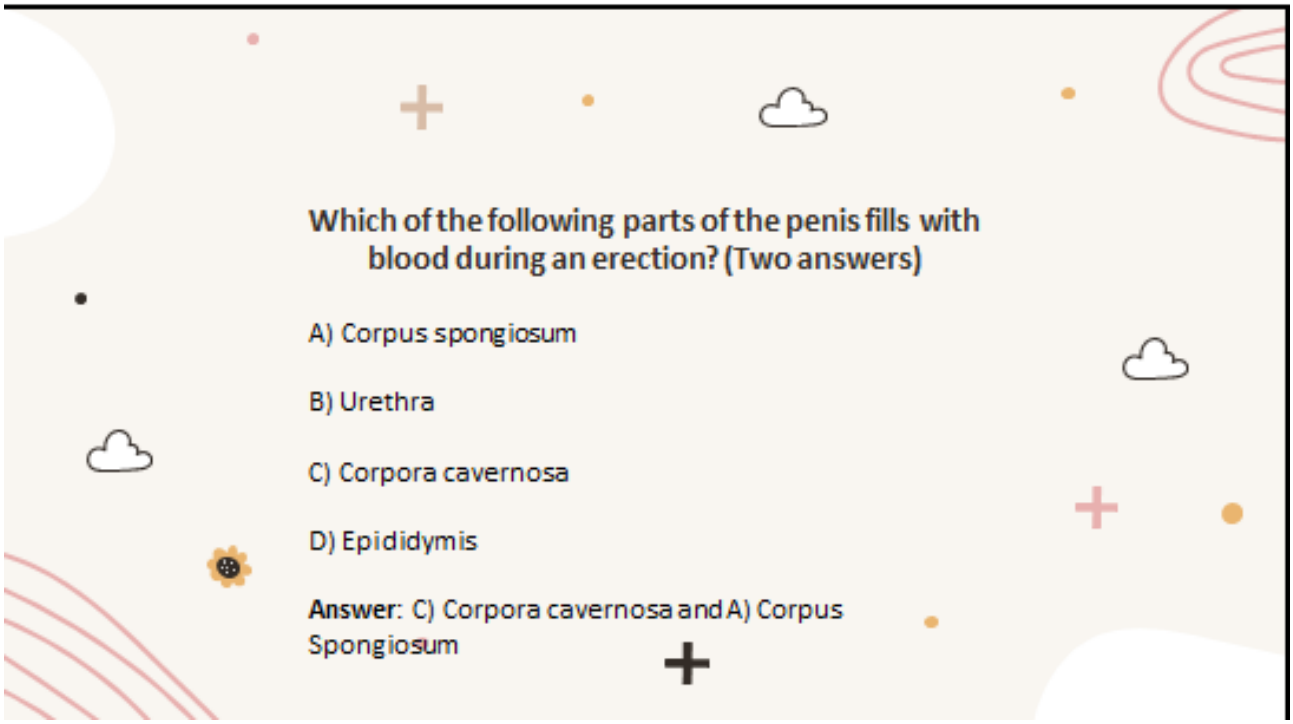
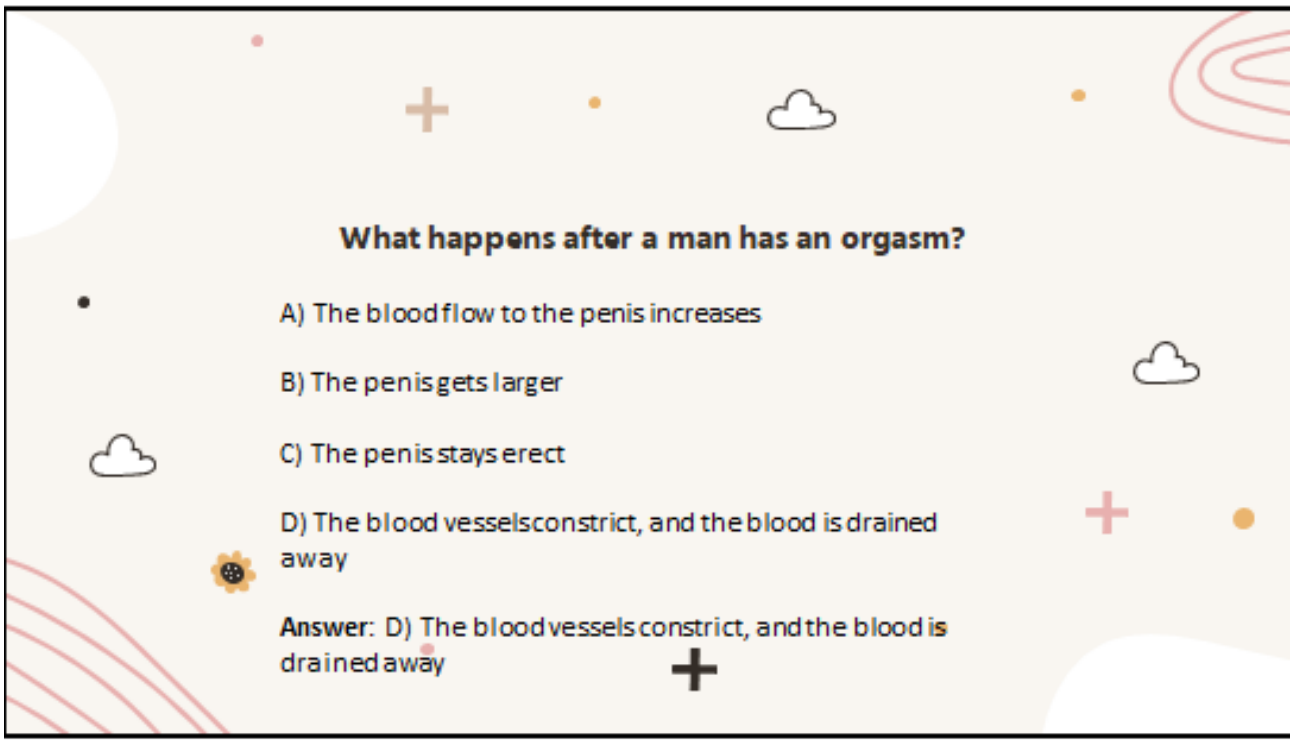

Which of the following parts of the penis fills with blood during an erection? (Two answers)
A) Corpus spongiosum
B) Urethra
C) Corpora cavernosa
D) Epididymis
Answer: C) Corpora cavernosa and A) Corpus Spongiosum


What happens after a man has an orgasm?
A) The blood flow to the penis increases
B) The penis gets larger
C) The penis stays erect
D) The blood vessels constrict, and the blood is drained away
Answer: D) The blood vessels constrict, and the blood is drained away

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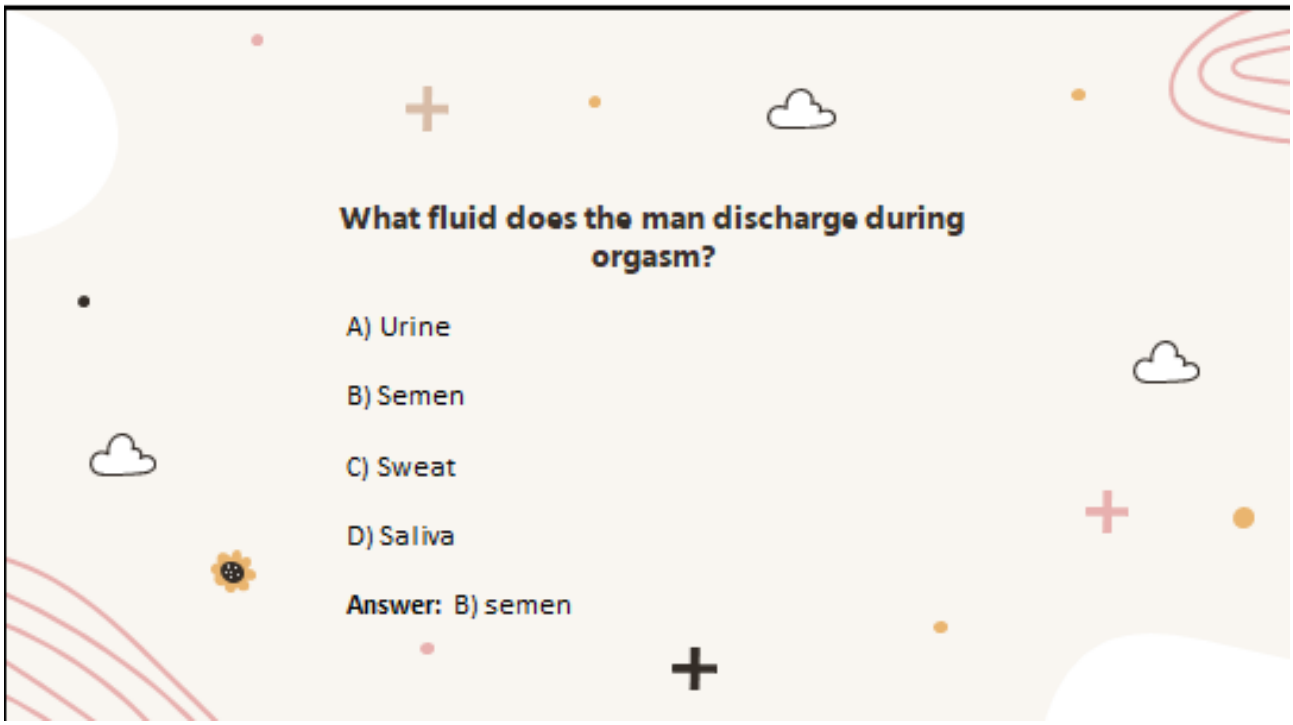
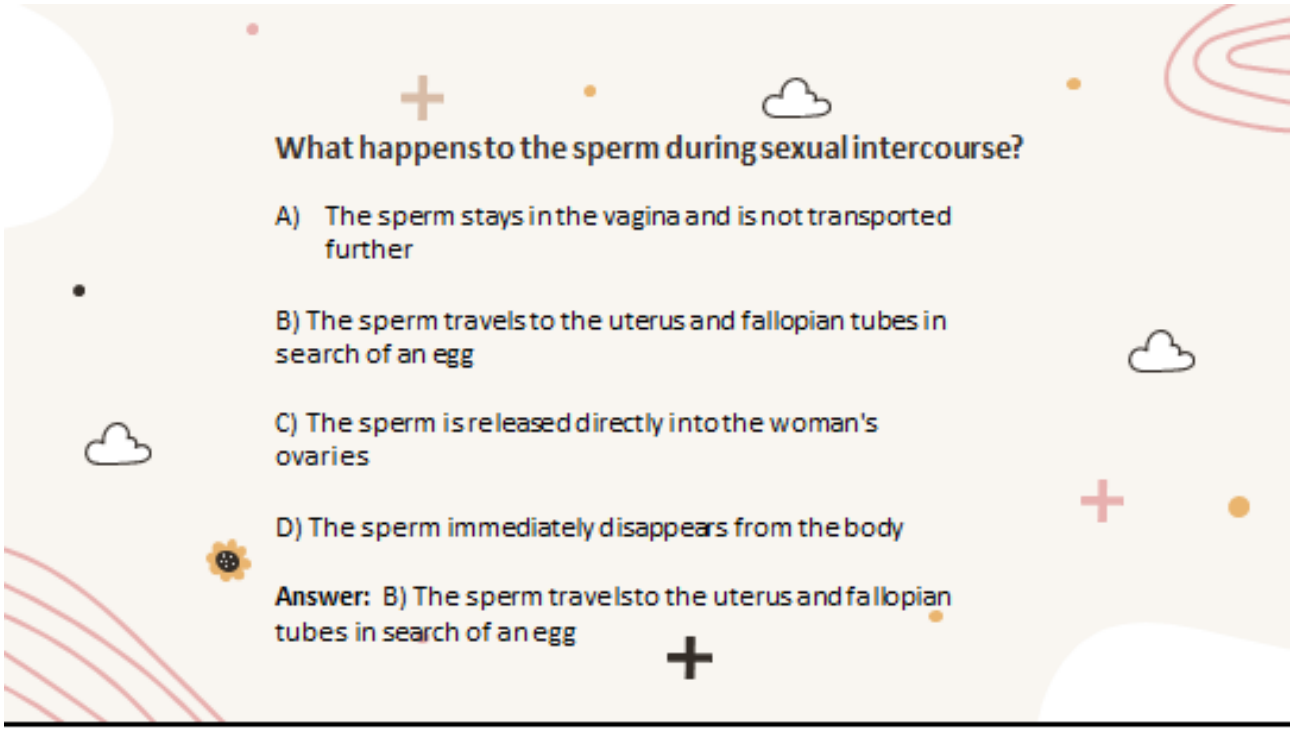

What fluid does the man discharge during orgasm?
A) Urine
B) Semen
C) Sweat
D) Saliva
Answer: B) semen


What happens to the sperm during sexual intercourse?
A) The sperm stays in the vagina and is not transported further
B) The sperm travels to the uterus and fallopian tubes in search of an egg
C) The sperm is released directly into the woman's ovaries
D) The sperm immediately disappears from the body
Answer: B) The sperm travels to the uterus and fallopian tubes in search of an egg

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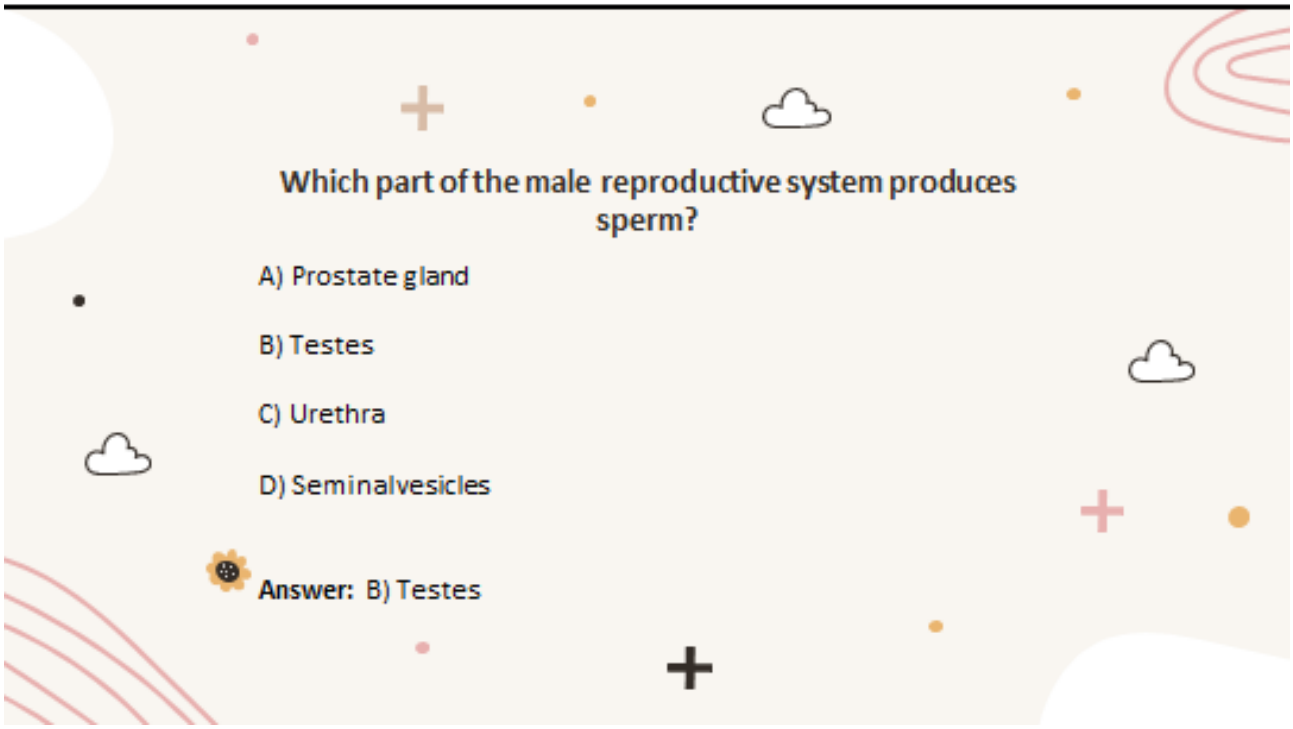
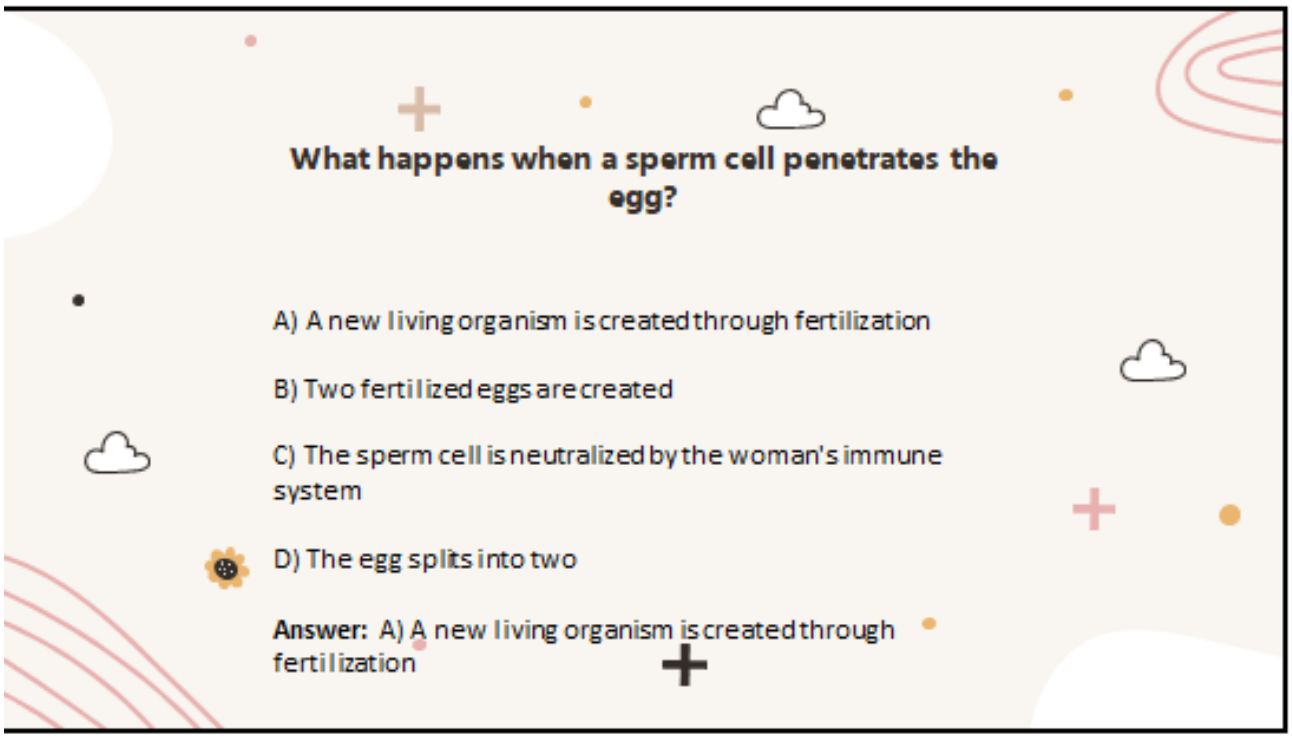

Which part of the male reproductive system produces sperm?
A) Prostate gland
B) Testes
C) Urethra
D) Seminalvesicles
Answer: B) Testes


What happens when a sperm cell penetrates the egg?
A) A new living organism is created through fertilization
B) Two fertilized eggs are created
C) The sperm cell is neutralized by the woman's immune system
D) The egg splits into two
Answer: A) A new living organism is created through fertilization

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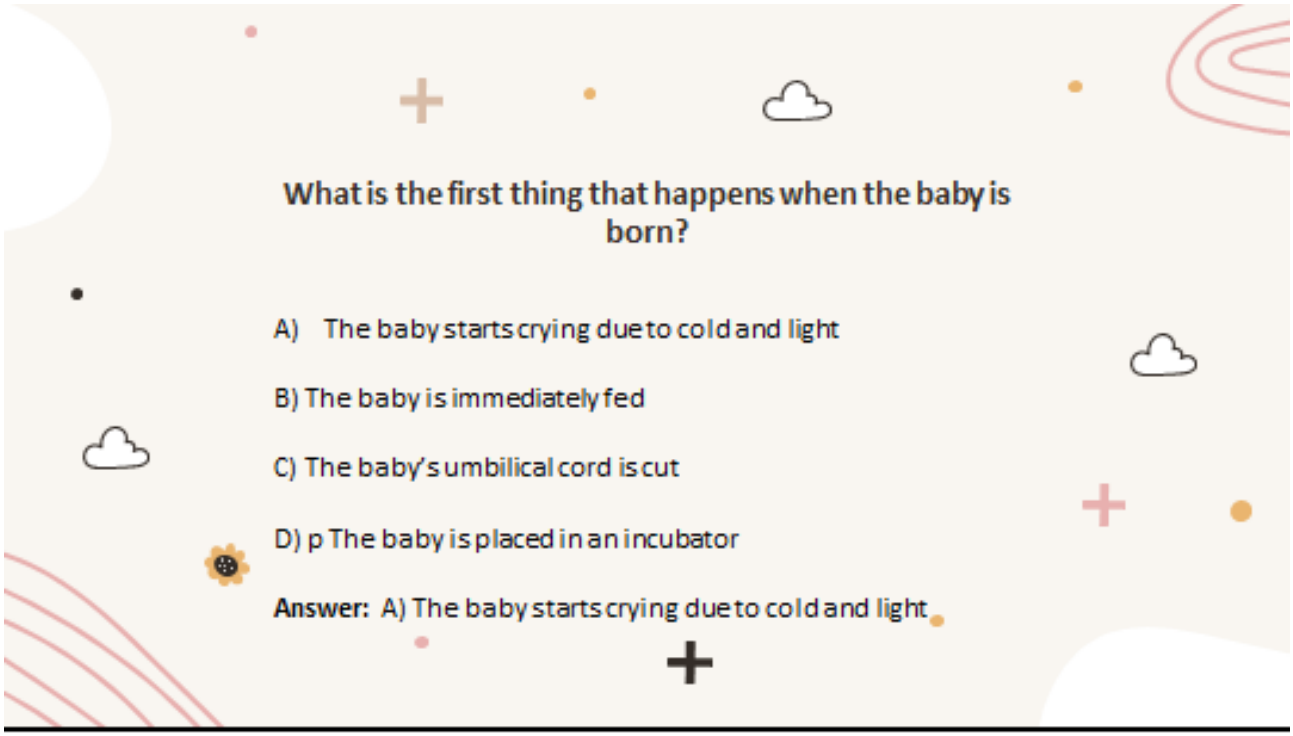
How long does the pregnancy process take in months?
A) 7 months
B) 12 months
C) 11 months
D) 9 months
Answer: D) 9 months


What is the first thing that happens when the baby is born?
A) The baby starts crying due to cold and light
B) The baby is immediately fed
C) The baby's umbilical cord is cut
D) p The baby is placed in an incubator
Answer: A) The baby starts crying due to cold and light

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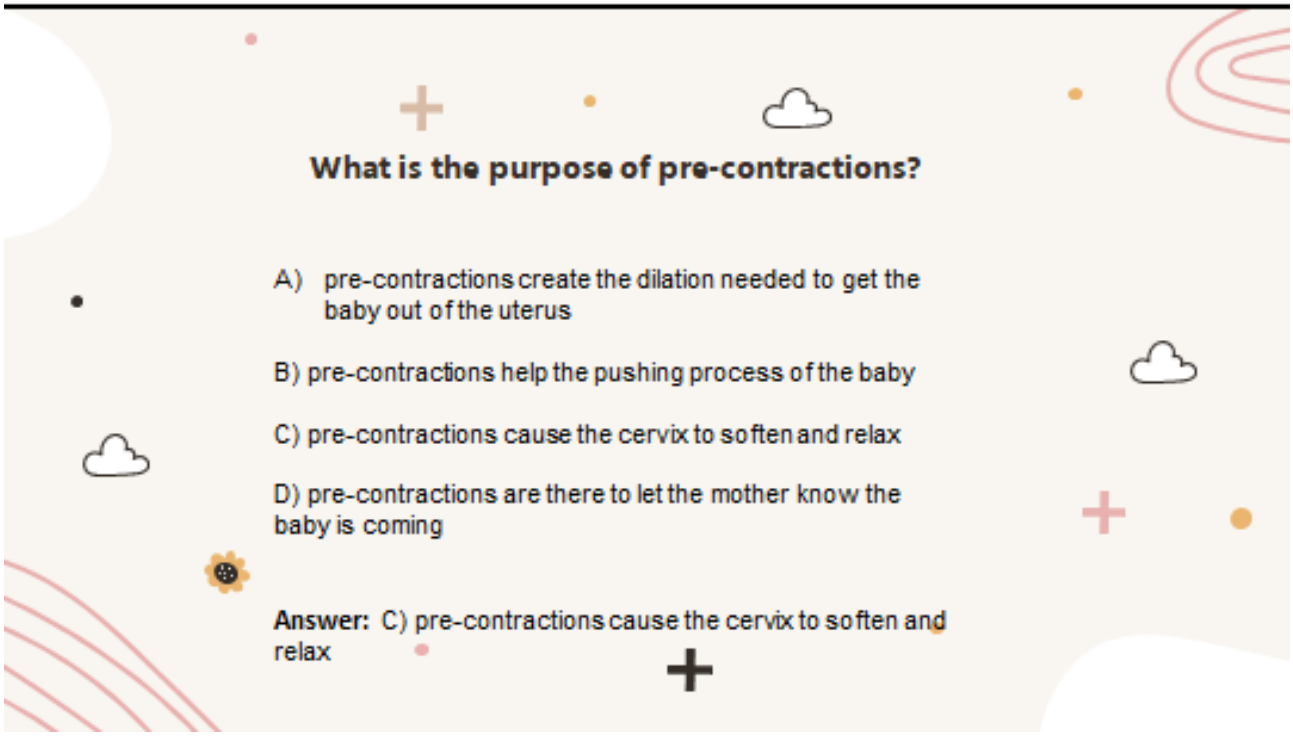
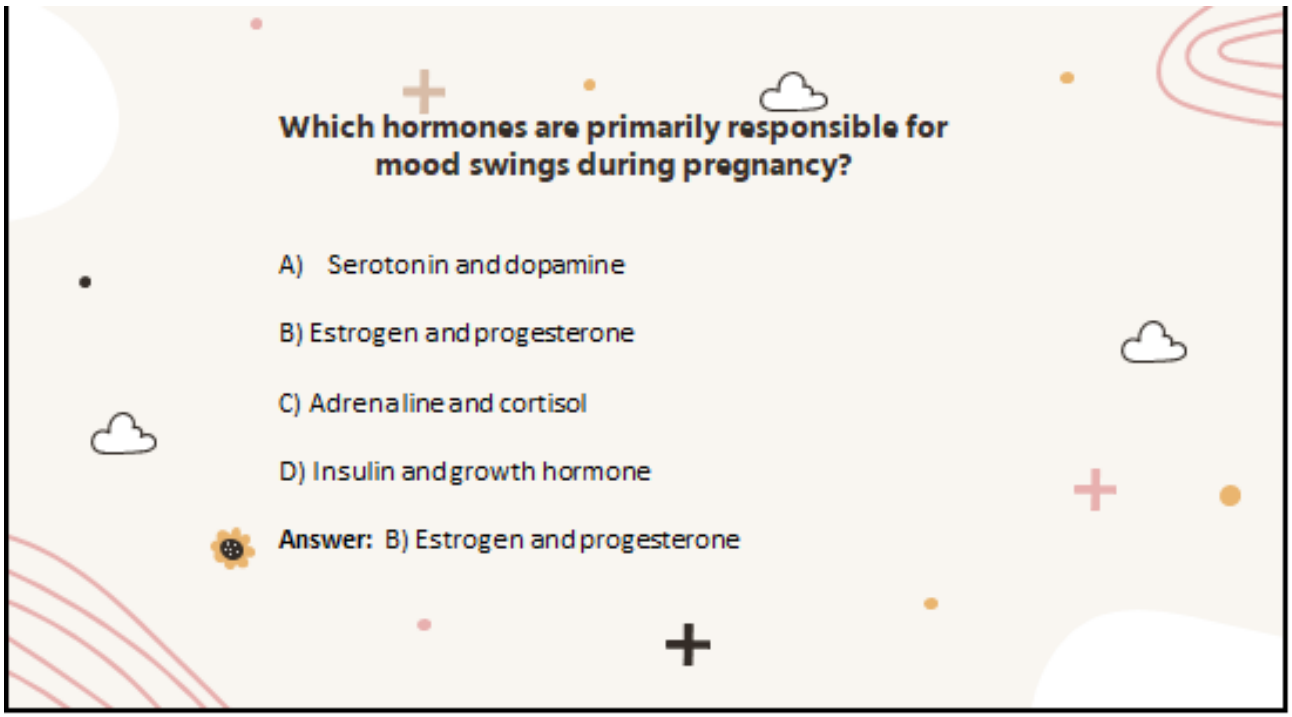

What is the purpose of pre-contractions?
A) pre-contractions create the dilation needed to get the baby out of the uterus
B) pre-contractions help the pushing process of the baby
C) pre-contractions cause the cervix to soften and relax
D) pre-contractions are there to let the mother know the baby is coming
Answer: C) pre-contractions cause the cervix to soften and relax


Which hormones are primarily responsible for mood swings during pregnancy?
A) Serotonin and dopamine
B) Estrogen and progesterone
C) Adrenaline and cortisol
D) Insulin and growth hormone
Answer: B) Estrogen and progesterone

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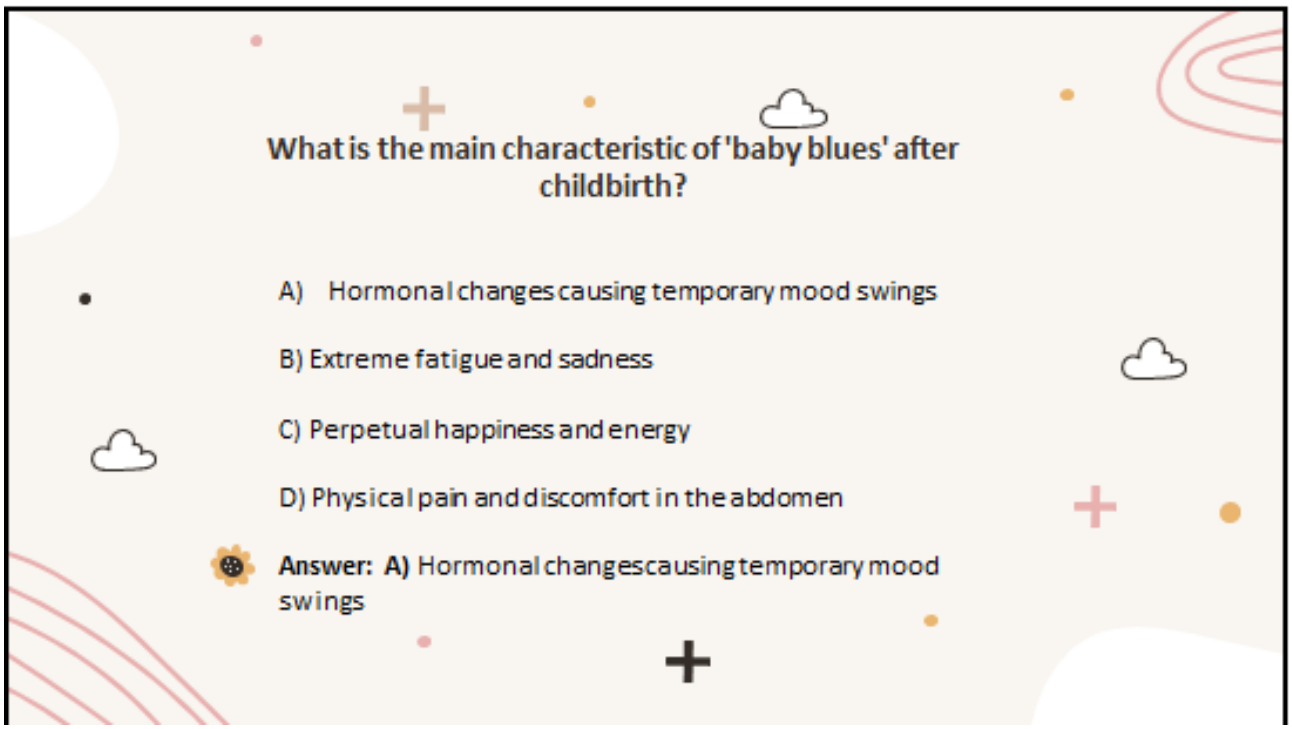
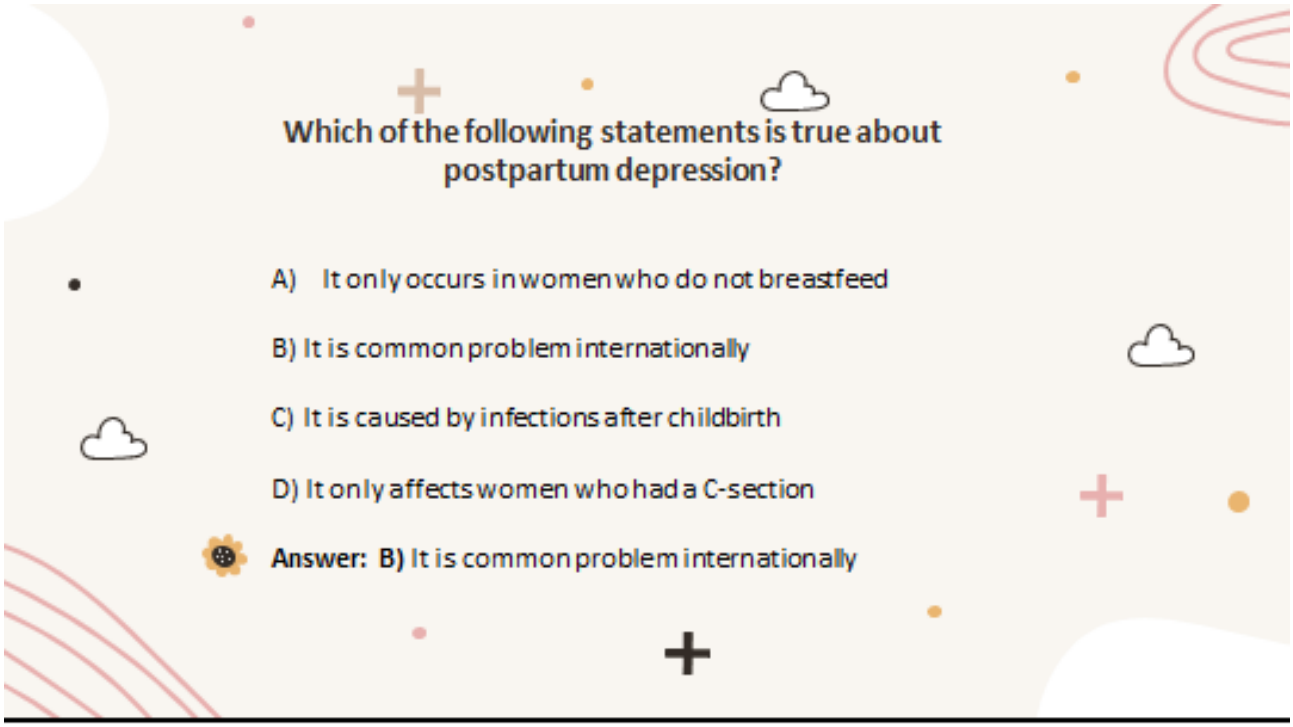

What is the main characteristic of 'baby blues' after childbirth?
A) Hormonal changes causing temporary mood swings
B) Extreme fatigue and sadness
C) Perpetual happiness and energy
D) Physical pain and discomfort in the abdomen
Answer: A) Hormonal changes causing temporary mood swings


Which of the following statements is true about postpartum depression?
A) It only occurs in women who do not breastfeed
B) It is common problem internationally
C) It is caused by infections after childbirth
D) It only affects women who had a C-section
Answer: B) It is common problem internationally

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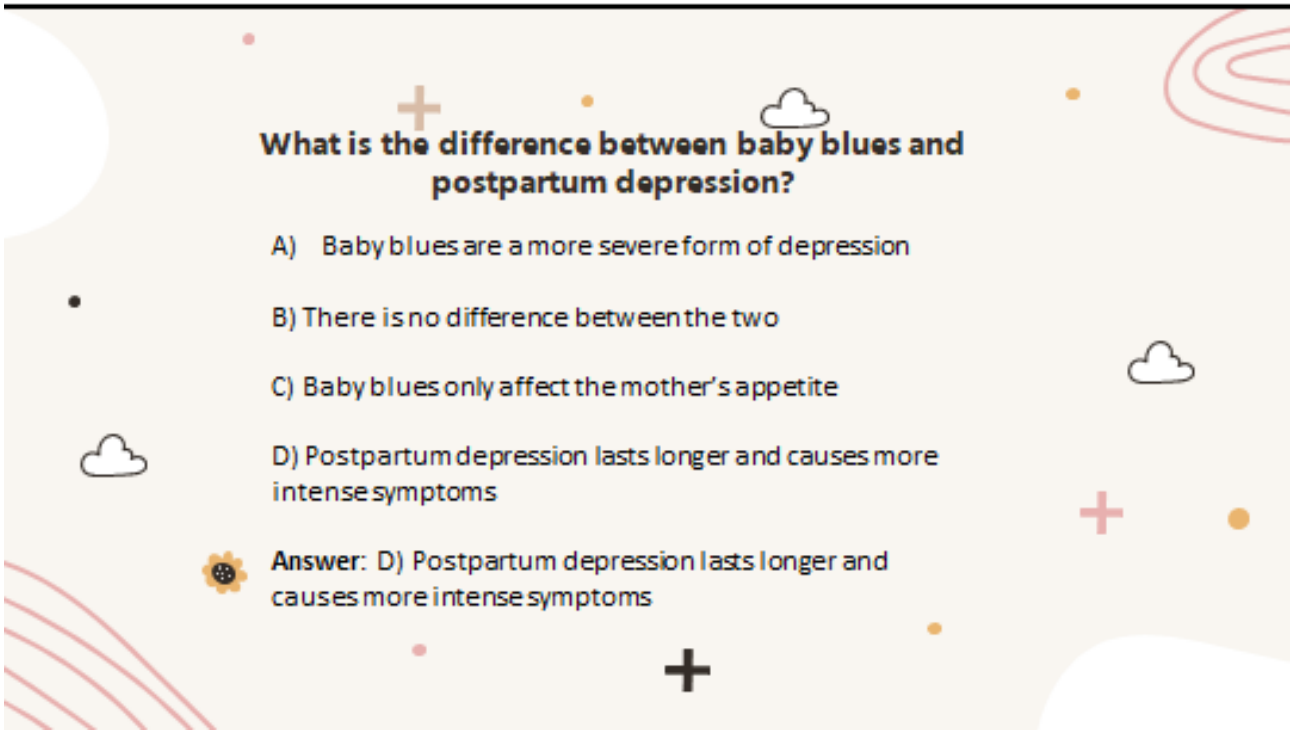
What is the difference between baby blues and postpartum depression?
A) Baby blues are a more severe form of depression
B) There is no difference between the two
C) Baby blues only affect the mother's appetite
D) Postpartum depression lasts longer and causes more intense symptoms
Answer: D) Postpartum depression lasts longer and causes more intense symptoms


What is an important aspect of a pregnant woman's psychological health?
A) avoiding stress
B) Taking medication for mood swings
C) Promoting feelings of anxiety
D) Isolating oneself from others to reduce stress
Answer: A) avoiding stress

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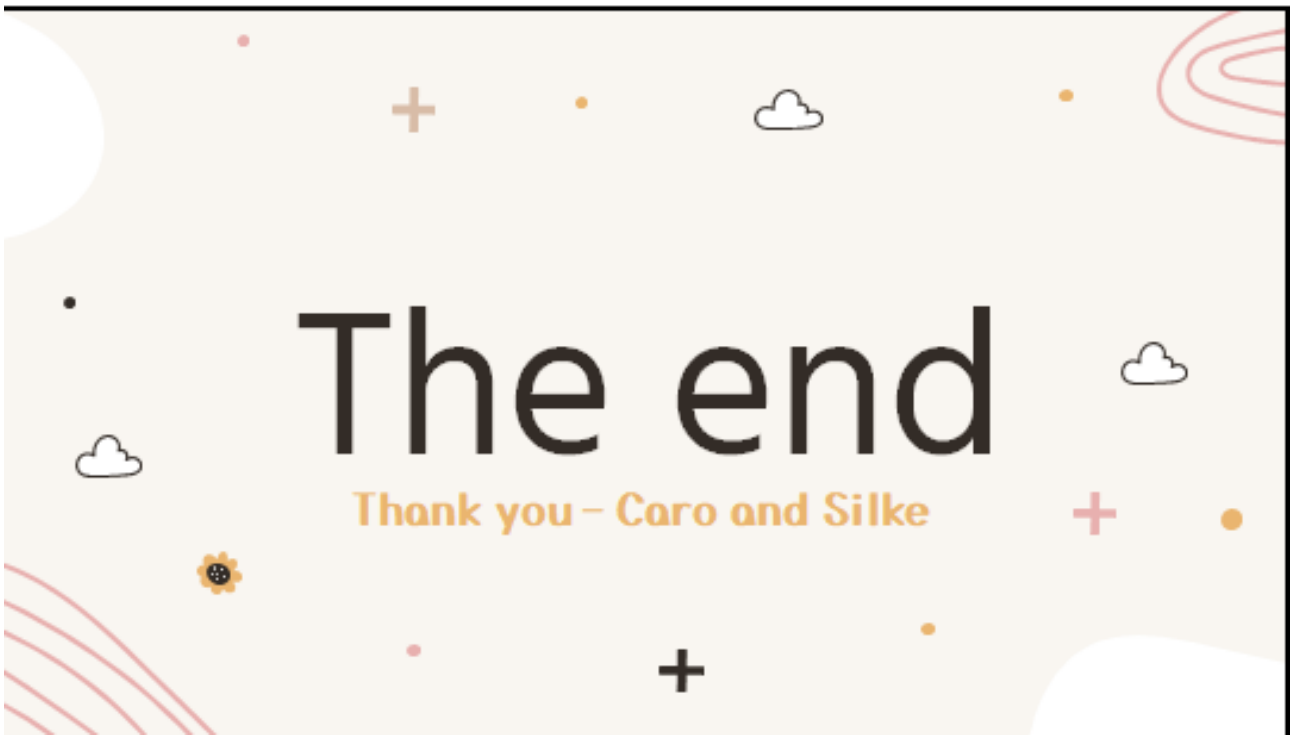
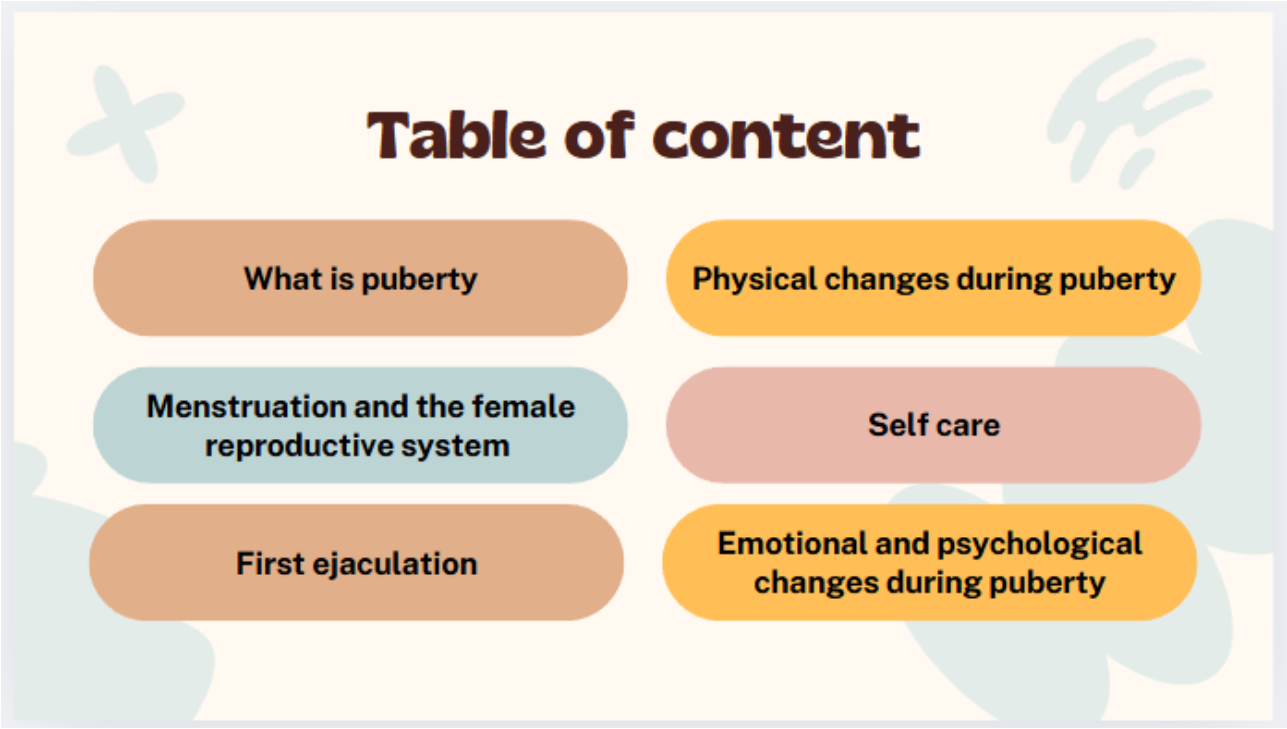
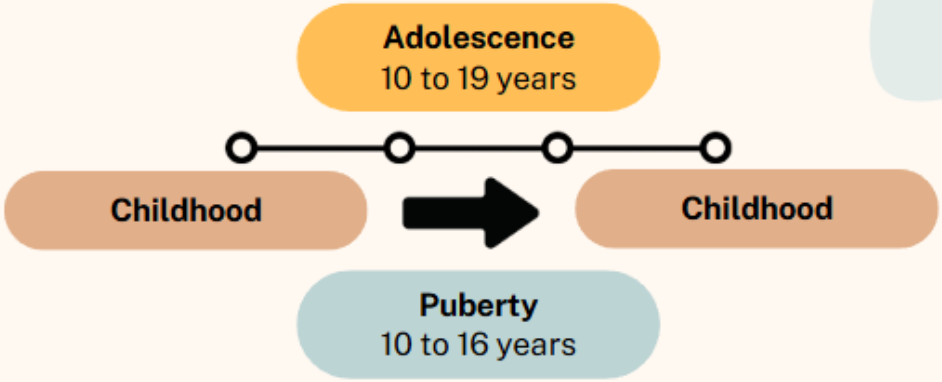

The end
Thank you – Caro and Silke

ATTACHMENT 3: SESSION - PUBERTY AND MENSTRUATION

POWERPOINT – PUBERTY AND MENSTRUATION



What is puberty?



Puberty is a natural phase in life in which the body develops from child to an adult. This process is driven by hormones and happens at different ages for boys or girls. During puberty, hormones help your body develop into a more mature version of itself.

What is puberty?

Puberty
10 to 16 years

During puberty, young people experience:

- Physical changes
- Emotional changes
- Social changes

Start of puberty

Europe:

- Girls: between the ages of 9.8 and 10.8 years

Africa:

- Girls: between the ages of 10.1 and 13.1 years

→ In general, girls enter puberty about one to two years earlier than boys.

What is puberty?

Gender characteristics = Visible differences between male and female bodies.

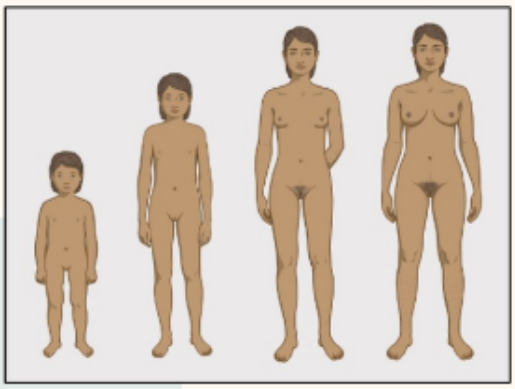
2 types of gender characteristics:

- **Primary gender characteristics** = are already present at birth
  - Boy: Penis, testicles,...
  - Girl: Clitoris, labia,...
- **Secondary gender characteristics** = do not develop until puberty
  - Men: Beard, pubic hair,...
  - Women: Breast, pubic hair,...

Physical changes during puberty

Changes during puberty for girls:

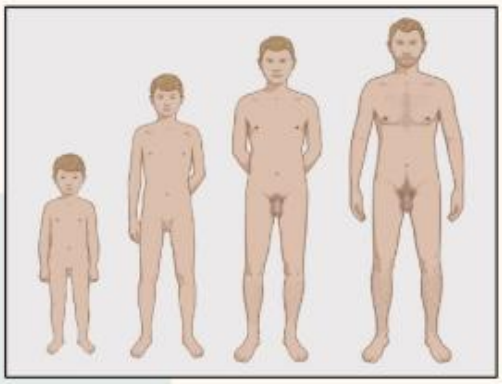
- Breast development
- Hair on the legs
- Hair in the armpits
- Hair in the genital area (pubic hair)
- Accelerated growth
- Hips grow wider
- First menstruation



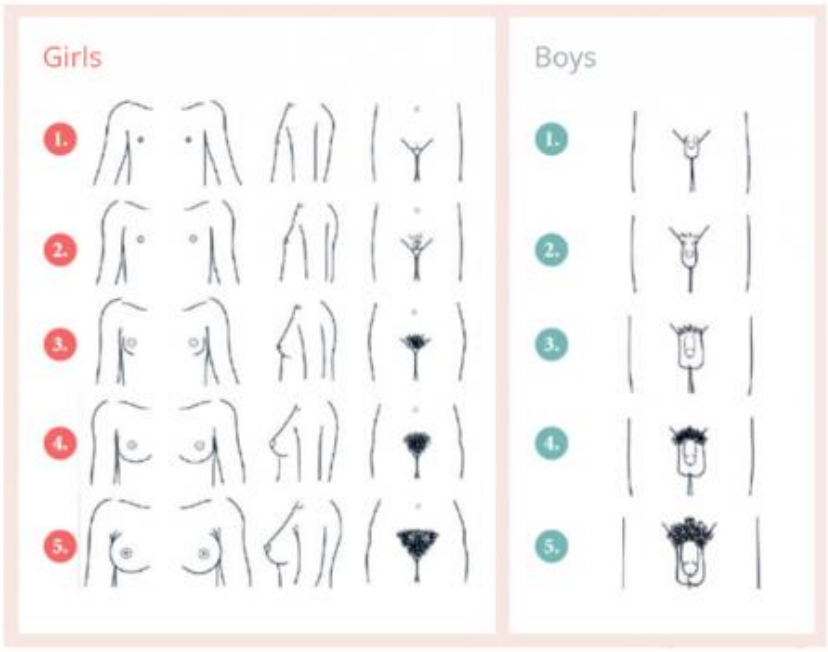
Physical changes during puberty

Changes during puberty for boys:

- Penis and testicles start growing
- Beard growth
- Hair in the armpits
- Hair in the genital area (pubic hair)
- Voice changes
- Accelerated growth
- Shoulders become broader
- Muscles get bigger
- First ejaculation



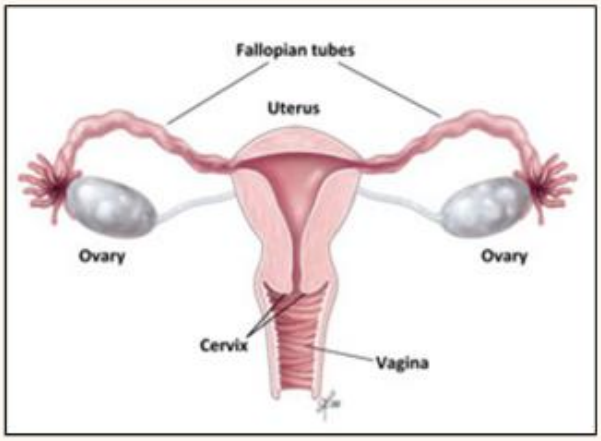
This is a proces ...



What is menstruation?

Menstruation is the monthly shedding of the lining of the uterus.

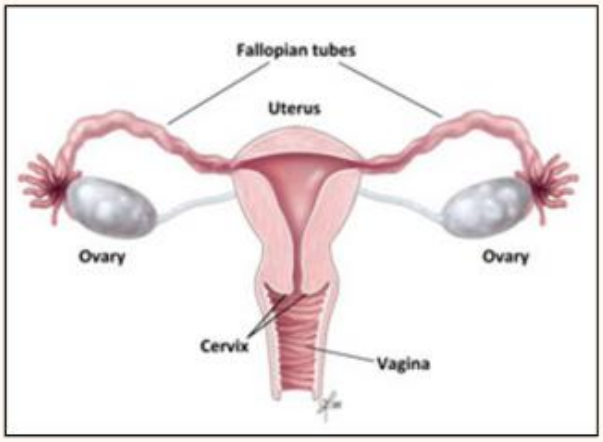
Menstrual blood, which consists of a combination of **blood** and **tissue from the inner wall of the uterus**, leaves the body through the cervix and vagina.



What is menstruation?

Hormones play an essential role in menstruation.

The **pituitary gland** in the brain and the **ovaries** produce and release certain hormones at specific times during the menstrual cycle.

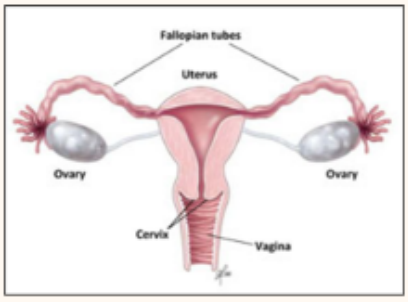


What is menstruation?

These hormones **stimulate ovulation**, in which an egg emerges from the ovaries and travels through the fallopian tubes to the uterus.

It also causes the **lining of the uterus to thicken**, allowing a possibly fertilised egg to implant if impregnation by a sperm cell occurs during its journey in the fallopian tubes.

If the egg is not fertilised by a sperm cell, pregnancy does not occur. The lining of the uterus is then broken down and shed, resulting in **menstruation**

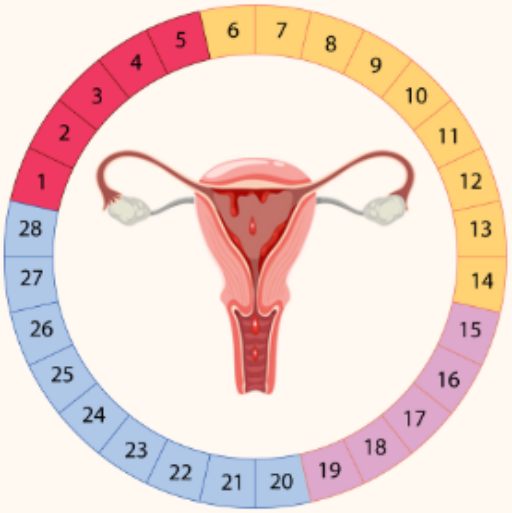


What is a menstrual cycle?

The menstrual cycle refers to the **series of biological processes** that take place in the female body **each month** in preparation for a **possible pregnancy**.

The cycle **starts on the first day of menstruation** and runs **until** the **first day of the next period**.

Although the **length of the cycle can vary** from person to person, the **process** occurs in the **same way for everyone.**

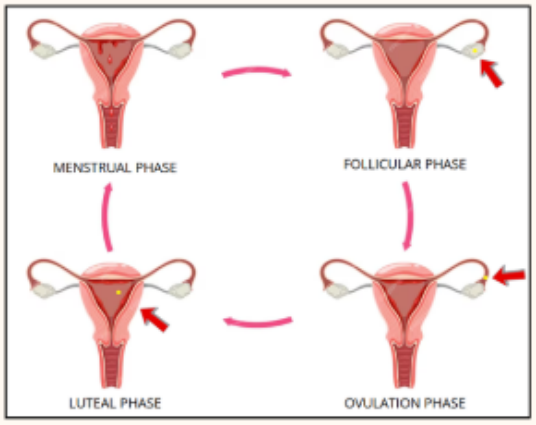


What are the four phases of the menstrual cycle?

The menstrual cycle consists of **four phases**, which are influenced by **fluctuations in hormone levels.**

These hormones control the **functioning** of the **reproductive organs** and cause specific **processes** to take place in the body.

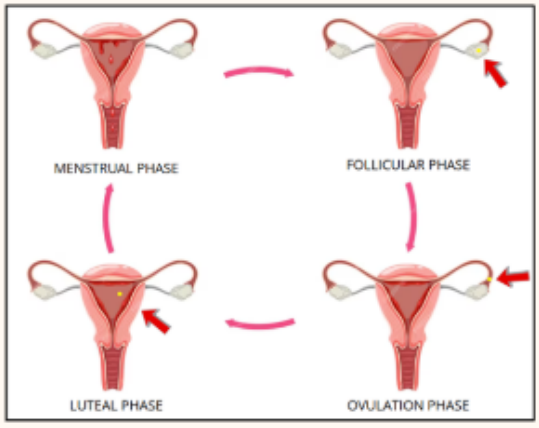
The four phases are:
- Menstrual phase
- Follicular phase
- Ovulation
- Luteal phase



1. Menstrual phase

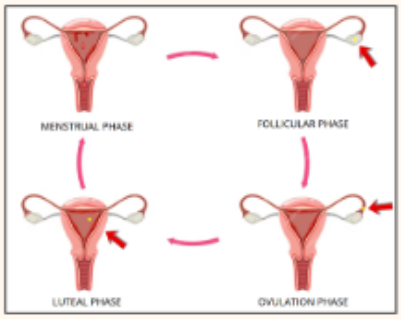
= This phase **starts** on the **first day of menstruation**. When **no impregnation** has taken place, the lining of the uterus is shed and discharged through the vagina.

Usually, this bleeding lasts three to five days, but a duration between three and seven days is also considered normal



2. Follicular phase

= This phase also **starts** on the **first day of menstruation** and **continues until ovulation**. Although the lining of the uterus is shed and discharged through the vagina, the body starts preparing for a new cycle at the same time.



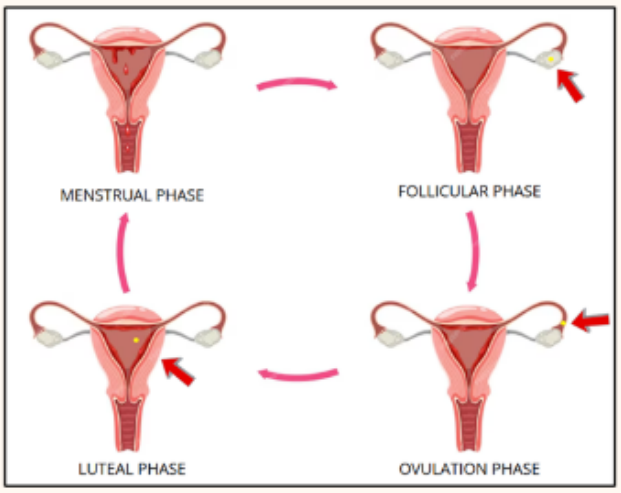
During this phase, **oestrogen levels gradually rise**. This **stimulates** the **building of a new lining** in the uterus in **preparation** for a **possible pregnancy**.

At the same time, **follicle-stimulating hormone (FSH) stimulates** the **maturation of several follicles** in the ovaries. Around **day 10 to 14**, one of these follicles develops into a **mature egg.**

3. Ovulation

= Around day 14 of an average 28-day cycle, **ovulation occurs**.

A sudden **rise** in **luteinising hormone (LH)** causes the **ovary** to **release an egg**, marking the moment of ovulation

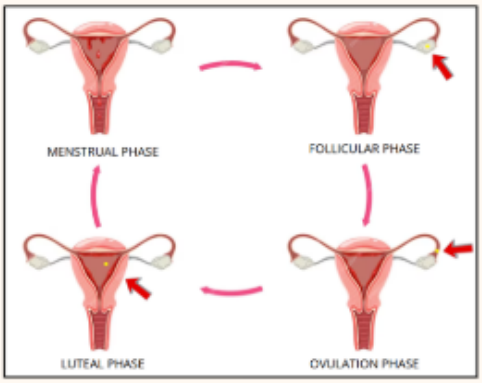


4. Luteal phase

= This phase runs from about **day 15 to day 28**. The egg leaves the ovary and travels through the fallopian tubes to the uterus.

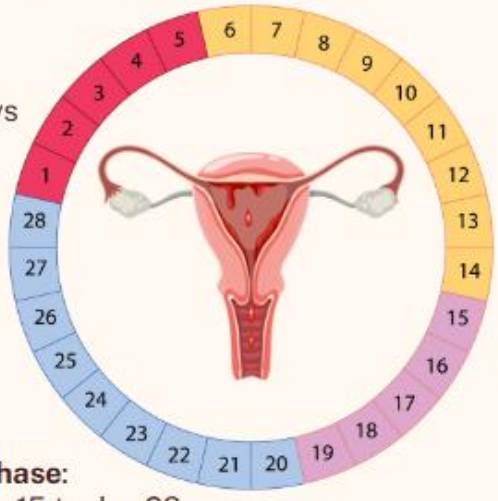
Progesterone levels rise to **prepare** the **lining of the uterus** for **possible implantation**. If the egg is **fertilised** and **attaches** to the lining of the uterus, **pregnancy occurs**.

If **fertilisation does not occur**, **oestrogen** and **progesterone levels drop**, causing the lining of the uterus to be **shed** and **menstruation** to begin.



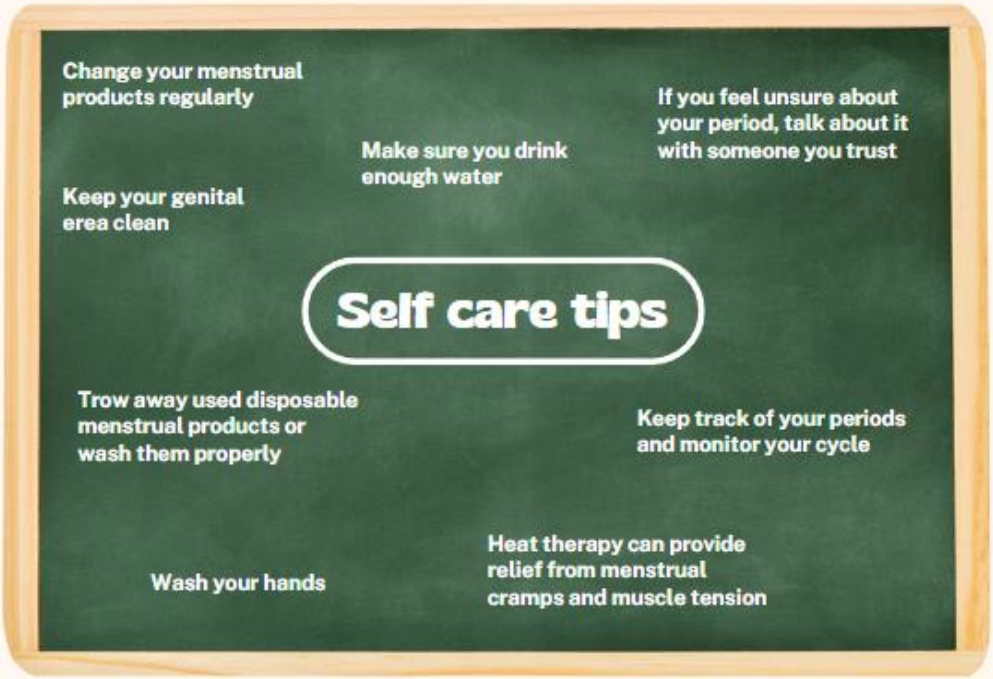
Follicular phase:
From day 1 to 10 à 14 days

Menstrual phase:
From day 1 to 3 à 7 days



Ovulation:
Around day 14 of an average 28-day cycle

Luteal phase:
From day 15 to day 28



First ejaculation

Most boys experience their **first ejaculation** between the **ages of 11 and 16**. The time at which this happens depends on the **functioning of their hormones.**

Ejaculation

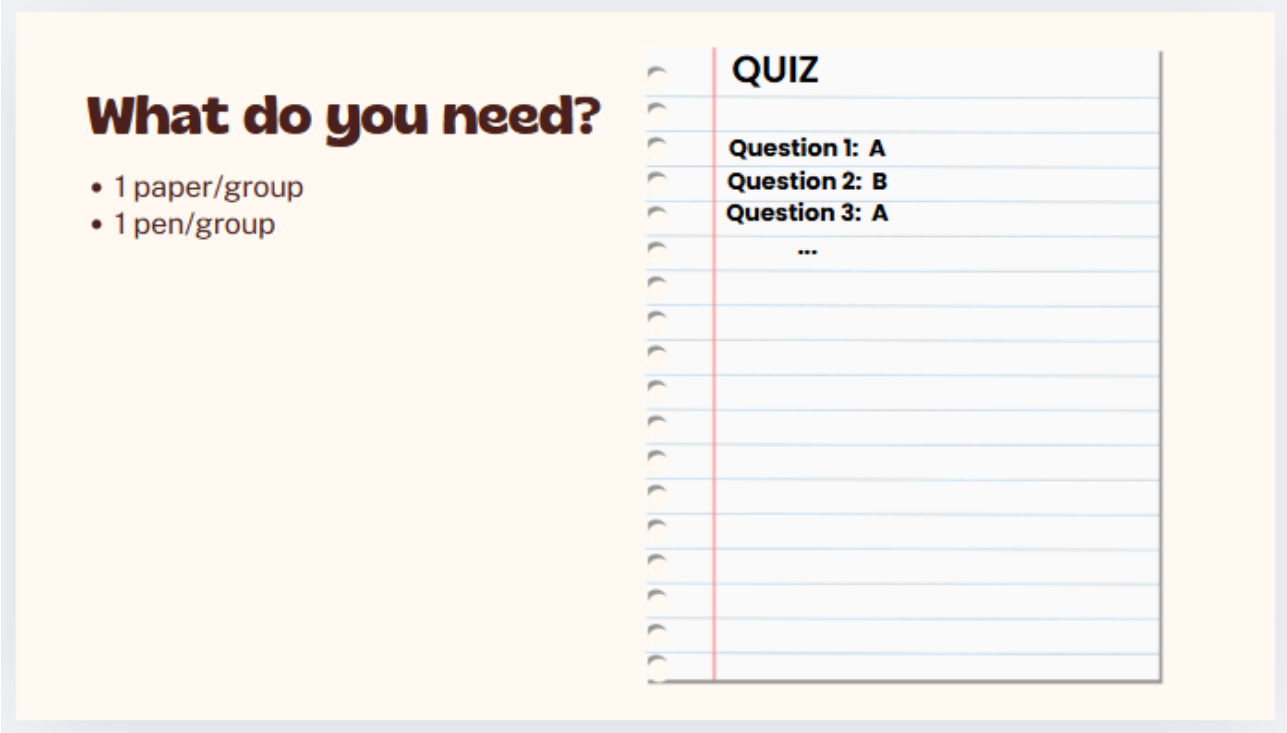
Ejaculation **can occur** either during **masturbation** or in **your sleep**. If it happens during sleep, it is called a **wet dream**. It is **not necessary** for a boy to have **dreamt about sex**. The sperm may simply need to **come out of the body**. Not all boys experience wet dreams.

During ejaculation, **millions of sperm cells are released**. From his first ejaculation, the boy is **fertile**. If he has sex with a girl, it is possible for her to become **pregnant.**

Emotional and psychological changes during puberty

- Experiencing hypersensitivity
- In search of your own identity
- Feeling insecure
- Peer pressure
- Inner contradictions
- Mood swings
- Getting interested in sexuallity

GAME – PUBERTY AND MENSTRUATION



1. At what age do most boys experience their first ejaculation, and what does this mean for their fertility?

A. Between the ages of 8 and 10; they are not yet fertile then
B. Between 11 and 16 years; they are fertile from then on
C. Between 15 and 18 years; but they cannot have children yet
D. Between 12 and 14 years; but only if they have wet dreams

Correct answer: B

→ Most boys experience their first ejaculation between the ages of 11 and 16. From then on, they are fertile and can get a girl pregnant if they have unprotected sex.

2. What is a secondary gender characteristic in boys?

A. Penis
B. Testicles
C. Beard growth
D. Clitoris

Correct answer: C

3. What grows on both boys and girls at puberty?

A. Breasts
B. Pubic hair
C. Penis
D. Clitoris

Correct answer: B

4. What is menstruation?

A. Release of an egg cell
B. Growth of the uterus
C. Secretion of mucus
D. Shedding of lining of the uterus

Correct answer: D

5. What do oestrogen and progesterone do in the cycle?

A. They cause pain
B. They regulate the day-night rhythm
C. They stimulate maturation of eggs and lining of the uterus
D. They stop menstruation

Correct answer: C

6. What is the correct order of the 4 phases of the menstrual cycle

A. Menstrual phase - Follicular phase - Luteal phase - Ovulation
B. Follicular phase - Luteal phase - Ovulation - Menstrual phase
C. Menstrual phase - Follicular phase - Ovulation - Luteal phase
D. Menstrual phase - Ovulation - Follicular phase - Luteal phase

Correct answer: C

7. What happens during the menstrual phase?

A. The lining of the uterus is shed through the vagina
B. The egg cell is fertilised
C. An egg matures in the ovary
D. The fallopian tubes contract

Correct answer: A

→ Explanation: During this phase, the lining of the uterus is shed if no fertilisation has taken place. This causes menstrual bleeding.

8. What happens during the follicular phase?

A. The uterus breaks down
B. The egg is released
C. Menstruation ends permanently
D. Oestrogen rises and stimulates a new lining of the uterus

Correct answer: D

→ Explanation: In this phase, oestrogen levels rise, stimulating the growth of a new mucous membrane in the uterus. At the same time, an egg matures in the ovary.

9. What happens during ovulation?

A. Menstruation starts again
B. The egg is released by the ovary
C. The fallopian tubes close off
D. Hormone levels drop sharply

Correct answer: B

→ Explanation: Around day 14, a spike in luteinising hormone (LH) triggers ovulation: an egg is released.

10. What happens during the luteal phase?

A. The egg cell ripens again
B. The lining of the uterus breaks down
C. The body prepares for a possible pregnancy
D. Menstruation stops temporarily

Correct answer: C

→ Explanation: Progesterone causes the lining of the uterus to thicken to accommodate a fertilised egg. If fertilisation fails, hormone levels drop and menstruation follows.

11. What is peer pressure?

A. Parents demanding something
B. Putting pressure on yourself
C. Group influence
D. Rules from school

Correct answer: C

12. Which 2 phases begin on day 1 of the menstrual cycle

A. Luteal phase - Ovulation
B. Follicular phase - Luteal phase
C. Menstrual phase - Follicular phase
D. Menstrual phase - Ovulation

Correct answer: C

13. What is the best way to wash the vagina?

A. Perfume soap
B. Just water
C. Shampoo
D. Antibacterial spray

Correct answer: B

14. How long does a normal period last on average?

A. 1-2 days
B. 3-7 days
C. 4-8 days
D. 2-7 days

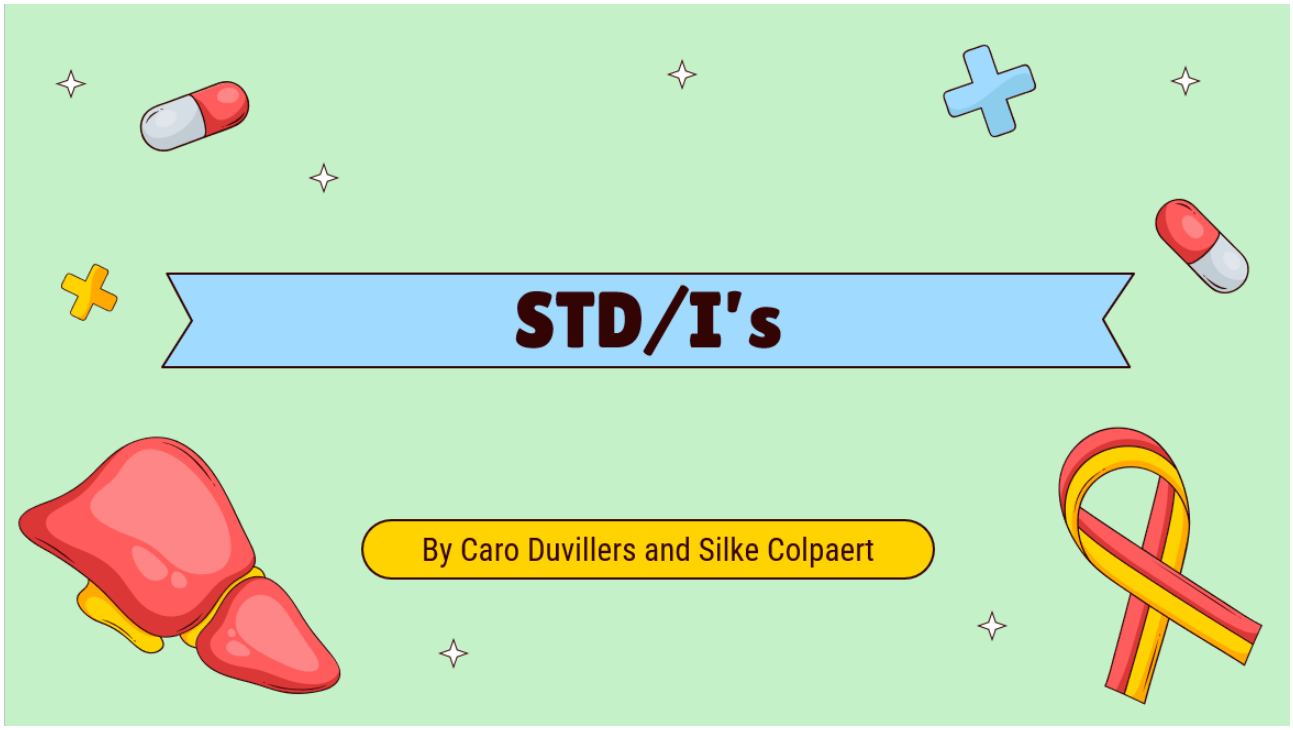
Correct answer: B

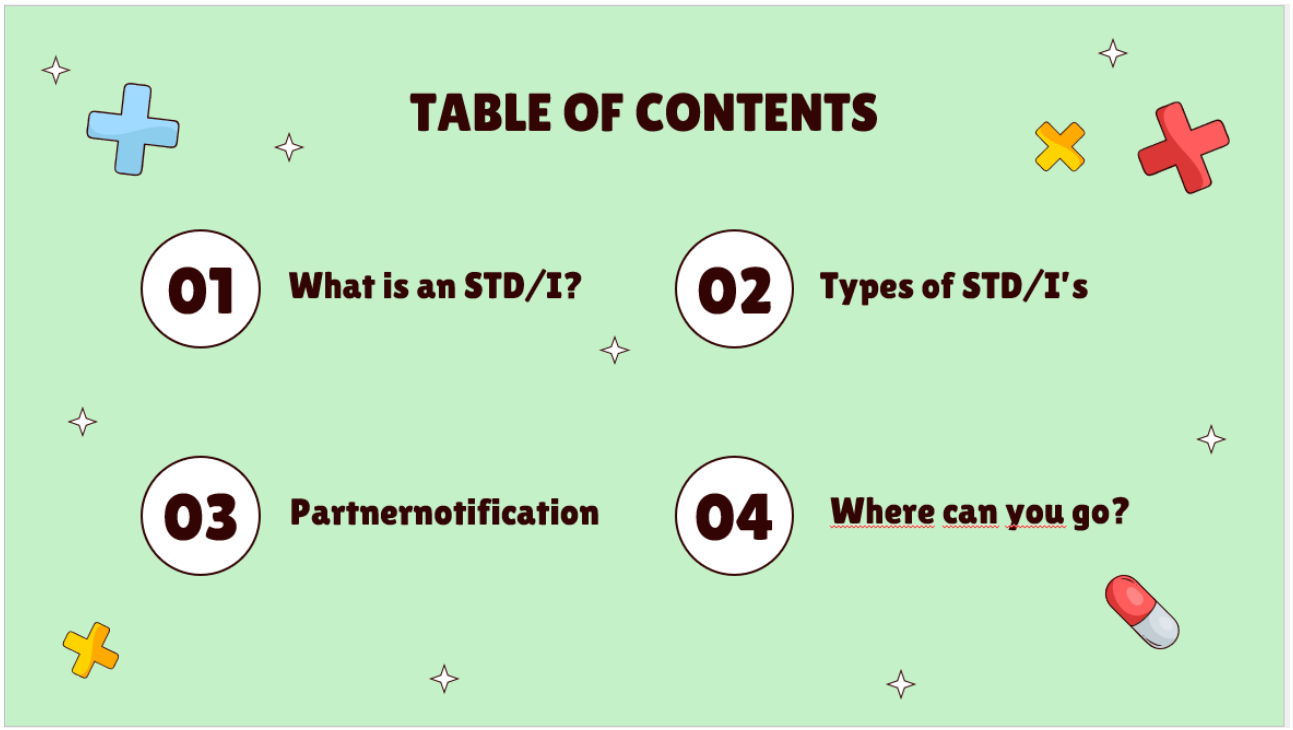

15. What is the age at which puberty usually begins in girls in Africa?
A. 10.1 and 13.1 years
B. 9.8 to 10.8 years
C. 10.3 to 13.2 years
D. 11.2 to 13.3 years
Correct answer: A


THE END

ATTACHMENT 4: SESSION - STI'S AND STD'S

POWERPOINT –STI'S AND STD'S



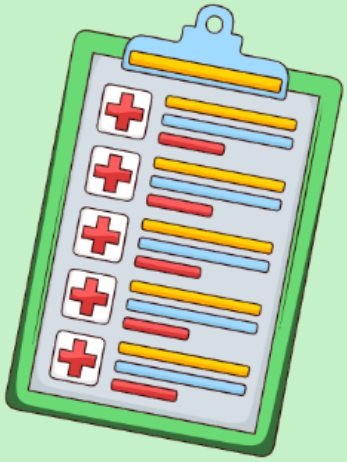


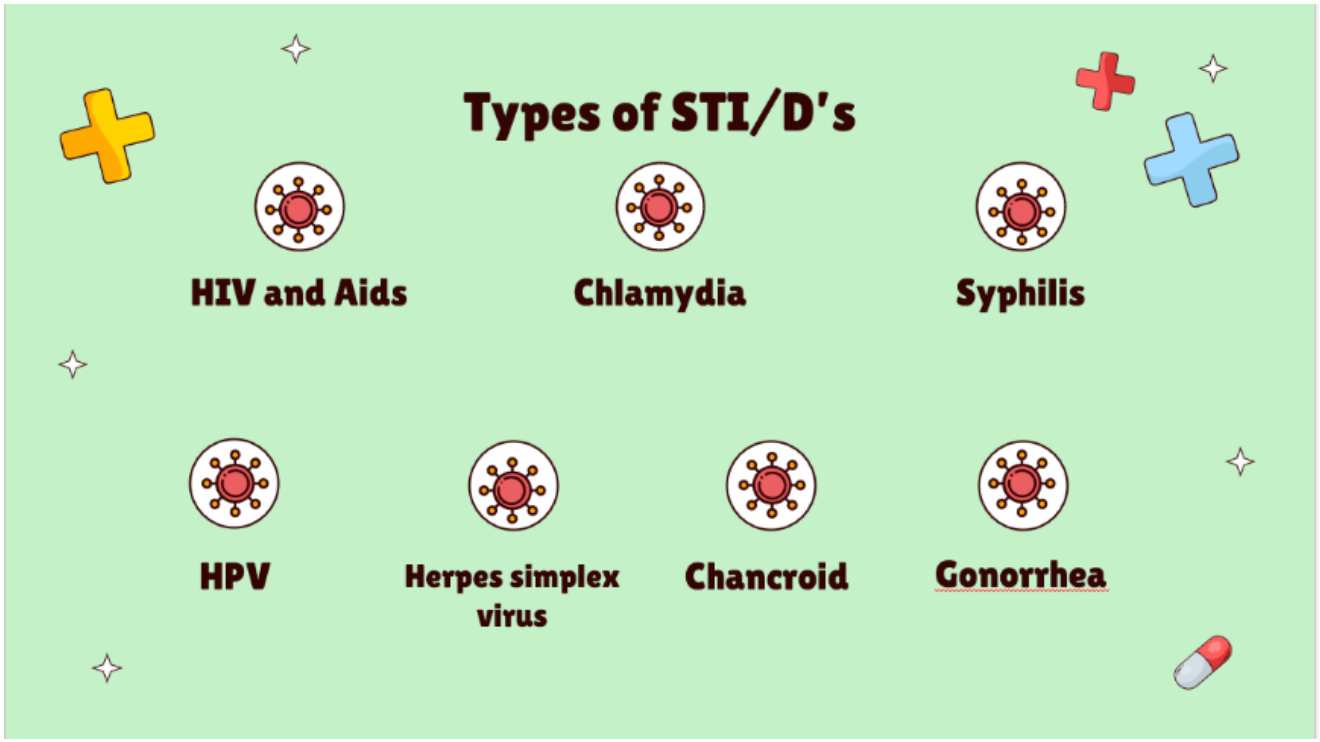
01

What is an STD/I?

An STI/D

- Sexually transmitted infection/disease
  - **STI** = Is more accurate because a person can be infected with an infection without already showing symptoms.
  - **STD** = Once the infection leads to symptoms or signs of illness, it is referred to as an STD
- Sexually transmitted infection is an infection that can be transmitted through sexual contact.




Types of STI/D's
HIV and Aids
Chlamydia
Syphilis
HPV
Herpes simplex virus
Chancroid
Gonorrhea


There will be pictures
shown that are
graphic!

HIV and Aids

- Enters immune cells and embeds in the DNA of the cell
- Factory cell
- Medication treatment
- Aids vs HIV?

Symptoms?

- acute HIV infection: flu-like symptoms such as fever, swollen glands, rash, weight loss, vomiting, nausea and sore throat
- Long-term complaints: extreme fatigue, night sweats, weight loss, fever, shortness of breath and diarrhea
- Sometimes healty again!

Chlamydia

- Infection caused by **Clamydia Trachomatis**
- Usually causes no symptoms and often goes away on it's own
- If symptoms accor, it can be treated with antibiotics
- Clamydia can be prevented with a condom

Symptoms?

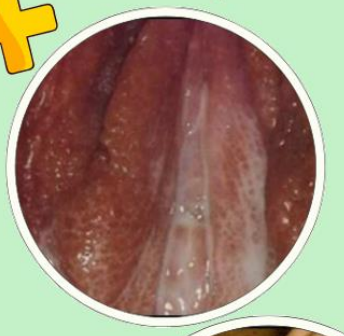
- Men:
  - Pain or burning sensation when urinating,
  - Discharge from the urethra,
  - Pain in the scrotum,
  - Itching or pain around the anus,
  - Diarrhea or other bloody discharge from the anus

Chlamydia

- Infection caused by Clamydia Trachomatis
- Usually causes no symptoms and often goes away on it's own
- If symptoms accor, it can be treated with antibiotics
- Clamydia can be prevented with a condom

Symptoms?

- Women:
  - Pain or burning sensation when urinating,
  - More or different discharge than usual,
  - Bleeding between periods,
  - Pain or bleeding during sex,
  - Lower abdominal pain,
  - Itching or pain around the anus,
  - Diarrhea or other bloody discharge from the anus
  - fertility problems

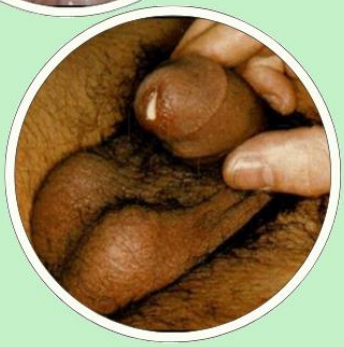


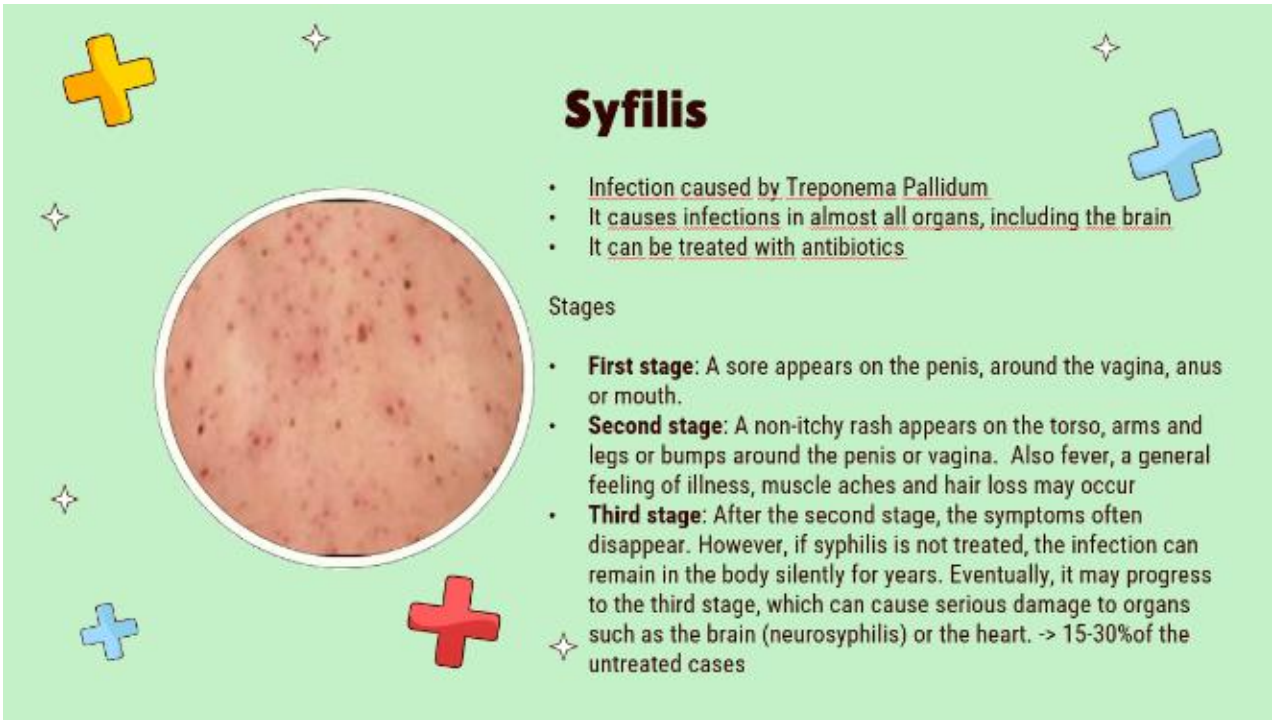
Gonorrhea

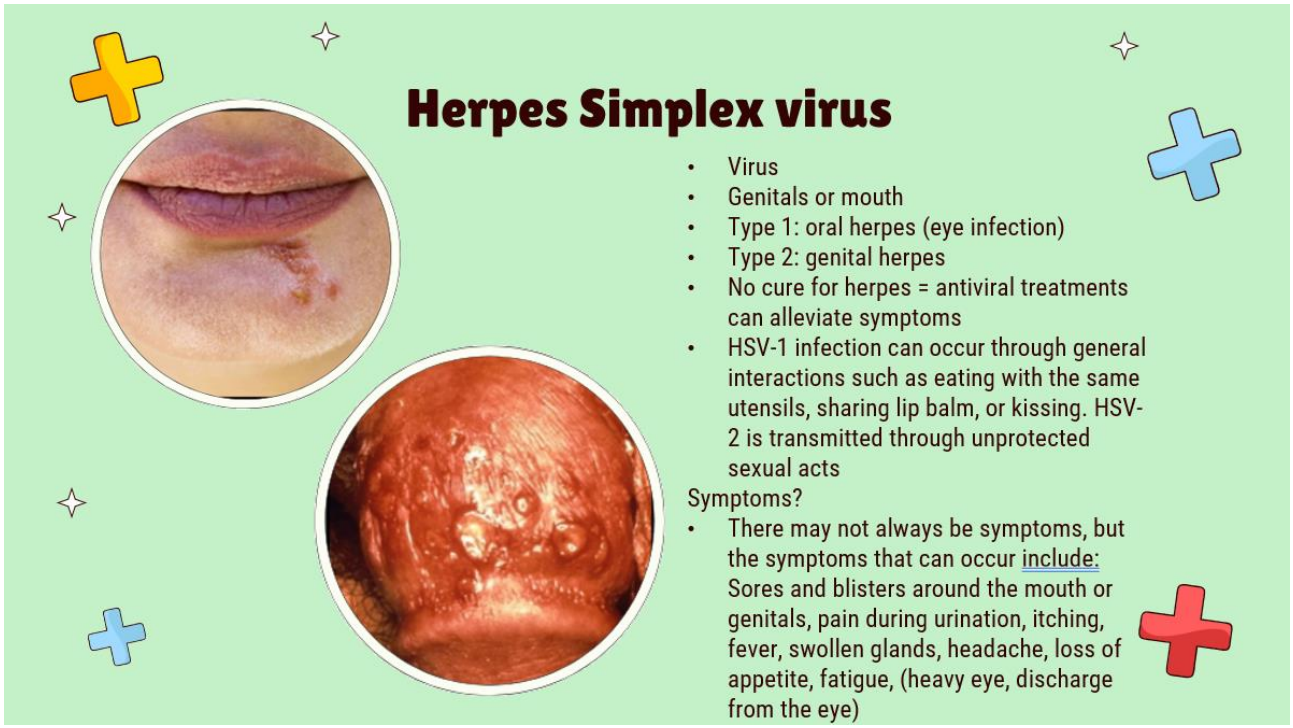
- Bacterium
- The bacterium can cause infections in men's urethra, rectum, throat and testicles
- Women can get infections in the urethra, cervix, fallopian tubes, throat and rectum
- Antibiotics

Symptoms?

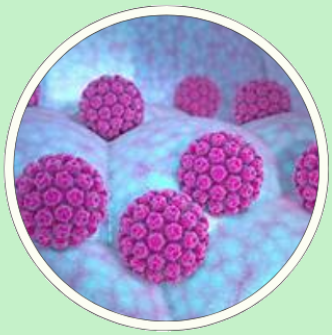
- Men: Pain when urinating, burning sensation when urinating, discharge from the penis, itching around the anus, blood or mucus from the anus, pain in the testicles
- Women: Pain when urinating, burning sensation when urinating, vaginal bleeding, more discharge than usual, itching around the anus, blood or mucus from the anus, severe abdominal pain




Syfilis
Infection caused by Treponema Pallidum
It causes infections in almost all organs, including the brain
It can be treated with antibiotics
Stages
First stage: A sore appears on the penis, around the vagina, anus or mouth.
Second stage: A non-itchy rash appears on the torso, arms and legs or bumps around the penis or vagina. Also fever, a general feeling of illness, muscle aches and hair loss may occur
Third stage: After the second stage, the symptoms often disappear. However, if syphilis is not treated, the infection can remain in the body silently for years. Eventually, it may progress to the third stage, which can cause serious damage to organs such as the brain (neurosyphilis) or the heart. -> 15-30%of the untreated cases


Herpes Simplex virus
Virus
Genitals or mouth
Type 1: oral herpes (eye infection)
Type 2: genital herpes
No cure for herpes = antiviral treatments can alleviate symptoms
HSV-1 infection can occur through general interactions such as eating with the same utensils, sharing lip balm, or kissing. HSV-2 is transmitted through unprotected sexual acts
Symptoms?
There may not always be symptoms, but the symptoms that can occur include: Sores and blisters around the mouth or genitals, pain during urination, itching, fever, swollen glands, headache, loss of appetite, fatigue, (heavy eye, discharge from the eye)

HPV

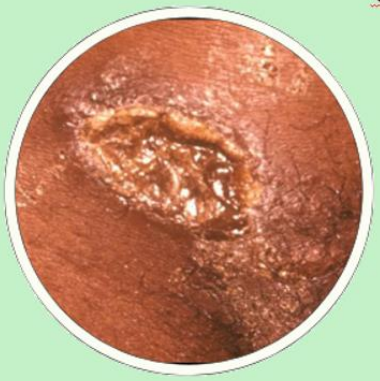


- Human papilloma virus
- The virus can cause cervical cancer and genital warts, but it can also lead to cancer in the penis, anus, vulva, vagina, mound and throat.
- You get HPV through sexual contact or intimate skin to skin contact. It's very infectious.
- Nearly 80-90% of the population will get it at some point, both men and women
- Most of the time, the body clears this virus on its own
- HPV-vaccin -> good protection

Pre-cancer symptoms of HPV?

- Bleeding, unusual discharge, or visible changes in the skin or mucous membranes

Chancroid



- Bacterial
- Very contagious
- Antibiotics

Symptoms?

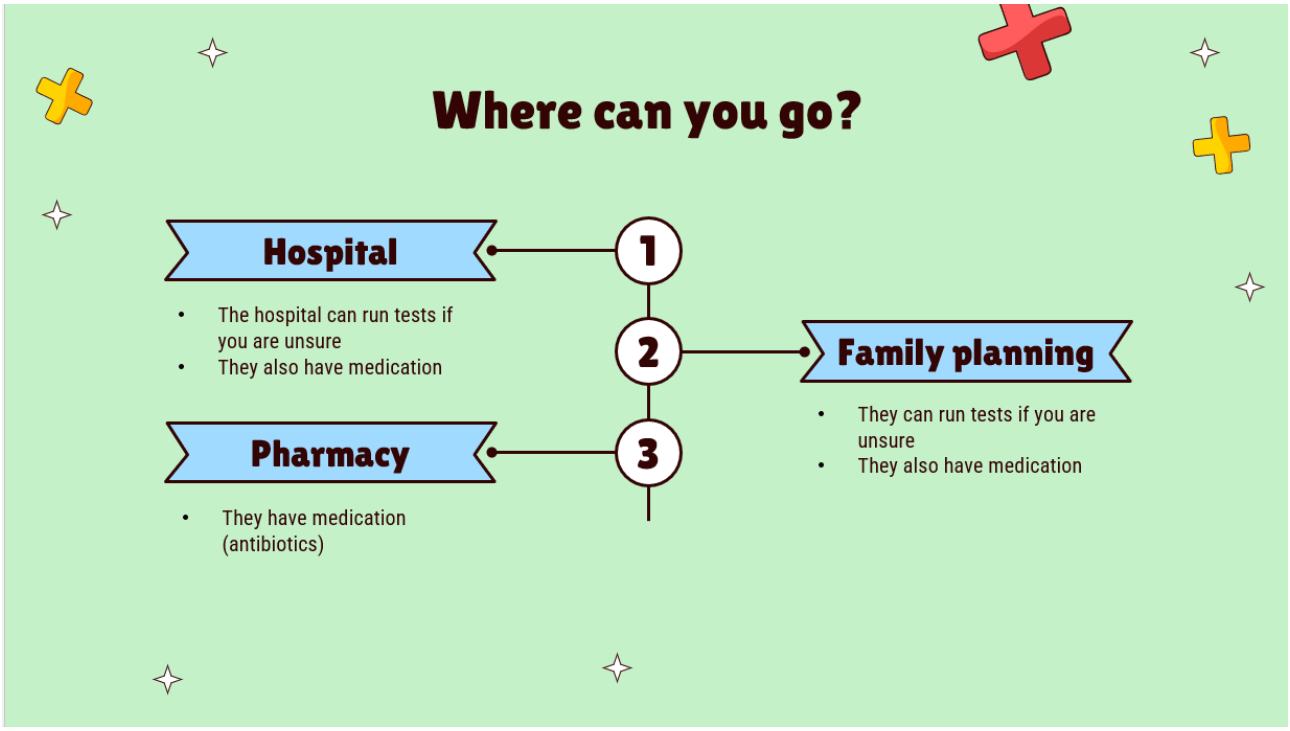
- Raised and painful bumps on the skin of your genitals
- Ulcers with ragged soft edges that develop from these bumps
- Reddened and shiny skin on the sores.
- Leakage of pus and infectious fluid
- Spreading and connecting of these sores into larger areas

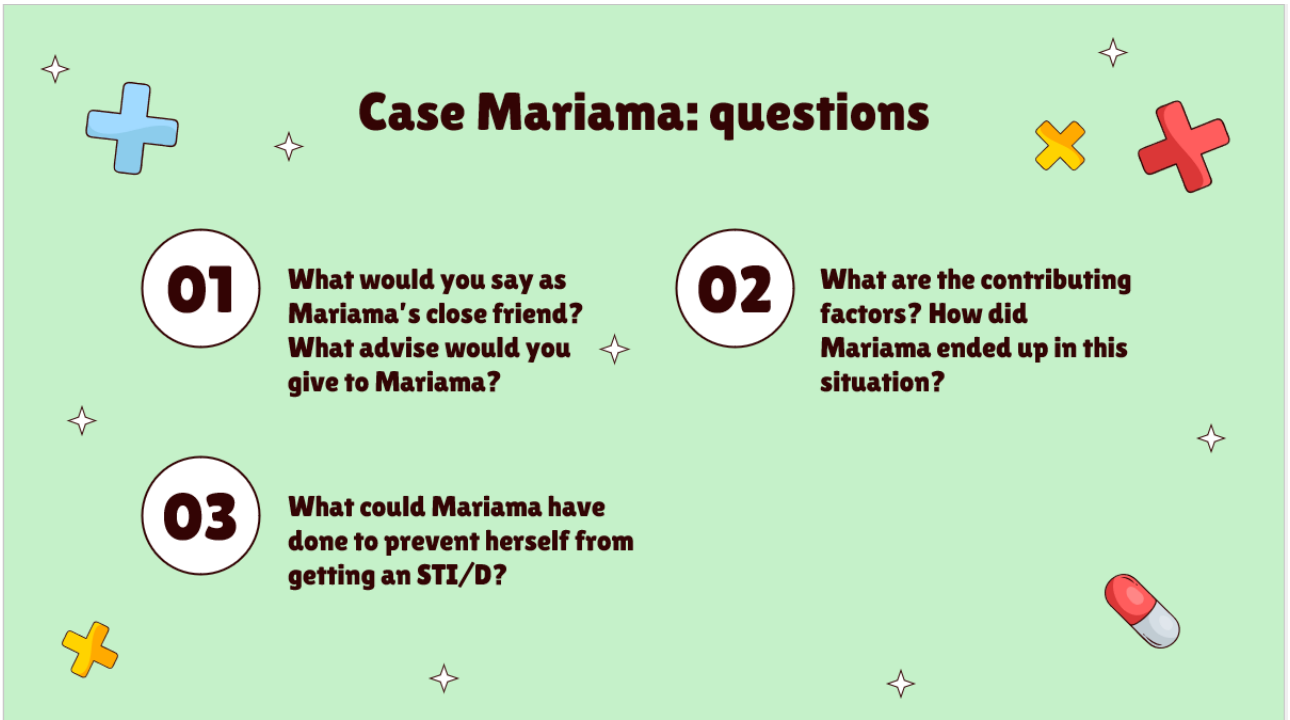
Women may not be aware of the sores, but they can be painful with men

Memory- game!

Partner notification

If you have an STD, it is important to inform your sexual partners. They can then get tested and if necessary, receive treatment. And they should also inform their sexual partners. This way, STDs will not be further spread


Where can you go?
Hospital
1
The hospital can run tests if you are unsure
They also have medication
2
Family planning
They can run tests if you are unsure
They also have medication
Pharmacy
3
They have medication (antibiotics)

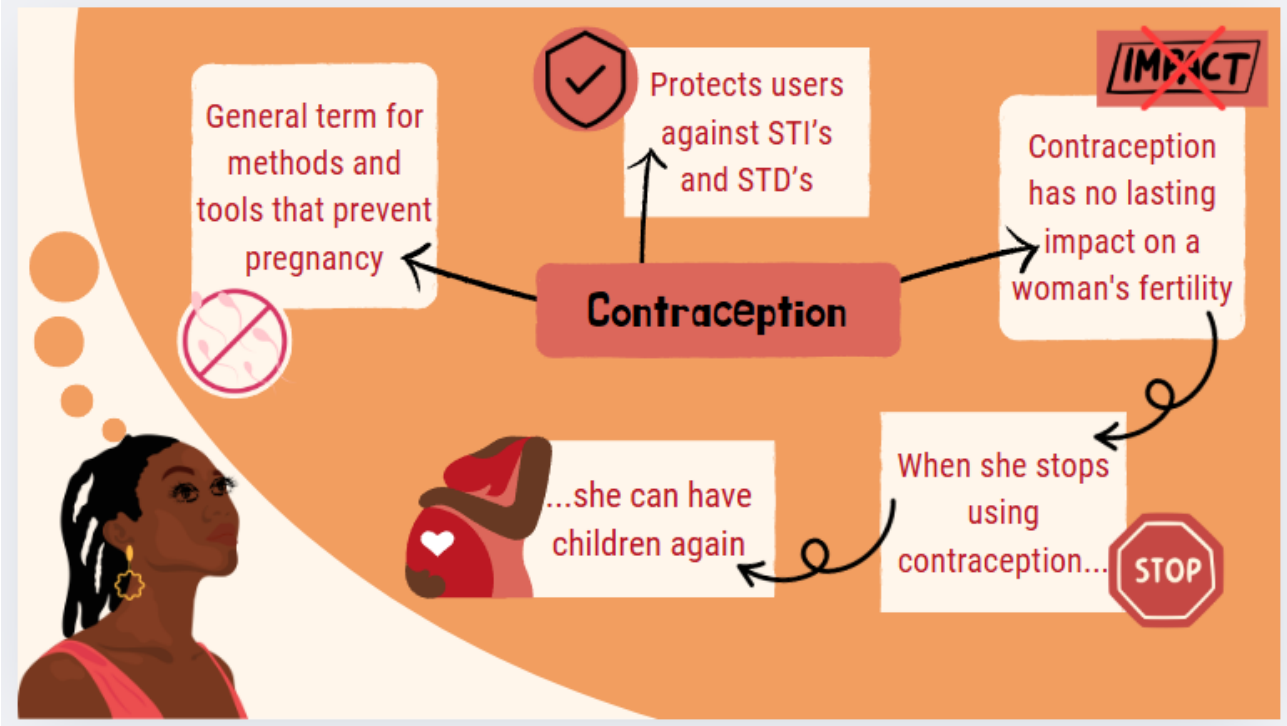

Case Mariama: questions
01
What would you say as Mariama's close friend? What advise would you give to Mariama?
02
What are the contributing factors? How did Mariama ended up in this situation?
03
What could Mariama have done to prevent herself from getting an STI/D?

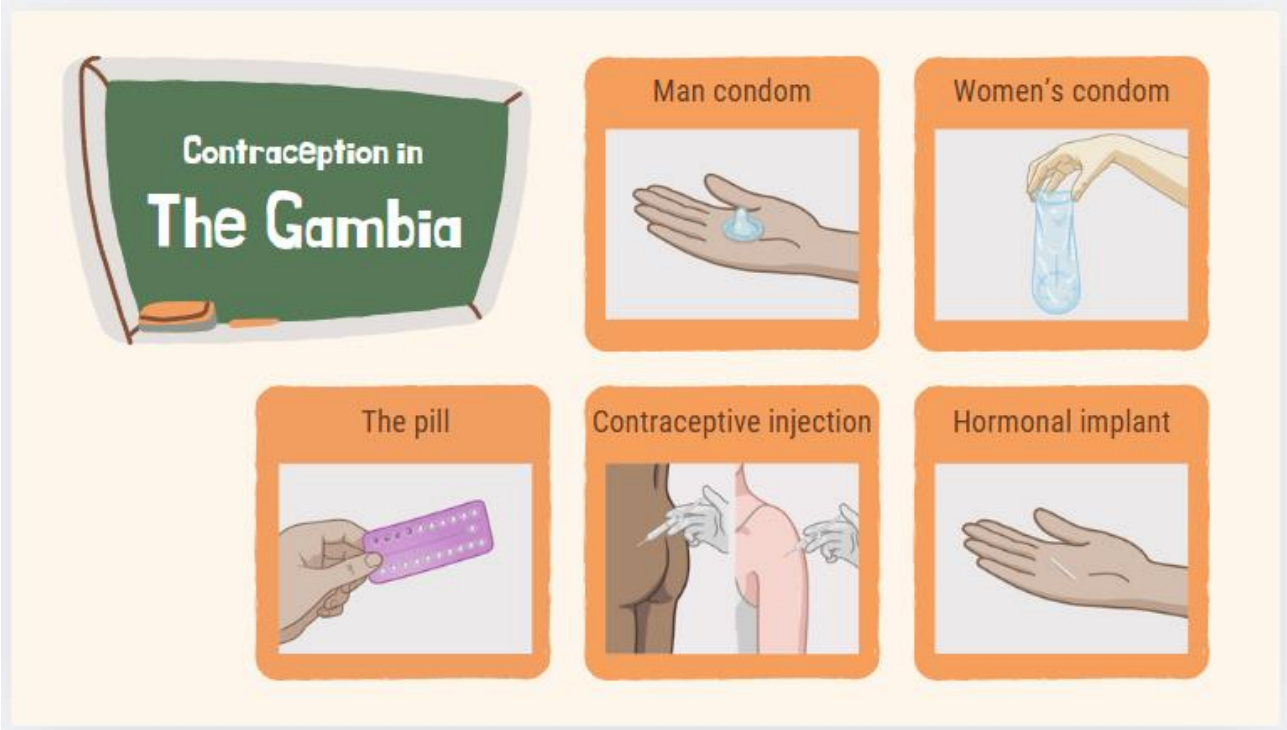

THANKS!
DO YOU HAVE ANY QUESTIONS?
How do you think about STD/I's now?
Did you learn something new?
Do you have any tips for us?
CREDITS: This presentation template was created by Slidesgo, including icons by Flaticon and infographics & images by Freepik

GAME - STI'S AND STD'S

ATTACHMENT 5: SESSION - CONTRACEPTION

POWERPOINT – CONTRACEPTION


General term for methods and tools that prevent pregnancy
Protects users against STI's and STD's
IMPACT
Contraception has no lasting impact on a woman's fertility
Contraception
When she stops using contraception...
STOP
...she can have children again


Contraception in
The Gambia
Man condom
Women's condom
The pill
Contraceptive injection
Hormonal implant


Where can you get it?
GMD
Hospital
Family Planning
Pharmacy
PHARMACY


Man condom
What is it?:
• Thin cover that you put over the stiff penis before having sex
• It catches the man's sperm during ejaculation
• It prevents an unwanted pregnancy
Reliability?:
• When it's used properly it is a very reliable form of contraception
• 98% reliable
• When it's not used correctly, the condom is less reliable
• About 18 out of 100 women become pregnant after a year of using the condom during sexual intercourse
Protection against STI's?:
• The condom offers protection against STI's
• The man and women's condom are the only contraceptives that offer protection against STI's

Presentation

How do you use it?

Women's condom

What is it?

- A female condom is a soft, thin pouch that you insert into the vagina before sex.
- The pouch has a flexible ring on both sides: a thin outer ring and a thicker inner ring.
- It catches the man's sperm during ejaculation
- It provides protection against STI's

Reliability?:

- When it's used properly it is a very reliable form of contraception
- When it's not used correctly, the condom is less reliable
- About 21 out of 100 women become pregnant after a year of using the women's condom during sexual intercourse

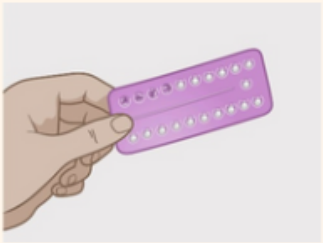
Protection against STI's?:

- The women's condom offers protection against STI's
- The man and women's condom are the only contraceptives that offer protection against STI's

Presentation

How do you use it?

The pill



What is it?

- The pill usually consists of a strip of 21 or 22 pills and sometimes it contains 24 or 28 pills.
- There are many different packages (different colours, rectangular, round,...)
- The pill contains 2 hormones.
- These hormones prevent ovulation and make it harder for sperm to enter the uterus

Protection against STI's?:

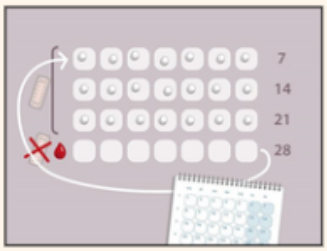
- The pill does not protect against STI's or HIV.
- Only a condom can protect you

The pill

Reliability?:

- The pill is reliable.
- About 9 in 100 women become pregnant when taking the pill for 1 year.
- The pill may be less reliable if:
  - You do **not** always take the pill **at the same time** (especially if you take it more than 12 hours later than usual)
  - You **vomit** within **2 hours** of taking the pill
  - You take certain **medicines**. Tell your doctor you are taking the pill. Then he/she can take this **into account** when prescribing medicines.
  - You **forget** to take a pill.
  - Taking a pill **only on the days you have sexual intercourse** is absolutely not reliable.

The pill



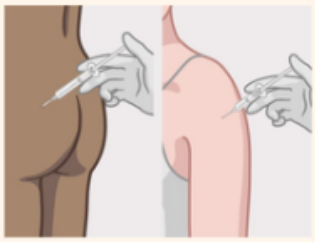
How do you use it?:

- A strip of 21 pills should be used as follows: Take 1 pill at the same hour every day. The days of the week are usually on the back of the strip. This way you can check that you haven't forgotten to take a pill.
- After 21 days (3 weeks), the strip runs out.
- In the next 7 days (1 week), you will not take a pill. This week you will start to lose blood from the vagina (menstruation).
- You are also protected this week.
- After 7 days (1 week), start a new strip of pills, even if you are still bleeding.
- Now repeat the previous steps.

Presentation

How does it look?

Contraceptive injection



What is it?

- It is an injection of a hormone into the arm or buttock to prevent pregnancy.
- After the injection a woman cannot get pregnant for the next 3 months.
- The injection is given by a health professional
- The injection contains 1 hormone that prevents ovulation, makes it harder for sperm to reach the uterus and reduces the chances of a fertilised egg implanting

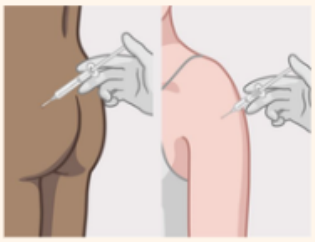
Reliability?:

- The contraceptive injection is reliable if you have a new injection every 3 months.
- Around 6 in 100 women get pregnant when they use the contraceptive injection for 1 year

Protection against STI's?:

- The contraceptive injection does not protect against STIs or HIV.
- Only a condom can protect you

Contraceptive injection



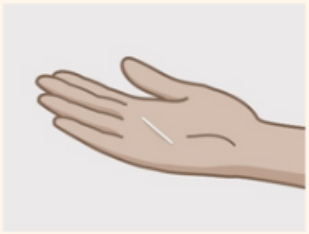
How do you use it?:

- The contraceptive injection provides protection against pregnancy for three months.
- It is used as described below:
  - Within the first five days of your menstrual cycle a health professional gives you an injection in your upper arm or buttock.
  - You then have to come back every three months (12 weeks) for another injection.

Presentation

How does it look?

Hormonal implant



What is it?

- The hormonal implant is a flexible plastic stick, the size of a lucifer.
- It contains one hormone that prevents ovulation.
- It also makes it harder for sperm to enter the uterus and reach the egg.

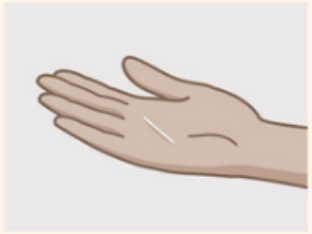
Reliability?:

- The hormonal implant is very effective when used properly.
- The chance of pregnancy is about 1 in 2000 (= 0,05 out of 100)

Protection against STI's?:

- The contraceptive injection does not protect against STIs or HIV.
- Only a condom can protect you

Hormonal implant



How do you use it?:

- A health professional will place the implant.
- The implant will be inserted with a needle just under the skin on the inside of your upper arm.
- This is practically painless.
- The hormonal implant remains effective for three years.
- After three years, it must be replaced

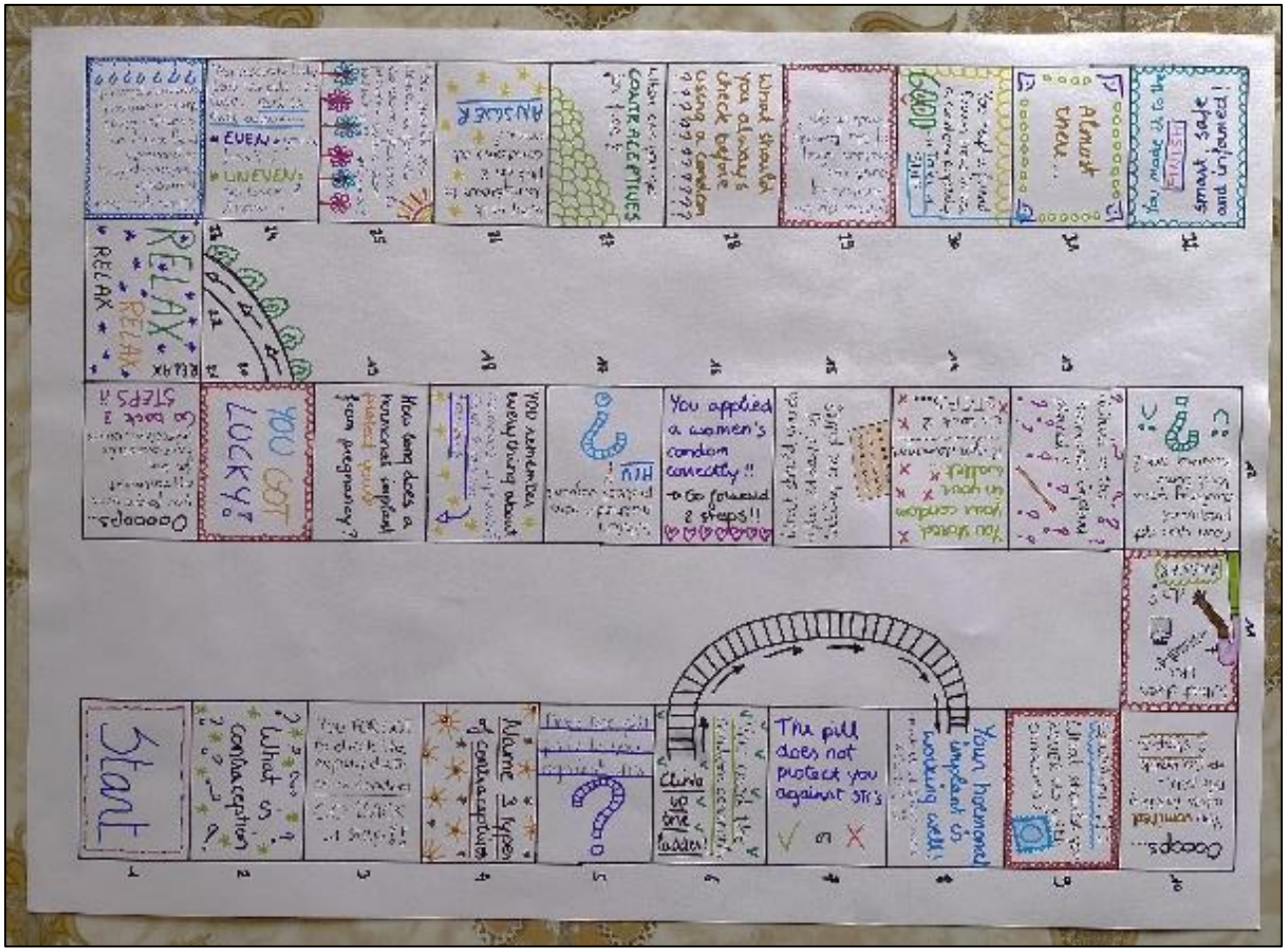
Presentation

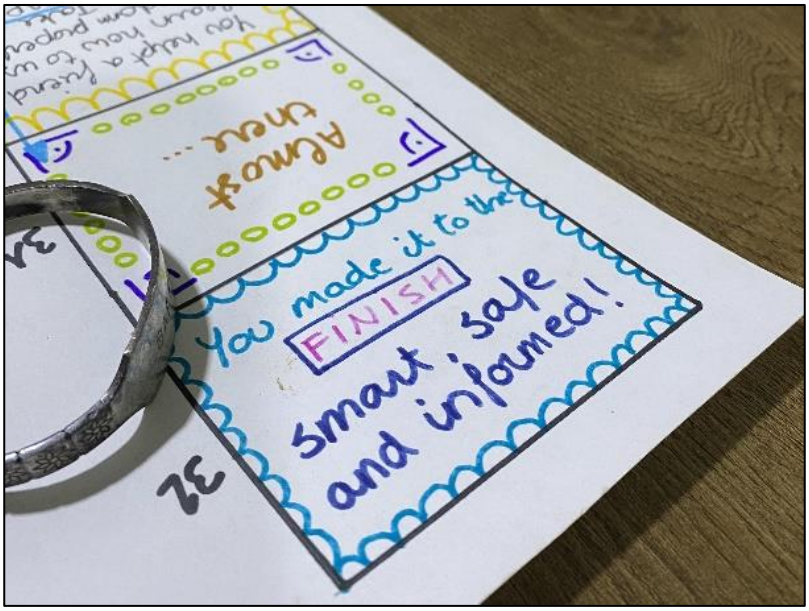
How does it look?


Side-effects of contraception
The pil
Contraceptive injection
Contraceptive implant
If you want to know the side-effects of the contraceptive you can read the package leaflet.
"Side effects vary from person to person – some people hardly notice them, while others may find them annoying. Fortunately, the symptoms often go away after a few months, once your body has adjusted to the hormones."


Thank you

GAME – CONTRACEPTION





EXTRA ATTACHMENTS

How to use a condom

Make sure the expiry date has not passed.

Tear open the package at the notch. Avoid using scissors, knives, teeth or sharp nails to prevent tearing.

Pinch the top of the condom closed to leave space for the sperm. Place the condom on the tip of the erect penis (erection).

Check that the rolled-up edge is on the outside. Then roll the condom all the way down over the penis to ensure it stays in place during intercourse.

The condom is ready for use.

After ejaculation, pull the penis back while it is still stiff.

Hold the condom tightly by the edge to prevent sperm from leaking out.

Tie a knot in the condom to prevent leaks and then throw it in the bin. Do not use it again.

Image source: (Sensoa, Tussen de lakens)

Contano Foundation - Made by Silke Colpaert and Caro Duvillers

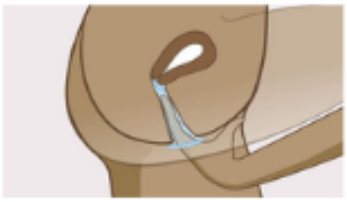
How to use a women's condom

Check that the expiry date is still valid.

Apply lubricant both on the inside and outside of the condom.

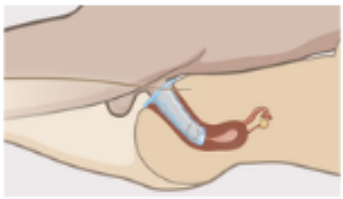
Press the inner ring together.

Insert the condom into the vagina.



Insert one finger into the condom and push the inner ring in as far as possible. Make sure the condom does not twist and that the penis stays inside the condom during penetration.

The outer ring ensures that the condom stays in place during sex. This ring stays outside the body and covers the area around the vagina.



After sex, grab the outer ring, turn it slightly and gently pull the condom out. Make sure no sperm comes in contact with the vagina.

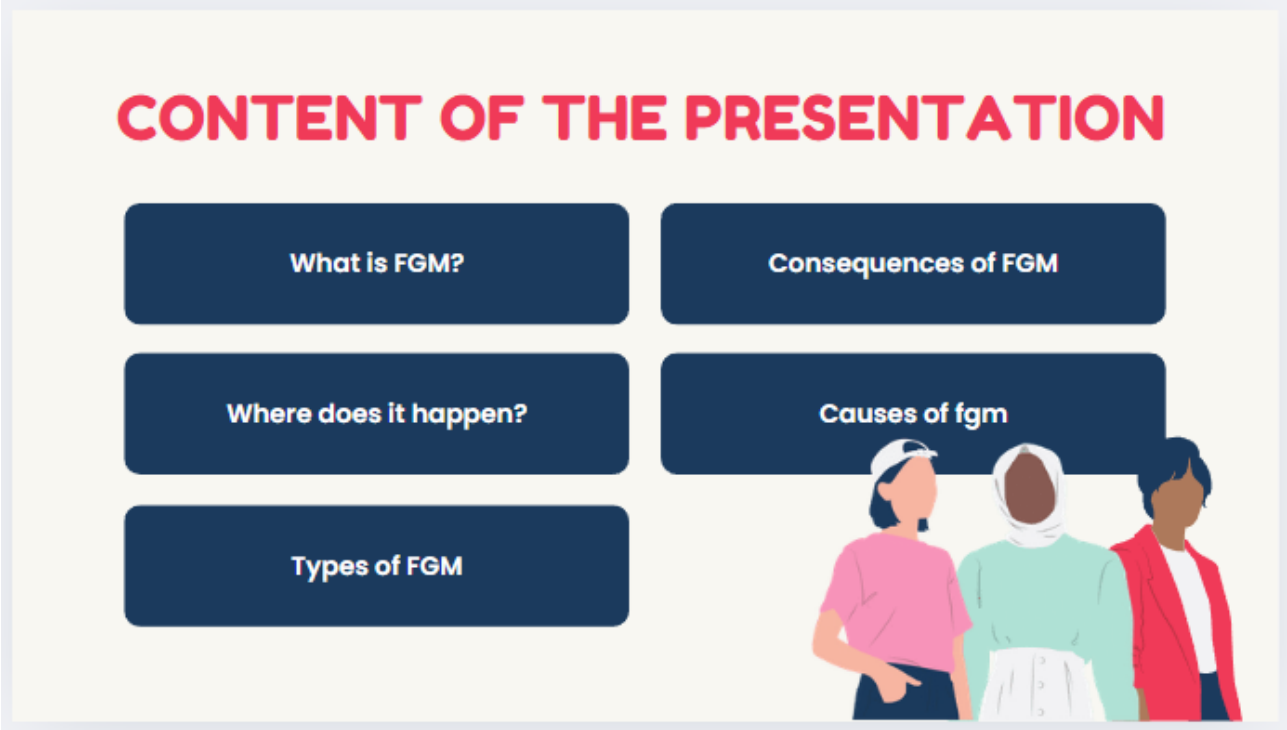
Throw the used condom in the bin.

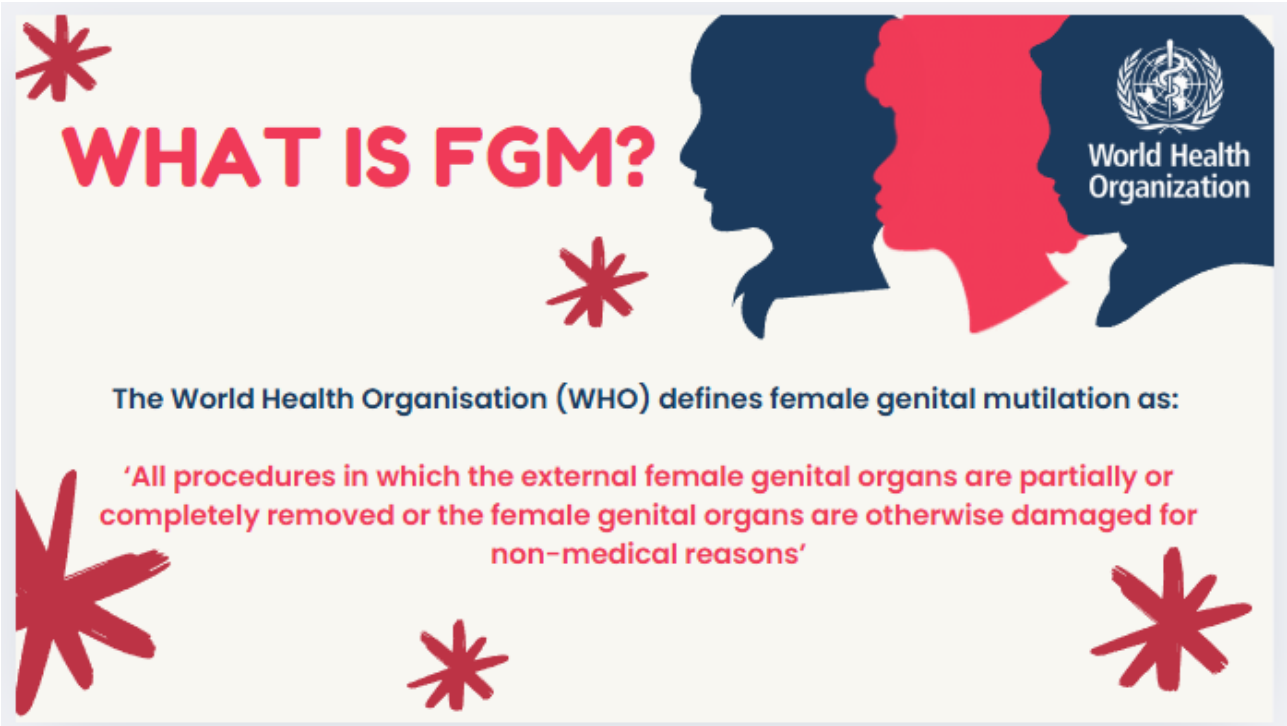
Image source: (Zanzu, Vrouwencondoom)

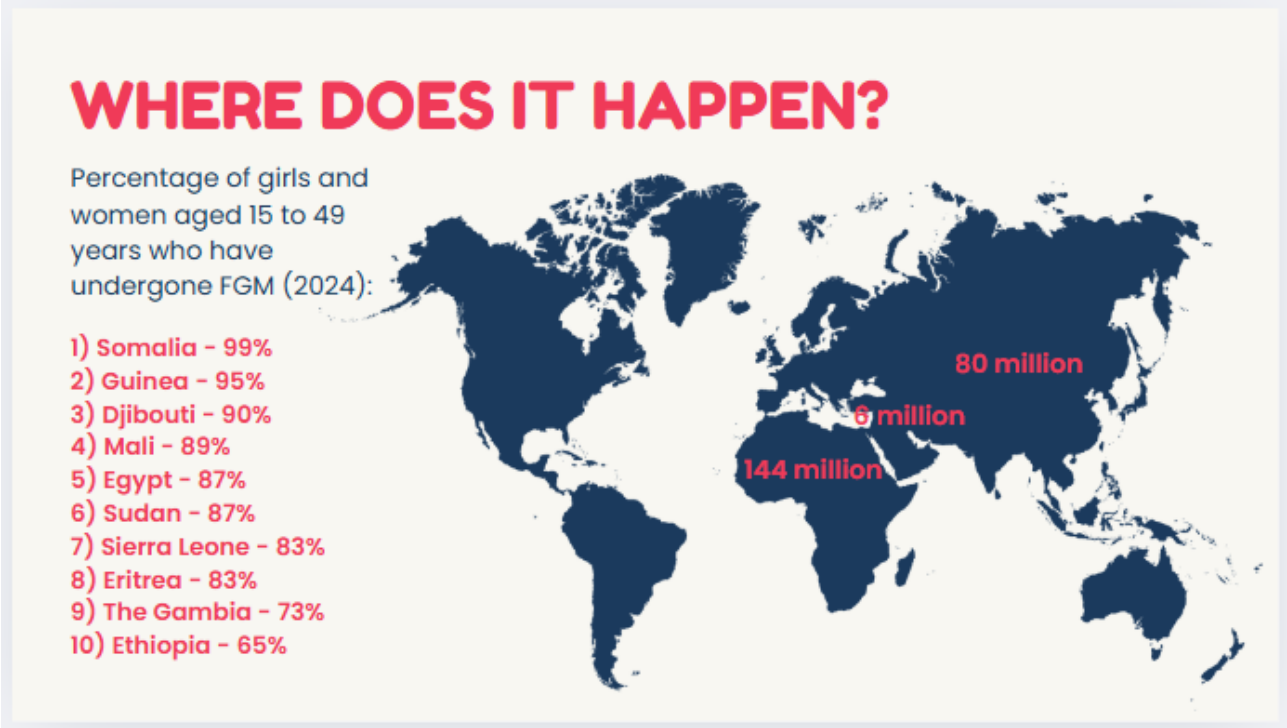
Contano Foundation - Made by Silke Colpaert and Caro Duvillers

ATTACHMENT 6: SESSION - FGM

POWERPOINT – FGM




WHAT IS FGM?
World Health Organization
The World Health Organisation (WHO) defines female genital mutilation as:
'All procedures in which the external female genital organs are partially or completely removed or the female genital organs are otherwise damaged for non-medical reasons'


WHERE DOES IT HAPPEN?
Percentage of girls and women aged 15 to 49 years who have undergone FGM (2024):
1) Somalia - 99%
2) Guinea - 95%
3) Djibouti - 90%
4) Mali - 89%
5) Egypt - 87%
6) Sudan - 87%
7) Sierra Leone - 83%
8) Eritrea - 83%
9) The Gambia - 73%
10) Ethiopia - 65%
80 million
6 million
144 million

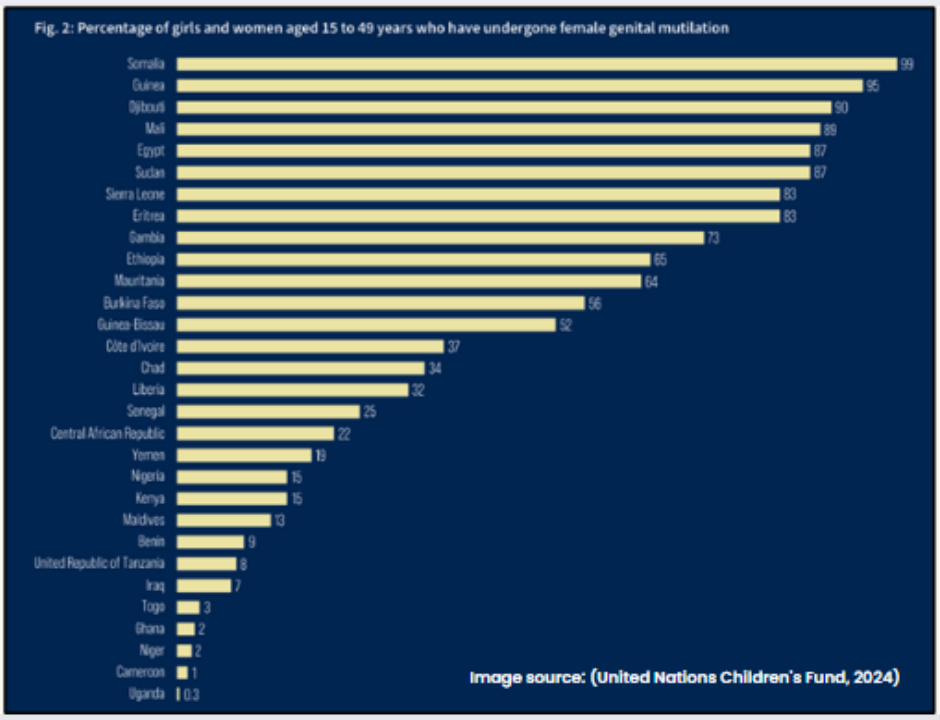
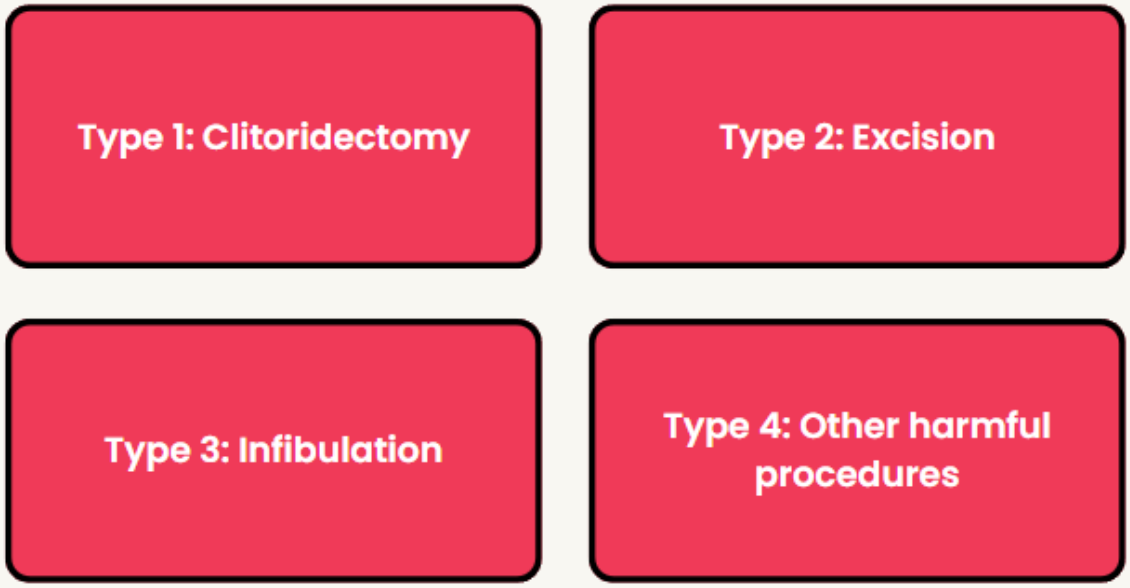
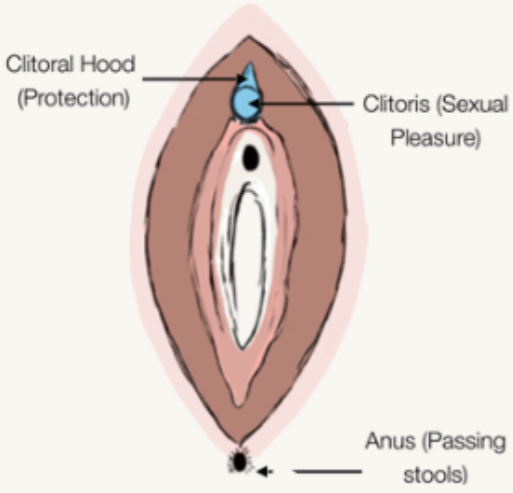


Fig. 2: Percentage of girls and women aged 15 to 49 years who have undergone female genital mutilation
Somalia 99
Guinea 95
Djibouti 90
Mali 89
Egypt 87
Sudan 87
Sierra Leone 83
Eritrea 83
Gambia 73
Ethiopia 65
Mauritania 64
Burkina Faso 56
Guinea-Bissau 52
Côte d'Ivoire 37
Chad 34
Liberia 32
Senegal 25
Central African Republic 22
Yemen 19
Nigeria 15
Kenya 15
Maldives 13
Benin 9
United Republic of Tanzania 8
Iraq 7
Togo 3
Ghana 2
Niger 2
Cameroon 1
Uganda 0.3
Image source: (United Nations Children's Fund, 2024)


Type 1: Clitoridectomy
Type 2: Excision
Type 3: Infibulation
Type 4: Other harmful procedures

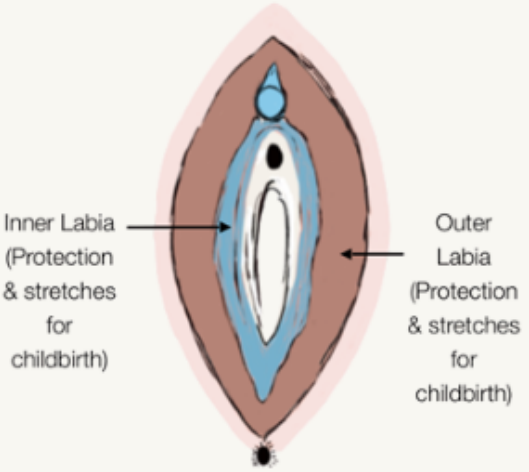
TYPE 1: CLITORIDECTOMY

Type 1: Partial or total removal of the clitoral hood and/or clitoral glans



TYPE 2: EXCISION

Type 2: Partial or total removal of the clitoral glans and inner labia with or without excision of the outer labia

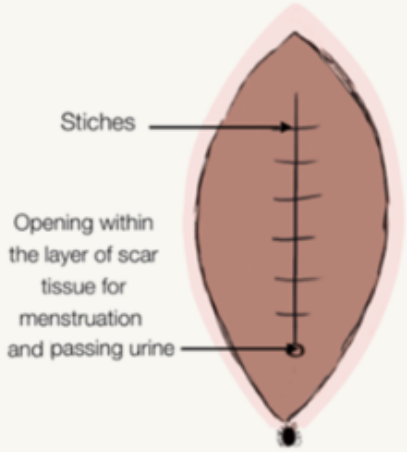


TYPE 3: INFIBULATION

Type 3: Usually includes partial or total removal of the clitoral glans and inner labia and/or outer labia, with inner and/or outer labia sewn/fused together leaving a small hole

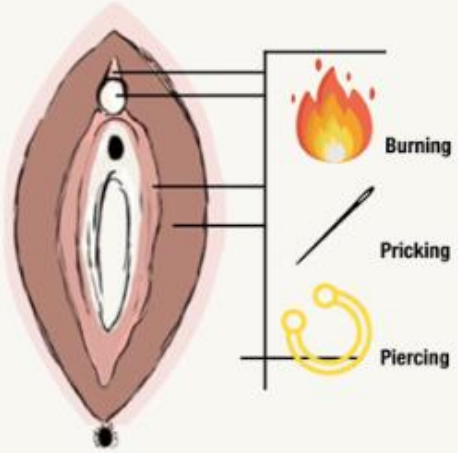
De-infibulation:

- First time having sex
- Childbirth



TYPE 4: OTHER HARMFUL PROCEDURES

Type 4: Any other injury to the genitalia including piercing, scraping, burning, stretching or pricking for non-medical purposes



CONSEQUENCES OF FGM

SHORT TERM CONSEQUENCES

- Severe pain
- Excessive bleeding
- Distension of the genital tissue
- Fever
- Infections e.g., tetanus
- Urinary problems
- Wound healing problems
- Injury to surrounding genital tissue
- Shock
- Death

CONSEQUENCES OF FGM

LONG TERM CONSEQUENCES

- **Urinary problems:** Painful urination, urinary tract infections
- **Vaginal problems:** Discharge, itching, bacterial vaginosis and other infections
- **Menstrual problems:** Painful menstruations, difficulty in passing menstrual blood, etc.
- **Scar tissue and keloid**
- **Sexual problems:** Pain during intercourse, decreased satisfaction, etc.
- **Increased risk of childbirth complications and newborn deaths:** Difficult delivery, excessive bleeding, caesarean section, need to resuscitate the baby, etc.
- **Women with type 3 (infibulation) may require de-infibulation:** This is the opening of the infibulated scar to allow sexual intercourse and childbirth. This can happen in several ways: through surgery, ...
- **Psychological problems:** Depression, anxiety, post-traumatic stress disorder, low self-esteem, etc.

CONSEQUENCES OF FGM

PSYCHOLOGICAL CONSEQUENCES

Female genital mutilation can have a lasting impact on a woman. The traumatic experience may initially be suppressed by the child, but may surface years later and manifest itself in various ways:

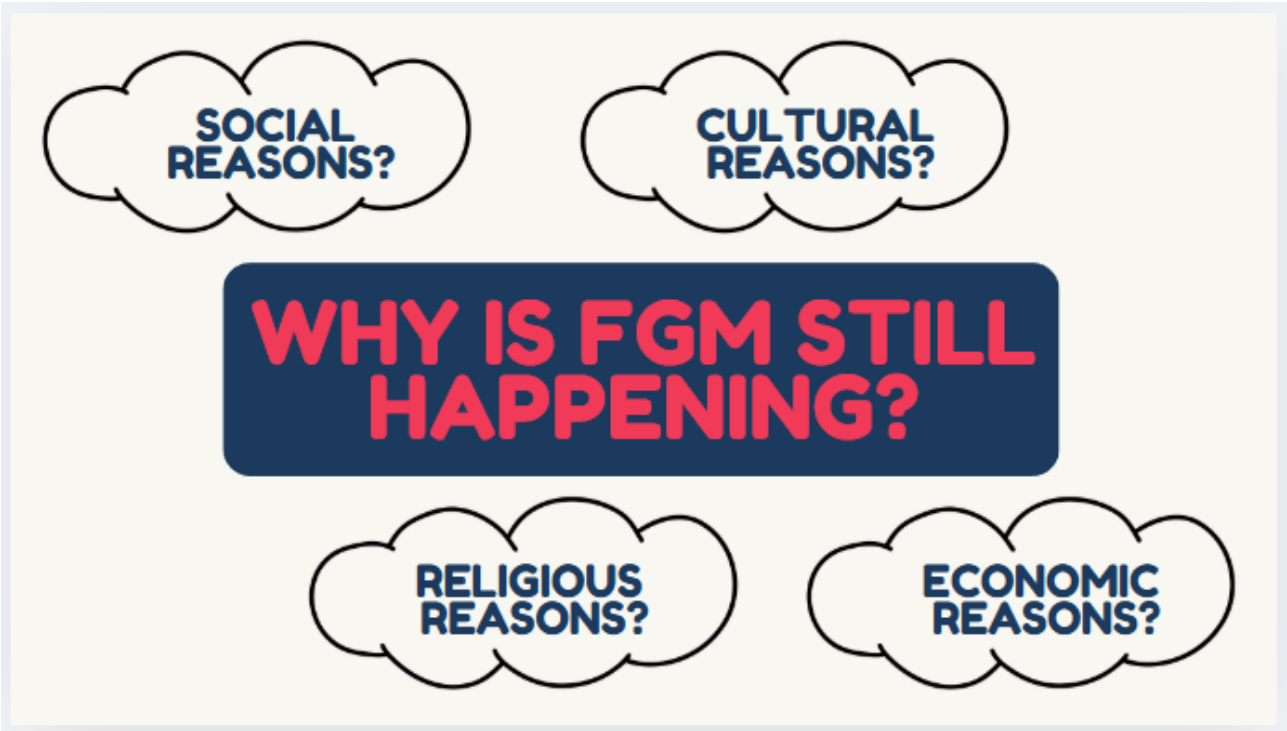
- Loss of trust in family
- Behavioural problems
- Anxiety, panic (flashbacks, nightmares)
- Depression - PTSD (Post-traumatic Stress Disorder)

FGM BAN IN THE GAMBIA

2015 - The Gambia took an **important step** in the fight against female genital mutilation by passing **a law banning the practice**.

2024 - There was an **unexpected proposal** to **reverse that ban**. That led to much debate, both within The Gambia and internationally. Fortunatly in July 2024 the **proposal was declined** and **they kept the ban**.

This shows how **fragile** such laws can be. It is not only about **legislation**, but also about **deeply rooted beliefs**, **social pressure** and a **lack of awareness** about the consequences. Amnesty International rightly highlights that **criminalisation** is only a **first step**. Without structural education and community-based initiatives, FGM is likely to continue in silence



CAUSES OF FGM

SOCIAL REASONS

- FGM is often necessary for **social acceptance** within the community.
- Girls and their families **experience social pressure** to avoid **exclusion** or **stigma**.
- Is seen as a way to **preserve virginity** and **control sexual behaviour**.
- Contributes to **family honour**; the girl is considered "**honourable**".
- In some cultures, FGM **increases the chances of marriage** and **bride price**.
- Uncut girls are sometimes seen as **unclean** or **unfit for marriage**.
- In polygamous marriages, FGM is sometimes used to **suppress women's sexual desires** and **protect the man's honour**.

CAUSES OF FGM

CULTURAL REASONS

- Considered **cultural heritage**, a tradition passed down through generations.
- Viewed as essential to **cultural identity** and **continuity**.
- **Female genital organs** are sometimes considered **unclean** or **ugly**.
- FGM is performed to **"cleanse" the body** or meet **beauty standards**.

CAUSES OF FGM

RELIGIOUS REASONS

- FGM **existed before** the coming of **monotheistic religions**.
- In some communities, it is **wrongly seen** as a **religious duty**.
- Neither the Bible, the Torah nor the Quran prescribe FGM.
- In 2006, Al-Azhar University in Cairo declared through **a fatwa** that **FGM has no basis in Islam**.
- This message was **confirmed by Islamic scholars** in the **Netherlands in 2007**.
- The Quran **highlights protection of the body** and **avoidance of harm**, including in:
  - Surah Al-Baqarah 2:195
  - Surah At-Tin 95:4
  - Surah Al-Ahzab 33:58
  - Surah Ar-Rum 30:30
- Conclusion: FGM **violates Islamic principles** and is **not supported by Islam**.

CAUSES OF FGM

ECONOMIC REASONS

- FGM is seen as a **required step to get married.**
- Women are often **economically dependent on men**, increasing the **pressure**.
- In some cultures, FGM is a **requirement** to receive an **inheritance**.
- Performing FGM can be a **source of income** for the **performers**.

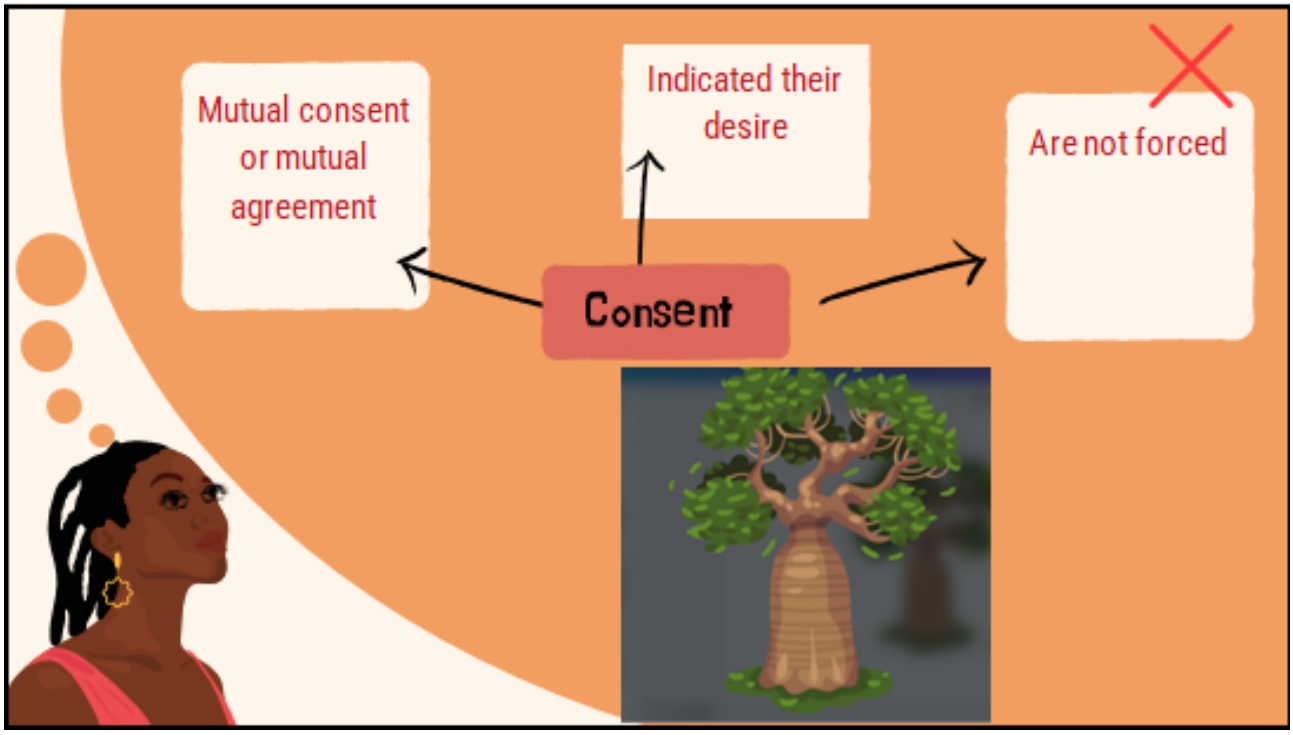
GAME - FGM

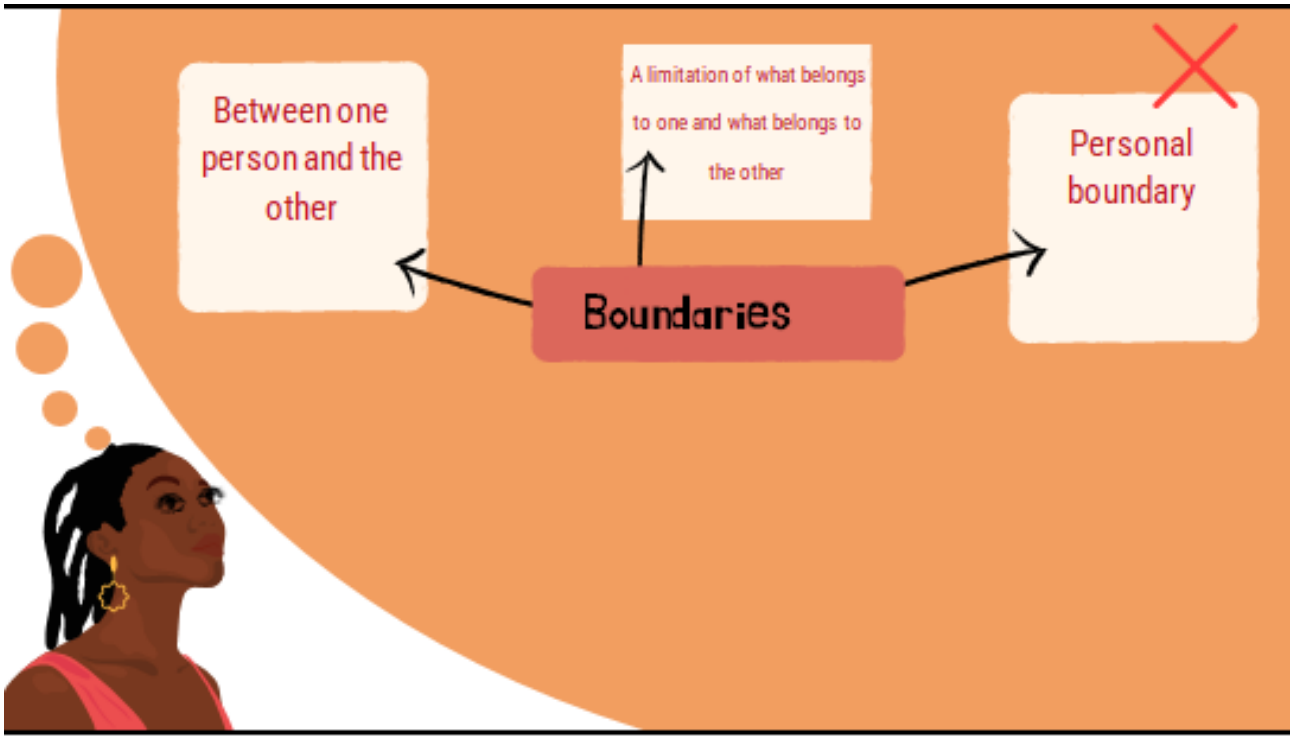

AWA
MOTHER
GRANDMOTHER
TEACHER
DOCTOR
IMAM
NEIGHBOUR
FRIEND
ACTIVIST
POLITICIAN

ATTACHMENT 7: SESSION - CONCENT AND BOUNDARIES

POWERPOINT – CONCENT AND BOUNDARIES

1





3

Practice: Boundary line

- The group will pair up and stand facing each other,
- The space between the rows should be about 6 large steps
- The participants in the left row walk towards the participants in the right row.
- The participants in the right row (right participants) will each individually signal when they find the person walking towards them to be too close.
- When the left participant gets too close, the right participant will stretch out their hand and say "stop!" It is important that the right participant feels this instinctively and does not look at the other participants.
- After the first round, the pairs can switch places. This way, participants won't always face their friend.

Practice: Body carrosel

This exercise is about sensing your boundaries and recognizing that they are different for other people. These boundaries are individual and situation-specific.

- The group is arranged in an inner and outer circle, forming pairs.
- Actions are read aloud, and the idea is to check in with yourself whether it feels okay or not. If it doesn't feel okay, you don't do it. Even if it feels okay to you but not to your partner, you don't do it. You respect the other person's boundary.

Discussion:

- Were many or few actions carried out?
- Was it difficult to set boundaries? Why? When?
- Did you always agree on what you did or didn't want to do?
- Would you do more actions if you had to do this exercise with one of your parents or friends? What about with a complete stranger?

5

Practice: Mythes

- The group is divided into small groups.
- Each group is presented with a statement. The task is for each group to agree or disagree with the statement and then provide an argument to support their position.

Statement 1

MEN ARE NEVER VICTIMS OF SEXUAL VIOLENCE.

- This statement is **incorrect**. While women are more often victims of sexual violence, men and boys in The Gambia are also affected. In 2023, 117 rape cases were reported. Although most victims were women, it is important to recognize that men can also be victims. However, data on male victims is limited, partly due to stigma and cultural taboos that make it difficult for men to report such incidents.

Statement 2

GIRLS AND WOMEN CANNOT SEXUALLY ABUSE ANYONE.

- This statement is **incorrect**. Although men are more often identified as perpetrators, women can also engage in sexually inappropriate or abusive behavior. In The Gambia, there have been cases of women involved in sexual abuse, although these are reported less frequently. Society often struggles to recognize female perpetrators, which contributes to underreporting.

Statement 3

MOST SEXUALLY TRANSGRESSIVE BEHAVIOUR IS COMMITTED BY A STRANGER.

- This statement is **incorrect**. In The Gambia, sexually transgressive behaviour is often committed by someone known to the victim. Data shows that most victims of sexual violence in The Gambia report incidents involving people they know, such as family members, friends or partners. This highlights the importance of addressing sexual violence within communities and breaking the culture of silence.

Statement 4

SEXUAL ABUSE RARELY OCCURS AMONG YOUNG PEOPLE.

- This statement is incorrect. In The Gambia, sexual abuse among young people is a serious issue. In 2023, 117 rape cases were reported and a significant number of victims were under the age of 18. About 30% of girls in The Gambia are married off before the age of 18, which increases their vulnerability to sexual abuse.

Statement 5

THERE ARE OFTEN FALSE ACCUSATIONS OF SEXUAL VIOLENCE.

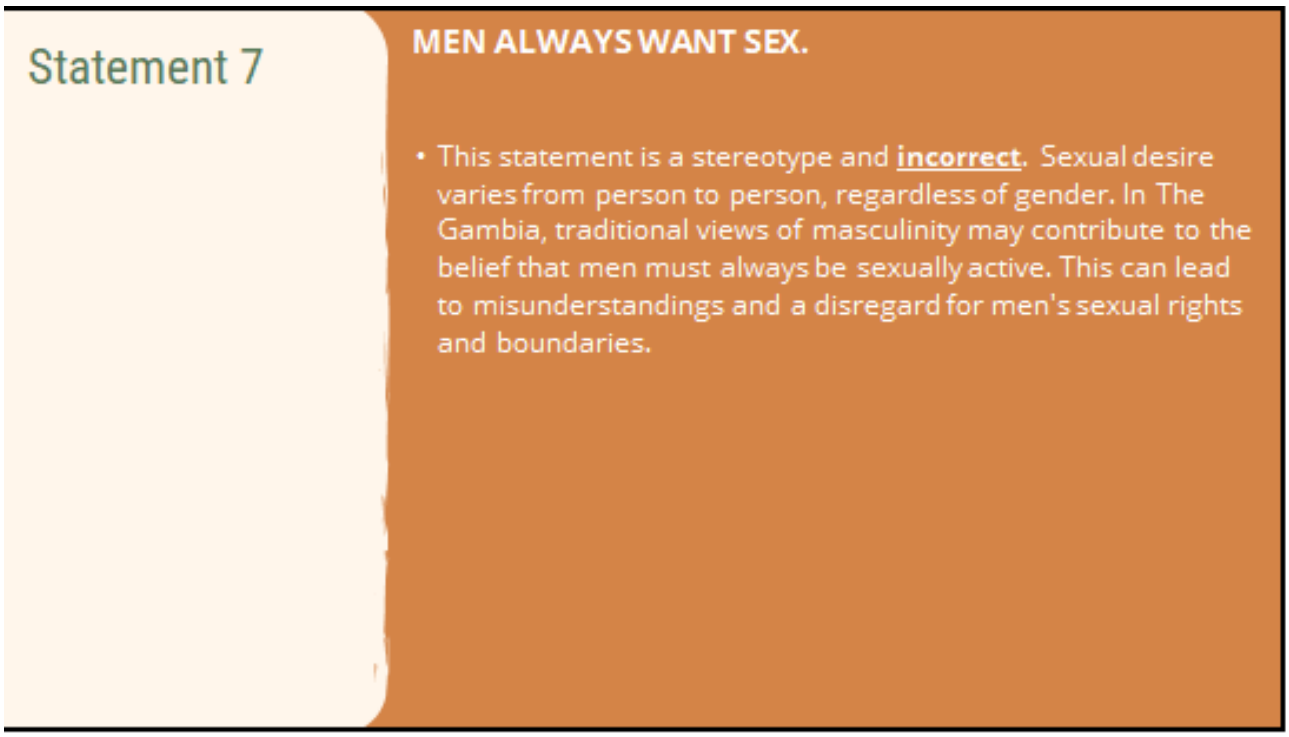
- This statement is **incorrect**. False accusations of sexual violence are rare. In The Gambia, it is more common for victims not to report incidents due to fear of stigma, social exclusion or a lack of trust in the justice system. According to a report by Afrobarometer, 63% of Gambians believe that victims of gender-based violence are criticized or mocked if they report it.

11

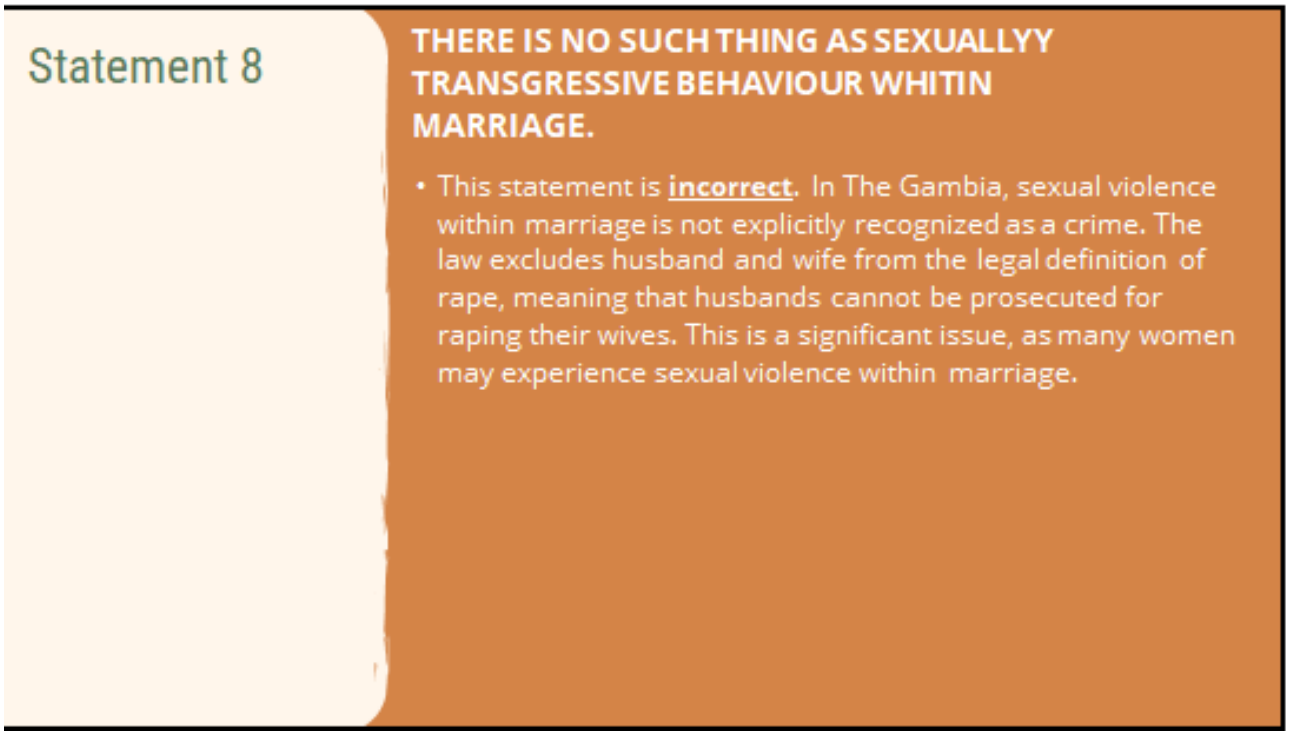
Statement 6

IF YOU DON'T RESIST SEXUALLY TRANSGRESSIVE BEHAVIOUR, IT'S YOUR OWN FAULT.

- This statement is **incorrect** and harmful. In The Gambia, as in many other countries, victims of sexually transgressive behavoirmay not resist for various reasons such as fear, trauma or cultural pressure. It is important to understand that the responsibility always lies with the perpetrator, regardless of the victim's response.

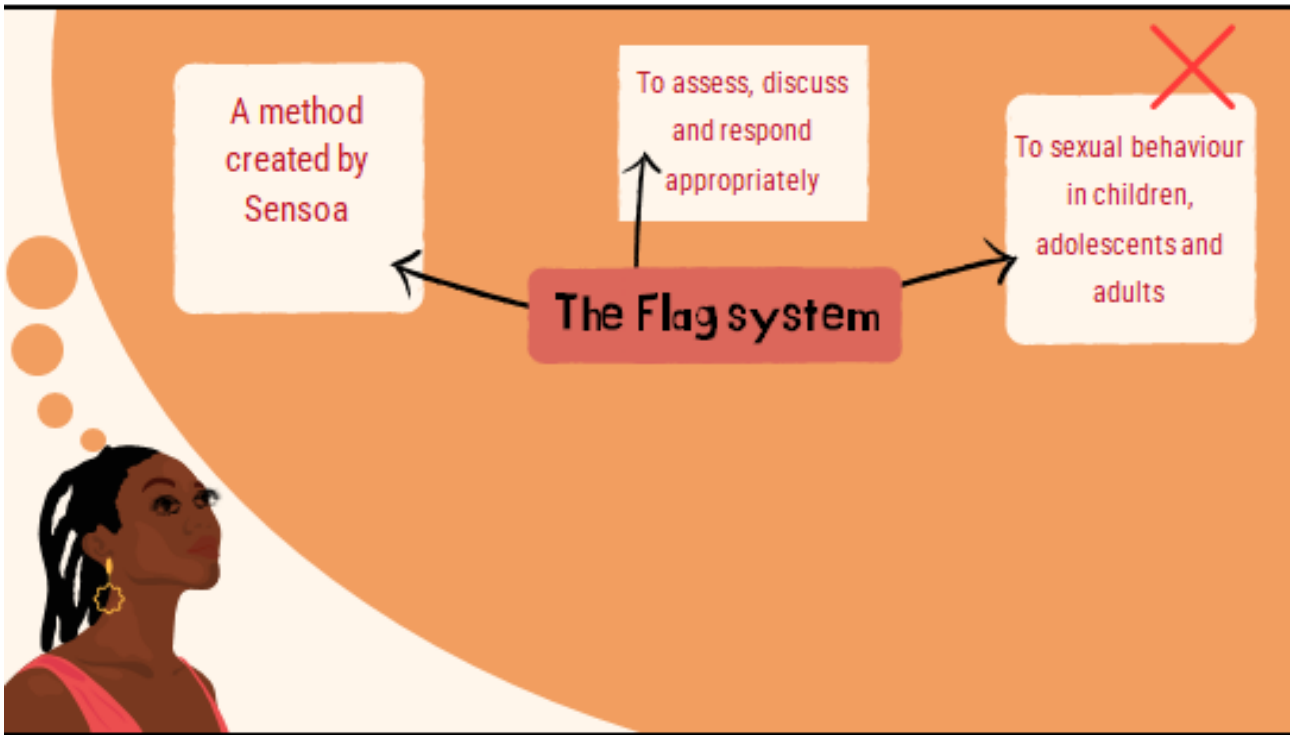

Statement 7
MEN ALWAYS WANT SEX.
• This statement is a stereotype and incorrect. Sexual desire varies from person to person, regardless of gender. In The Gambia, traditional views of masculinity may contribute to the belief that men must always be sexually active. This can lead to misunderstandings and a disregard for men's sexual rights and boundaries.

L3


Statement 8
THERE IS NO SUCH THING AS SEXUALLYY TRANSGRESSIVE BEHAVIOUR WHITIN MARRIAGE.
• This statement is incorrect. In The Gambia, sexual violence within marriage is not explicitly recognized as a crime. The law excludes husband and wife from the legal definition of rape, meaning that husbands cannot be prosecuted for raping their wives. This is a significant issue, as many women may experience sexual violence within marriage.


The Flag system

.5


A method created by Sensoa
To assess, discuss and respond appropriately
To sexual behaviour in children, adolescents and adults
The Flag system

Practice

The Flag system

- Divide the class into small groups and give each group the worksheets with six situations involving boundary-crossing behavior.
- Ask the groups to categorize the situations into 'okay' and 'not okay.
- Rank the situations from 'completely okay' to the most severe 'completely not okay.'
- the young people go over their rankings and explain why they consider certain behaviors to be (not) okay.
- Ask them what they think makes a certain situation acceptable or not.
- Write their answers on the board.
- Connect their input to the official criteria of the Flag System.

17

Criteria

The Flag system

Mutual consent
- *Can be withdrawn at any time*
- *Not by surprise*
- *Limited language ability*
- *Non-verbal*
- *Nuance Quran*

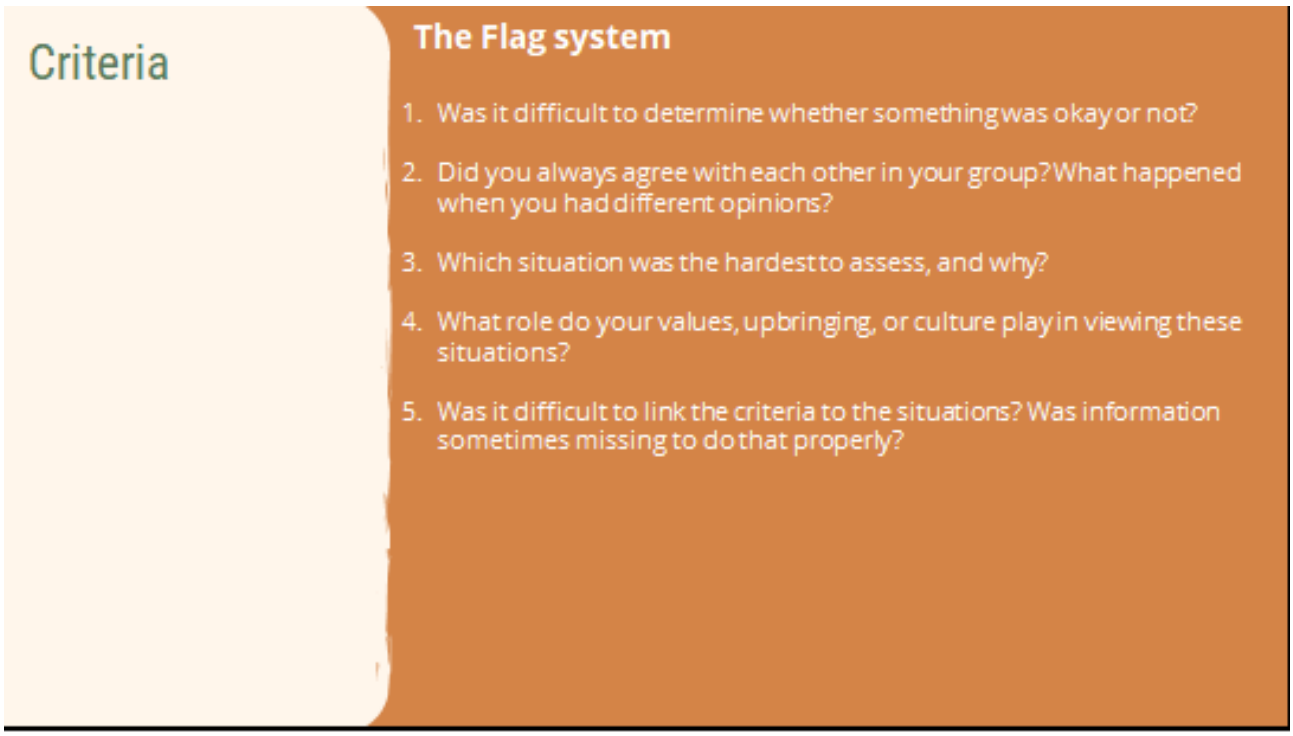
Voluntariness
- *Not forced (also not in Marriage)*
- *UDHR*

Equality

Developmental or functional level
- *Sexual behaviour is okay when it fits a certain age or developmental phase*

Context
- *Privacy and acceptable*

Impact
- *Sexual behavior is okay if it does not cause harm to the involved parties physically, psychologically, or emotionally,*


Criteria
The Flag system
1. Was it difficult to determine whether something was okay or not?
2. Did you always agree with each other in your group? What happened when you had different opinions?
3. Which situation was the hardest to assess, and why?
4. What role do your values, upbringing, or culture play in viewing these situations?
5. Was it difficult to link the criteria to the situations? Was information sometimes missing to do that properly?

L9


Thank you

ATTACHMENT 8 : INTERVIEW MR. KELEPHA KOITA

We conducted an interview with Mr. Koita, an assistant social worker, because we wanted to learn more about the laws in The Gambia regarding rape and sexual-related crimes. We also wanted to hear his perspective, as a local man, on the topic of sexuality. In this, we included his religious, cultural and gender-specific views.

The interview took place on 14th of march 2025 at 3:00 PM at Happiness Guest Rooms, Basse.

What are the laws in The Gambia regarding sexual violence?

When it comes to child marriage, rape or gender-based violence in general, we have the constitution, which is the supreme law of the country, that prohibits these matters. We also have acts that support this supreme law. For example, we have the Women's Act of 2010, the Children's Act of 2005, the Sexual Offences Act and the Trafficking Act.

What happens if a sexual-related crime occurs?

In this aspect, we face a challenge here in The Gambia. If someone reports it, the authorities will do what they need to do. If the first point of contact is the hospital, the social workers there will coordinate everything and a referral to the police will take place. The social workers will maintain contact with the victim to follow up on the case. The police handle the legal aspects and the application of the law. If there is a violation, the court will be involved. Sometimes these things happen but are never reported. This is because of the culture of silence. Families do not want a bad reputation. Besides, it could also be that the crime is conducted by the family's breadwinner, they don't want to lose them for economic reasons.

What does rape mean here in The Gambia?

First of all, it is unacceptable. It happens often, but it is not reported. Rape in The Gambia is often committed by close family members. To avoid damaging the family’s honor, they choose to remain silent. The big challenge here is the culture of silence.

Can a man rape his wife?

The law states that rape is not possible if it happens within a marriage. Only if the parties are not married can prosecution take place.

Are there other reasons why people remain silent, such as economic reasons?

Men are often the breadwinners of the family. If these men go to jail, no money comes in. Furthermore, we must always remember that there is a culture of silence. These topics are often very sensitive, so people prefer to avoid them.

We also heard from the hospital that the weapon used is an important detail in an assault. A hospital worker told us that using a knife on someone is considered assault, but using a razor blade is not. Is this true? How is assault perceived?

It does not matter what type of weapon is used. You must always go to the police. Anything that causes physical harm is considered assault.

What are the religious influences on consent and permission? We heard that a woman cannot refuse her husband if he wants sex. Is this true?

According to the religion, this is true. It is stated in the Quran that a woman cannot say no to her husband.

Are there other things in the Quran related to sex, consent, permission, assault, etc.?

It mainly concerns what the woman and the man agree upon in their marriage. Religion is not strictly applied to certain matters. It depends on the individual's interpretation. Many people also use the Quran as an excuse. People here are often not well-educated about the Quran, so sometimes they just say things.

Is there a difference between culture and religion?

People mix these concepts. As I said, people use the Quran as an excuse to obtain or do things. For example, FGM is not religiously supported but is still practiced as part of Islam. It is purely cultural. There is a link between FGM and Islam in a story, a hadith of the Prophet Muhammad. In this story, the Prophet comes into contact with people who practice FGM. The Prophet told them that if someone cannot stop practicing FGM, they should just cut a little bit. What this means is that whether you do it or not, you are still a good Muslim.

Is there a good understanding of what happens in the body when someone is pregnant or menstruating?

Most girls do not have that knowledge. Especially when a woman is pregnant, she often does not know what is happening in her body. They definitely need support.

In type 3 (infibulation) of FGM, the vagina is normally completely sewn shut with a small hole left for menstruation and urine. We have read that when a girl has sex for the first time, this little hole has to be opened. How do they open this?

Normally before a girl is given to her husband if she is sealed. She's taken back to the circumciser (the women who do the cutting) to unsealed her by using a blade to open the vagina so that the husband can have access to her. Immediately after she's unsealed, her husband will have sex with her for continuous three days to avoid it getting close again.

Do you know of any other ways to perform this practice?

Yes, sometimes unsealing happens through penetration of the man. The girl still gets tears in her eyes, but this time not because of a knife.

How does this happen for childbirth?

For child birth most of the time they undergo C-section or they get expanded which sometimes leads to fistula.

ATTACHMENT 9: INTERVIEW IMAM ALPHA SIDIBEH

This interview with imam Alpha Sidibeh from Mansanjang Kunda district took place on 16 April 2025. The interview was conducted by Silke Colpaert and Caro Duvillers, as part of our bachelor thesis on sex education. During the interview, this topic was discussed, with a particular focus on religion, culture and social challenges. The meeting was supervised by Mr. Kelepha Koita, assistant social worker.

What are the jobs of an imam?

The primary role of an imam is to lead the prayers. In Islam, there are five daily prayers and it is the imam's responsibility to guide these. In addition to leading prayers, an imam also acts as a mediator within the community, especially in resolving family issues, such as conflicts between husbands and wives.

I am also involved with the ADRS (Alternative Dispute Resolution Service), an institution that aims to resolve disputes peacefully. This helps to prevent people from taking their cases directly to court.

How many Imams work in Basse?

There are many imams in Basse, more than 100. Every settlement has its own imam.

How does Islam in general look at sex education?

In Islam, there is no issue with educating people or discussing sex. Islam is all about learning and understanding. The goal is to help people gain knowledge. You need someone to guide and teach you how to approach such matters.

Is there an age or time in Islam when sex education is appropriate?

In our community here, we have two influences: Islam and our culture. Sometimes, these two are mixed. In Islam, from the age of 7, it is important to know many things about religion. Sex and marriage is part of that. From the age of 7, it is your right to learn about religion and yourself. The challenge, however, lies in the culture, which sometimes conflict with religious teachings.

According to Islam, what is the purpose of sex education?

We don't start with sex between two people. We start with, for example, a girl to preserve herself and to guide herself from others. To not be harmed before the age of marriage. We also talk about adultery, we don't allow that. That's why we talk to them about: don't do this, don't do that. Don't go for early marriage, don't go for early sex. We don't talk about how sex between two people works, except when the person gets married. Then we start advising the person: do this with your wife, do this with your husband.

How is the importance of knowledge about one's own body highlighted in Islam?

It is written in the Quran. It gives you the story about how a man starts. Starting with sperm, from sperm to this, then to that… until the child is born. The stages of making a child.

This is told in the story of our father which is Adam and Hawwa. We are all descended from them. The Quran speaks about sperm, explaining that it remains for 40 days and after those 40 days, it transforms into something else.

How is reproduction and the human body discussed in Islamic teachings?

It is discussed after they get married, on the wedding night, because here we mix religion and culture. We don't forget about our culture, because sometimes people see things from both an Islamic perspective and a cultural side.

Is it allowed in school to be taught about topics such as menstruation, puberty and reproduction?

Yes, especially menstruation is even taught in Islam. Girls are taught how to clean themselves and after menstruation, how to perform the ritual washing of the body. This washing is called ghusl in Arabic. It is required to remove ritual impurity (Janaba in Arabic), before a girl is allowed to pray.

- What about boys? Do they also learn about things related to girls, like menstruation?

Yes!

What is the Islamic view on the use of contraception within marriage?

In the holy book many things are mentioned, especially about that topic. Having a child every two years is going to affect the parent and the child. So in Islam, it's allowed to space the children because of health issues for the mother or the child.

In Islam, if a lady goes to a health centre and the doctor advises her not to get pregnant and if she then forces herself to get pregnant, it's just like killing herself.

- So contraception is only used to space the children?

Yes, but not because you can't feed them. You know, some people have the mentality that if you have 10 children, you cannot feed them because rice is costly. This is not true. We believe that everything comes from God. God is the sole provider. So having many children doesn't mean you cannot feed them.

- What kind of contraception do they use for spacing the children?

This is left to what the doctor advises. Some people use the injection or the pill. Some companions of the Prophet Mohammed, when they had sex with their wives and the sperm was about to come, they pulled back. This is called 'Azl' and they saw it as a form of birth control.

This is why some scholars don't allow condoms, because they say that if someone can just pull back when the sperm is coming, then you don't need condoms. So, some scholars allow condoms and some don't.

- You say some scholars. So not everybody?

I say 'some' because everybody has their own way of interpreting the story of 'Azl'. Some will say that in the time of the Prophet there were no condoms. So if they could use 'Azl', why use a condom? These scholars always look at how it was back then.

Can contraception also be used for the purpose of postponing children for economic or personal reasons, for example? Or is it only allowed in case of medical emergency?

In Islam, we don't allow that for economic reasons. It is against our faith. Only for medical reasons or spacing the children. I can give you an example about abortion. We don't allow that, but in Islam, when it comes to life or your life is threatened, it's allowed to save the mother.

Even alcohol is not allowed in Islam, because it's not good for your health. But for example, when you go to a place and they don't have water to drink and you are thirsty and the only thing you have is alcohol, then it's allowed. In Islam, they want you to save your life and drink the alcohol.

Is there a difference of opinion among scholars within the Islamic tradition on contraception?

I already answered that.

How do you look at contraception before marriage?

Sex before marriage is not allowed in Islam.

- But does it happen a lot, sex before marriage?

We are in a society where the majority are Muslims, but there are people among us who do that. However, it is not Islamic. We do not allow it.

We see many cases of rape of unmarried girls by men. Does it change your view on contraception before marriage if it is a way of protection from getting pregnant by your rapist.

Yaah, we just mentioned that in Islam, what matters most is life and dignity. We live in a society where there are people who could potentially harm you at any time. So we allow women to protect themselves in such situations.

- If I understand correctly, contraception is allowed to protect yourself, but it's not allowed just to have sex?

Yes, contraception is allowed to protect yourself, but not for other intentions. When you are in a safe environment, there is no reason to use it.

- We see a lot of rape cases here in Basse. I think you (Mr. Kelepha Koita) can confirm that. So, is it allowed here in Basse?

Yes, it is allowed for that purpose alone.

Is it permitted in Islam to inform young people about sexual relations before marriage if it is done in an educational way?

I already answered that.

According to Islam, how can young people properly prepare for marriage?

In Islam, age matters. You need spiritual preparation and to be psychologically fit for marriage. Because in our culture and even in Islam, it's not only you and your husband, like in other countries. It's a family matter. A person should be well prepared.

- Do you as an imam prepare those girls and boys?

Yes, I do talk to some of them before marriage. I provide counseling and coaching to both genders.

- What is then discussed in those preparations?

Some of them are just about: what is marriage? Because you need to know and understand what it is. And second, we always ask whether you are forced. Did someone force you to marry? For me, I sometimes use a telephone when someone lives far away to ask this question. I ask this 3 or 4 times to both men and women.

At what age can you get married?

Our Prophet married Aisha at the age of 9. The Prophet's daughter was 14 years old. One of his friends, who was a worker, came to him and asked if he could marry his daughter. The Prophet said that the 14-year-old girl was too young, so he could not give her to him. Two years later, one of his companions came to him and asked if he could marry his daughter. The Prophet said that the 16-year-old girl was too young, so he could not give her to him. When she reached 18 years old, Ali came and the Prophet gave her to Ali.

So people think the Prophet married Aisha at the age of 9, but this is not the correct information. Some people used to rely on that to say that a girl can marry at any time, but that's not true. A girl cannot marry at any time, because marriage is about consent. A 13-year-old girl cannot give her permission. She doesn't understand marriage and is not physically fit for it.

- So, 18 is the age when it is allowed to get married?

Yes, 18 and above.

Extra questions:

- Some people associate FGM with religion. What do you think about this?

Mutilation in all forms is not good. We all know that. FGM is more of a cultural thing.

- I read a story in the Hadith about someone who was performing FGM and someone said: 'Don't do it, just cut a little.' What can you tell me about that?

Yes, at the time the Prophet migrated from Mecca to Medina. He met a woman who was performing FGM. Her name was Umm Atia. He asked her: 'What are you doing here?'. She explained the reason why she was doing it. The Prophet said, 'Ah, okay, if this is the reason you are doing it, don't cut it all, just a little bit.'

Because Umm Atia explained to him why she was doing it, some people think the Prophet thought this could be good for them. They believe that if you cut a little part it can be good for their health.

If you want to do it, you can, but nobody can force you to do it. However, it doesn't deny you from being a Muslim if you do it or not. So, it's like a choice and part of culture.

- I have a question about STI's and STD's. I heard that when someone gets a sickness, it's considered God's will. Correct me if I'm wrong. I was just wondering, does Islam recognize these infections and diseases?

I will start with your first question. That's not true, not everything is God's will. For example, on the highway vehicles are passing by fast. If you lie down on the road and get hit, that's not God's will. You killed yourself. Smoking is harmful, so if you smoke until you get a disease, that is also not God's will.

But if I'm just sitting here, talking to you and a coconut unexpectedly falls on my head, that can be considered God's will, because I have no control over that. Not everything is controlled by God. We also have a part to play, because He gave us brains.

And to answer your second question: yes, Islam is aware of it. That's why Islam teaches that if you have a disease, you must isolate yourself. This actually happened several times during the time of the Prophet.

- Can you use contraception if someone is infected with an STI and they want to have sex?

Yes, that one is medical. So if it's harmful, Islam will tell you to stay away from it, because losing one life is better than losing two. That's why we closed all our mosques during COVID-19.

- COVID-19 came from China to The Gambia. Do you think this is man's fault or God's will?

This is man's fault, because we asked people to stay away from each other. The first case of COVID-19 was a woman from the UK who brought it here. So it's a man's fault.

ATTACHMENT 10: INTERVIEW FAMILY PLANNING - SIDI JAHN

This interview with Sidi Jahn from Family Planning, Koba kunda took place on 18 March 2025. The interview was conducted by Silke Colpaert and Caro Duvillers, as part of our bachelor thesis on sex education. During the interview, contraception and STI's were discussed, with a particular focus on what part Family Planning takes in this. The meeting was supervised by Mr. Salima Moujtahid, worker from Contano Foundation.

What is the function of Family Planning?

Family Planning ensures that women can space their pregnancies. Spacing pregnancies is important for the health of the woman as well as for the health of the family. We also offer awareness programs to raise consciousness about early pregnancies. Furthermore, we also conduct HIV testing and provide counselling for patients who seek advice.

You mention counselling, what does that entail?

Counselling is done in steps. When a woman comes in, we first ask the reason for her visit. We then adapt our services to that request. If we cannot provide the services the patient wants, we refer them to the hospital.

What would be a case in which you refer someone to the hospital? Women sometimes come to us because their implant is gone. They no longer see the implant in their arm and ask for our help. We then refer them to a doctor.

What contraceptives do you offer?

We have condoms and female condoms. We also offer the injection, the pill and the implant. The implant and the injection are administered here by a nurse. We have a nurse here who is ready every day for the women who come here.

Are these free of charge?

Yes, all our services are free.

Are the tests to detect STI's free?

In Family Planning, these tests are free. We receive resources from UNFPA. These resources also allow us to offer free antibiotics and contraception.

Can people always come here for free contraception?

Yes, if something runs out, I buy new ones in the shop.

How do you take into account the cultural and religious influences on contraception?

We hold a committee with religious leaders every month. In that committee, we discuss the necessity of contraception and also the vision and opinion of the religious leaders. We are also bound to confidentiality. If a woman comes to us, that stays with us.

Which STI's do you often see in Family Planning?
We see HIV, Chlamydia and Chancroid.

Can men also come here?
Yes, everyone is welcome, but we mainly see women. Men do come sometimes to ask for condoms.

ATTACHMENT 11: CERTIFICATE E-LEARNINGS – CARO DUVILLERS

SOAIDS Nederland | Academie.

Certificaat

Wij verklaren hierbij, dat

Caro Duvillers

heeft deelgenomen aan de e-learning

Basiskennis soa's

afgerond op

26 maart 2025

(tijdsinvestering e-learning: 2 uur)

Hanna Bos
Arts Maatschappij & Gezondheid Infectieziektebestrijding KNMG
bij Soa Aids Nederland

SOAIDS Nederland | Academie.

Certificaat

Wij verklaren hierbij, dat

Caro Duvillers

heeft deelgenomen aan de e-learning

Een sekspositieve benadering

afgerond op

26 maart 2025

(tijdsinvestering e-learning: 1 uur)

Hanna Bos
Arts Maatschappij & Gezondheid Infectieziektebestrijding KNMG
bij Soa Aids Nederland

ATTACHMENT 11: CERTIFICATE E-LEARNINGS – SILKE COLPAERT

SOAIDS Nederland | Academie.

Certificaat

Wij verklaren hierbij, dat

Silke Colpaert

heeft deelgenomen aan de e-learning

Basiskennis soa's

afgerond op

27 maart 2025

(tijdsinvestering e-learning: 2 uur)

Hanna Bos
Arts Maatschappij & Gezondheid Infectieziektebestrijding KNMG
bij Soa Aids Nederland