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SEXUALITY EDUCATION IN
SCHOOLS: THE
INTERNATIONAL
EXPERIENCE AND
IMPLICATIONS FOR NIGERIA

by

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Executive Summary

Nigeria is in the early stages of carrying out its new national policy on sexuality and reproductive health education. Worldwide, school-based programs are an important element of efforts to improve the reproductive health of young people. This paper reviews the international experience and its implications for Nigeria. The main findings are as follows:

Comprehensive sexuality education is effective in improving key youth reproductive health (YRH) behaviors. In a wide range of settings in both developed and developing nations, comprehensive school-based sexuality education has influenced important behaviors such as delaying sexual initiation, reducing the number of sexual partners, and increasing use of condoms among youth who are sexually active. This finding bodes well for Nigeria, a country with considerable linguistic and cultural diversity.

Virtually everywhere, sexuality education is controversial and difficult to carry out on a national scale, especially while trying to maintain the quality of that education. In Nigeria, as elsewhere, such controversy and problems are to be expected. Effectively addressing the concerns of parents, teachers, and the broader community will be essential to eventual success.

Despite these problems, even conservative countries have made headway in incorporating high quality sexuality education in the schools. Although not an easy or quick process, opposition to sexuality education can be diminished through active engagement of religious leaders, parents, and teacher groups. Advocates for sexuality education in Nigeria must plan accordingly for such long-term engagement and not expect overnight success. It is also important to involve young people themselves in the advocacy effort in as many ways as possible and to give parents better skills for transmitting information on sexuality and reproductive health to their children.

Programs, to be effective, must “do it right.” It will be important to implement a sound curriculum and adequately train and support teachers and students. The common characteristics of successful sexuality education programs apply equally in Nigeria as elsewhere. Maintaining these characteristics as the program extends nationally will require attention to technical standards as well as to political and budgetary support. Training and retraining of teachers will be a major challenge in Nigeria, as well as ensuring adequate funding at the state level to support sexual and reproductive health programming for adolescents. Critical steps to ensure effective implementation include monitoring of state-level efforts based on workplans with specific targets, continued advocacy with state governments, and introducing sexuality education into pre-service teacher training.

The challenges to implementation vary from country to country and even within countries. Local adaptation—to culture, language, religion, and so forth—is often necessary. In a country as diverse as Nigeria, such adaptation will be critical to success at the level of the school and the individual student. Faith-based organizations in particular can play a central role in developing and promoting culturally appropriate materials for sexuality education.

Abbreviations

AIDS	Acquired immune deficiency syndrome
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
NGO	Nongovernmental organization
SHEP	School Health Education Program, Tanzania
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UN	United Nations
UNAIDS	United Nations Program on HIV/AIDS
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
YRH	Youth reproductive health
WHO	World Health Organization

Introduction

The Youth Reproductive Health Challenge in Nigeria

The current cohort of Nigerian youth is the largest ever. To contribute their full social and economic potential, young people need the knowledge and skills to make the right choices about when to have to sex and how to protect themselves from infection and unintended pregnancies. The reproductive health challenges Nigerian youth face are similar to those of young people in many other African countries: high rates of teen pregnancy, high and rising rates of HIV infection, early marriage for young girls, malnutrition, and harmful traditional practices such as female genital cutting. Increasingly, policymakers are acknowledging the link between better youth reproductive health (YRH) and other aspects of healthy youth development including livelihoods, mental health, and road safety.

The Role of Schools

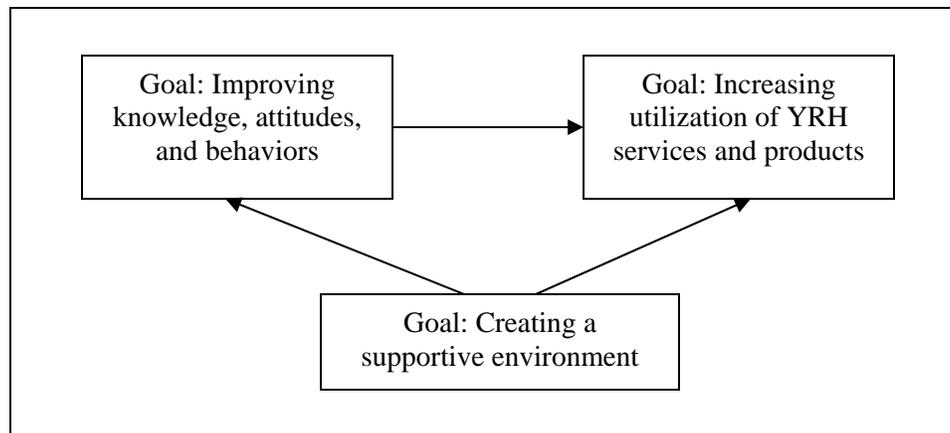
In Nigeria, as elsewhere in Africa and the developing world, schools play a key role in imparting important information on health and human relations. Although too many Nigerian youth still lack access to secondary or even primary education, for those young people who do attend school, the school setting provides an important venue to transmit information and skills that can protect youth against risky behaviors.

School-based sexuality and reproductive health education is one of the most important and widespread ways to help young people improve their reproductive health. Countries in every region have organized sexuality education programs of one type or another. Such programs, if thoughtfully designed and well implemented, can provide young people with a solid foundation of knowledge and skills. This paper summarizes the international experience in carrying out school-based sexuality education programs and the applicability of this experience to Nigeria. It was originally commissioned to provide input for the National Stakeholders Meeting on Adolescent Sexuality and Reproductive Health Education, held in Abuja, Nigeria, in September 2003. The authors incorporated feedback and results from that meeting to revise and update the report. Our hope is for the paper to support the efforts of Nigerians to implement the country's new policy on sexuality and reproductive health education.

How Sexuality Education Fits into Efforts to Improve YRH

By providing students with information and skills, sexuality education complements other efforts to provide quality reproductive health information and services and to create an enabling context that allows young people to practice positive behaviors (see Figure 1).

Figure 1. YRH Program and Policy Goals



What Do Sexuality Education Programs Try to Achieve?

Like other YRH programs, sexuality education aims to achieve a range of outcomes, some of which apply to sexually active youth and some to those not yet having sex. These objectives include

- Reduced sexual activity (including postponing age at first intercourse and promoting abstinence);
- Reduced number of sexual partners;
- Increased contraceptive use, especially use of condoms among youth who are sexually active for both pregnancy prevention and prevention of HIV/AIDS and other sexually transmitted infections (STIs);
- Lower rates of child marriage;
- Lower rates of early, unwanted pregnancy and resulting abortions;
- Lower rates of infection of HIV/AIDS and other STIs; and
- Improved nutritional status.

Sexuality education programs are part of a suite of proven interventions (see Table 1) that include activities such as peer education, mass media, social marketing, youth-friendly services, and policy dialogue and advocacy. School and livelihood opportunities complement and reinforce these approaches.

Table 1. Effective YRH Program and Policy Actions

Program and Policy Action	Program Target Group
<i>Provide information to young people</i>	
Sexuality, reproductive health, and HIV/AIDS education	In-school youth, ideally starting before teens become sexually active
Peer education programs	Out-of-school youth; youth in hard-to-reach groups such as sex workers, streets kids
Mass media	All young people, especially those at highest risk of unhealthy behaviors
<i>Provide services to young people</i>	
Social marketing of condoms	Sexually active young people
Workplace programs and private sector initiatives	Employed youth; youth who use private, for-profit health services
Public sector and NGO health services	Poor youth; rural youth
Community-based programs	Out-of-school youth; poor youth
Youth-friendly services	All youth
<i>Create a positive context</i>	
Policy dialogue and advocacy	Decision makers; legislators; community leaders; youth; religious leaders; businesses; civil society
National YRH policies and service guidelines	
Supportive legal framework	
Mass media and community mobilization efforts to change social norms	Parents; teachers; religious leaders and other influential adults; youth
Education opportunities, especially for girls	All youth, particularly those at risk
Linkage of YRH with other youth activities, including youth development programs, education, and job training and other livelihood programs	

Source: Adapted from World Bank, 2002a

What Is the Policy Environment for Sexuality Education?

Advocates worldwide recognize the need to address the political and social context in which young people make decisions about sex and reproduction. Globally, commitment to meeting YRH needs has never been higher. International conferences and agreements such as the 1989 Convention on the Rights of the Child, the 1994 International Conference on Population and Development (ICPD), the U.N. World Program of Action for Youth to the Year 2000 and Beyond, and the 2001 U.N. General Assembly Special Session on HIV/AIDS have affirmed the needs of young people for information, counseling, and high-quality sexual and reproductive health services.

Against the background of these international agreements, to which Nigeria is a signatory, the government of Nigeria has recently taken a number of important policy steps to support YRH care, including the following:

- The government formulated and launched a national YRH policy.
- Reproductive health is on the concurrent legislative list in Nigeria, and, therefore, the three tiers of government, including the states and local governments, are expected to formulate independent policies to guide their programs and service delivery.
- In 2002, the Federal Ministry of Education approved the teaching of sexuality and life planning education in the secondary schools. This policy directive paved the way for development of a national curriculum, recently approved after extensive stakeholder review and debate.

<p>Box 1. What Is Sexuality Education?</p> <p>Sexuality education is the lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships, and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles. Sexuality education addresses the biological, socio-cultural, psychological, and spiritual dimensions of sexuality.</p> <p>Source: SIECUS (Sexuality Information and Education Council of the United States) www.siecus.org</p>

How Widespread Is School-based Sexuality Education?

First established on a national scale in Europe in the 1960s, developing countries introduced school-based sexuality education in the 1980s. The emergence of HIV/AIDS gave many governments the impetus to strengthen and expand sexuality education efforts and, currently, more than 100 countries have such programs, including almost every country in sub-Saharan Africa (McCauley and Salter, 1995; Smith, Kippax, and Aggleton, 2000; Rosen and Conly, 1998). U.N. organizations such as UNFPA, UNESCO, and UNICEF have traditionally been the leading international supporters of sexuality education. The World Bank, through its intensified efforts to help countries fight HIV/AIDS, has also become a major funder (World Bank, 2002b). Many other bilateral donors and private foundations and organizations support and promote sexuality education worldwide.

The Effectiveness of Sexuality Education

Are Sexuality Education Programs Effective at Improving YRH?

A recent review of school-based programs in developing countries (FOCUS, 2001) found strong evidence of the effectiveness of such programs in improving YRH outcomes. Seventeen of 19 school programs that had undergone relatively rigorous evaluation were effective in improving young people's knowledge of sexual and reproductive health, including contraception and HIV/AIDS prevention. Nine of 14 school programs were effective in improving YRH behaviors such as delaying sexual debut, decreasing the number of sexual partners, and increasing condom use among youth who are sexually active.

The FOCUS review includes a description of three Nigerian programs. Although different in their approach, all three show a significant impact on reproductive health knowledge and behaviors.

Program 1: HIV/AIDS education for secondary school students.¹ A new HIV/AIDS curriculum was developed and carried out during six weekly sessions lasting 2–6 hours in Ibadan, Nigeria. The educational sessions used a variety of techniques, including lectures, films, role plays, debates, stories, songs, and essays. A physician carried out the curriculum with the assistance of two trained teachers. Key findings are as follows:

- *The sessions improved knowledge and attitudes:* Six months after completion of the intervention, the intervention group had improved knowledge about AIDS and improved attitudes toward people with AIDS.
- *The sessions reduced the number of sexual partners:* Youth who participated in the intervention had fewer partners after the intervention.

Program 2: Linking schools with private physicians. An integrated school and clinic program in Benin City, Nigeria, was carried out in 1998 to teach students about STIs and encourage them to receive treatment for STIs from trained, private medical doctors. Adolescents in four schools received both formal and peer education on STIs. Eight schools served as a control group. Adolescents in the intervention schools learned about the symptoms and ways to recognize various STIs; the complications arising from nontreatment or delayed treatment; the need for early and effective treatment; the need to inform sexual partners and to treat them for STIs; and the effective methods for preventing STIs, especially correct use of condoms. Additionally, private doctors, pharmacists, and patent medicine distributors in the neighborhood of the intervention schools received training in youth-friendly services and in the World Health Organization (WHO) approach to syndromic management of STIs.² Peer educators received a list of trained providers to whom they could refer their peers for appropriate services. An evaluation after one year yielded the following findings:

- *The intervention improved knowledge:* Students in intervention schools had significant increases in knowledge of STIs, use of condoms, and knowledge of the correct treatment-seeking behavior for STIs compared with students in the control schools.
- *The program appeared to lower STIs:* The self-reported symptoms of STIs in the six months after the intervention were lower in the intervention group as compared with the control schools.

¹ The three examples are adapted from FOCUS, 2001.

² Syndromic management bases STI treatment decisions on the recognition of easily identifiable signs and syndromes (symptoms).

- *The program improved health-seeking behavior:* The in-school activities and the physician training significantly increased students' use of private physicians, where they received more effective and comprehensive treatment of their STIs compared with the care received through patent medicine providers and pharmacies.

Program 3: The West African Youth Initiative. This peer program took place in Nigeria and Ghana. The project worked with organizations serving youth to develop peer programs in three types of sites: secondary schools, postsecondary schools, and out-of-school settings. Each community selected a site for the project and then chose a comparison site. The baseline and follow-up studies (two cross-sectional samples) included 100 youth from each site (100 intervention and 100 comparison). Key findings are as follows:

- *The program had the greatest impacts on secondary school and postsecondary school students:* Specifically, among secondary and postsecondary school women, greater awareness of youth programs was reported among the intervention group at follow-up.
- *The program increased knowledge and self-efficacy:*³ In-school males (secondary and postsecondary) from intervention schools reported greater knowledge and self-efficacy than students from comparison schools (controlling for age, living arrangement, etc.).
- *The program reduced risky behaviors:* Among in-school males and secondary-school females, youth from intervention schools reported greater recent use of protective methods against STIs (that is, using condoms, staying with one sexual partner, or abstaining) than comparable youth from nonintervention schools.
- *The program did not affect behaviors of out-of-school youth:* This finding may be a consequence of the fact that out-of-school youth are a heterogeneous group that does not necessarily congregate in specific, fixed locations like schools.

Based on these and other findings, the FOCUS review strongly endorses school-based sexuality and reproductive health education as a means to improve YRH. Specifically, the review recommends the following:

Where school enrollment is fairly high, a comprehensive approach should include school-wide reproductive health education to reach large numbers of young people. Ideally, governments should scale up these efforts to be national in scope; should begin them, with age-appropriate information, in primary school; and should adequately train and support teachers to impart reproductive health education. Further research is needed to determine how to strengthen connections among school programs and commercial sources as well as among other nonclinical sources of reproductive health care. (FOCUS, 2001:14)

Do School-based Sexuality Education Programs Lead Teenagers to Have Sex?

One of the main fears of parents and other adults is that giving adolescents information about sex will cause them to become sexually active. The evidence from two recent reviews shows this not to be the case. In one exhaustive study, the World Health Organization reviewed 47 sexuality education programs in both developed and developing countries. In another study, the U.S. National Campaign to Prevent Teen Pregnancy reviewed over 250 programs in the United States and Canada. Both found that, in almost

³ Self-efficacy is a person's sense that he or she has the power or capacity to act or make a decision, such as whether to have sex or whether to use contraception.

all programs, sexuality education did not lead to either the initiation of sexual activity or an increase in the frequency of sex among youth (Katz and Finger, 2002).

Do Sexuality Education Programs Promote Abstinence?

Virtually all comprehensive sexuality education programs promote abstinence from sexual activity as part of the curriculum, and try to teach young people how to resist pressure for unwanted sex. One type of program known as the “abstinence-only-until-marriage” approach teaches young people the social, psychological, and health gains to be realized by abstaining from sexual activity. Such abstinence-only programs do not offer students other strategies, for example, quality information for youth who already are or may become sexually active. How effective are abstinence-only programs in achieving important YRH outcomes such as delaying sexual activity? Only three such programs have undergone rigorous evaluation. All three are in the United States, including one large program that was carried out statewide in California for students ages 12–13. None of the programs report any significant impact on the initiation of sexual activity, frequency of sexual activity, number of sexual partners, use of condoms, or use of contraception (Kirby, 2001). By contrast, programs that provide comprehensive information and include abstinence promotion as an important message have been shown to delay sexual debut, decrease the number of sexual partners, and increase condom use among youth who are sexually active (FOCUS, 2001).

Are Sexuality Education Programs a Good Investment of Public Funds?

Sexuality education programs are relatively low-cost. A review of YRH programs in African countries found that such programs cost between US\$0.30 and US\$71 per year per person, with a median cost of about US\$9 per person per year (World Bank, 2003). Moreover, recent studies have found that sexuality education programs offer a good return on investment. For example, a study in Honduras found that for each \$1.00 invested in sexuality education to prevent HIV infection among youth, the program would generate up to \$4.59 in benefits from improved health and reduced medical care costs. This estimate only includes the economic benefits of averted HIV infection and does not include the benefits of other potential program outcomes such as increased education, reduced STIs, and reduced teen pregnancies and abortions (Knowles and Behrman, 2003). *Confronting AIDS*, the World Bank’s (1997) major policy document on the epidemic, uses a similar public investment rationale to recommend that countries carry out sexuality education programs. The report states:

Given the other broad social benefits and the relatively low cost of adding HIV/AIDS education to existing programs, HIV/AIDS education is likely to be a good investment in preventing HIV ... Reproductive health education in the school system—which includes information on the benefits of postponing sexual activity as well as how to prevent pregnancy, STDs, and HIV for those who do not abstain—is a potentially powerful intervention. Besides preventing HIV among students who might otherwise adopt risky behavior, these programs have many other benefits. They prevent STDs and associated infertility, and they prevent unwanted pregnancy, which may lead to abortion or to girls’ dropping out of school. (World Bank, 1997: Box 3.10)

The cost data come mainly from evaluations of pilot programs. As sexuality education programs scale up, they are likely to become even more cost-effective by taking advantage of economies of scale (Smith and Colvin, 2000).

The Implementation Experience

Almost everywhere, sexuality education programs have faced serious implementation challenges that diminish their reach and effectiveness. As a result, many programs never move beyond the pilot stage. Those that do too often suffer from common problems such as lack of specific information in the curriculum on contraception and HIV/STI prevention; inadequate teaching materials and training; a scattershot approach to providing specific information that undermines comprehensive student understanding; and a tendency to delay introduction of sexuality education until secondary school—too late for the majority of youth in many developing countries who have already dropped out (Rosen and Conly, 1998).

This section discusses two types of implementation challenges and the experience in addressing them. One type of challenge involves getting programs started, keeping them going and scaling them up from small pilot projects to the national level. The main issues surrounding this first type of challenge are political ones. A second type of challenge involves making such programs effective at the level of the individual student or school. Although often related to the political context, such challenges often are more of a technical nature.

Getting the Program Started, Keeping It Going, and Scaling Up⁴

Opposition—usually but not always from conservative, religious sectors of society—in many countries has blocked or severely hampered the spread of sexuality education. As Senderowitz (2000) points out, of the range of YRH interventions, school-based programs typically are the most exposed to criticism and opposition. Sexuality education programs usually unfold in the public sector, are highly visible, and are often under the control of local authorities and thus more open to revision or elimination. Getting the necessary approval and buy-in from the government, community and religious leaders, parents, and teachers has been a struggle, both for pilot programs and when attempting to take programs nationwide. Despite these problems, sexuality education programs have made headway in many countries, even in relatively conservative societies such as Egypt, Mali, Pakistan, and Yemen (Beamish, 2003; Greene, Rasekh, and Amen, 2002; Khan and Pine, 2003; Al-Rabee, 2003).

What sort of opposition do programs face?

Many societies recognize the reproductive health threats facing young people—especially HIV infection and unwanted pregnancy—and see the schools as an appropriate venue for addressing such threats. They are, however, also concerned with upholding traditions and beliefs, including the expectation that young people abstain from sexual activity until marriage. Thus, traditional and religious leaders—who view themselves as the repository and transmitters of community values and beliefs—are often in the forefront of opposition to sexuality education in the schools. These conservative forces often mobilize parents and some teachers as allies.

- Religious groups have strongly opposed school-based sexuality education in the United States, Mexico, and Kenya (Pick de Weiss, 2000; Rosen and Conly, 1998).
- In Malaysia, although a nationwide family health education curriculum is in place, it gives students little or no information on sexuality or sexual practice, in large part because of strong resistance from parents and religious leaders. Political leaders are reluctant to risk a religious backlash by openly supporting sexuality education (Smith, Kippax, and Aggleton, 2000).

⁴ This section draws in part on Rosen, 2000.

- Despite an improving climate for adolescent reproductive health programs in parts of sub-Saharan Africa—particularly as societies recognize the enormous impact of the HIV/AIDS crisis on young people—resistance from religious and traditional leaders are features of most countries (Calves, 2000; Caldwell et al., 1998; CEDPA, 1998; Pathfinder, 1999).
- Similarly, in India, conservative forces have effectively blocked sex education in the schools (Greene, Rasekh, and Amen, 2002).

Some teachers and school administrators find sexuality education personally objectionable or lack sufficient understanding of the subject and thus are reluctant or refuse to go along with such programs (Smith, Kippax, and Aggleton, 2000). For instance, such opposition from teachers and teacher organizations is a problem in South Africa (Department of Education, 2002). Other school officials may have no personal objection but resist sexuality education because they fear overcrowding the existing curriculum, taking on increased responsibilities with no increase in compensation, or complaints from irate parents (McCauley and Salter, 1995).

What are some of the strategies to overcome opposition to sexuality education?

Inform the debate. Accurate and understandable information can defuse conflict and mobilize support for programs by demonstrating the magnitude of adolescent health problems. Such information can also help to allay the unfounded fears of parents and community leaders alike: that such programs promote sexual activity.

- In Mexico, a successful effort to establish a nationwide sexuality education program relied heavily on research to overcome opposition from both organized religious groups and politicians fearful of public opinion (Pick de Weiss et al., 1998). A key study showed that students taking a pilot sex education course were more likely to use contraception but no more likely to have sex than students who did not take the course. As another powerful tool in gaining support from politicians, advocates used a public opinion poll showing widespread, though muted, support among parents for improving sexuality education. By publicizing the high level of public support for such programs, advocates helped embolden many supporters who might otherwise have remained silent (Pick de Weiss, 2000).
- Advocates for sexuality education in Australia are using results of a recent national survey on sexuality to press for more widespread and better sexuality education in the schools there (Carbone, 2003).
- Similarly, in the United States, advocates for sexuality education often cite polls showing that nine in 10 Americans support teaching sexuality education in high school and that 84 percent support teaching it in junior high school (Greene, Rasekh, and Amen, 2002).

Involve traditional and religious leaders. Successful programs make contact with and enlist the support of traditional and religious leaders.

- The Lentera Project of the Indonesia Planned Parenthood Association, a peer education program to inform youth about sexuality, involved skeptical religious leaders in a number of its activities. Many who attended such events later became more accepting of the project's work (IPPA, 1999).
- A program in Bangladesh that raised contraceptive prevalence from 19 to 39 percent among newlywed adolescents involved local religious leaders as a key component of its community awareness strategy (Barkat et al., 1999).
- In Iran, the government responded to concerns over rapid population growth, health problems, and parents' concerns of well-being of young people by launching an intensive effort to improve reproductive health conditions, with a focus on young people. High-ranking religious leaders,

including the Ayatollah Khomeini himself, voiced their support for reproductive health services (Greene, Rasekh, and Amen, 2002).

- Factors facilitating the widespread implementation of sexuality education in the Netherlands included the support of religious institutions (Greene, Rasekh, and Amen, 2002).

Communicate openly. Open communication—through the mass media and at a more personal level—helps remove the taboo from discussing adolescent sexuality and also can provide information, redefine social norms, and change attitudes and behaviors.

- To address anticipated resistance to a new sexuality education program, government officials in Tanzania launched a mass media campaign using radio, television, and newspapers. The campaign played a key role in bolstering public support for the program and gaining community acceptance (WHO, 1999).
- In China, the government recently began producing a television series on sexuality aimed at educating the 20 million young people entering puberty each year. The mass media effort coincides with the first widespread effort in China to incorporate comprehensive sexuality education in the schools (People’s Daily, 2003).

Involve caring adults. Many programs have overcome resistance by drawing on the support and active involvement of teachers, parents, and other caring adults.

- In Iran, the involvement of parent-teacher associations has eased the introduction of government-sponsored reproductive health education in the schools (Greene, Rasekh, and Amen, 2002).
- In Senegal, organizers of sexuality education courses involve parents and teachers in the design of the program and invite them participate in various program activities (World Bank, 2003).
- In Mexico, Peru, and Chile, school-based sexuality education programs have special parent involvement activities, a component that has helped to convince local school administrators and teachers of the value of the program (Rosen, 2000).
- In the MEMA kwa Vijana program, set up in 62 primary schools in rural Mwanza, Tanzania, discussions with educational leaders were key to making the sexuality education program an acceptable and feasible part of the school curriculum (World Bank, 2003).
- In South Africa, the Department of Education has successfully piloted sexuality education programs that incorporate an element of parent education (Department of Education, 2002).
- In Jordan, despite the reluctance of many teachers to avoid discussions of sexuality and reproductive health, educators and school social workers are among those now advocating for more attention to sexuality and reproductive health within the school curriculum (Almasarweh, 2003).

Mobilize the community. Particularly where resistance to sexuality education may initially be high, community involvement has proved successful.

- In Tanzania, the School Health Education Program (SHEP) reaches 16,000 students in 35 secondary schools with a schools-based campaign to mobilize young people against HIV/AIDS. Involvement of the wider community has been a critical program element, yet one that program officials see as demanding and time-consuming (World Bank, 2003).
- One project, working in a rural area of Peru, used the community “self-assessment” approach to design culturally appropriate adolescent sexuality programs. Project staff gathered information on youth concerns from young people and key adults, including parents, civic authorities, teachers, health workers, and clergy. Adults and youth formed adolescent health committees to identify and

set priorities for adolescent sexual and reproductive health needs and to propose concrete actions (Hammer and Alegria, 1999).

- A community mobilization approach for YRH has proved successful in a wide range of countries, including in Bangladesh, Burkina Faso, Egypt, and Kenya (Senderowitz, 2000).

Test the waters. Where controversy is likely, a gradual approach may be appropriate.

- In the Central Asian republics of Kazakhstan, Turkmenistan, and Azerbaijan, sexuality education, sexuality education courses were piloted first as a way to garner broader support (UNFPA, 1999).
- In Morocco, opposition to a new sexual health curriculum forced the Ministry of Education to postpone wide-scale introduction of certain controversial topics. The Ministry took a “go-slow” approach to implementing the curriculum at selected schools (Beamish and Abderrazik, 2003).
- In Pakistan, strong taboos against open discussion of sexuality still exist. To overcome such prohibitions, one NGO is piloting reproductive health education in secondary schools and partnering with the Ministry of Social Welfare to provide sexuality education to adolescents (Khan and Pine, 2003).

What has been the experience in bringing sexuality education programs to scale?

Although small-scale programs can be effective in improving key YRH behaviors, few countries have successfully brought sexuality education to the national scale (Senderowitz, 2000, citing Smith and Colvin, 2000). To scale up effectively, countries must have a plan that is realistic, including ensuring that the teaching of sexuality does not take too much time from other subjects. The plan should also detail teacher training and include a budget for materials.

- In Mongolia, a locally-developed and tested sexuality education curriculum has now been implemented in 60 percent of schools nationwide (Gerdtz, 2002).
- In Mexico, a lack of teacher training has tempered the country’s success in enacting a national policy on school sexuality education. Although the Ministry of Education has developed required texts on human biology and life skills, as well as on health, sexuality, contraception, and STIs, teachers are largely still untrained (Greene, Rasekh, and Amen, 2002).
- In Tanzania, program officials piloting sexuality education cite scale-up as their greatest challenge, one that requires management, training, resources, consistent sensitization and monitoring, and collaboration across sectors and within communities (World Bank, 2003).
- In Colombia, despite a positive political and legal environment, efforts to implement sexuality education nationwide have foundered for lack of teacher training and unwillingness to commit the necessary resources. Years after the launch of the program, just 1 percent of eligible teachers had been trained (Smith and Colvin, 2000).

Making the Program Effective at the Individual/School Levels

Like any effort aimed at promoting or changing behaviors, sexuality education must be done “right” if it is to succeed. Political opposition of the type discussed in the section above can easily diminish the effectiveness of existing programs by limiting the quality and scope of course content or by curtailing funding. However, even after overcoming such opposition, sexuality education programs must work hard to be effective for individual students. This section discusses the key elements of programs that have done this successfully and some of the common implementation problems they face.

What are the key elements of successful sexuality education programs?

The most basic requirement for effectiveness is a curriculum that has proved to make a difference in student knowledge and behavior. Experts have also identified several other elements of effective programs, summarized in Box 2.

Box 2. Key Elements of Successful Sexuality Education Programs

According to UNAIDS, an effective school-based sexuality education program

- Recognizes the child/youth as a learner who already knows, feels, and can do in relation to healthy development and HIV/AIDS-related prevention.
- Focuses on risks that are most common to the learning group and with responses that are appropriate and targeted to the age group.
- Includes not only knowledge but also attitudes and skills needed for prevention.
- Understands the impact of relationships on behavior change and reinforces positive social values.
- Is based on analysis of learners' needs and a broader situation assessment.
- Has training and continuous support of teachers and other service providers.
- Uses multiple and participatory learning activities and strategies.
- Involves the wider community.
- Ensures sequence, progression, and continuity of messages.
- Is placed in an appropriate context in the school curriculum.
- Lasts a sufficient time to meet program goals and objectives.
- Is coordinated with a wider school health promotion program.
- Contains factually correct and consistent messages.
- Has established political support through intense advocacy to overcome barriers and go to scale.
- Portrays human sexuality as a healthy and normal part of life and is not derogatory against gender, race, ethnicity, or sexual orientation.
- Includes monitoring and evaluation.

Source: Adapted from World Bank, 2003

What other key implementation challenges do programs face?

Local adaptation. Countries often set national guidelines that local schools can modify. For both political and practical reasons this arrangement makes sense. It allows groups with opposing philosophies to compromise to reach students with essential messages, while allowing for some variation. Countries with linguistic and cultural diversity often translate curricula, and approve local adaptation of materials to ensure cultural relevance. In such circumstances, national officials must monitor such adaptation closely so that the changes do not make the curriculum ineffective. The following are examples of local adaptation:

- Schools in the Netherlands are expected—though not required—to include sexuality education in their curricula. As Greene, Rasekh, and Amen (2002: 48) note, “95 percent of secondary schools and about 50 percent of primary schools do so [include sexuality education]. Schools can choose the materials, methods, approach, and time spent on each objective but pregnancy, STIs, sexual orientation and homophobia, value clarification, respect for differences in attitudes, and skills for healthy sexuality are obligatory topics. The core message is that young people should take responsibility if they decide to have sex, and the underlying goal is that they learn to distinguish

between safer and unsafe sexual practices and to care for their health and well-being. Students are taught the life skills they need to negotiate these practices.”

- To make the sexuality education curriculum politically acceptable in Jamaica, program officials eliminated discussions of same-sex relations and of anal intercourse.
- In Mexico, state-level secretaries of education choose the textbooks for sexuality education. If officials wish, they can select textbooks that omit key information. Conservative parents’ groups are asking to have a greater say in the choice of textbooks (Greene, Rasekh, and Amen, 2002)

Making the course mandatory or optional. In deference to the wishes of parents, many countries make sexuality education an optional course, offering students the chance to opt out of part or all of the sessions they or their parents may find objectionable.

- In Britain, where sexuality education is optional, only a tiny percentage of students have withdrawn from the course based on parental objections (OFSTED, 2002).
- The Chilean program had a similar experience, with few students withdrawn (Murray et al., 2000).

Organizing the course. Countries vary in their approach. Some introduce the curriculum as a stand-alone course and others integrate it into another course with similar goals and objectives. Some make it an “examinable” and others do not test students on their achievements in learning the subject matter (Senderowitz, 2000).

Training teachers. Teacher training is a challenge everywhere, including in developed countries.

- A recent national review of sexuality education in Britain recommends that, “teachers should be given further guidance about content and methods in teaching about sexuality,” and schools should establish expert teachers (OFSTED, 2002: 38).
- A study of sexuality education in the Asia-Pacific region found that lack of teacher training is a barrier to quality programs (Smith, Kippax, and Aggleton, 2000).

Selecting and motivating teachers. Teacher selection and motivation is often problematic. The question of who should teach the curriculum also depends on whether the course is stand-alone or integrated within existing courses. Ensuring that teachers are motivated is also a challenge. Not unreasonably, some teachers expect extra compensation for the added responsibility.

- One of the lessons learned from the SHEP program in Tanzania is the difficulty of motivating teachers to carry out sexuality education. Already lacking incentives, teachers expect extra pay for anything outside their normal duties. These attitudes can reduce the effectiveness of the course (World Bank, 2003).
- The experience in Senegal shows that in-depth knowledge of the school environment is essential to teacher motivation and successful implementation. Officials running the program there argue that only education professionals thoroughly familiar with schools should manage and implement sexuality education. Furthermore, those involved must see it as an essential part of their work and not something extra that merits additional compensation (World Bank, 2003).

Conclusions and Implications for Nigeria

This section briefly discusses the findings of the review and their relevance to Nigeria.

Comprehensive sexuality education is effective in improving key YRH behaviors. In a wide range of settings in both developed and developing nations, school-based sexuality education has improved important behaviors such as delaying sexual initiation, reducing the number of sexual partners, and increasing use of condoms among youth who are sexually active. This finding bodes well for Nigeria, a country of linguistic and cultural diversity.

Virtually everywhere, sexuality education is controversial and difficult to carry out on a national scale, especially while trying to maintain the quality of that education. In Nigeria, as elsewhere, such controversy and problems are to be expected. Effectively addressing the concerns of parents, teachers, and the broader community will be essential to eventual success.

Despite these problems, even conservative countries have made headway in incorporating high quality sexuality education in the schools. Although not an easy or quick process, opposition to sexuality education can diminish through active engagement of religious leaders, parents, and teacher groups. Advocates for sexuality education in Nigeria must plan accordingly for such long-term engagement and not expect overnight success. It is also important to involve young people themselves in the advocacy effort in as many ways as possible and to give parents better skills for transmitting information on sexuality and reproductive health to their children.

Programs, to be effective, must “do it right.” It will be important to implement a sound curriculum and adequately train and support teachers and students. The common characteristics of successful sexuality education programs apply equally in Nigeria as elsewhere. Maintaining these characteristics as the program extends nationally will require attention to technical standards as well as to political and budgetary support. Training and retraining of teachers will be a major challenge in Nigeria, as well as ensuring adequate funding at the state level to support sexual and reproductive health programming for adolescents. Critical steps to ensure effective implementation include monitoring of state-level efforts based on workplans with specific targets, continued advocacy with state governments, and introducing sexuality education into pre-service teacher training.

The challenges to implementation vary from country to country and even within countries. Local adaptation—to culture, language, religion, and so forth—is often necessary. In a country as diverse as Nigeria, such adaptation will be critical to success at the level of the school and the individual student. Faith-based organizations in particular can play a central role in developing and promoting culturally appropriate materials for sexuality education.

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