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Comprehensive sexuality education in sub-Saharan Africa: adaptation and implementation challenges in universal access for children and adolescents

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Introduction

Universal health coverage (UHC) means access to promotive, preventive, curative, rehabilitative and palliative health services for all without financial hardship.[1] UHC is embedded in the right to health, is key to sustainable development and aims to reduce social inequalities and inequities.[2] Sexual and reproductive health and rights (SRHR) are not only core components of the right to health and sustainable development but also necessary for achievement of gender equality and elimination of discrimination.[2] Few elements of SRHR services, family planning and antenatal care, for example, are part of the World Health Organization's (WHO) tracer indicators for monitoring UHC.[3] The Guttmacher Lancet Commission calls for a more comprehensive packaging of SRHR in the UHC service coverage index, comprehensive sexuality education included.[3]

Comprehensive sexuality education (CSE) is a curriculum-based process of participatory teaching and learning about aspects of sexuality aimed at equipping children and young people with knowledge, skills, attitudes and values that empower them to realise their sexual and reproductive health well-being and rights; develop healthy interpersonal relationships; reflect on the impact of their choices on self and societal well-being; and secure and protect their rights throughout their lives.[4] Comprehensive sexuality education is fundamental in ensuring universal access to sexual and reproductive health and rights and advancing gender equality.

Implementation of CSE programmes in sub-Saharan Africa (SSA) has been on the increase following the first International Conference on Population and Development held in 1994.[5] In 2013, 20 countries signed the "Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern Africa" to facilitate CSE adaptation and implementation.[5] Consequently, many countries in SSA developed policies to support CSE implementation. However, CSE, gender sensitisation and human rights education are not supported due to lack of political will.[5] The 2003 Maputo Protocol initiated by members of the African Union encourages Member States to integrate gender sensitisation and human rights education at all levels of education; it has not been ratified by two-thirds of the African Member States.[6] Implementation of CSE is donor-driven with oversight given to both Education and Health Ministries, creating funding and accountability problems.[5] Although implementation engages various stakeholders, children and adolescents are often left out in discussions of implementation strategies.[5] In addition, there are disagreements on when sexuality education should be offered. Before colonialism, in some East African communities, sexuality education was provided to adolescents by uncles and aunts during initiation ceremonies to prepare them for marriage.[7] With colonialism, formal education was introduced elongating the period between puberty and marriage.[7] This social change has created tensions as sexuality education is considered

appropriate only when preparing young people for marriage.

The aim of this commentary is to highlight sub-Saharan Africa's CSE curriculum adaptation and implementation challenges and recommend areas for improvement. The commentary briefly discusses popular CSE curriculum content, different approaches to sexuality education, CSE relevance, and thoroughly reviews CSE adaptation and implementation challenges with recommendations to counter bottlenecks.

Content and popular modes of delivery

Comprehensive sexuality education has been introduced in various countries in SSA. Some of the popular guidelines include: The WHO Regional Office for Europe and BZgA (German Federal Centre of Health Education) Standards for Sexuality Education in Europe; the International Planned Parenthood Federation (IPPF) Framework for Comprehensive Sexuality Education; the United Nations Educational, Scientific and Cultural Organization (UNESCO) international technical guidance on sexuality education; Population Council's "It's all one curriculum"; the UNFPA operational guidance for comprehensive sexuality education; and Sexuality Information and Education Council of the United States (SIECUS) guidelines. The commonest themes across these guidelines include but are not limited to: (i) the human body and development, (ii) sexual and reproductive health and rights, (iii) values, culture, and sexuality, (iv) relationships, (v) gender, and (vi) diversity.[8] The popular method of delivery of the comprehensive sexuality education in SSA is in schools, youth-friendly health facilities and youth centres, and the instructors are normally teachers, health providers or trained peers.[8]

Approaches to sexuality education

Different approaches are used in teaching sexuality education. These include faith- and culture-based, public health and rights-based approaches. The faith- and culture-based approaches believe that sexuality education should impart cultural and religious "moralistic" views on sexuality with the purpose of preventing adolescents and young people from engaging in premarital or extramarital sex.[9] Public health approaches are propelled by health concerns; their aim is to impart knowledge that will help adolescents and young people to protect themselves from sexually transmitted illnesses (STIs), and unintended pregnancies.[9] This approach teaches the use of contraceptives as well as interpersonal and communication skills that help young people avoid risks and pursue their goals in life.[9] The rights-based approach emphasises the principles of SRHR with content beyond pregnancy and disease prevention.[10] The guidelines' contents cover issues such as gender norms, diversity, sexual expression and pleasure, sexual relations and violence. Teaching fosters critical thinking through participation and reflection.[10] However, it should be noted that the approaches are not mutually exclusive. Implementers of sexuality education programmes might use abstinence-only as their main approach but supplement it with some concepts from public health approaches e.g. STIs prevention and rights-based approaches e.g. gender equality.[11]

Most sexuality education programmes in SSA are school based and emphasise abstinence as the main contraception method.[5] Other topics covered in the programmes include STIs and unintended pregnancies and their prevention. Issues on gender inequality, power dynamics, abortion, homosexuality, and masturbation are rarely discussed as they are in conflict with gender norms, and religious and cultural beliefs.[5]

Why is comprehensive sexuality education relevant for SSA?

The need for comprehensive sexuality education in SSA is reflected in high rates of HIV/AIDS in young people, child marriages, adolescent pregnancies, abortion, and violence against children. Adolescents (age 10–19) make up 23% of the SSA population[12] with more than 80% of HIV-infected adolescents living in the region. The adolescent pregnancy prevalence rate is estimated at 19.3%, the highest across the globe.[13] Child maltreatment is pervasive in SSA; the violence can be attributed to the generally low position of the child in African society, and cultural, social and religious beliefs.[14] Appropriate administration of CSE equips children and young people with decision-making skills useful in tackling challenges related to relationships and sexuality.[4] Moreover, CSE discusses gender inequality and power dynamics within communities and challenges cultural beliefs that normalise violence.

According to research, quality CSE improves children and young peoples' sexual knowledge, self-confidence and esteem, positively changes attitudes, gender and social norms, strengthens decision-making and communication skills and builds self-efficacy.[15,16]

Adaptation and implementation challenges

Several studies have discussed CSE adaption and implementation challenges.[11,15,17,18] They include but are not limited to: ideological, institution-related, instructor-related, parent-related, and student-related factors.

Ideological factors

Most communities in SSA describe themselves as religious and/or traditional.[19] Religious books and some cultures teach premarital sexual abstinence, monogamy, belief in the sanctity of life and opposite-sex sexual relations. Some topics offered in CSE, including masturbation, abortion, and sexual orientation, contradict these beliefs.[17] Sexuality education in some African communities is viewed as appropriate in marriage ceremonies. Such beliefs have contributed to CSE resistance in schools with sexuality education limited to abstinence, unwanted pregnancies and STIs prevention, denying children and young people access to SRHR information.[17] Moreover, establishment of youth-friendly clinics to offer SRHR services may be restricted as community members or citizens may not feel comfortable having their children accessing these services.

Some communities are patriarchal and as such men are assigned a dominant role whereas women are expected to be compliant and submissive.[20] Teachings on gender equality in school may conflict with community beliefs and practices.[11]

The CSE curriculum adaptation and implementation process in some SSA countries normally fails to acknowledge that sexuality education existed in such societies prior to Westernisation and that integration of indigenous knowledge and practices could enrich these curricula and give them legitimacy. Different cultures taught sexuality in various ways, including the use of aunts, uncles and grandparents in conveying sexuality education and use of media such as storytelling, circumcision songs and phallic objects to teach sexuality.[21] Some programmes have borrowed concepts from traditional methods of discussing sexuality. A study on Ugandan youth preferences for content in an internet-delivered CSE programme (CyberSenga) incorporated the term "Senga" referring to a paternal aunt tasked to discuss sex, sexual development and sexual decision-making with nieces.[22] The use of the term promoted acceptability as beneficiaries appreciated the cultural value attached to the "Senga".[22] Integration should go beyond concepts; research should explore how sexuality was historically taught within SSA and ways of incorporating resources (community members) and techniques employed into CSE curricula.

Institutional factors

These refer to organisational factors at government level and at school level

Government level

Funding for CSE in most SSA governments is limited.[17] As such, non-governmental organisations (NGOs) step in to support governments in rolling out the CSE curriculum; projects are short-lived, with no sustainability measures.[17] Moreover, the multiplicity of NGOs hinders the standardisation of the curriculum as most implement different curricula with different goals.[17]

Most governments that implement CSE roll it out at a national level for standardisation purposes by developing a "one size fits all" curriculum ignoring the differences in culture, language and subnational problems.[17] For example, in Kenya, some areas may have a high prevalence of HIV whereas others might have a high prevalence of female genital cutting, calling for variations in approach. Moreover, standardisation leaves little room for contextualisation. Even though the curriculum may be open to contextualisation, the teachers may not have the skills, materials, time or motivation for this.[17] As governments decentralise sexuality education, the organisational culture of relevant implementing authorities should be assessed; the inability and lack of capacity to adapt unconventional programmes and accommodate stakeholders across and outside government hinders curriculum roll-out.[11] In Nigeria, the federal structure allows for adaptation of sexuality education policies based on States' requirements.[11] Despite the flexibility, implementation across States varied.[11] States like Lagos and Kano had considerable success in rolling out the Family Life and HIV Education (FLHE) curriculum

because of having capable organisational structures with adaptive capacities.[11]

Research shows that stakeholder participation in curriculum development is necessary for successful implementation.[17] However, it is challenging for curriculum developers and implementers to attain consensus on what is to be included in the curriculum as different stakeholders have different agendas.[17] In the development of a CSE curriculum, young people from Ghana complained that their input was not taken up.[17] The lack of involvement of young people in decision processes is based on the perception that young people are not mature enough to make decisions and as such leaders or parents decide what is best for them.

CSE is taught differently in different countries. In some countries, CSE is integrated in different subjects which might be elective. In Ghana, CSE is taught under Management in Living, a popular course for girls but not for boys, limiting boys' access to CSE.[17] In Kenya, CSE is part of the life skills curriculum, an unexaminable subject. Since most teachers focus on examinable subjects, CSE is neglected.[17]

Although countries like Ghana have put in place a specific committee to be in charge of ensuring implementation of CSE in schools, some countries like Kenya lack oversight.[17] Monitoring and evaluation of the CSE programmes in some SSA countries is thus poor as implementation guidelines which lack indicators for evaluation are not distributed countrywide. Although some evaluations may be done, they tend to be on the teachers' mode of delivery rather than on the impact of CSE on student outcomes which are harder to measure.[17]

School level

Some of the SSA population hold conservative beliefs with regards to sexuality; these groups resist CSE implementation in schools.[17] Most CSE curricula are implemented in schools, leaving out school-unenrolled children and young people.[23] Nonetheless, some programmes have targeted some school-unenrolled adolescents: in Zambia, for example, safe spaces have been created to allow young people to play games, receive vocational training as well as sexual and reproductive health information.[5] In Kano State, Nigeria, local sexuality education advocacy champions identified and negotiated inclusion of sexuality education in Islamiyya schools (informal modern Quranic schools) in order to reach a huge proportion of children who attend Islamic schools.[11]

Instructor-related factors

Some schools in SSA, especially those located in rural areas, lack basic facilities. With the roll-out of free primary education in most SSA countries, there is a high enrolment rate and as such teachers might have a class of over 100 pupils.[23] With such a class, it is hard for teachers to teach CSE using participatory methods.[23] Some of the CSE curricula are implemented as an extra-curricular activity. This implies asking an overburdened teacher to take on more duties. Moreover, teachers hardly receive any on the spot guidance in areas in which they experience difficulties. They are not always offered refresher courses; hence teachers resort to prescriptive methods, which are unproductive in delivering CSE.[23] In addition, teachers have their own cultural and religious beliefs that influence teaching. In Uganda, it was reported that teachers offering CSE courses insisted on teaching abstinence and used fear-based approaches.[23]

CSE is frequently implemented piecemeal. When trained teachers are transferred, students cannot continue with learning.[23] At times, other untrained teachers are forced to take over the uncomfortable task of teaching CSE. Without training, they are unlikely to utilise facilitative methods.[23]

Parent-related factors

Some parents do not support CSE; in The Gambia only 32% of women aged 15–49 years stated that condoms should be part of the HIV/AIDS prevention.[18] This low support was reported in four other West African countries.[18] Consequently, implementation of CSE may be resisted with parents confronting instructors offering CSE courses due to the fear that the curriculum promotes promiscuity or is being offered outside the right environment (should be offered by aunts and uncles instead).[7]

Student-related factors

Some children in SSA may miss school as their parents are unable to pay fees for utilities and as such fail to benefit from CSE.[17] Due to unequal power relations between teachers and students, students may not feel comfortable discussing their anxieties or difficulties with teachers who may have a judgmental attitude.[23] Moreover,

students have their own language when it relates to sexuality. Due to secrecy revolving around sexuality, young people often devise their own way of talking about sexuality. An example is Kenya where there is a popular song among the young people *"Wamlambez, Wamnyonyez"* (translates as lick and suck) that discusses foreplay and sexual intercourse in graphic details. However, the song is in Sheng (a mixture of English, Swahili, and local languages) and most parents and teachers would have no idea of what is being said.

Recommendations

Opposition from some conservative religious groups and concerned parents hinders universal access to sexual and reproductive health information. Therefore, there is need to mobilise political will and all stakeholders in rolling out of CSE by raising awareness on what CSE entails and why it is important.[11] Setting up a CSE national coordination body will be useful in coordinating resources and activities and monitoring and evaluating implementation at the national, regional and local levels as needed.[11]

Universal CSE implementation is pegged on funding. Trainings (exchange programmes or use of experts) are needed on developing funding applications as well as advocacy on the need for universal access to CSE. Once funding is received, organisational culture and capacity of implementing bodies should be assessed and if need be trainings conducted to ensure that the organisational structure is flexible to adapt unconventional programmes and accommodate multiple stakeholders.[11] When implementing CSE curricula, implementers should anticipate community resistance; innovative champions have been used in Nigeria to navigate community resistance.[11]

Learning should integrate CSE curricula with indigenous African knowledge and practices on sexuality education. To provide legitimacy to CSE, efforts to adapt and implement CSE in SSA should be preceded by research to determine how these populations envision, experience and verbalise their sexuality; in what social and mental structures it is shaped; and existing educational interventions.[24] In addition, other forms of disseminating information on sexuality or facilitating discussions e.g. through digital media, traditional and contemporary songs or art should be explored in order to reach out-of-school youth.

Since teachers in most African schools are overwhelmed with work, it is important to consider the use of some community members who are comfortable playing these roles to offer sexuality education. In rolling out universal health coverage, community health units have been established. It may be beneficial to engage out-of-school youths and train them to offer CSE in schools and communities as part of the community health strategy.

Conclusion

Comprehensive sexuality education plays an important role in equipping young people with sexual and reproductive health information. However, implementation of CSE is challenging, hindering universal access. The main CSE implementation challenges include community resistance, CSE implementers with rigid organisational structures and culture, inadequate financing of programmes, poorly trained and overworked instructors, and exclusion of out-of-school children and young adults. The highlighted challenges need to be addressed to promote universal access to CSE which is a conduit for achieving sexual and reproductive health and rights.

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