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Advocacy for school-based sexuality education: lessons from India and Nigeria

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Drawing on evidence from a wider study on the cost and cost-effectiveness of sexuality education programmes in six countries, and focusing on the examples of India and Nigeria, this paper argues that advocacy is a key, yet often neglected component of school-based sexuality education programmes, especially where sex and sexuality are politically or culturally sensitive issues. It also suggests that advocacy is not a one-off activity but needs to be carried out continuously and adapted as contexts and needs change. Overall, this piece recommends that advocacy should be a key component of sexuality education work, and needs to be planned and budgeted for. Without such investment, country-level sexuality education programmes are likely to fail.

Keywords: sexuality education; advocacy; community ownership; India; Nigeria

Background

A growing number of countries have started implementing or are scaling up school-based sexuality education programmes. This comes as a result of an increasing awareness of the need to equip young people with the knowledge and skills necessary to make better-informed choices and decisions about their sexual and social behaviour and sexual health. Such education needs to include appropriate and context-specific approaches; be age-specific, or phased according to specific age groups, starting at an early age[1]; have appropriately trained teachers and other support staff; and, importantly and critical for this paper, it needs to have support and ownership from a range of people both in and beyond the school, including parents and other members of the community (UNESCO 2009).

Sexuality education also has a potentially critical role in the context of HIV and AIDS. With 60% of young people between 15 and 24 years of age unable to correctly identify ways of preventing HIV transmission (UNAIDS 2008), sexuality education has the potential to contribute significantly to improving young people's knowledge base, thereby also supporting HIV prevention efforts. This is particularly important because young people are at heightened risk of acquiring HIV. In 2009, young people aged 15–24 years accounted for 41% of new HIV infections in all people aged 15 and older, with young women making up more than 60% of all young people living with HIV and 72% of all

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young people living with HIV in sub-Saharan Africa (UNICEF 2011). In Nigeria, for instance, young people between 15 and 29 years of age contribute 60% of new HIV infections, and 21% of upper primary school students and 20% of junior secondary school students are estimated to be sexually active.[2]

In addition to HIV, young people continue to have high rates of STIs. According to an International Planned Parenthood Federation (IPPF) report, at least 110 million new cases of curable STIs occur each year among young people aged 10–24 years (IPPF 2006).

A number of studies, reviews and meta-reviews provide evidence of the impacts and potentials of sexuality education (Aten et al. 2002; Borgia et al. 2005; Gallant and Maticka-Tyndale 2004; Maticka-Tyndale, Wildish, and Gichuru 2007; Gordon 2007; Kirby, Laris, and Rolleri 2005; Kirby, Obasi, and Laris 2006; Kirby 2009). Overall, findings show that effective sexuality education programmes can:

> reduce misinformation; increase correct knowledge; clarify and strengthen positive values and attitudes; increase skills to make informed decisions and act upon them; improve perceptions about peer groups and social norms; and increase communication with parents and other trusted adults. (UNESCO 2009, 2–3)

Programmes can also help young people to:

> abstain from or delay the debut of sexual relations; reduce the frequency of unprotected sexual activity; reduce the number of sexual partners; and increase the use of protection against unintended pregnancy and STIs during sexual intercourse. (UNESCO 2009, 3)

Despite the growing body of evidence in support of sexuality education, it is still not being provided to young people in a majority of countries. Resistance to implementing sexuality education stems primarily from a range of mistaken concerns and beliefs, e.g. that sexuality education leads to early sexual debut, that sexuality education deprives children of their innocence, that it is against the culture or religion, or simply fear on the part of lawmakers and education professionals that parents will object to it being taught in schools (UNICEF 2011).

Hence there is a continued need to provide the evidence base for why school-based sexuality education is important, how to best implement school-based sexuality education programmes, but also what external or contextual factors need to be taken into consideration when designing, implementing and scaling up school-based sexuality education programmes.

This paper is based on a study which explored the cost and cost-effectiveness of sexuality education programmes in high-, middle- and low-income countries: Nigeria, Kenya, India, Indonesia, Estonia and the Netherlands.[3] These country examples highlight the key role of advocacy as a cost component of successful sexuality education programmes. Here, the term advocacy is used in a broad sense and involves activities and interventions focused on raising awareness, building support and ownership. Such activities can be carried out with a range of stakeholders including parents, teachers, other school personnel, community leaders and members of government institutions.

Building on frameworks aimed at fostering support for comprehensive sexuality education developed by IPPF (2009) and others, and focusing on the cases of India and Nigeria, this paper examines the role of advocacy as a key, yet often neglected component of sexuality education programmes, especially where public discussion of sexuality and sexual health are politically and culturally charged issues. We draw on some of the findings of the wider costing study, but with the aim of focusing on whether and how advocacy – as a key stage in programme development and implementation, and as a cost component – can significantly affect the likelihood of success, particularly in contexts where public

discussion of sexuality and sexual health are sensitive issues. While only two studies are explored in some level of depth, the paper also provides some suggestions on what such findings might imply for policy and programme recommendations relating to advocacy more broadly.

Description of programmes

In Nigeria, the Family Life and HIV Education (FLHE) programme is implemented by state governments and is currently being scaled up across all 36 states in the country with support from the Global Fund.[4] In the states where it is being scaled up, the programme is

Table 1. Sexuality education programmes.

	Country	
	Nigeria	India
Name of sexuality education programme	Family Life and HIV Education	Adolescent Reproductive and Sexual Health Curriculum
Geographical area	Lagos State	Orissa State
Intra-/extra-curricular	Intra-curricular	Intra-curricular
Integrated/stand-alone	Integrated	Integrated
Targeted age group/classes	13–15 years Junior secondary school (grades 1–3)	13–16 years High school (grades 8–10)
Period considered	1999–2009	2010–2014
Programme duration years	3	3
Total number of hours	43	34
Schools covered in 2009	319	5560
Total programme costs	3,400,000	10,800,000
Annual costs in 2009	562,000	3,502,000
Schools covered in 2009	319	5560
Cost per school in 2009	1762	630
Cumulative number of students	694,000	990,000
Students reached in 2009	246,000	780,000
Cost per student in 2009	6.90	13.50
Total training costs	298,000	407,000
Total number of trained teachers	1500	5560
Costs by phase		
Programme development	387,000	271,000 (2%)
Teaching materials	49%	43%
Operations	36%	22%
Training	10%	18%
Advocacy	5%	17%
Programme implementation	3,000,000	10,200,000
Teachers' salaries	69%	80%
Operations	11%	4%
Teacher training	9%	5%
Teacher materials	6%	9%
Advocacy	5%	2%
Programme update		303,000
Teaching materials		14%
Operations		33%
Training		12%
Advocacy		41%

Note: All costs are in US dollars.

compulsory, integrated and intra-curricular. The programme was first introduced in schools in 2004, and was scaled up starting in 2007 at state level in Lagos State. The original Nigerian Sexuality Education Curriculum, approved in August 2001, was changed to 'FLHE', and the revised curriculum excludes discussion of condoms, contraception and sexual behaviour, which parents, politicians and religious leaders found too explicit. The programme is delivered through 27 lessons spread over 3 years to students between 11 and 14 years of age. By late 2011, an estimated 1061 schools had been reached. Overall, the scale-up initiative is expected to reach an estimated 20,000 teachers and 2,088,000 students within the first phase, which will run until December 2012 (Ojomo 2011). Advocacy costs made up 5% of programme development phase costs as well as 5% of programme implementation costs (see Table 1).

In Orissa State, India, the Adolescent Reproductive and Sexual Health (ARSH) curriculum[5] is implemented by the state government, is intra-curricular and is compulsory. Although programme development began in 1998 and was launched in six states in 2002, implementation was suspended between 2003 and 2006 due to political opposition. The programme was reintroduced in 2007 in Orissa with the aim of covering all 30 districts, targeting young people aged 13–16 years. Implementation started in September 2010 in 6 out of the 30 districts, with the plan to add 6 districts on a yearly basis. The programme is 3 years long, consisting of a total of 34 hours of class contact time. Advocacy-related costs incurred during programme development, implementation and update phases range from 2% during the development phase to 41% during the update phase (see Table 1).

Role of advocacy in the implementation and scale up of the sexuality education programmes

Based on both the country programmes explored in this study and also on the authors' first-hand experiences and knowledge, advocacy, be it in the form of community and wider stakeholder engagement through workshops and sensitisation meetings, or as public information and media-based work, is a critical ingredient of developing, implementing and updating a sexuality education curriculum. Advocacy is often neglected, or even if it is considered, it may not be given sufficient importance, with it perhaps being included as an afterthought, or when implementation bottlenecks emerge.

Orissa State, India

The sexuality education programme in Orissa was initiated in 1998 and implemented until 2002 when it was shelved due to political opposition; it was reinstated in 2007 through a different process. The initial implementation was carried out as a national-led process in which Orissa along with five other states (Gujarat, Madhya Pradesh, Maharashtra, Rajasthan and Kerala) were selected as pilot states for the school-based adolescent education programme. This programme was developed as a result of a national-level policy decision made by the Ministry of Human Resource Development, the National Council for Education, Research and Training (NCERT) and UNFPA. NCERT developed the programme and it appears it did not anticipate either the need for wider advocacy or the need to address specific issues that concerned State and District level stakeholders.

Despite a well thought through pilot programme in four districts in Orissa, which included a compulsory curriculum consisting of three components – on growing up and sexuality, HIV/AIDS and drug abuse – a clear target population (pupils aged 13–16 years), with classes every week for 4 hours over a 4-year period, with one teacher in each

pilot school being female, and regular monitoring and appraisal (by the Project Directorate and Project Officer) and an end-of-pilot evaluation, the pilot was not taken up. Although the pilot was entrusted to the State Council of Training, Research and Education (SCERT), together with a State Population Education Cell established under the aegis of SCERT, and comprising resource persons from various disciplines who collaborated with Teacher's Education Colleges, Institutes for Professional Development officials, district educational administrators and community representatives, socio-cultural conflicts and political opposition prevented the project from being implemented at a wider scale after the pilot.

The conflicts evolved around the nature and content of the curriculum – it was seen, among other things, to be too explicit, targeting children who were too young and therefore potentially encouraging promiscuity. This reaction came mostly from conservative groups, who claimed that, '. . . sexuality education will harm the youth and pollute the nation and culture' (TARSHI n.d., 2; see also McManus and Dhar 2008). Reading between the lines, implementation was also viewed as a top-down process, with little consultation and real involvement of state- and district-level actors. If such consultation had occurred, not only might the curriculum have been 'more appropriate' for the context, but perhaps more importantly there would have been buy-in and ownership of both the process of implementing sexuality education in Orissa and the content of the curriculum.

Between 2003 and 2006, the components of the sexuality education programme were split and adolescent education was merged with the Reproductive and Child Health (RCH) programme initiated by the government of India, while the sexuality, HIV/AIDS and drug abuse modules were taken up by National AIDS Control Organization (NACO) and Orissa State AIDS Control Society (OSACS). In 2007, with the creation of the National Rural Health Missions (NRHM), the RCH programme became a part of the NRHM, and the NRHM in Orissa in 2008 reintroduced ARSH education through the combined participation of the health sector, educational institutes and community leaders.

In addition and in response to the initial stalling of sexuality education, an expert consultation was convened by a number of UN organisations, bringing together a range of people including educationists, teachers, young people, peer educators, media persons, practitioners including the representatives of state governments, teacher education institutions, teachers' unions, medical doctors, representatives of UN agencies and civil society (UNFPA 2009). The involvement of young people themselves was critical, as was their role in advocating for their needs in terms of sexuality education.

At the expert consultation the following were proposed: in the light of cultural specificities, each state should propose its own teaching–learning materials; involvement of the family and the community was critical; education was not just for young people but also for parents, education administrations and the community; different constituents needed to be consulted in the development of the school curriculum; and teachers needed to be equipped with adequate resources, training and support to deliver an adolescence education programme for which particular skills and pedagogy were necessary. 'In general, it was suggested that there ought to be increased communication, between and among adolescents, teachers, parents, and the wider community' (UNFPA 2009, 4).

The importance of political will was also highlighted in which members of state government stressed the importance of:

> . . . a) government ownership; b) conducting sensitisation activities with community leaders, government officials and school principals, for example through multi-stakeholder advocacy workshops; c) regular monitoring and supportive supervision of the programmes; d) collaboration with the media; and e) acceptance among teachers, parents and students.

> In particular, regular and sustained engagement with the media was considered critical to strengthen the efficacy of AEP across the country. (UNFPA 2009, 5)

Turning back to Orissa, and building on the expert consultation, to ensure that the curriculum reflected the existing knowledge level of pupils, the needs and priorities of the local area, and that it was culturally specific to Orissa, extensive engagement with teachers, parents and pupils took place. Findings from this process were then used as a basis for developing the curriculum, identifying the materials that were needed and defining the mode of training. Additionally, and critically, this process led to ownership, buy-in and support from teachers, parents and other key State- and District-level actors.

Thus, the new curriculum emphasised three major components: (1) the conceptualisation of ARSH as a specific form of education developed for the Indian social and cultural context; (2) the inclusion of curriculum content suitable to address the concerns of young people; ensuring this corresponded with the content of existing school curricula at different stages; and (3) the identification of curriculum strategies (educational methods) suited to the specific needs of this new curricular area.

Another important component, and in order to prepare for implementation as well as to ensure continued ownership and support by a range of different stakeholders, was training and capacity building. Cadres of people trained in Orissa included primary care physicians and district coordinators of NRHM who were to become master trainers; resource people including teachers and health workers were also trained to become master trainers. All government high school science teachers were to be trained at district headquarters by physicians, and every school in the district was to have a 1-day orientation programme to sensitise all teachers. Finally, health workers were also to undergo an orientation programme at their respective health centre to facilitate community participation and mobilisation in ARSH.

All the above laid the ground for a potentially more successful and owned process. However, this process of ownership building or advocacy during the adaptation phase of programming has considerable costs associated with it, as can be seen in Table 1. Without this considerable and well thought through advocacy process, the fate of the current Orissa programme could well have gone the way of the 2002 pilot.

Nigeria

While there was no pilot in Nigeria, from the start a range of different stakeholders were involved in discussions around a potential sexuality education programme. These consultations led to the development of a national-level curriculum which, with some modifications, has now been relatively successfully scaled up in Lagos State and is also being implemented across all 36 states.

In 1999, the National Council on Education approved the integration of the Nigerian Sexuality Education Curriculum into the school system at all levels and gave the directive that appropriate steps be taken by relevant agencies to ensure the integration of comprehensive sexuality education into school curricula. Following this directive, a National Implementation Committee was set up by the Federal Ministry of Education (FME) to carry out this mandate. The Committee included representatives of the Federal Ministries of Education and Health, the Nigerian Educational Research and Development Council, UNFPA, WHO, UNESCO, UNAIDS, UNICEF, the Ford Foundation and a non-governmental organisation (NGO), Action Health Incorporated (AHI).

The curriculum was developed through an inclusive, representative, participatory process led by the Nigerian Education Research and Development Council, the FME, the

Universal Basic Education Commission and AHI, between 1999 and 2001. This process drew on the perspectives of reviewers and experts from the six geopolitical zones in Nigeria to ensure national coverage and socio-cultural applicability to the diverse communities in the country. A range of other groups and individuals including academics, state ministries of education, civil society organisations and religious groups also contributed to the development and review of the curriculum. The technical and plenary sessions of the Joint Consultative Committees on Education held in 2000 and 2001 also contributed to shaping the curriculum into a nationally acceptable document. In August 2001, during the 48th session of the National Council of Education, the 'National Sexuality Education Curriculum for Upper Primary, Secondary and Tertiary Institutions' was approved.

During programme implementation, in response to concerns from parents, politicians and religious leaders that the curriculum was too explicit, discussions on condoms, contraception and masturbation were removed and the title was changed from 'Sexuality Education' to FLHE. The exclusion of these key themes related to sexuality education is problematic, particularly in a country with a generalised HIV epidemic and with a large and vulnerable population of young people. Further research is, therefore, needed on how to ensure that fully comprehensive sexuality education is delivered in such settings. However, the fact that concerns were taken into account, and individual states were allowed to adapt the curriculum to suit their socio-cultural characteristics, meant that despite not being fully comprehensive, many of the original objectives of the curriculum continued to be met.

Lagos State was particularly successful in its process of engagement and advocacy. Led by AHI, who partnered with the Lagos State Ministry of Education, a series of advocacy and consultative meetings took place between 2000 and 2003. Participants included the Lagos State Agency for the Control of AIDS, the Parents–Teachers Association, The National Union of Teachers, the All-Nigerian Conference of Principals of Secondary Schools, the State Primary School Board, the Conference of Primary School Headmasters of Nigeria, government officials in the education sector, members of the media, religious leaders and community representatives. In addition, and similar to India, a needs assessment was carried out in 25 public junior secondary schools in Lagos State to ensure the curriculum was appropriate for the needs there, the socio-cultural context, and that materials and strategies for teaching the curriculum also reflected this.

Beyond Lagos State, successful partnerships between civil society organisations and the State-level Ministry of Education (MoE) have also driven classroom delivery of FLHE: these include the Girl Power Initiative in Cross River and Edo States, Global Health and Awareness Research Foundation in Enugu State and Youth, Adolescent, Reflection and Action Centre in Plateau State[6] (UNESCO 2010). A recent partnership is with the Association for Reproduction and Family Health which will see FLHE scaled up to all primary and junior secondary schools countrywide (Nigeria Federal Ministry of Education 2011).

The success of the programme has also led to its implementation in public senior secondary schools in Lagos State. Alongside a comprehensive in-service teacher training programme, a curriculum related to FLHE was also developed and approved as a compulsory course for student teachers in the first year of their training. The National Commission for Nomadic Education has adapted the FLHE curriculum for schools run for nomads and an e-Learning tool based on the FLHE curriculum is also being piloted, targeting both in- and out-of-school youth.

With an impact evaluation being carried out by an external organisation (Philliber Research Associates; Esiet et al. 2009), overall the sexuality programme in Lagos State

has been a success, in no small part due to the efforts to be consultative, participatory and inclusive.

The importance of advocacy

Both the Indian and Nigerian examples illustrate the critical importance of advocacy, community involvement and ownership. Outreach, consultation and participatory design and implementation can be the make-or-break factor with respect to subsequent implementation. In Nigeria, the net effect was a programme that lost its fully comprehensive design features; in India, the outcomes are yet to be seen. These examples also underscore that advocacy needs to be carefully planned and budgeted for to ensure adequate support to advocacy over the duration of the programme in contexts where sexuality and sexual health are sensitive topics. This sensitivity is greater when dealing with young people and where gender roles are strongly regulated by religious and other social norms.

Linked to the above, advocacy cannot be an afterthought or only brought in when facing implementation challenges. Rather, it needs to be built into the development phase of a sexuality education programme. If advocacy-related activities and processes are initiated from the very start, then engagement and ownership are more likely, thus also making sexuality education more likely to succeed, be sustained and replicated or scaled up.

It is also critical that advocacy is continuous, and that it is not a one-off process. As situations continually change with new cohorts of teachers, pupils and parents and with the external environment also continually changing, not only does an approach to sexuality education need to be flexible and adaptable, but key stakeholders need to be continually brought on board to own the process. Hence key stakeholders, including students and their families, need to be continually reached, informed and supported.

Although advocacy needs to be continuous, it does not necessarily need to be carried out at the same level or intensity throughout the lifespan of a programme. Thus, for instance, during the development or adaptation phases of a sexuality education programme, perhaps more efforts need to be spent on raising awareness and getting support. During implementation, such intensity may not be necessary but advocacy may be necessary to counter resistance, which may be sparked by a new political climate or curriculum content changes.

Advocacy-related activities need to occur at all levels and for a range of different stakeholders. Hence advocacy needs to be carried out with, and ranging from, members of national-level government and education sector personnel, to teachers, parents, community leaders and pupils themselves.

Processes of advocacy, community mobilisation and engagement need to be continuous, budgeted for and planned with a long-term time horizon and time frame in mind. This may be a challenge because of changes over time, including in political and technical administrations. Nevertheless, efforts could be made to ensure some form of continuity. There are examples, for instance, where continuities in health policies, despite changing governments and administrations (e.g. Bangladesh), have allowed for successful health outcomes (e.g. see Rodriguez Pose and Samuels 2010).

In the case of sexuality education, continuity could be sought through, for example, ensuring that some job descriptions include activities around advocacy; that both the pre- and in-service training for teachers place sufficient emphasis on advocacy; and that there are community-based structures and processes in place which can facilitate advocacy on a sustained basis. Regarding the latter, there is a large body of literature on ways of engaging and involving communities in a sustained manner; such a literature could therefore be drawn on for the purposes of promoting sexuality education in schools.

Evidence from the case studies presented here (i.e. Nigeria) as well as evidence from other countries, for example, Vietnam (UNESCO 2010), also shows that partnerships between MoE, NGOs (national or international) and civil society organisations, including youth networks, are also critical for ensuring the successful implementation of sexuality education programmes. Awareness-raising, consensus-building and advocacy-related work are central functions of many of these partnerships.

Findings from this study build on work carried out by UNESCO and partners (2010) exploring factors which contribute to the successful implementation of effective school-based sexuality education. These 'levers of success' include many features which can be encouraged, stimulated and facilitated through advocacy. The levers identified include high-level political commitment to addressing HIV and AIDS; sensitisation of a range of different stakeholder groups; involvement of young people as partners in advocacy; sensitising parents, teachers and decision makers; and working proactively with the media to influence public opinions. Advocacy-related activities are a key ingredient of sexuality education programmes. However, they need to be carefully planned and allocated an appropriate budget together with a clear indication of how such activities can be sustained. Without such an investment and without far-sighted programmers and policy makers, sexuality education programmes are likely to fail.

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Notes

1. UNESCO's technical guidance (2009) focuses on 5–18 year olds. Depending on the context, the age at which to start sexuality education may differ. European standards on sexuality education start at birth (2010).
2. Nigeria Federal Ministry of Education 2011. Fact sheet on HIV/AIDS in Nigeria's education sector, Abuja, Nigeria.
3. Further documentation including a summary and full report of the study: 'UNESCO (2011) school-based sexuality education programmes: A cost and cost-effectiveness analysis in six countries' is available online at http://unesdoc.unesco.org/images/0020/002070/207055E.pdf (accessed August 2012).
4. See http://www.tribune.com.ng/index.php/health-news/19039-flhe-will-care-for-students-health-arfh. This is a Global Fund Round 9 grant supporting the Federal Ministry of Education and managed by the Association for Reproduction and Family Health (ARFH).
5. Known at national level as the Adolescence Education Programme (AEP), see http://ncert.nic.in/ncert/aerc/ncert_AEP.html (accessed September 2011).
6. For further information, see Girl Power Initiative – http://www.gpinigeria.org/; Global Health and Awareness Research Foundation – http://www.kabissa.org/civiorg/208; and Youth, Adolescent, Reflection and Action Centre – http://www.yaracnigeria.org/ (accessed September 2011).

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