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Between the "Blindfold" and Reality:

*Impact of Culture on
Sexuality Education of
Young People in
Madagascar's
Betsimisaraka Region*

Mireille Rabenoro

Incorporating Youth and Provider Perspectives in the Design of Youth-Friendly Services in Nigeria

Maria de Bruyn and Ejike Oji

Porno, Peers and Pleasure: Pertinent Sources of Sexuality Education for Adolescents in Sub-Saharan Africa

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In This Issue

Foreword

Feature

- 4 Between the "Blindfold" and Reality: Impact of Culture on Sexuality Education of Young People in Madagascar's Betsimisaraka Region

Issue in Focus

- 7 Incorporating Youth and Provider Perspectives in the Design of Youth-Friendly Services in Nigeria

Region Watch

- 9 Promoting Adolescents' Access to Sexuality Education: Challenges and Rewards

Research Notes

- 11. 'Sexuality Education An Effective Tool for Control of HIV/AIDS Epidemic' Result of Formative Evaluation of the National Sexuality Education Curriculum in Nigeria

Viewpoint

- 13 Porno, Peers and Pleasure: Pertinent Sources of Sexuality Education for Adolescents in Sub-Saharan Africa
- 15 Notes to Contributors Guidelines for Submissions
- 15 About the Contributors
- 16 Book Review

Foreword

By Richmond Tiemoko, Ph.D
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Promoting Access to Sexuality Education for All: The Way Forward

The second edition of *Sexuality in Africa Magazine* focuses on Access to Sexuality Education. Because they largely ignored the fact or did not plan appropriately, the development challenges posed by human sexuality in the current epoch has taken many African institutions by surprise, so to speak. African countries sooner or later have to face up to the reality that the greater percentage of Africa's population today is made up of adolescents and young people. While this mass constitutes a potential development force, it can only contribute its quota to socio-economic development when individuals have knowledge and skills to protect themselves and enable them live healthy lives.

Unfortunately, much of the health concerns of adolescents find their origins in sexuality or related issues. Problems arise not only as a result of the ways in which adolescents choose or otherwise to express their sexuality but also as a result of the ideology of adults and the attendant sexual practices. These constitute a major risk factor for many young people and include: Sexual abuse and violence, child marriages, early sexual debut (especially with girls), premarital sex and HIV infections – all of which are predominantly propagated by the sexual practices and values of adults.

Societies and institutions have failed the young people by shaming and silencing sexuality and related issues. If so many adolescents are being infected with HIV and STIs, if many girls are experiencing unwanted pregnancies and risky abortions, if many girls and boys are engaging in sexual intercourse at an early age, if many adolescents are sexually abused and exploited, it is largely because adults and the social institutions they control have failed the young people. Adolescents need sound knowledge, accurate information and relevant skills to face the various challenges of growing up and to be able to express their sexuality in a healthy, pleasurable and responsible manner.

Faced with the HIV/AIDS epidemic, many African countries with the support of international organisations have initiated various school-based sexuality education programmes. However, for various reasons, such initiatives are hardly ever scaled up in scope or in depth. Sexuality education programmes with a focus on preventing premarital sex while neglecting other related concerns – health and rights of the target groups – are most likely to fail.

Sexuality is a lifelong experience and as such sexuality education is a process of learning and skills development for life. The type of sexuality education needed in Africa is, therefore, a comprehensive one that addresses the various aspects and issues of human sexuality and equips young people with skills to live positive and

healthy sexual lives. Sexuality education definitely goes beyond sex education, which aims at preparing young people for puberty, and preventing unwanted pregnancies and STI, and as such focuses on providing information on sexual anatomy and physiology.

Sexuality education 'is a lifelong process of acquiring information and forming attitudes, beliefs, and values about one's identify, sexual development reproductive health, interpersonal relationships, intimacy, body image, and gender roles. Sexuality education addresses the biological, socio-cultural, psychological and spiritual dimensions of sexuality.' (SIECUS)

Comprehensive sexuality education that fully covers all aspects and forms of human sexuality and addresses the various dimensions of sexual health and well-being is required to help African adolescents grow up to be fully responsible and caring sexual beings.

Sexuality education should not be conceptualized as a one-size-fits-all commodity. Adolescents are not a homogenous group and it is crucial to provide and cater for all; taking into cognizance the diversity of adolescents. Specifically, school-based sexuality education programmes should not be seen as the panacea. Where formal education has left out about half of the target population, as it is often the case in many countries, school-based sexuality education would not suffice. Effort would have to be made to provide sexuality education for the millions of out-of-schools girls and boys, and for the growing numbers of girls and boys in particularly difficult circumstances. Sexuality education programmes should also cater for children with disabilities.

Access to sexuality education for all requires using existing methodologies and also designing new and appropriate means and channels for providing such information. Access to sexuality education for all calls for creative strategies including edutainment, use of the world-wide web, informal interpersonal learning as well as many others. Promoting access of adolescents to sexuality education requires the provision of youth-friendly service delivery systems.

Adults and parents have a great role to play in providing an enabling learning environment for adolescents. Thus, in promoting access to sexuality education for adolescents, programmes should also aim at improving 'sexuality literacy' of the adults.

Lastly, a recurring issue in sexuality education debates is how to develop appropriate and acceptable curricula in terms of what should be taught, how, where and by whom. These questions call for more research and innovative approaches.





1

Feature

Between the “Blindfold” and Reality: Impact of Culture on Sexuality Education of Young People in Madagascar’s Betsimisaraka Region

The information contained in this article came from research (two sets of focus group discussions (FGDs) conducted by the author. The first set of FGDs conducted in the year 2000 involved young people in Madagascar’s provincial capital of Toamasina aimed at providing information to guide the setting up a reproductive health clinic for adolescents. The second set of FGDs were conducted in 2002 and involved various age groups – from sexually active adolescents to elderly men and women – in Beforona, a rural village in the province of Toamasina, aimed at identifying sex-related customs in traditional Betsimisaraka (the main ethnic group in Toamasina province).

One major taboo, so strong in all the regions of Madagascar that it could be described as the ‘mother’ of all taboos, at least in this specific area, is that sexual intercourse – or even mere mention of it – between relatives of opposite sexes, is strictly forbidden. Cousins, even very remotely related, who wish to marry, must go through strictly regulated rituals to make their union acceptable. However, marriage is not allowed between first cousins; because their parents (who are siblings) are considered to be from one and the same womb. The result, as far as could be observed among the Betsimisaraka ethnic group in the town of Toamasina and the village of Beforona, is a sharp contrast between the strenuous efforts made by male relatives ‘not to see’ the sexual activities of female relatives, and the great sexual freedom enjoyed by virtually every group of the population, regardless of their age, gender or status.

By Mireille Rabenoro, lecturer, Department of English, Ecole Normale Supérieure, the University of Antananarivo, Madagascar



Photo : Focus Development Association, Antananarivo, Madagascar



Parents 'Blind'

Among the Betsimisaraka, as among most other ethnic groups of the country, the no-sex taboo between relatives results in parents doing their utmost to avoid facing the fact that their sons and daughters have reached the age when sex is a fact of life. Significantly, the money offered by a young man and his family to his prospective bride's parents is named the 'tapi-maso' (blindfold).

But the most significant form of the taboo is undoubtedly reflected in the custom whereby, once they reach the age of 14-15, girls sleep at night in a different house from their parents. This may be either some disused house that the young girls clean up themselves, or a new house that their brothers have built for them, so that their male relatives do not have to see their sexual activities. Several girls of about the same age may sleep in the same house, or a girl may stay with her younger sisters and brothers. In the case of girls who have brother-roommates, the boys must be aged six years or less. Under this

It is in fact within the context of such living arrangements, when several girls live together, that they get their sexuality education. This is mostly during discussions at night; the older ones answer questions about sex posed by the younger ones.

Like the girls, boys, once they attain a certain age live in a house away from their families. According to a participant in the FGDs involving elderly men in Beforona: "*There are disused cabins in the forest. That is where young men and girls live, once they have left school... Only young people with [formal] education go on living with their parents until they get married.*"

In the rural context, therefore, sexuality education is conducted among peers;



Photo: Focus Development Association, Antananarivo, Madagascar

Other sources [1] have shown that urban parents are afraid that they would encourage their children to experiment with sex if they provide them any form of sexuality education.

According to a participant in the FGDs for young men in Toamasina:

"It is impossible to talk about sexual matters to one's parents because they find it embarrassing, as in their days there was no sexual education at school. And for the Malagasy, [sex] was something sacred to humans; that was why it was taboo for our ancestors to talk about it".

The statement, however, seems a misconception of the actual reality. Elderly men and women in the rural village of Beforona, just like the other groups, spoke very freely about sex, as long as there were no relatives of the opposite sex and no direct descendants of theirs in the focus group. From all indication, it is probably formal education, christianisation and westernisation in general – to which rural populations have been exposed to a much lesser degree – that makes adults in urban areas reluctant to speak openly about sex.

As for the sexuality education provided at school, it is widely

...the money offered by a young man and his family to his prospective bride's parents is named the 'tapi-maso' (blindfold)

arrangement, they all still take their meals with their parents. When one of the older girls takes a man home with her, all the siblings go and sleep in their parents' house. From the research findings, this custom is peculiar to girls with both parents from the Betsimisaraka ethnic group.

During the FGDs there were participants who said that they still lived in their parents' homes but had to conceal their sexual activities from them. It turned out that the fathers, whose daughters still remained at home, had their origins from other ethnic groups; only their wives were of Betsimisaraka stock.

Peers: Main Source of Information

between those girls and boys who are sexually active and those who are about to become sexually active.

Urban youth have no access to this type of peer sexuality education. For one, there are no such facilities as disused houses in town, but also because urban, and usually formally educated parents, are reluctant to talk to their children about sexuality:

'My younger sister, who is 16, asks very direct questions, and our mother answers that she does not know. She doesn't want my sister to know about too many things, being so young' (Young women's group, Toamasina).



...sexuality education is included only in the curricula of secondary schools. Rural youth often leave school before they have completed primary school, so sexuality education at school is irrelevant as far as they are concerned

considered 'useless', 'unpractical', or even as 'boring' as any other subject matter by urban youth of both sexes. It should be noted that sexuality education is included only in the curricula of secondary schools. Rural youth often leave school before they have completed primary school, so sexuality education at school is irrelevant as far as they are concerned.

Social Integration

When a girl moves out of her parents' house, the silent message is directed both at young men, who understand that she is now ready for sexual relations, and her parents. The male parent is not even supposed to 'see' that anything is happening, while the female parent often commands: '*If you have decided to do so, then you must do some weaving (to furnish the house)*', or: '*Get to work now; if you are to set a house apart, then you are old enough to have*

an income'. And when a boy is old enough to have women, his father will tell him to get to work (on his own patch of land, or work for wages by planting ginger for other people).

Coming of age, thus, appears to impact on both the sexual and the economic aspects of life: the girls start to work. They weave mats or get salaried work - to furnish and get their houses ready. The idea is so they can pay a man to repair some disused house for them to live in. They also need cash to buy clothes, because all women's focus groups agreed that '*when you have grown out of childhood, you must be cleanly*'.

The statement below highlights a typical mother's attitude to her daughter's coming of age:

'When I had my first period, my mother just gave me pieces of cloth,

saying: That's the way women are' (Young women's group, Beforona)

This attitude is justified by the belief, as expressed by a young woman in Beforona, that: '*A mother's role is to tell you, you must get to work, the moment you stop going to school*' (meaning: Her role is not to teach you about sex).

In fact, when asked about the sexuality education they give to their sons and daughters or that they received from their parents, all participants said that they received lessons on good social behaviour, rather than on sexuality education. The Box below highlights some of these.

It is no wonder that in a recent study, [2] among the indicators on 'support from the community', for example on the use of condoms, the indicator on 'support from the parents' ranks strikingly lowest. In fact, any information/education/communication programme, particularly in connection with the prevention of HIV/AIDS, must take into consideration this element central to Malagasy culture and attitude to sexuality education. The fact is that sex, including the question of partners both within and outside of marriage is considered to be a part of the Creator's plan for humans (*'kabarin-Janahary*'). So, there is nothing to learn about it. But it is considered the duty of the parent of same sex to warn the children about the social implications of sexual activity.

Notes

¹ For example, 'Etudes qualitatives sur les connaissances, attitudes et pratiques en matière de planning familial', N. Ravaozanany et al., UNFPA and Appui au Programme de Population (APPROPOP, USAID), 1995-1996)

² Evaluation of the Madagascar Top Réseau Adolescent Reproductive Health Program, A. Plautz and D. Crapper, PSI Washington Research Division/PSI Madagascar, April 2003).

Advice To Sons

■ '*Don't go with a girl who is underage, or you may be sent to jail*' ('To go with' - '*miaraka*'- is the word politely used by all participants which means 'to have sex'.)

■ '*Don't go with another man's wife, it would get you into trouble with the community*' (Elderly men, Beforona)

■ '*Don't go with a woman before you have money to give her. Because if a young man does not give money to his girlfriend, she may take his clothes and give them to her brothers, and then his father will be brought to shame*' (Adult woman, Beforona)

Advice To Daughters

■ '*Don't go with a man who cannot give you money, it would bring shame on your parents... Don't go with boys who are too young to give you money*

■ '*Don't go with two men at the same time, it would get you into trouble*

■ '*Be polite with your in-laws* (Adult woman, Beforona).



2

Issue
in Focus**BEST PRACTICE****Incorporating Youth and Provider Perspectives in the Design of Youth-Friendly Services in Nigeria**

By Maria de
Bruyn and Ejike
Oji, Ipas

Introduction

Around the world, about 6000 young people aged 15-24 years are infected with HIV each day; it is estimated that 7.3 million young women and 4.5 million young men are now living with HIV/AIDS [1-3]. Fewer than 5% of the poorest young people use modern contraceptive methods [1]. About 14 million adolescents aged 15-19 years give birth each year [4]. UNFPA reports that 10-14% of young unmarried women around the world have unwanted pregnancies [1].

Where abortion is highly restricted by law, adolescents undergo risky and unsafe abortions with serious complications such as sepsis, haemorrhage, uterine and bowel perforations, and secondary infertility [4-5]. Among those admitted for hospital treatment of complications, women aged below 20 account for 38-68% of cases in some developing countries [6].

Efforts have been made around the world to promote sexual and reproductive health (SRH) education for adolescents to delay sexual activity, increase contraceptive use, decrease rates of HIV infection and sexually transmitted infections (STI) as well as unwanted pregnancies. A review of 53 comprehensive HIV/AIDS and sex education programmes found that 22 programmes delayed sexual activity, reduced the young people's number of sexual partners, or reduced unplanned pregnancy and STIs. Only three programmes were associated with increased sexual behaviours, while 27 programmes appeared to have no influence on sexual activity and pregnancy or STI rates [7]. On the other hand, evaluations of abstinence-only sex education programmes did not show that they delay sexual activity or reduce teen pregnancy rates. Adolescents who receive abstinence-only education or pledge to maintain virginity may even be more likely to have unprotected sex when they do become sexually active [8].

Greater attention is also being given to creating youth-friendly SRH services (YFS). An evaluation of 39 interventions found that such programmes influenced young people's knowledge and attitudes more than their behaviours [9]. However, YFS strategies can contribute to increased clinic use and adolescents' satisfaction with services [10-11].

A Pilot Project

Given the above context, we developed a pilot project to promote YFS among providers of post-abortion care. The project took an innovative approach whereby young people and providers were given the opportunity to engage in dialogue on what makes services unfriendly or attractive to youth. The methodology included four major elements:

- provision of SRH education to a group of female and male university students
- training of the youth on drama / theatre skills under the guidance of an expert
- development of a drama script about unwanted pregnancy and its consequences and performance of the drama to an audience of health-

...we developed a pilot project to promote youth-friendly services (YFS) among providers of post-abortion care

service providers

- a facilitated discussion session on the essential elements of YFS between the youth and providers based on the issues arising from the educational and drama sessions

The young people who participated were offered financial reimbursement of travel expenses, certificates and a copy of a workbook on SRH [12]. The providers were given a guide on adolescent SRH services [13].

Implementation

To implement the project, Ipas partnered with Baziks Theatre, Abuja and representatives of the Women's Sexual and Reproductive Health Rights Project, sponsored by the Society of Gynaecologists and Obstetricians of Nigeria, and PACNet, a post-abortion care network. Twenty-four service



providers (13 men and 11 women) from nine public and private hospitals nurse-midwives.

The 22 young people recruited by word of mouth included 11 women and 11 men aged 19-24 years. 15 were students from six universities and a polytechnic institute; the others were recent university graduates. Only three had been exposed to an SRH educational programme prior to this project and almost all said they had never received any materials on SRH from health workers.

The young people participated in 12 educational sessions covering the following topics: basic reproductive anatomy, pregnancy prevention, contraceptive methods, unsafe abortion, post-abortion care, abortion permitted by law, HIV/STIs, alcohol and drug abuse, sexual violence, and SRH rights. Following several weeks of drama instruction, they developed a play about a young woman who has an unsafe abortion following an unwanted pregnancy. Fifteen students were actors and the others served as stagehands.

In May 2003, the young people performed the play to an audience of 24 health-service providers and representatives of the National Council of Women Societies (NCWS) in Nigeria, the National Association of Women Journalists (NAWOJ), and the International Federation of Women Lawyers (FIDA). The youth gave a second performance later to a larger group of women and other service providers.

Outcomes

A pre- and post-intervention quiz completed by 16 youth showed that one of the most significant new knowledge acquired was with regard to the fact that adolescents younger than 18 years can access contraceptive methods through family planning clinics. An end-of-project evaluation showed that 21 of the young people had learned something new about SRH.

During the discussions between the young people and service providers, the young people identified a number of elements that YFS should comprise:

- no discrimination based on age or social status
- warm reception and friendly environment
- tolerance and patience on the part of providers
- observance of confidentiality
- privacy in the location of services
- qualified providers and a counselling unit with trained staff

- relevant equipment and adequate bed space
- subsidized costs of services and drugs
- availability of services in the evenings and weekends, as well as emergency services.

The providers all agreed that the play had brought up many issues about which they had never thought or that they had not felt were very important. Some of the elements of YFS they highlighted corresponded with the young people's suggestions, while others reflected their concerns from a

A major strength of the project was the fact that the young people were able to participate actively and creatively

health-facility management point of view:

- Providers should be friendly.
- Providers should be trained in communication, counselling and the provision of education and services to youth.
- Services should be open to youth and adults, male and female.
- Services should be confidential.
- Facilities should have opening hours convenient for youth, including 24-hour services.
- Youth should be able to make appointments by phone and be attended to promptly.
- The physical environment should be clean, air-conditioned, friendly, have music.
- Services should be accessible and affordable.
- Services should be cost effective.

The young people were quite positive about the discussions held with the health-service providers. As one said, "I think the discussion with the health-care providers concerning youth-friendly services helped them to see things from a different view, and they know what the youths really needed from them to make the services friendly. The drama presented to them also had a positive influence on them concerning the issue."

All of the young participants said they would recommend a project like this to their friends. Ten said they would not change anything in the project. Others proposed making it available to a wider

audience by using a different venue or involving radio and television.

There was insufficient time during the project period for follow-up. One provider from a public hospital nevertheless started taking action based on the new lessons learned. The provider asked the records clerks in her health facility to select clients by age so that adolescents can be sent immediately to a physician designated to treat young persons.

As follow-up, Ipas has held discussions with providers on how the recommendations can be implemented in a feasible and practical manner. In addition, a videotape of the performance has been disseminated to NGOs as an awareness-raising tool.

Project Strength

The project staff recognized that educating the youth about SRH enabled them to convey their messages about the problem of unwanted pregnancy and its consequences in a convincing manner. The inclusion of gender and human rights perspectives in the training also had positive impact. Also noteworthy was the fact that the group comprised both female and male young adults who participated as equals; equitable participation was encouraged throughout the project.

A major strength of the project was the fact that the young people were able to participate actively and creatively. While many YFS projects train youth as peer health educators, few give them the opportunity to engage in direct dialogue with service providers regarding how services should be organized.

An unexpected outcome of the project was a statement of support by national women's organisations who proposed to advocate for a revision of the current legislation on abortion in Nigeria.

Recommendations

Given the time and expense that this particular project involved, it is clear that not all collaborative youth-provider interventions to define YFS would be able to accommodate a drama production. An alternative would be to record a drama produced by young people for use in similar interventions. Doing this in a real hospital or clinic setting would also make it more "true to life."

It might be tempting for programme managers to simply show such a videotape to health-service providers so that they can draw their own conclusions about what YFS should be. However, the elements of YFS could



3

Region
WatchPromoting Adolescents'
Access to Sexuality Education
Challenges and Rewards

Action Health Incorporated (AHI) is a not-for-profit, non-governmental organisation founded in Lagos, Nigeria in 1989 and it is dedicated to improving the health and upholding the rights of Nigerian adolescents.

AHI envisions a Nigeria where young girls and boys would grow up to assume control over their lives and are guaranteed access to basic information, skills and services to enhance their sexual and reproductive health and rights.

Pilot Project

In actualising this vision, one of AHI's flagship pilot project is its community advocacy and teacher training for the implementation of the approved National Sexuality Education (NSE) Curriculum. For this pilot project, AHI chose to work in Lagos State- Nigeria's most populous and metropolitan city and the country's commercial nerve centre. While AHI led the advocacy and lobby for the development of the NSE curriculum, devoting an enormous amount of time and other resources to achieving this singular feat; AHI's decision to work with the Lagos State government to pilot implementation of the project was premised on the fact that the state had demonstrated the political will to take the process forward by

providing funds and other resources to support the work.

Strategies

The most successful strategies employed are highlighted below: **Advocacy**: Sensitisation visits to commissioners and other key personnel in the State Ministry of Education (LSMOE) and outreach seminars targeted at school principals, parents, teachers and religious groups proved to be very effective in helping them understand the importance of sexuality education.

Capacity Building for Teachers: This was essential and very useful in enabling them grasp the technical contents of the course, imbibe the new teaching methodologies required (role play for example) and to improve on their 'sexuality comfort level'. The reality is that many of the teachers also came to the course with their own biases!

Materials Development: Strategic resource materials were developed to fill the gaps. Largely, there were no existing texts, aids or teacher guides suitable for the local context.



Monitoring: Visits to the schools were organized to receive feedback on the implementation process and to enable programme managers respond to challenges and also to motivate the teachers who were more or less volunteers to the scheme and who often face stigma.

Challenges

A major challenge was the misconceptions held by various stakeholders over the essence of sexuality education and what it promotes. Many were of the opinion that it promotes promiscuity. Here, the sensitisation programmes remain very useful. Implementation of a programme like this is quite expensive and the government was



unable to cover all the costs. AHI has received support from donors such as the Ford Foundation, Packard and MacArthur Foundations who have provided funding for different components of the project. So far, only 400 out of the 1,400 teachers in the State's Sexuality Education programme have been trained due to inadequate resources.

Expectedly, some teachers also find it more difficult than others to adapt to the new teaching methodologies. The monitoring visits and meetings held assisted in addressing some of the problems faced by the teachers. The mass media has remained a great asset and ally of AHI in raising awareness about sexuality education, and in the creation of a more enabling environment.

A major challenge remains how to obtain the resources to cover the costs of the Lagos State programme and to enable the scaling up of this very important project to other states of Nigeria. Fortunately, the UNFPA has taken on the challenge of scaling up in 15 other states as well as the Ministry of Education in Cross River State, of Nigeria.

Looking back over the two-year period that the pilot project has

Incorporating Youth and Provider Perspectives

Continued from p.8

vary from place to place. Moreover, one of the most important components of this strategy was enabling the young people and health-service providers to engage in a face-to-face dialogue.

An alternative strategy could involve showing a recorded drama to young people and health-service providers separately so that they can use it as a basis for defining YFS and then bringing them together for a joint screening and discussions.

Conclusion

The project demonstrated that it is possible to enable young people and health-service providers to communicate as equals about the concept of youth-friendly services. The providers appreciated the opportunity to interact with young people outside of the clinic setting, while the young people felt that they

been implemented, significant progress has been made: 400 teachers have been trained so far; ground-breaking resources have been developed; there is certainly increased awareness of, and support for sexuality education and youth development programmes by communities and various opinion leaders, and there is more positive coverage of sexuality education programmes in the Nigerian media.

Perhaps, more satisfying is the fact that many other states have begun to show interest in implementing the programme.

The key lessons learned are highlighted below. These may be useful to others on the continent who may wish to pilot the implementation of sexuality education in schools.

Advocacy is key: It is crucial to reach as many of the stakeholders as possible and convince them. In that way they would become supporters and advocates rather than detractors.

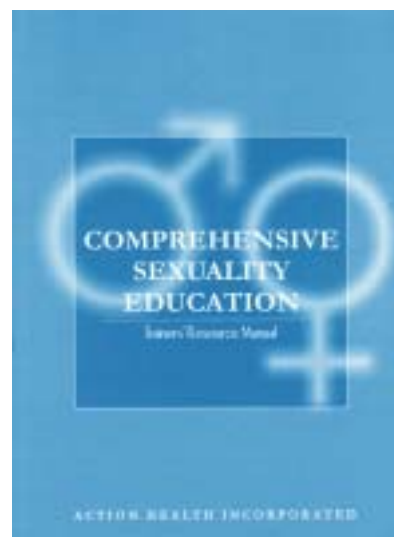
Monitoring of teachers involved in programme implementation is very important.

Fundraising and mobilisation is also critical.

There is need to *build capacity* of implementing partners as well as *evaluate and measure* outcomes of project. It is also important to *build and incorporate sustainability plans* from the design stage, and *make a meaningful and valuable contribution*.

References

1. UNFPA. 2003. State of world population 2003. Making 1 billion count: investing in adolescents' health and rights. New York: UNFPA
2. UNAIDS. 2004. 2004 Report on the global AIDS epidemic. Geneva: UNAIDS.
3. Department of Economic and Social Affairs. 2004. World Youth Report 2003. The global situation of young people. New York: United Nations
4. Treffers P. December 2002. Issues in adolescent health and development. Adolescent pregnancy. WHO/FCH/CAH/02.08 & WHO/RHR/02.14. Geneva: WHO.
5. McIntyre P. October 2002. Adolescent friendly health services. An agenda for change. WHO/FCH/CAH/02.14. Geneva, Department of Child and Adolescent Health and Development, World Health Organisation.
6. Olukoya AA, Kaya A, Ferguson BJ and AbouZahr C. 2001. Unsafe abortion in



The Trainers' Manual developed by AHI is a major resource for teachers of sexuality education in Nigeria.

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adolescents. International Journal of Gynecology & Obstetrics, 75: 137-147.

7. The Alan Guttmacher Institute. September 2003. Sex education: needs, programmes and policies.
8. Grunseit A. 1997. Impact of HIV and sexual health education on the sexual behavior of young people: a review update. UNAIDS/97.4. Geneva: UNAIDS.
9. Finger W, Pribila M. YouthLens: research that guides reproductive health efforts for youth. Network, 23/1; <http://www.fhi.org/NR/Shared/enFHI/PrinterFriendly.asp>; accessed 7 October 2003.
10. Mmari KN, Magnani RJ. Does making clinic-based reproductive health services more youth-friendly increase service use by adolescents? Evidence from Lusaka, Zambia. Journal of Adolescent Health, 2003, 33:259-270.
11. Population Council. Mexico: Strengthen Education on Adolescent Reproductive Health. OR Summary No. 36. September 2003; <http://www.popcouncil.org/frontiers/orsummaries/ors36.html>; accessed 15 October 2003.
12. Watson C, Brazier E. 2000. You, your life, your dreams: a book for adolescents. New York: Family Care International.
13. Barnett B, Schueller J. 2000. Meeting the needs of young clients: a guide to providing reproductive health services to



4

Research
Notes

Result of Formative Evaluation of the National Sexuality Education Curriculum in Nigeria:

Sexuality Education An Effective Tool for Control of HIV/AIDS Epidemic

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Adolescence is a period of transition from childhood to adulthood and as adolescents prepare to enter adulthood, they face enormous challenges in an environment of rapid urbanisation and social changes. Various studies [1-2] found the attributes of adolescence to include risk-taking, deviant behaviours, and potentially destructive behaviours with or without understanding the immediate or long-term consequences of their actions. Coping with the physical, emotional and social changes that accompany this period was also identified as a major problem faced at this developmental stage. [3]

The Challenges

The challenges are compounded by a compendium of factors including: inadequate access to appropriate information, education and services to meet their peculiar needs during this transitional period; weakening of traditional norms and support systems, especially the reduction in the influence of the extended family due

to urbanisation; the globalisation of communication and the mixed and confusing messages about male versus female sexuality portrayed in the mass media; decline in the annual earnings of families - resulting in pressure on young people to contribute to family income; and gender

for equipping adolescents with accurate, crucial information and skills related to sexuality.

Adolescents Vulnerable

Studies have shown that many adolescents are vulnerable; therefore they need to be empowered with relevant knowledge that will enable them cope with various developmental problems facing them. Sexuality education empowers adolescents to make rational decisions about their sexuality. Sexuality education also empowers adolescents to decide when and with whom to become

sexually active. It also equips and enables them to avoid non-consensual sex, sexual violence and abuse. Thus, with sexuality education, adolescents can also avoid unwanted pregnancies, and the attendant problems such as the need to drop out of school, unsafe

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inequalities including the double standards applied to the issue of pre-marital sex whereby sex is restricted for girls and tolerated for boys.

Useful Tool

Researchers and programmers have identified and proffered Sexuality Education as a useful tool



abortions and Sexually Transmitted Infections (STIs), including HIV/AIDS.

Study Design

A formative evaluation of the newly developed National Sexuality Education (NSE) Curriculum in Nigeria was conducted. This was done at the field-trial stage of the curriculum development- a stage in curriculum development before the actual implementation of the curriculum. This study was designed to examine the effects of the NSE on students' knowledge of and attitude towards sexuality issues, taking into consideration effects of antecedent variables of gender, religious leaning and students' background, among other things.

The study adopted the pre-test / post-test control group quasi-experimental design, with a 2x2x2x2 factorial analysis. The sample was randomly and purposively selected from Ibadan, Oyo State, comprising six hundred and sixty nine (669) adolescents, ranging between 12- 20 years of age (mean= 15). Four schools were exposed to treatment (Sexuality Education in a classroom setting as prescribed by the curriculum) for ten weeks.

Another set of four schools served as the control (no sexuality education was provided). Seven hypotheses were tested at 0.05 level of significance. Four validated and reliable instruments, including Student Background, Sexuality Information Tests and Attitude Towards Sexuality Issues Questionnaire were used for data collection.

Analyses

Analyses of Covariance (ANCOVA), basic descriptive statistics and qualitative methods were used to analyse the data. Findings show that a significant main effect of treatment (Sexuality Education-SE) was found on knowledge of (F (1, 669= 6557.498; P<0.05) and attitude towards sexuality issues [F (1,669 = 4395.316; P < 0.05)]. In fact,



at the pre-test level, up to 99 percent of the students scored less than 50% on knowledge of sexuality issues.

Variables such as religion and students' background were found not to have significant main effect on students' knowledge of and attitude towards sexuality issues; but gender had significant main effect on students' attitude towards sexuality issues [F (1,699 = 10.879; P< 0.05)]. There was a significant interaction effect of treatment and gender on students' knowledge of sexuality issues [F (1,699 = 4.428; P< 0.05)]. Females in the treatment group performed better than the males in the post-test that assessed knowledge of sexuality issues.

The study further revealed the extent of use of prescribed learning materials and activities in the sexuality education class. For instance, 'lecture method' was the most frequently used and role-play, the least; and this is a departure from the curriculum prescription. Teachers' opinion about the content of the curriculum, teaching methodology, evaluation technique, the naming of the curriculum as well as administrative hindrances associated with the inclusion of the subject in the school curriculum also yielded varied results. **Implications**

The implications of the findings for curriculum developers,

governments, teachers, parents, students and the Nigerian society, in regards to large-scale implementation of the Sexuality Education Curriculum, are enormous. Increase in knowledge of, and attitude towards sexuality issues are significant findings of the study that are very important in combating the scourge of HIV/AIDS. These are equally important in responding to other sexuality-related problems that affect Nigerian adolescents.

The conclusion is that if sexuality information is made accessible to Nigerian adolescents in both rural and urban areas, this would invariably become a significant tool to combat and curb the spread of HIV/ADS in the country; especially among adolescents who have higher vulnerability and are the future of the nation.

References

1. Irvin, C.E.Jr., & Millstein S.G. (1986) Biopsychosocial Correlates of Risk-Taking Behaviours During Adolescence: Can the Physician Intervene? *Journal of Adolescent Health Care* 7: 82-96
2. Cole, M. & Cole, S.R. (1996); *The Development of Children*, New York; WH Freeman and Company
3. Action Health Incorporated (1999) *Meeting the Sexual and Reproductive Health Needs of Young People in Nigeria: A Guide for Action*. Lagos: AHI



5

Viewpoint

Porno, Peers and Pleasure: Pertinent Sources of Sexuality Education for Adolescents in Sub-Saharan Africa

By Stella Nyanzi, doctoral research student, London School of Hygiene and Tropical Medicine

Introduction

Sexuality education is an umbrella definition that refers to the life-long socialisation process of acquiring information and forming attitudes and beliefs about sex, sexual identity, relationships and intimacy. It should aim at developing the knowledge, autonomy and life-skills of adolescents so that they can ably make judgements and informed choices about their sexual bodies, rights, health and general well-being.

Good Intentions

Several international conventions, declarations and 'good intentions'

teenage pregnancies, vulnerability to sexual violence and abuse of sexual rights mainly of women and girls. Albeit, ratifying and adapting these universal instruments, many sub-Saharan countries are rife with heated debates on the advantages and disadvantages of providing sexuality education to adolescents.

These debates are evident right from the highest acclaims of society, down to individual units of social organisations at the grassroots level. Conditions prevalent in the sub-Saharan health care systems further complicate the issue, such that even in cases where governments are open to the possibility of providing sexuality education to adolescents, sustainability is an issue due to limited resources to cover the activities.

Sexuality education programmes have often been designed

Sexuality education programmes have often been designed based on international or otherwise western models and theories of psycho-social behaviour

attest for sexuality education as an empowering human right whose provision would combat and alleviate persistent indicators for poor reproductive health; particularly sexually transmitted infections like HIV/AIDS, high maternal and infant mortality rates,

based on international or otherwise western models and theories of psycho-social behaviour. These are often derived from top-down blueprints conceived and developed by official technocrats and academics far removed from the social reality of the youths who are

the beneficiaries of such programmes. These programmes also tend to be gerontocratic because of the rigid and often puritanical ideals and values of adults regarding adolescent sexuality and also because these ideals are handed down in a prescriptive tone that often has the effect of putting off adolescents rather than capturing their attention. Emphasis is oftentimes on the risks, dangers and disastrous consequences of 'adolescents indulgence'. In these cases, sexuality is discussed within a health framework, with the concomitant denial of pleasure or purity which sexual activity can be comprised of.

Poor Indicators

Sub-Saharan African countries have some of the poorest performance indicators of sexual and reproductive health including maternal mortality, adolescent pregnancies, sexually transmitted disease and fertility. In addition, the current HIV/AIDS epidemic has had its greatest impact in the region, and seems to be persistently



growing in many areas, although success in reducing incidence rates has been recorded in countries like Uganda. Infection rates are highest among the younger reproductive age-categories.

Research driven by the claim that HIV infection in sub-Saharan Africa is predominantly spread through unsafe heterosexual activity, has generated evidence to show that adolescents who have grown up since the advent of the epidemic do indulge in unsafe sexual behaviour. As a result, several and diverse health initiatives sponsored by international and national bodies have emphasized the need for sexuality education.

Resistance

While the value of sexuality education is acknowledged, the intervention is also resisted in many African societies particularly because of the argument that premature exposure to knowledge about sexuality would, indeed, do more damage to adolescents than help them overcome problems they encounter in growing up. Proponents of this view further argue that the current mode of delivery of sexuality education is a-cultural because indigenous socialisation processes in Africa prohibited through taboo – cross-generational discussion of sexual behaviour.

As a result, parents and children never ever discussed sex and its related behaviours. Rather, diverse social institutions of initiation rites and ceremonies were the time and place for adolescents and their peer-group to get exposure to sexual information – predominantly in preparation for adulthood, marriage and related responsibilities. Traditionally, discussion about sex and sexuality was largely cushioned in proverbs, riddles and indirect language. Adults never crossed the borders of appropriateness when discussing sexuality in the presence of children.

School-Based Programmes

A UNAIDS [2] assessment of sexuality education reported that out of 53 evaluations of specific programmes, 27 reported neither



For many young people in sub-Saharan Africa, the booming cybercafe business provides easy-to-access pornographic sources of 'sexuality education'

increase nor decrease in sexual activity and attendant pregnancies and sexually transmitted infections; 22 reported it led to delayed sexual debut, reduced number of sexual partners, or reduced unplanned

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pregnancy and STD rates; and only 3 reported an increase in sexual activity as a result of sexual health education.

In order to overcome the aforementioned cultural barrier, sexuality education interventions in Africa have predominantly been school-based whereby schoolteachers introduce sexuality education into the school curricula. Studies evaluating this channel of delivery report success in increasing awareness and knowledge of sexuality and reproductive health among target adolescents. Other successful sexuality education programmes work with peer groups and faith-based institutions.

A few programmes for out-of-school youths employ strategies such as drama presentations, sports events as well as the mass media (radio or television).

Research Findings

My ethnographic research about sexuality, sexual behaviour and reproductive health in both East and West Africa reveals that it is important to unravel and harness adolescent emic understandings of sexuality as a pleasurable, accessible, beneficial and natural experience; in order for adolescent sexuality education campaigns to be appropriate, appreciated and applied by the recipients. Otherwise, adolescents will continue to seek out and rely on more pertinent and, perhaps, inaccurate sources of sexuality information: namely pornography, peers and pleasurable experiences which appeal more to pubescent curiosity.

References

1. Tiendrebeogo G., Meijer S., Engleberg G. (2003) Life skills and HIV Education Curricula in Africa: Methods and Evaluations. Technical Paper Number 119. Africa Bureau Information Centre
2. UNAIDS (1997) Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People: A Review Update . Geneva: UNAIDS www.unaids.org/html/pub/publications/irc-pub01/jc010-mpactyoungpeople_en_pdf.pdf.



Notes to Contributors

Guidelines for Submissions

The editors welcome submissions on the thematic focus of future issues of the Magazine, as well as other areas of sexuality, sexual health and rights. Themes for upcoming 2004 issues include:

Issue 3: Violence Against Women and Girls

Issue 4: Sexuality and HIV/AIDS
2005 issues will cover the following subject areas: Rethinking Masculinities, Sexuality and Religion, and Sexuality and the Media.

ARSRC seeks articles for submission which are objective, analytical and mirror current / contemporary issues and debates in the areas of Sexuality, Sexual Health and Rights in Africa. Articles should reflect a holistic /comprehensive approach to sexuality; taking sexuality discourse beyond health to

incorporate broader issues of the expression of sexuality without guilt, fear or ill-health. While priority would be given articles that have not been previously published, already published material may be considered depending on how relevant the subject area and focus is to ARSRC's work. However, for already published articles, full details of previous publication and where to seek permission for reprint must accompany the article.

We particularly welcome articles related to our thematic focus for the following sections :

Region Watch: Topical issues with a country or sub regional focus
Programme Feature: best practices from programme implementers

Research Notes: Focus on relevant research and methodologies

Viewpoint: Reactions to previous magazine issues or on a subject area that a reader wishes to express very strong views or opinion.

Length

Feature articles : 1,000 -1,500 words

Research issues : 800-1,000 words

Opinion articles : 400-500 words

Photos

We welcome photos with or without articles and will give appropriate credit when photo is used.

Presentation

Please submit initially, an abstract with your name, contact address, phone number, email address and details about yourself as you would wish it to appear on the list of contributors

*****All contributors will receive a copy of the issue in which their contribution has been published.

About Contributors to this Edition

Mireille Rabenoro is a lecturer in the English Department of the Ecole Normale Supérieure of the University of Antananarivo. She has conducted a number of research studies on gender issues, including those that resulted in the development of the National Gender Policy (2001) and the National Gender and Development Action Plan (2003).

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BOOK REVIEW

Improving Adolescent Reproductive Health Programmes in Africa: Lessons from Kenya

Review by Arit Oku-Egbas, Africa
Regional Sexuality Resource

The 35-page publication, published by The Centre for the Study of Adolescence, Nairobi, Kenya in 2003 makes interesting and easy reading and is recommended for programme implementers and all those who are working to promote the access of adolescents to youth-friendly and effective sexual and reproductive health programmes. Though the publication largely explores the Kenyan experience it nevertheless provides useful insights and lessons for others working in the different regions of the continent. It clearly and succinctly highlights the main issues.

The publication documents the main lessons learned and experiences from the Kenya Family Health Programme (KFHP) that was implemented by the Government of Kenya in collaboration with NGOs between 1997 and 2002. The programme aimed to "increase utilisation and improve quality of family planning information and services" and was targeted at different age groups. One unique characteristic of the programme was the fact that it drew diverse stakeholders and is an example of the kind of synergy that can exist between government, donor agencies and non-governmental actors in development work.

The introduction draws attention to the almost dismal landscape associated with adolescent sexuality on the African continent within the context of a changing social world order, globalisation, wars, political instability, drastic cuts on education budgets, with the backdrop of increasing and desperate poverty as well as a dearth of information and essential services. The result is that adolescents encounter a tumultuous and dangerous world in which they must grow-up and survive. The HIV/AIDS epidemic seems the last straw within this very unfortunate landscape – adolescents, especially girls, bear the brunt of the disease, which has continued to spread unabated. In the midst of this is the near absence of

political commitment on the part of the various African governments.

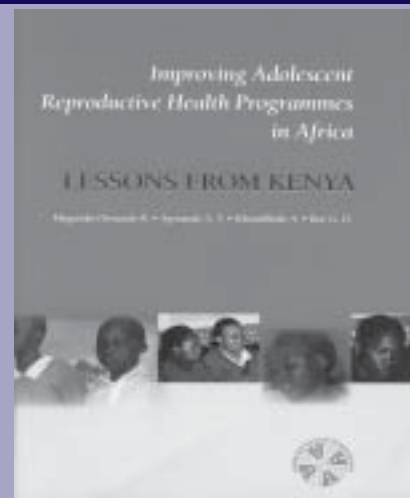
The situation certainly calls for a focus on adolescents considering their numbers and high level of vulnerability. "According to UNFPA, 50% of all new infections occur among young people between the ages of 15 and 24 years" (p.8).

The authors plot the way forward noting that while there are a number of programmes to promote the sexual health of adolescents, mostly small-scale, peer education programmes, many of them lack creativity and impact because they hardly take cognisance of the special needs of the target group as well as the communities and the socio-cultural contexts within which they exist.

While the authors appear quite critical of Africa's Adolescent and Reproductive Health (ARH) programmes, - "Africa is full of pilot ARH initiatives. Most rarely go beyond the pilot stage" – the truth remains that for as long as the programmes are donor driven, and many programme implementers are in the business because they have no other source of livelihood – the dream of scaling up programmes to reach increasing numbers and to have impact will remain just that - a dream. While it is pertinent to advocate for donors to be more responsive to the needs of target communities and to expand scope and length of their funding cycles, it is equally important that on the continent we begin to look inward for funding sources.

As pointed out at a recent seminar, if the NGOs do not start to behave like businesses they will soon run out of business. [1] The speaker further noted:

Why is ARH not prioritised by African Governments? Most of the resources for ARH are derived from external funds. Yet, the external funding landscape is not likely to get better. The African continent has an indigenous giving culture: there is a need to learn how churches are generating resources. A lot of organisations have sources of



Authors: Muganda-Onyando R,
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generating surplus. How are they doing this? There is a need to look at endowments and subsidies from both public and private sectors.

Adolescent Reproductive Health in Kenya, as pointed out by the authors is reflective of the general situation on the continent but they identify a window of opportunity - "currently, 56% of Kenyan adolescents are not yet sexually active" (p.11) noting that this group can be targeted in programmes to delay sexual debut.

In the KFHP which is the focus of the publication, The Kenyan Government collaborated with the European Union (EU) and the Department for International Development (DFID) and fourteen NGOs (including church-based groups) and provided a variety of services including clinic based services.

Some of the key lessons and best practices that evolved from the KFHP programme are highlighted and can serve as a reference for others in the field.

The publication is certainly very informative especially because it is practical and makes reference to actual realities encountered in the field during implementation of a project. It also contributes to the much needed literature on sexual and reproductive health with a specific focus on Africa.

(Footnote)

1. During the ARSRC's Sexuality Institute (October 3-9, 2004) Dr. Babatunde Ahonsi of the Ford Foundation's Office for West Africa chaired a panel titled: Resource Mobilisation for Promoting Access of Adolescents to Sexuality Education and made the cited observations.