Reaching adolescents through teachers & community-based educators

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Sexuality education - Definition

- Sexuality Education is defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information.

Key statement 1. Children & adolescents need & have a right to sexuality education.
HIV/AIDS

Knowledge of HIV and HIV prevention remains low among young people

Proportion of women and men aged 15–24 in sub-Saharan Africa with comprehensive correct knowledge of HIV transmission and reporting condom use at last higher-risk sex, * around 2000 and 2014 (percentage)

Menstruation

How knowledgeable are adolescent girls in low- and middle-income countries about menstruation & how prepared are they for reaching menarche?

Recognition that is a physiological process ranges from 6.0% to 86.3%

Poor awareness prior to reaching menarche ranges from 32.5% to 81.6%

Initial perception upon reaching menarche is that it is life-threatening, many believe it is unnatural

Poor awareness of the origins of menstrual blood as high as 97.5%

Negative feelings including fear, disgust, anxiety and confusion

V Chandra-Mouli, S V Patel, M Sommer. Systematic Review: Knowledge and Understanding of Menarche, Menstrual Hygiene and Menstrual Health among Adolescent Girls in Low- and Middle-income Countries. Submitted for review.
Key statement 2. Sexuality education is not just about teaching about sex, reproduction & avoiding sexual & reproductive health problems.
It aims to:
- improve knowledge & understanding
- promote self awareness & equitable social norms
- build social skills to make and follow through on choices
Key statement 3. Sexuality education does not harm children & adolescents; it can do them a lot of good.
Sexuality education:
✓ Does not lead to early or increased sexual activity

Well designed & well conducted sexuality education can:
✓ bring about positive changes in sexual behaviour (demonstrated in more studies),
✓ reduce negative health outcomes (demonstrated in less studies)

Sexuality education that addresses gender & power:
✓ are more likely to be effective in reducing unwanted health outcomes

Key statement 4. We are failing to reach children and adolescents with sexuality education.
Sexuality education – generating evidence

Evidence generated

(i) Effectiveness of interventions
(ii) Effective means of delivering interventions at scale in a sustained manner
(iii) Cost of delivering them
Sexuality education – developing policy/programme support tools

Advocacy & programme support tools developed
Sexuality education – Content
(from UNESCO, International technical guidance on sexuality education, 2009)

- Relationships
- Values, Attitudes and Skills
- Culture, Society and Human Rights
- Human Development
- Sexual Behaviour
- Sexual and Reproductive Health
Sexuality education – Process
(from UNESCO, International technical guidance on sexuality education, 2009)

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<th>Characteristics</th>
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<td>1. Involve experts in research on human sexuality, behaviour change and related pedagogical theory in the development of curricula.</td>
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<td>2. Assess the reproductive health needs and behaviours of young people in order to inform the development of the logic model.</td>
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<td>3. Use a logic model approach that specifies the health goals, the types of behaviour affecting those goals, the risk and protective factors affecting those types of behaviour, and activities to change those risk and protective factors.</td>
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<td>4. Design activities that are sensitive to community values and consistent with available resources (e.g. staff time, staff skills, facility space and supplies).</td>
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<td>5. Pilot-test the programme and obtain on-going feedback from the learners about how the programme is meeting their needs.</td>
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<td>6. Focus on clear goals in determining the curriculum content, approach and activities. These goals should include the prevention of HIV, other STIs and/or unintended pregnancy.</td>
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<td>7. Focus narrowly on specific risky sexual and protective behaviours leading directly to these health goals.</td>
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<td>8. Address specific situations that might lead to unwanted or unprotected sexual intercourse and how to avoid these and how to get out of them.</td>
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<td>9. Give clear messages about behaviours to reduce risk of STIs or pregnancy.</td>
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<td>10. Focus on specific risk and protective factors that affect particular sexual behaviours and that are amenable to change by the curriculum-based programme (e.g. knowledge, values, social norms, attitudes and skills).</td>
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<td>11. Employ participatory teaching methods that actively involve students and help them internalise and integrate information.</td>
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<td>12. Implement multiple, educationally sound activities designed to change each of the targeted risk and protective factors.</td>
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<td>13. Provide scientifically accurate information about the risks of having unprotected sexual intercourse and the effectiveness of different methods of protection.</td>
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<td>15. Address personal values and perceptions of family and peer norms about engaging in sexual activity and/or having multiple partners.</td>
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<td>16. Address individual attitudes and peer norms toward condoms and contraception.</td>
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<td>17. Address both skills and self-efficacy to use those skills.</td>
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<td>18. Cover topics in a logical sequence.</td>
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Sexuality education - Good practice
(from UNESCO, International technical guidance on sexuality education, 2009)

Implement programmes that include at least 12 or more sessions
Include sequential sessions over several years
Select capable and motivated educators to implement the curriculum
Provide quality training to educators
Provide on-going management, supervision and oversight
Sexuality education – taking evidence to action

“Most adolescents & youth do not yet have access to comprehensive sexuality education (CSE), despite repeated intergovernmental agreements to provide it, support from the UN system, & considerable project-level experience in a wide range of countries and research showing its effectiveness.”


- They reach pupils late
- They do not reach marginalized adolescents
- Their messages do not relate to the realities of many adolescents' lives
- They are poorly delivered
- They are not linked to health services

THE NEED FOR REPRODUCTIVE HEALTH EDUCATION IN SCHOOLS IN EGYPT

Two Steps Forward, One Step Back

SRH education in schools in Egypt has experienced both progress and setbacks. In 2010, the press reported that the Minister of Education ordered the "removal of the contents related to male and female genital systems and sexually transmitted diseases from the school curriculum in the science books for grade 9." The order was not adopted, either because it was never actually given or because the minister retracted it. The only real change has been the inclusion of reproductive systems in the science books of grade 8 instead of grade 9, which child health advocates saw as a move in the right direction. However, in 2011, following the revolution and the subsequent political instability, the newly appointed minister ordered the removal of the same topics, along with family planning methods, from the 12th grade curriculum for the sake of shortening its contents.
Key statement 5. A small number of countries are pushing beyond 'boutique' projects to implement large scale & sustained sexuality education programmes in schools.
Positive deviant countries - Nigeria

- 2002 - After an extensive consultative process, a national policy was made to scale up school-based education using the Family Life & HIV Education (FLHE) curriculum.

- Trained 'carrier-teachers' deliver FLHE to junior & senior secondary schools

- 2012 – FLHE has now been introduced in more than 30 (out of 36) states

- Well-done studies in some states have shown improvements in knowledge, understanding & reported behaviours.

Positive deviant countries - Pakistan

- Perceived the need for life skills based education
- Motivated to implement it
- Had a good understanding of the political, social and cultural environments
- Able to advocate effectively
- Able to identify and generate financial resources
- Had an in-depth understanding of the education system’s capacities and limitations
- Able to train and support the education system staff

Key statement 6. While there is continued (and growing) resistance, there are also global and regional initiatives to move the agenda forward.
“We, the Ministers of Education and Health from 20 countries in Eastern and Southern Africa, gathered in Cape Town, South Africa on 7 December 2013, working towards a vision of young Africans who are global citizens of the future...

...we will lead by bold actions to ensure quality comprehensive sexuality education and youth-friendly sexual and reproductive health services in the ESA region".