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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Addressing Barriers to Expanding Sexuality Education in Ethiopia

Background

Ethiopia is a country whose population is highly dominated by youth. More than 63% of the total population of Ethiopia is below the age of 25 years. Young people of ages 10 to 24 are the largest group to be entering to adulthood in Ethiopian history. This cohort of young people makes up 35% of the total population (Census 2007). This young section of the population in Ethiopia is faced with multiple and interrelated social, economic and health problems. Pervasive gender inequality, sexual coercion, early marriage, high levels of teenage pregnancy, unsafe abortion, sexually transmitted infections (STIs), and HIV/AIDS are among the sexual and reproductive health problem faced by many young Ethiopians. These are further complicated by limited access to SRH information and quality adolescent and youth friendly sexual and reproductive health information and services in the country. Existing interventions in the country are urban focused and with limited coverage despite the fact that about 94% of the population resides in rural areas. Most programs for young people in the country, do not meet the unique service and informational needs of young people; nor do they effectively segment them by factors known to have a profound effect on their SRH needs. They just tend to deliver generic, age- and gender-blind messages and services that fail to recognize the distinct needs of girls versus boys at different ages, as well as the unique needs of married adolescent girls.

Barriers

There has been an effort to integrate family life education in school based programs but this has not been fully materialized for certain reasons. A comprehensive sexuality education (that encompasses gender, sexual and reproductive health and rights and HIV/AIDS (including information about services and clinics), sexual citizenship, pleasure, violence, diversity and relationships) is almost nonexistent either as a standalone or integrated programs. The limited interventions that exist focus more on HIV prevention alone and are not implemented in a coordinated and regular manner.

Though students at the primary level are introduced to family life topics such as personal hygiene, harmful traditional practices, menstrual hygiene, among others, there is very limited information on sexual and reproductive health topics such as physiology, reproduction cycle, and life skills. Issues on HIV prevention and contraception are included mainly in biology text book from grade 7 onwards. Otherwise, age tailored comprehensive sexuality education that could also reach children and young people (level I-IV) is lacking. Current effort to reach young people in school and out of school mainly for those in high schools through Anti HIV Clubs has limited harmonization and inclusion of evidence based approaches in many of the programs. Though both public sector offices mainly Population Department, and NGOs promote implementation of

school based RH programs, there has not been a responsible body that oversees the proper implementation of these programs. There is a National Adolescent and Youth Reproductive Health Strategy that clearly stated young people of age 10-24 years have the right to access appropriate information and services, translation of the strategy in to effective programs requires a huge effort to bring relevant actors on board. The strategy is not well known among school officials, teachers, those in charge of the education sector who have direct contact with young people; and among health service providers. There is weak linkage between the school based programs and health services. In addition there is limited participation of the young people in the design and implementation of the programs.

Addressing the barriers

The National Adolescent and Youth Reproductive Health Strategy is a very important framework within which expansion of a comprehensive sexuality education could be entertained. All stakeholders should be oriented/sensitized on the strategy and the need to have a comprehensive sexuality education. As revision of the existing curriculum requires much effort, a stand-alone programs tailored could be considered while working towards an integrated approach. Revision and harmonization of existing materials including peer education manuals to include evidence based best practices and approaches is important. Health service providers need to be trained (both in the pre service and in service education) to cater to the needs of young people. We have over 33, health extension workers who have a wide reach of young people in the rural areas and enhancing the capacity of these front line workers is critical both in reaching the young people with information and improving the link to youth friendly services provided at health centers.

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.