Module 2: Evidence based approaches to sexuality education for adolescents - Adolescent health and development with a particular focus on sexual and reproductive health - Assignment

Cecilia Capello
Enfants du Monde, Grand-Saconnex, Switzerland

I am doing this assignment for Burkina Faso as I am currently working as back-stopper of RH projects implemented in Burkina Faso. This document is based on a literature review and not on personal experience.

Barriers to the expansion of sexual education in Burkina Faso

1. Social-cultural factors. Social pressure is still a strong influence in society, especially in certain rural areas, and discussion of sexuality between the generations remains taboo. The topic of sexuality is still surrounded by silence. This is linked not only to the nature of the topic, but also to the belief that things are learnt through experience, at the moment in which they happened, and therefore there is no need to explain them in advance.
2. Reaching the youth through school. The youth have mainly be reached through schools. In the formal education sector, sexual education is included in the school curriculum of the Population Education course (EMP- Formel) at the primary and secondary level. Burkina Faso also implemented some programs targeting the youth enrolled in the non-formal education system. The low school enrollment (and especially the poor representation of the female population) and the paucity of programmes for the non-formal education system and for the out of school population, represent important barriers to reaching the adolescents with sexual education.
3. Level of knowledge of educators in sexual health. As mentioned above, sexual education is included in the school curriculum at the primary and secondary level. Skills and competencies in the public sector do not always match the needs for achieving tasks and human resources have not always undergone quality formal training in sexual education.
4. Reproductive health (RH) services. The use of RH services by the youth is low. Young people feel uncomfortable (i.e. ashamed) in going to health facilities for sexual and reproductive health (SRH) education, as a reflection of socio-cultural norms. Moreover adolescents clinic are generally located in cities, and this excludes the young in rural communities.
5. Coordination of interventions. Despite the fact that national policies and programs in the country target adolescents and young adults, activities are often implemented within single projects concurrent to the availability of funds. Efforts are needed to improve the coordination among implementers, especially at ground level.
6. Youth involvement in policy elaboration and programme designing. Government documents identify youth involvement as a part of their program; however, details on how youth are to be involved in the formulation, implementation, and evaluation of the program are often scarce. NGO programs mainly involve the youth indirectly in defining issues and program objectives, while the direct involvement is scarce. Also during

programme evaluation, the involvement of adolescents may often be limited to a "post-intervention survey" conducted among adolescent programs, more than youth representatives serving as participants on the evaluation team.

7. Programmes evaluations. While there are project evaluations, reflecting the use of mid-term and final reviews, it was difficult to find objective studies to determine if youth behaviour has evolved consequently to the national youth health educational programme. This may be due to the scarcity of evaluations or simply to the fact that their results are not widely shared with the general public.

Suggestion on overcoming these barriers

1. Using a community participation approach allows programs to serve youth better. The involvement of youth and adult community members, including political leaders, religious leaders, health service providers, parents, teachers, community members and youth in youth programme designing and implementation will create an enabling environment that will encourage young people to take charge of their own reproductive and sexual health.
2. Designing programmes to reach the non-formal education system and the out of school population.
3. Continuous capacity building of the human resources involved in sexual education in schools.
4. Youth centres. The successes of the different experiences implemented in delivering sexual education through designated youth centres in Burkina should be analyzed and documented. Only once a full analysis is done, the scaling-up of the most effective components of the youth-friendly services should be explored and, if this is done, a number of aggressive campaigns to increase youth access should be carried out.
5. Youth-friendly RH services. An in-depth study and analysis of the reasons for low use of available health services needs to be undertaken, as well as an evaluation of what has been accomplished and its impact. Successful components of youth-friendly services need to be scaled up as well as capacity building of health center personnel and of any other community health personnel (i.e.: CHWs, health volunteers, etc.). This will make their services and attitudes youth friendly, for example the reduction of physical barriers can improve privacy, while a timetable more youth-friendly can improve access. Moreover, the change of health workers' attitude, like the improvement of confidentiality, can increase trust towards the service providers.
6. Leadership and coordination. Efforts have to be put into revitalizing the NGO network on SRH of young people in order to strengthen coordination of project activities at the national and community levels. Strong government leadership is essential to succeed.
7. Mobilising young people from the outset of the conception phase of a project. Young people should be involved at all levels of project development, implementation and evaluation.

8. Programme evaluations are needed to assess the impact of the different experiences implemented in Burkina on sexual education, and to design and carry out evidence-based interventions. To this regard, significant investments in building national capacity in designing, management, follow-up and evaluation of projects are necessary.

References

- Biddlecom AE, Munthali A, Singh S, Woog V. Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. Afr J Reprod Health. 2007;11(3):99–100.
- Calvés AE. Assessing adolescent reproductive health policies and programs. Ccase studies from Burkina Faso, Cameroon, and Togo. 2002 Jul. 41 p.
- Community-based initiatives in youth sexual and reproductive health in rural Burkina Faso: Findings from baseline evaluation research. Project report. Plan International BF. 2001.
- Guiella G, Woog V. Santé sexuelle et reproductive des adolescents au Burkina Faso: Résultats d'une enquête nationale en 2004. New York: The Alan Guttmacher Institute. 2006 Sept. 152 p. Report No.: 21.
- Guiella G. Santé sexuelle et de la reproduction des jeunes au Burkina Faso: un état des lieux. New York: The Alan Guttmacher Institute. 2004 Mai. 40 p. Report No.:12.
- Ouedraogo C, Woog V et Ouedraogo O. Les adultes face aux comportements sexuels des adolescents : difficultés et enjeux. New York: Guttmacher Institute, 2007. Report No.:32.
- Ouedrago C, Sondo G, editors. Mieux comprendre les comportements des jeunes en matière de sexualité et face aux STI : le rôle de données qualitatives. In: Gourbin C. Santé de la reproduction au Nord et au Sud. Louvaine: Chaire Quetelet; 2004. French.