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

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Introduction

Kenya, with the youth constituting 36% of its population, and a signatory to the International Conference on Population and Development (ICPD), recognizes the essence of sexuality education. As such, national guidelines on adolescent reproduction health are existent as well as sexuality education in schools. Parallel efforts include the *Tuko Pamoja* programme for example. Though these are in place, studies in Kenya show that 50% of new HIV infections occur among young people aged between 15-24 years [Ministry of Public Health and Sanitation, 2005]. A poor impact of the sexual education could partly explain. What could be some of the barriers therefore?

Barriers to sexuality education

1. Lack of evidence-based approaches

Though evidence exists about the consequences of lack of proper sexual education among the adolescents like a high prevalence of HIV/AIDS for example, the curriculum in place is not based on firm evidences on sexuality education programmes that would be effective in the Kenyan context.

2. Traditional practices, taboos and myths about sexual education

It is still widely a taboo to discuss sexual matters especially between parents and adolescents. The adolescents therefore end up sourcing the wrong information from peers. It is also believed that this information would make adolescents engage in sexual encounters. Also, the practice of female genital mutilation (FGM) by some communities is based on the belief that this delays sexual debut amongst girls and reduces the number of sexual partners by decreasing libido.

3. Lack of a comprehensive youth involvement

There lacks comprehensive involvement of the youth in the decision-making about their sexuality. For example, emphasis on abstinence leaves out those who already have had sexual debut, as well as a growing number of adolescents with sexual orientation towards same sex. Adolescents in rural settings could also be marginalized from youth groups, which are more vibrant in urban areas.

4. Gender inequality

Gender roles dictate that girls take a passive role in decision making while boys are supposed to appear aggressive. Consequently, girls are at risk of coerced sex from older men while boys are likely to engage in risky activities like 'buying' sex from commercial sex workers.

5. Poverty and lack of education

School may be the only place where comprehensive sexuality education would be taught. However, this leaves out adolescents who may not be able to attend school. Groups in marginalized remote regions of Kenya would fall here as well in slums. The poor may also engage in child prostitution.

Suggested solutions

Current research revealed and emphasized the need for sexuality education throughout the world. Although the research findings (contained in the review documents for this module) could not have been conducted in Kenya, some important conclusions can be adapted in solving the Kenyan issues above.

1. Need for an evidence-based curriculum on sexual education

Sexual education in the Kenyan curriculum needs to be based on firm evidence of what approach works and which one does not. Involvement of sexuality researchers, focus on adolescent sexual needs and a logical framework would be very useful, for example, while emphasis has been put on abstinence, the IPPF report showed that abstinence only was bound to fail, with abstaining adolescents more likely of not seeking reproductive health for STIs after initiation of intercourse.

2. Making a case for sexuality education

As seen from the UNESCO document about joint involvement of governments in Latin America, political commitment is needed in Kenya in demystifying the taboos, myths and misinformation surrounding sexual education. The IPPF report indicated teaching of sexuality education did not hasten sexual debut while UNESCO emphasized the need of involvement of parents through assignments on sexual education that the adolescents can discuss with their parents at home. During such sessions, the adolescents can also inform their parents about the dangers of FGM for example in specific communities.

3. Youth involvement

Though studies have shown that adult-based approaches have had more positive results in sexual education than peer-based approaches, it is worth-noting that studies about the latter are also lacking. However, adolescents' active involvement is essential as was seen in the recommendation from the UK-Youth parliament.

4. Poverty eradication

By emphasizing gender equality in opportunities such education and including sexual education in the country's strategies of MDG1, forced early marriages would decrease as well as sexual

health-literacy. Therefore, other than the Kenyan government's commitment to free primary education, sexual education should also be made compulsorily universal.

Assignment documents

1. IPPF. From evidence to action: Advocating for comprehensive sexuality education. London: IPPF; 2009.
2. UNESCO. International Technical Guidance on Sexuality Education. Volume I. The rationale for sexuality education. Paris: UNESCO; 2009.
3. UNESCO. International Technical Guidance on Sexuality Education. Volume II. Topics and learning objectives. Paris: UNESCO; 2009.
4. UNESCO. Levers of Success. Case studies of national sexuality education programmes. Paris: UNESCO; 2010.