COMPREHENSIVE SEXUALITY EDUCATION

Key considerations for implementation and scaling up in West and Central Africa

LESSONS LEARNED AND PROMISING PRACTICES FROM FOUR COUNTRIES

Foreword

West and Central Africa has some of the poorest sexual and reproductive health outcomes in the world. This is particularly true for adolescents and youth under 24 years, who represent 65 per cent of the population. The region has one of the highest adolescent fertility rates in the world, which is more than twice above the world average, with more than one in ten girls aged 15 to 19 giving birth. In addition, the region has high rates of child marriage, a low level of education among girls, limited access to reproductive health services and gender inequality.

Young people in this region can be a great driver of sustainable development, but only if investments are made in health, education, employment and good governance. Investments in sexual and reproductive health and rights are particularly crucial to ensure that young people are educated, healthy and empowered. Achieving this will require technical and financial commitments to implement effective, high-impact interventions focused on young people and in response to their specific needs.

The French Muskoka Fund contributes to the work of the United Nations Population Fund (UNFPA) to strengthen technical and financial support for the sexual and reproductive health of adolescents and youth in eight countries* in the region. Key interventions that have been recognized as effective include comprehensive sexuality education (CSE), a core component of UNFPA's new strategy (2018–2021) for adolescents and youth.

CSE is a "curriculum based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives."[1]

This regional report, Comprehensive sexuality education: Key considerations for implementation and scaling up in West and Central Africa, documents promising practices and lessons learned, from four West African countries (Benin, Côte d'Ivoire, Senegal and Togo), and proposes key recommendations to be shared with all countries in the region.

The UNFPA West and Central Africa Regional Office (WCARO) reiterates its full support to governments and other partners for developing and scaling up CSE programmes in all countries throughout the region.

This support will enable young people throughout the region to develop their health and well-being with dignity.

Mabingue Ngom

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Acronyms

AIDS	acquired immunodeficiency syndrome
AYSRH	adolescent and youth sexual and reproductive health
CCA	*centres conseils adolescents* [youth guidance centres] (Senegal)
CSE	comprehensive sexuality education
CSO	civil society organization
DD	demographic dividend
GBV	gender-based violence
HIV	human immunodeficiency virus
ICT	information and communication technology
M&E	monitoring and evaluation
NGO	non-governmental organization
SRH	sexual and reproductive health
STI	sexually transmitted infections
UNFPA	United Nations Population Fund
MEN	*Ministère de l'Éducation Nationale* [Ministry of Education] (Senegal)
ONEG	*Observatoire National de l'Égalité du Genre* [National Gender Equality Observatory] (Côte d'Ivoire)
PARC	*Projet d'appui au renouveau des curricula* [Project to support the curricula reform] (Senegal)
PESC	*Promotion de l'éducation sexuelle complète* [Project to promote comprehensive sexuality education] (Togo)
UN	United Nations

1

Introduction

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1.1 Objectives and methodology

In 2016, the United Nations Population Fund (UNFPA) conducted four missions to document the implementation of comprehensive sexuality education (CSE) in West and Central Africa. The four countries visited were Benin, Côte d'Ivoire, Senegal and Togo. These missions aimed to review the status of CSE within the framework of the Muskoka Initiative on Maternal, Newborn and Child Health,[2] as well as the activities carried out by UNFPA regional and country offices in partnership with governments and other stakeholders on adolescent and youth sexual and reproductive health (AYSRH).

Specific objectives focused on the analysis, evaluation and documentation of the key implementation stages of CSE programmes, in addition to the results obtained, promising practices and difficulties identified and overcome. The findings were to be used to put forward recommendations and share the lessons learned with other countries in the region.

Methods included analysing, assessing and documenting:

- processes, activities and outcomes
- promising practices for advocacy, development, institutionalization, implementation and scaling up in educational settings
- challenges faced.

The missions were conducted in three stages. First, a document review was carried out to analyse:

- national information and communication documents
- national policies and strategies
- project documents
- evaluations of projects, curricula and training manuals
- national and international research on scaling up CSE.

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This review allowed for the analysis of implementation and scaling-up strategies, as well as activities implemented and their results. This then facilitated the development of research questions and identification of priorities for the field visits.

The second stage involved field visits, which were conducted in September and October 2016. Key partners were interviewed individually and in groups to collect qualitative data (see country reports for a full list of individuals interviewed).

The third stage involved analysing the information gathered and preparing the country reports.

UNFPA used the results of these missions to develop recommendations and share lessons learned with other countries in the region.

This regional report, based on the four country reports, provides an overview of the status of CSE implementation in the region. It describes the main outcomes, promising practices, challenges and recommendations for each of the key stages of implementing CSE programmes. This documentation will be made available to countries in the region and will serve as a basis for the development of UNFPA technical support. In addition to this report, four country reports are available.

This report comprises several chapters:

- Chapter 2 focuses on the context and provides a description of CSE and its impact. It also reviews evidence-based methods and strategies aimed at improving AYSRH, and defines scaling up in this context.
- Chapter 3 analyses the key elements of scaling up CSE and identifies promising practices and recommendations to support such efforts.
- Chapter 4 includes recommendations for UNFPA, governments and other partners to address short- and medium-term priorities.

2

Context

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2.1 Sexual and reproductive health of adolescents and youth in the region

In West and Central Africa, 64 per cent of the population is under 24 years.[3] If this population is educated, healthy and employed, the region could benefit from the demographic dividend. One of the major obstacles to harnessing the demographic dividend is AYSRH in the region, which is characterized by high rates of adolescent pregnancies and a high percentage of unmet needs for family planning. For example, in West and Central Africa:

- among adolescents, 9 in 10 births are the result of child marriage[4]
- the largest percentage (28 per cent) of women aged 20–24 reported that they had given birth before the age of 18[5]
- the proportion of girls aged under 15 years giving birth is 6 per cent, which is the highest rate among African regions[6]
- compared with other age groups, adolescents have the lowest contraceptive prevalence rate (21 per cent for the 15–19 age group against 64 per cent for the 35–39 age group) and the highest rate in unmet family planning needs (25 per cent for the 15–19 age group against 14 per cent for the 35–39 age group).[7]

In this context, more than anywhere else, AYSRH remains a societal and public health priority to ensure that young people develop to their full potential and that the demographic dividend is captured. The impact of these statistics is felt in the education sector, as reflected by the number of absences and drop-outs, as well as the decline in the quality of education for young people. This in turn impacts the world of work, reducing opportunities and options for young people.

Given the low levels of knowledge on sexual and reproductive health (SRH) and the limited access to and use of SRH services and contraceptives among adolescents and youth, effective CSE should be provided in educational settings, with access to quality SRH services ensured for this population.[8]

Demographic dividend

The demographic dividend is the economic growth potential that can result from shifts in a population's age structure. This mainly occurs when the share of the working-age population (15 to 64) is larger than the non-working-age share of the population (14 and younger, and 65 and older).

http://www.unfpa.org/demographic-dividend

2.2 What is comprehensive sexuality education?

“Comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.”[9]

CSE covers a number of different topics to enable adolescents and youth to make informed decisions about their health and sexuality. The "International technical guidance on sexuality education. An evidence-informed approach" identifies eight key concepts, as well as topics and learning objectives for the following age groups: 5–8 years, 9–12 years, 12–15 years and 15–18+ years.[10] The eight concepts are:

1. Relationships
2. Values, rights, culture and sexuality
3. Understanding gender
4. Violence and staying safe
5. Skills for health and well-being
6. The human body and development
7. Sexuality and sexual behaviour
8. Sexual and reproductive health

CSE is education delivered in formal and non-formal settings, and is:

- scientifically accurate
- incremental
- age- and developmentally-appropriate
- curriculum-based
- comprehensive
- based on a human rights approach
- based on gender equality
- culturally relevant and context appropriate
- transformative
- able to promote the acquisition of life skills needed to support healthy choices.[11]

A quality CSE programme enables adolescents and youth to understand social norms linked to gender, from which they can draw on to address gender-based violence (GBV). In addition, CSE helps adolescents and youth acquire key skills, such as self-awareness, assertiveness, communication, negotiation and refusal.

2.3 Comprehensive sexuality education, sexual and reproductive health, and youth

2.3.1 Effective interventions

Several articles have been published in recent years on the effectiveness of sexuality education programmes in schools.[12, 13, 14, 15] Fonner et al. assessed 64 studies on the subject and found that students who received sexuality education in an educational environment:

- were more informed about HIV
- had fewer sexual partners
- were more likely to delay sexual debut or refuse sexual relations and ask their partner to use a contraceptive.[16]

The authors concluded that “comprehensive school-based sex education interventions adapted from effective programs and those involving a range of school-based and community-based components had the largest impact on changing HIV-related behaviors”,[17] with examples of such components including:

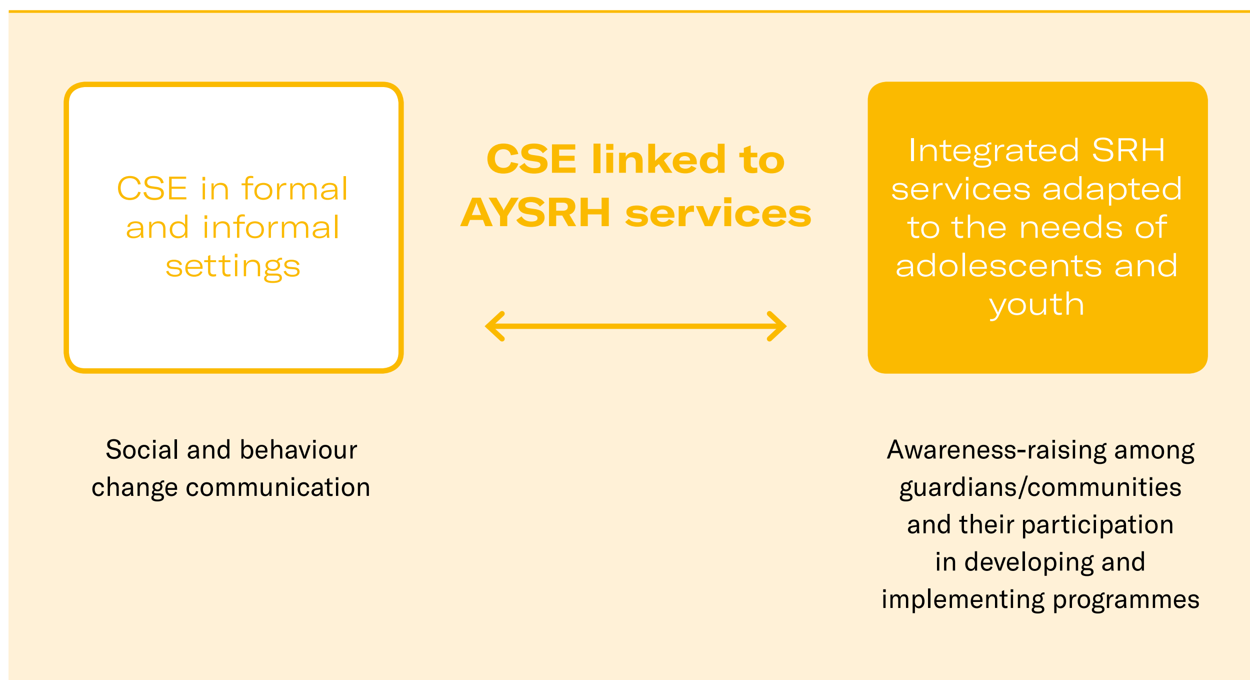
- training for health-care providers on AYSRH
- condom distribution
- involvement of teachers, parents and the community in developing programmes.

More and more studies are revealing the importance of linking education and behaviour change to health and support services. In Ghana, Aninanya et al. showed that the addition of targeted school-based and outreach activities increased service usage by young people more than community mobilization and training providers in youth-friendly services provision alone.[18]

Overall experience shows that successful measures link CSE to other complementary SRH-related interventions, including those that:

- aim to build awareness and acceptance among young people and their guardians, and promote the rights of adolescents and youth to SRH education and services
- address gender inequalities, in particular, beliefs, attitudes and social norms
- target young adolescents (10–14 years)
- train, supervise and support health-care providers
- improve access to, and experiences of, health centres (e.g. flexible hours, friendly services).[19, 20]

Figure 1: Young people's needs



A programme is more effective when adolescents and youth advocate for AYSRH interventions, and participate in their development and implementation. This is because different approaches are needed to address the various needs of all adolescents and youth. The United Nations defines youth as those aged between 10 and 24 years. However, national policies may define youth differently, which complicates the development of youth programmes. Given that youth needs differ from adult needs (for example, the needs of a 14-year-old girl are different to those of a 25-year-old woman), it is crucial that programmes target under 25-year-olds, in order to reach young people who are often unable to access adult health services.

International studies have also identified ineffective and unsustainable interventions.[21] For example, peer education programmes may positively affect peer educators themselves, but have a negligible impact on changing the behaviour of others. These programmes can raise awareness and refer adolescents and youth to health centres, though they have proven ineffective beyond this. Health services delivered outside of established health centres, such as youth centres, are equally ineffective, as they are not cost-effective, difficult to scale up and often not sustainable. Furthermore, the majority of these centres are not used for SRH services and those that are used are often unable to reach the most vulnerable populations.

2.3.2 Effects of comprehensive sexuality education

Effectively implemented CSE can have a significant impact on SRH. It can:

- reduce misinformation and increase correct knowledge
- limit risky behaviours by reducing:
  - the frequency of sexual intercourse
  - the number of sexual partners
- increase the adoption of responsible behaviour, such as:
  - abstaining from sexual relations
  - delaying the debut of sexual activity
  - increasing the use of condoms and other contraceptives
- identify and promote positive values and attitudes
- develop individuals' ability to make informed decisions and abide by them
- improve perception of peer and social norms
- foster communication with parents or other trusted adults.[22]

Moreover:

- CSE does not promote early or risky sexual activity
- abstinence-only programmes have proven ineffective
- programmes focusing on gender equality are considerably more effective than those ignoring the issue.[23, 24]

Comprehensive school-based sex education interventions adapted from effective programmes and those involving a range of school-based and community-based components, such as training health-care workers to offer youth-friendly services, distributing condoms, and involving parents, teachers, and community members in intervention development, had the largest impact on changing behaviours.[25]

2.4 Scaling up comprehensive sexuality education programmes

CSE has been tested and its benefits proven through several pilot programmes in various countries. It is therefore time to ensure that all adolescents and youth benefit from such programmes. The question is no longer "do we need CSE?", but rather "how can we guarantee quality CSE for countries' adolescents and youth?" The answer to this question lies in scaling up CSE.

The World Health Organization and ExpandNet define scaling up as: "deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and programme development on a lasting basis".[26]

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According to ExpandNet, “deliberate efforts” mark scaling up as a guided process (in contrast to the spontaneous diffusion of innovations), while “policy and programme development on a lasting basis” stresses the importance of institutional capacity building and sustainability.

ExpandNet identifies two key types of scaling up:

1. vertical, which institutionalizes the process through political, legal, budgetary or other health system changes
2. horizontal, which scales up through expansion or replication.

Both types of scaling up are necessary for integrating interventions within the systems of relevant ministries, which will ensure the sustainability of CSE, as well as its implementation throughout the country and for all target populations.

ExpandNet identifies four guiding principles for the scaling-up process:

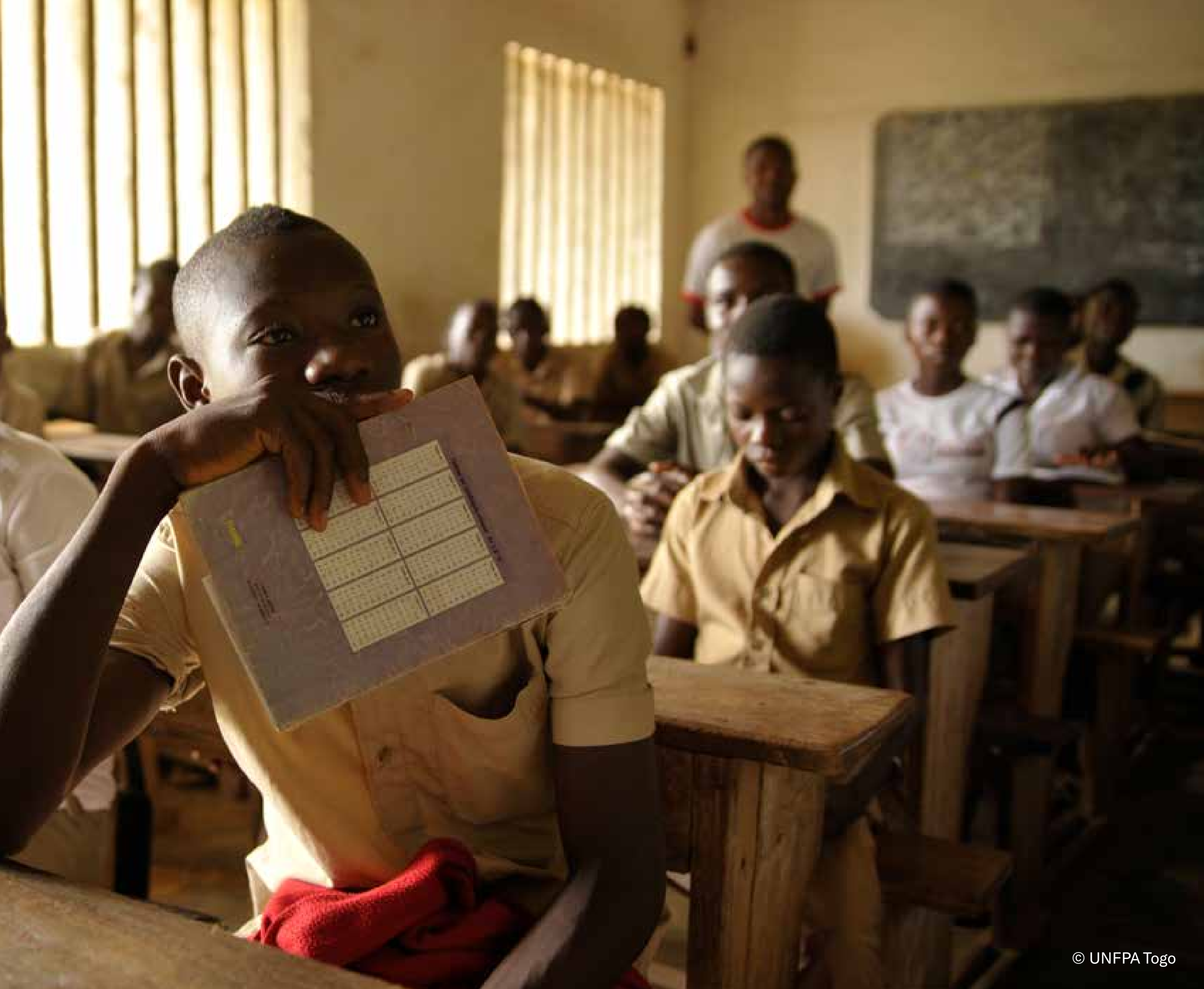
1. systems thinking
2. a focus on sustainability
3. enhancing scalability
4. respect for human rights, equity and gender perspectives.

Chapter 3 identifies the key elements of implementing and scaling up CSE, which complement those presented in "UNFPA Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender" and those included in the "International technical guidance on sexuality education. An evidence-informed approach". The chapter identifies the specific characteristics of the region, along with some promising practices and local lessons learned. It then builds on country experiences to put forward recommendations for countries attempting to scale up its CSE.

Young people, including adolescents, should be involved as key stakeholders in developing, implementing, monitoring, disseminating and scaling up CSE.

3

Key elements of implementing a comprehensive sexuality education programme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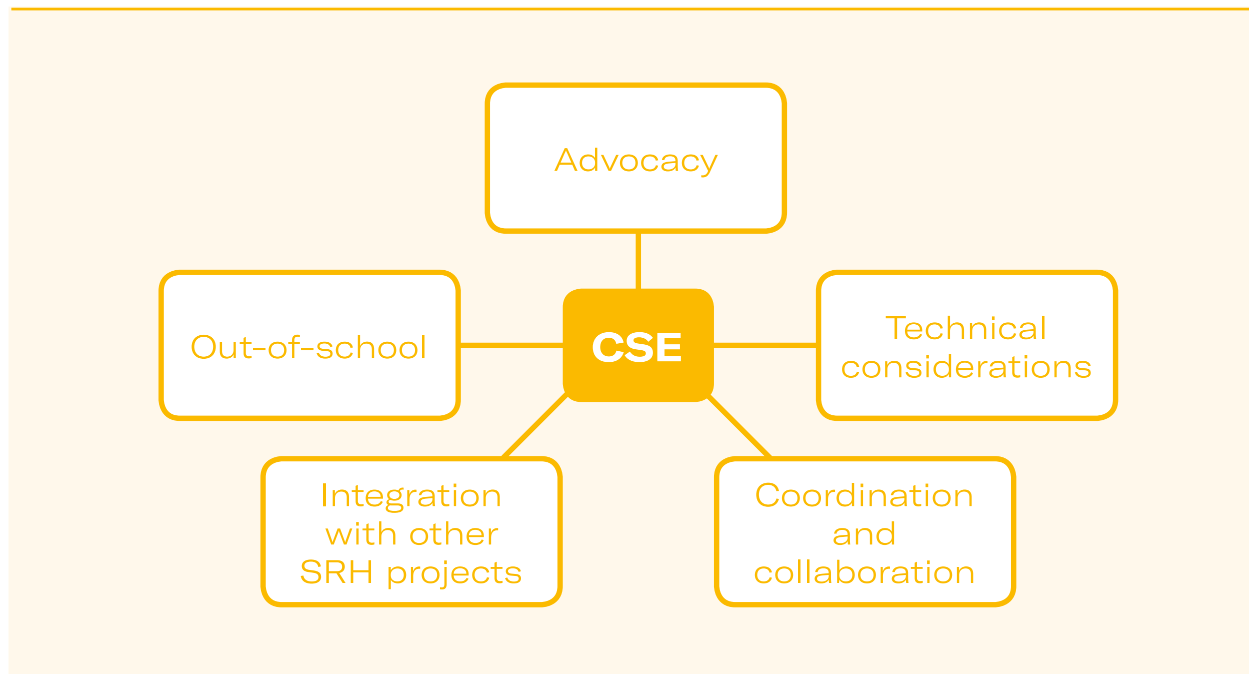
The CSE documentation process in Benin, Côte d'Ivoire, Senegal and Togo identified several key elements for implementing and scaling up CSE. These four countries are yet to scale up CSE and are at various stages of the process.

Nonetheless, recomendations can be made from lessons learned, promising practices and existing challenges.

The summary identified five key elements: advocacy, technical considerations, collaboration and coordination, integration with other SRH projects and out-of-school activities, which are essential for implementing CSE and form the basis of scaling-up processes. Other significant elements, such as financing, fall outside the scope of this report.

Figure 2: Key elements for implementing comprehensive sexuality education



3.1 Advocacy

Sustaining CSE programmes over time requires capacity-building among partners and other stakeholders so that they are able to support CSE, especially when faced with reluctance or changes in government.[27]

Advocacy is not an isolated effort, but rather a long-term process that should adapt to a changing environment. Advocacy work with policymakers, such as parliamentarians and ministers, as well as with civil society, is essential if CSE is to be included in national priorities. This inclusion will facilitate the development of a legal framework and strategic plans suitable for scaling up, and ensure that CSE can be implemented in all formal and informal environments.

3.1.1 Policies and legal framework

The four countries under review have policies and legal frameworks for scaling up CSE, and in some cases, for the protection of girls. In addition, all are signatories to the following international conventions and campaigns:

- Convention on the Rights of the Child
- International Conference on Population and Development Programme of Action
- Maputo Plan of Action for the Operationalization of the Sexual and Reproductive Health and Rights Continental Policy Framework, 2007–2010
- African Charter on the Rights and Welfare of the Child
- African Union Campaign to End Child Marriage.

Each country has also developed national plans and strategies for related topics (e.g. adolescents and youth, AYSRH), which identify the main intervention areas and priorities for implementing comprehensive sexuality education and improving access to SRH services for adolescents and youth. Some countries, such as Côte d'Ivoire, have developed national CSE plans (with the draft version awaiting validation by the Ministry of Education), while others have devised road maps for implementing CSE. The four countries covered by this report are not the exceptions in the region; other countries have developed legal frameworks and similar plans or strategies that could be used to scale up CSE.

Although policies and legal frameworks have been developed, their implementation is often problematic. Most of the countries reviewed have a very low level of knowledge and poor application of laws, often due to the lack of an implementing decree, as well as a sociocultural context that discourages law enforcement.

To ensure CSE is scaled up, specific activities need to be implemented to address the lack of awareness and enforcement of laws and legal texts. In this regard, Côte d'Ivoire has prepared a compendium of legal and non-legal texts to inform people about the available legislation that could be used to address GBV and adolescent pregnancies in schools. The compendium informs and justifies the provision of CSE and AYSRH services, and can be used to remind school head teachers (among others) of their responsibilities with regards to CSE and adolescents under their care. Adopting and implementing decrees and accountability systems must be used to counter the lack of enforcement of existing legislation.

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Current laws and policies are often inadequate and, above all, ill-suited to reproductive health issues. For example, the age of consent (for screening, contraceptive use, etc.) is often a barrier to accessing SRH services if the adolescent requires parental approval for using such services. SRH legislation is being revised in several countries, including Côte d'Ivoire. Such reviews provide the opportunity to ensure that legal frameworks are adapted to reproductive health needs and do not constrain the provision and scaling up of CSE and AYSRH services. Advocacy work is therefore necessary in each country.

3.1.2 Targets and strategies

Advocacy activities should be conducted with parliamentarians, ministers and civil society to ensure that CSE is included among government, ministry and education priorities, and that the legal framework and national strategies are suitable for scaling up. Without advocacy, ownership of CSE may fail and affect its implementation. The start of advocacy efforts depends on the national context. Several countries in the region have used studies on child marriage and adolescent pregnancy to generate discussion, lead advocacy efforts and raise the issue at the political level. Basing advocacy on a broader theme, such as the demographic dividend, is also advantageous, as it establishes the link between AYSRH and its effect on the country's social and economic development.

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First step

Establish the rationale for CSE by collecting updated information on, for example:

- sexually transmitted infections (STIs)
- adolescent pregnancy and child marriage
- age of first sexual activity
- AYSRH information and services
- youth's demographic and economic situation
- the sociocultural environment
- and how AYSRH affects education and the country's development.

Drawing on its global experience on the demographic dividend, CSE and AYSRH, as well as its strong relationships with ministries and professionals in the health, education, youth and child protection sectors, UNFPA is well positioned to take the lead in building a convincing case for CSE.

- A study which publishes up-to-date data on AYSRH can initiate policy dialogues and be used for advocacy strategies.
- More exhaustive themes, such as the demographic dividend, are an entry point.

An advocacy strategy should:

1. **Evaluate the political and sociocultural context.** This facilitates the identification of opportunities and challenges related to implementing CSE, and involves asking questions such as:

   - Are the policies and legal framework responsive?
   - Are AYSRH, CSE and the demographic dividend part of the political discourse?
   - What are the sociocultural barriers that hinder an open discussion on sexuality?
   - Are teachers' unions for or against CSE?
   - What are the opportunities or entry points that could be used to initiate discussions about CSE and AYSRH?
   - Is there an ongoing discussion about, for example, the demographic dividend, a programme being developed (e.g. the Global Financing Facility or the World Bank's Sahel Women's Empowerment and Demographic Dividend (SWEED) initiative) or a campaign on adolescent pregnancy?

2. **Identify stakeholders**, their points of view on CSE and their potential influence. This involves determining which stakeholders (including policymakers, technical staff, parents, faith-based and community leaders, adolescents and youth, journalists, technical and financial partners, civil society organizations (CSOs)) are for or against CSE, the rationale behind their positions, and their potential influence on other members of the target population.

   This enables those who support CSE implementation to be identified and is useful for preparing counterarguments against groups that may resist CSE, and changing negative attitudes.

3. **Consider local data, experiences and ongoing discussions on CSE.** Local data, such as adolescent pregnancy rates and the effect of SRH on communities and countries, can help persuade those against CSE to change their minds, if presented appropriately.

4. **Identify the actions required at each level (from national to operational).** Based on the target and the level, different strategies will be required, which could include

   - a national media plan
   - awareness-raising campaigns at the community level
   - meetings and workshops
   - and the involvement of young people, influential persons, teachers, parents and the community.

For more details on strengthening policy and advocacy efforts, please see: "UNFPA Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender".

Effective advocacy reduces the obstacles and challenges to implementing and scaling up CSE, and ensures that leaders, policymakers and educators have a common understanding of CSE. Establishing a CSE advocacy group that comprises influential persons, such as faith-based leaders, prominent members of society and journalists, will help positively influence social norms and change negative perceptions of CSE. Effective advocacy will also help initiate discussion on sexuality – a topic that has been, and sometimes still is, considered taboo.

It is therefore essential to work with young people to encourage leadership and their ownership of CSE. It is also important to increase their capacity to advocate for CSE, which can be achieved by including young leaders as partners in policy actions and by integrating courses on advocacy for sexuality, human rights and diversity into CSE curricula.

Promising practices in the region:
In Togo, key stakeholders supported several actions to remove barriers to CSE implementation. The Federation of Parent–Teacher Associations established member associations to support CSE implementation and improve communication between parents and children about SRH. Other stakeholders signed partnership agreements to help promote and advocate the project. These stakeholders included the National Youth Council, journalists of the Network of African Media against AIDS, Tuberculosis and Malaria in Togo, faith-based leaders of the Protestant Association for Medical, Social and Humanitarian Work in Togo, and the Muslim Union of Togo.

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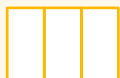


Côte d'Ivoire

During the 2012–2013 academic year, a study found that there were 6,718 cases of STIs and 5,076 adolescent pregnancies recorded in schools, including 1,137 in primary and 3,939 in secondary schools. In total, 77.6 per cent of the cases were among students aged 11 to 15 years.

While there have always been cases of adolescent pregnancies in schools, the 2012–2013 study clearly pointed to the need to take urgent action. Intense advocacy efforts by stakeholders, coupled with awareness-raising among political authorities on the magnitude of the problem, led to the development of an accelerated plan (2013–2015) to reduce such pregnancies through the Zero Pregnancies in Schools campaign. Without the political will and government leadership to address this issue, this campaign would not have been developed or implemented.

Stakeholders used the publication of the study to draw the nation's attention to the issue of adolescent pregnancies. This generated political support to address this issue, which continues to date.

Adolescent pregnancies and the campaign are still discussed at the Cabinet level. This interest at the highest political level has not only opened up the discussion on AYSRH, but has also created a shared sense of responsibility.

The campaign includes classroom teaching activities (life skills), activities in school clubs, extracurricular activities, AYSRH services and the use of information and communication technologies (ICTs) (see section 3.5 for more information). The campaign was launched on 28 February 2014, with several ministers in attendance, demonstrating its multisectoral dimension.

While this approach is a promising first step, having galvanized all stakeholders, more still needs to be done. To meet young people's needs for quality sexuality education, the country is establishing CSE in formal and informal settings, through the development and implementation of the 2016–2020 National Comprehensive Sexuality Education programme. None of this would be possible without the ownership and political backing of the Ministry of Education and the Ivorian Government.

3.2 Technical considerations

3.2.1 Entry-point activities

Part of the advocacy strategy will be to identify an entry-point activity that can facilitate CSE implementation. Côte d'Ivoire used national campaigns, such as the Zero Pregnancies in Schools and No to Early Marriage campaigns, to initiate dialogue and build momentum around efforts to integrate sexuality education, which had been overlooked for several years due to the political environment. These campaigns helped initiate action for mainstreaming CSE in the education system. The advantage of campaigns is that they are based on pre-existing issues that stakeholders have identified as a priority. Advocacy actions carried out during a campaign help to open up discussions on subjects considered taboo, such as sexuality. Using data (such as adolescent pregnancy rates) and focusing media attention on the issue will improve understanding of the impact that SRH has, especially on girls, which can generate the necessary political will to scale up CSE. However, there are certain drawbacks to using campaigns as entry-point activities, such as the fact that CSE programme content may be incomplete, with limited skills development. As such, campaigns can only be the initial phase of a CSE programme.

Planned reforms to the education sector, such as Benin's review of school curricula, also represent an opportunity for CSE integration without causing major disruptions. These reforms can also help integrate CSE into existing education systems, such as training and supervision, as they are often accompanied by activities that ensure their implementation. However, educational reforms also carry a risk given the state of the education sector in most countries in the region.

Education for All or compulsory schooling for children aged 6 to 16 years can have an impact on the education sector and its already scarce human and financial resources, as it requires the construction of new classrooms, recruitment of new teachers, and procurement and distribution of textbooks, among other factors. Reforms to education systems therefore carry a risk or could at least lead to delays, as scaling up CSE may not be a national priority.

Numerous technical decisions will affect different aspects of scaling up CSE and must therefore be taken into consideration when deciding how to implement it.

An entry-point activity facilitates the development and implementation of a CSE programme.

An entry-point activity may be a national campaign, a strategy, a policy or legislative changes that relate to, for example, child marriage, adolescent pregnancy and AYSRH.

The demographic dividend can also be used as an effective entry point, as it underscores the link between the AYSRH and its effect on a country's development.

3.2.2 Integrated or stand-alone?

Most countries already have some CSE content included in existing subjects (such as in life and earth sciences, which generally address puberty, sexual maturation, etc.) or through extracurricular programmes. The first step is therefore to analyse existing content and identify its strengths and any gaps.

Deciding whether to integrate CSE into one or several existing subjects or to create a new stand-alone CSE-focused subject is one of the most important decisions to be made, as it will affect the scaling-up process. While integrating CSE into existing subjects reduces the pressure on an already busy school timetable, it also impacts the costs involved, since it involves developing, printing and distributing additional teaching materials in schools throughout the country, as well as training and supervising more teachers (all those with new CSE content). Moreover, some teachers may not feel comfortable discussing certain topics and are therefore likely to teach them poorly or not at all. These issues make it difficult to deliver a high-quality CSE programme.

Delivering CSE as a stand-alone discipline will decrease development and implementation costs, and facilitate support and supervision of the appointed teacher. However, a teaching period would need to be created for this in the school timetable, which would mean reducing the time allocated to one or more existing disciplines. Developing a new discipline is often a long and complicated process and, depending on the country, may not be appropriate (e.g. if the school curriculum is already overburdened). However, an advantage of CSE as a stand-alone discipline is that teachers that volunteer or are appointed can be selected based on their knowledge about the subject and how comfortable they are discussing sensitive issues, thus ensuring that all topics are taught.

The advantages and disadvantages of both options should be assessed in the national context (see Table 1). Depending on the option selected, sector policy changes (the creation of a new CSE teacher category, etc.) or the development of instruments (decrees, sector policy papers) may be needed for implementation and to ensure there is accountability for this.

Table 1: Comprehensive sexuality education as an integrated or a stand-alone subject

CSE	Advantages	Disadvantages	Implications
Integrated	• Reduced pressure on school timetable.	• Harder to implement a high-quality programme. • Higher costs because: – more teaching materials need to be developed, printed and disseminated – more teachers need to be trained – more supervision is needed. • Takes longer to scale up. • Poor-quality or complete lack of teaching of certain topics.	Requires: • substantial financial resources • a sectoral decree to ensure that all teachers and schools implement the changes • changes in the terms of reference of teachers and other managerial staff to hold them accountable for teaching CSE.
Stand-alone subject	• Lower development and implementation costs. • Facilitates supervision of, and support provided to, the appointed teacher. • Facilitates the integration and teaching of all topics at school. • Increased likelihood of using participatory teaching methods. • Rapid implementation, as fewer teachers need to be trained.	• The process to establish a new subject can be long and complicated. • Requires an allocated teaching period in the school timetable.	• Requires the establishment of a new teacher category (CSE teacher), and therefore a pre-service training programme.

Another important consideration when deciding to introduce CSE as an integrated or a stand-alone subject is whether it will be optional or mandatory and covered by a national exam (see Table 2). If CSE is integrated, certain topics can be made compulsory and included in national exams. However, there is the risk that exams will include little CSE content, as priority will be given to the main subject.

If selected as a stand-alone subject, it should be compulsory and include an exam to ensure that all young people are taught CSE. Without this, and given the existing pressures on the education sector, CSE will be neglected for other disciplines that are subject to exams and considered an education priority (languages, mathematics, etc.).

Table 2: Comprehensive sexuality education as an optional or a compulsory subject

CSE	Optional	Mandatory	National examination
Integrated	• Adolescents and youth may not receive a CSE. • Adolescents and youth do not take the same optional subjects, therefore run the risk of not covering all topics.	• Certain topics can be made compulsory.	• A comprehensive evaluation of CSE may not be feasible because priority will be given to the main subjects.
Stand-alone	• CSE will not be taught to some adolescents and youth.	• CSE will be taught to all adolescents and youth. • Requires a national exam to ensure it is being taught.	• Possible evaluation of necessary skills.

With varying degrees of success, initial projects on family life and population education and life skills, for example, were developed in the four countries reviewed. These projects integrated their content into mostly compulsory subjects, such as life and earth sciences or civic education. The four countries have now similarly opted to integrate CSE into existing subjects.

However, since integrated CSE is yet to be scaled up in these countries, it is not included in national exams.

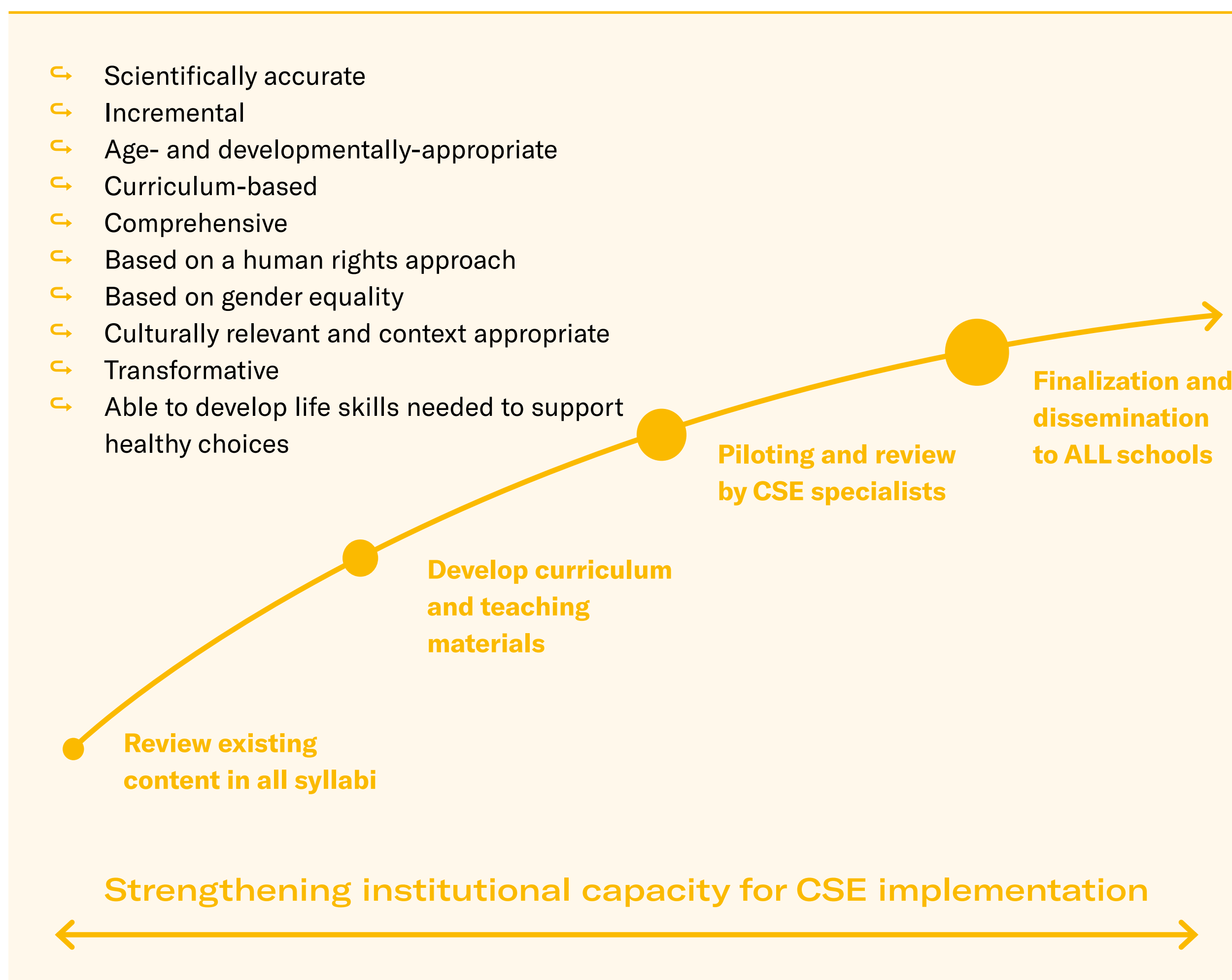
3.2.3 Developing curricula and teaching materials

To implement CSE, a series of scientifically accurate, age- and culturally-appropriate, gender responsive and rights-based materials need to be developed (Figure 3). Moreover, all CSE must be based on an incremental approach, to enhance knowledge and skills by drawing on what is already known. More and more complex concepts can be gradually added to the existing knowledge base.

As a first step, existing content must be analysed, then new curricula and teaching materials developed. All new materials must be tested under realistic conditions in classrooms and revised by education and SRH specialists. When finalized, teaching materials should be printed and distributed to schools throughout the country. Each country should identify what types of teaching materials are needed (manuals for learners and teachers, visual aids, brochures, etc.). The number and type of materials will depend on the status of CSE in schools' existing programmes.

After analysing existing materials, most countries will develop a reference framework on CSE themes and sub-themes based on international guidelines. These benchmarks are then integrated into the various materials that the country has identified as relevant.

Figure 3: Development of teaching materials



Country experience has shown that a participatory process is important for ensuring that CSE is understood and that stakeholders have ownership of its content. Benin is one particular example of a country adopting an inclusive approach to develop a CSE programme, through which it consulted with key stakeholders. This consultation on the development and introduction of sexuality education in school curricula facilitated ownership of the project from its initial stages. This involved a number of workshops with:

- the Ministries of Education, Health, Family and Youth
- parent–teacher associations
- technical and financial partners
- faith-based leaders
- CSO representatives
- youth representatives
- education and SRH consultants and specialists.

These workshops aimed to create a common understanding of CSE and reach a consensus on the approach. They also facilitated the development of a toolkit comprising six themes and 25 sub-themes in a conceptual and methodological framework. For each sub-theme, the learning objectives for each education level are presented, as well as the expected behaviour change.

In Benin, a CSO is leading a team to develop CSE teaching materials. To ensure that CSE is seamlessly integrated within national education systems, the team includes former inspectors from the Ministry of Education. CSE training was provided, which enabled them to develop the curricula. The development team comprises those with experience in the national education system and SRH specialists. Although the team develops manuals and other materials, they are reviewed and validated by key stakeholders during workshops, as part of a process that ensures content quality. As a result of this process, teachers, head teachers and parents are more likely to accept the content. See Box 1 for more information about the approach used by Benin.

In Senegal, a coalition of stakeholders initiated work to develop a CSE programme. This took the form of a consensus-building workshop, which was attended by various ministries, the United Nations, technical and financial partners and CSOs, which developed a reference document identifying the seven main themes of a national CSE programme. A workshop with experts from the Ministry of National Education (MEN) then took place to finalize the CSE content and ensure it complied with MEN guidelines and standards. This development process allowed all stakeholders to express their views, propose components and reach a final consensus. In addition, the project to support the curricula reform (PARC) has been identified as an opportunity to integrate CSE into school curricula. To this end, the coalition is providing technical and financial support to PARC to help integrate CSE into school programmes.

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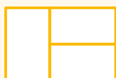
Box 1



Benin – integration into existing subjects

Benin is developing its CSE programme through an inclusive process and has decided to integrate CSE into existing subjects. Participation of key stakeholders in situation analysis workshops facilitated the development of a common understanding of CSE and its importance. Initially, six CSE themes (and 25 sub-themes) were identified:[28]

1. human development
2. sexual behaviour
3. interpersonal relations
4. values, attitudes and behaviours
5. sexual and reproductive health
6. culture, society and human rights

A curriculum toolkit was developed, which presents the conceptual and methodological framework for CSE and develops for each sub-theme the learning goals per education level, as well as behaviours to be acquired and developed. For each sub-theme, the CSE programme document provides:

- learning goals
- targeted behaviours
- risk and protective factors
- teaching activities and methodology
- information on how the sub-theme can be integrated within the curricula.

This document allows teachers to see how and where to integrate CSE in the school curriculum without affecting their schedule. Teachers' guides and student handbooks have also been developed and validated, as well as a CSE communication plan.

3.2.4 Training, supervision, and monitoring and evaluation

Training

Training that only covers content and teaching methods is often less effective than training that also includes personal reflection (see Table 3),[29] since this allows learners to consider their own values and attitudes towards issues such as sexuality, gender and relationships. This approach helps to break down prejudices and bring about a change of attitude towards themes that are culturally taboo.

Quality pre-service training is cost-effective, as it is more in-depth and could even benefit the SRH of the trainee teacher. As a result, CSE integration in pre-service training programmes should be a priority. Moreover, all trainee teachers of subjects that integrate CSE should also receive training. Each country should decide how to implement teacher training, considering:

- whether CSE will be taught as a stand-alone subject or integrated into other subjects
- whether it will be taught throughout the pre-service training programme (which will make it possible to improve knowledge and skills as the trainee teachers' expertise grows) or for one term only.

These decisions will affect the content of training programmes (see Table 4). There are also aspects to be considered regarding situations where CSE is taught as a stand-alone subject, such as:

- who will be responsible for delivering this specialized subject
- whether a new pre-service training programme will need to be developed.

Table 3: Advantages and disadvantages of different training content

Training content	Advantages	Disadvantages	Decisions/implications
Training on CSE content and teaching methodologies	• Shorter and less costly for in-service training.	• Inadequate preparation for the teacher to cover difficult themes.	• Will affect the duration of pre-service or in-service training and the method used.
Training that includes personal reflection	• Allows the trainee to deconstruct their prejudices and change their attitude.	• Longer and more expensive for in-service training.	• Will affect the duration of pre-service or in-service training and the method used.

The four countries in this report have yet to establish quality pre-service training, given that the CSE development process is in its early stages. With UNFPA support, some countries, such as Benin, had previously integrated family life and population education into their pre-service training programmes. This content is still being taught, but it does not cover all CSE themes. As a result, Benin launched a project to build the capacities of institutions that provide pre-service training, so that they can adapt their programmes to align them with the new CSE requirements and syllabi. In most countries, government institutions, private training schools and universities provide the pre-service training. Standardized training is preferable for all graduates, so that the same syllabus is taught across the board. However, this is sometimes challenging.

In-service training is essential for teachers and managers, but it is more expensive and sometimes disrupts the running of the school. The method to be used will depend on the number of trainees and the funding available. Some countries opt for cascade training (see Box 2), using existing training systems organized by the Ministry of Education. The advantage of this approach is that it facilitates the integration of CSE into ministry systems, which could improve accountability, as more managers at all levels are trained and therefore involved. Training can take place during scheduled sessions (generally lasting a few hours) between teachers and managerial staff in charge of in-service training. The disadvantage is that training will need to be delivered across several sessions, which lessens the benefits because the sessions are interrupted. However, this type of training can be cheaper to implement.

Box 2

Cascade training in Côte d'Ivoire

In **Côte d'Ivoire**, cascade training was conducted on the lessons developed as part of the Zero Pregnancies in Schools campaign. Heads of pedagogy and professional development organized work sessions for focal points and pedagogical advisers of the sector, which allowed them to take ownership over the teaching content. The focal points and advisers then cascaded the training to teachers and other school staff to make each staff member aware of their role in implementing the campaign. The teachers' orientation on the lessons was carried out during pre-established work sessions, which meant that they were only introduced to the content, rather than receiving a full CSE training session. Cascade training was used because of financial constraints and the need to rapidly scale up the programe.

Table 4: Advantages and disadvantages of different types of training

Type of training	Advantages	Disadvantages	Decisions/implications
Pre-service training	• More cost-effective. • Allows for more in-depth training based on the school CSE programme. • May benefit the SRH of the trainee teacher.	• Will affect the timetable.	• Pre-service training may be within the purview of another ministry and require coordination between ministries, consequently complicating or delaying implementation. • Is the programme optional? • Is the programme stand-alone? • Will components be integrated into other subjects? • Will CSE be taught throughout the training period or for one term only? • Who will teach it? • A specialized teacher? Will this require a new programme to be developed?
In-service training	• Essential for reaching teachers who are already teaching. • Facilitates integration of CSE into ministry systems. • Could increase accountability.	• More costly and difficult to implement. • Difficult to find time for quality training. • Training is often reduced to superficial content.	• When and where would training be conducted? During the school year, students would miss out on classes. During the vacation period, teachers expect to be paid. • Cascade training? Less costly but less effective. The method used will depend on the number of trainees and available funds.

An alternative to cascade training is a residential training session, during which teachers are expected to attend training outside of the school. This option is more expensive and could affect schools' teaching schedules if it is conducted during the academic year. The advantages of this method are that it is higher quality and more in-depth, and that it facilitates monitoring and evaluation of the training and its impact, which helps to adjust training to ensure that the teaching is effective. Each country should develop a **training plan** that includes the number of trainees, methods to be used, quality criteria (content, duration, etc.) and a cost estimate. Coordination and collaboration will be key, since many CSOs work in the area of teacher training. This will ensure that the same teachers are not trained several times by different stakeholders and also that non-governmental trainers comply with a standardized training curriculum tailored to CSE programmes.

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In Togo, the project to promote comprehensive sexuality education (PESC) was piloted for two years, and included teacher training in the target schools. An evaluation of PESC identified the following lessons:

- There was a low level of ownership of the self-training CSE manual developed for teachers' use. This CSE self-training approach was inadequate, as some of the information was inaccurate.
- The skills-based approach was poorly grasped by some teachers, which affected the teaching of CSE.
- Teaching CSE using a skills-based approach requires time, yet most teachers in classes with students preparing for official exams merely brush over the subject.
- The three-day training programme is insufficient for ensuring ownership of the content and methodologies.
- Even after the training sessions, some teachers are uncomfortable discussing certain CSE themes.[30]

Supervision, and monitoring and evaluation

Quality implementation of CSE depends on supervision and support given to teachers by their supervisors, inspectors and other senior staff. Experience in HIV education has shown that effectiveness lies in the competency, motivation and quality training of teachers, and the monitoring, supervision and support provided to them.[31] Teaching CSE requires teachers to have a good knowledge of the content, though they must also feel comfortable talking about the subject. Support should be provided to help teachers overcome any difficulties or identify appropriate methods for content that is problematic. Supervisory officials at the regional level (inspectors or equivalent officials) or at the operational level (directors, head teachers or equivalent education officials) should be included in CSE training plans to effectively monitor teachers. Systems such as school and teacher supervision forms should be revised to include CSE.

CSE programmes that are effectively implemented can have a significant impact, but often implementation does not meet the programme requirements. Monitoring and evaluation, which is an important factor for any implementation, is key to scaling up, since it allows the implementation process and its impact to be analysed, and the programme to be adjusted to ensure the best results. Monitoring and evaluation is conducted at three levels: national, district and operational.

To successfully scale up CSE, it must be integrated into all monitoring systems of the Ministry of Education, including school inspection systems or the Education Management Information System. This requires extra supervision, support, training and pedagogical control, as well as the allocation of adequate budgetary resources for training, system adaptation, pedagogical supervision and analyses at the national level.

3.2.5 Institutional context

Implementing CSE requires efficient coordination and collaboration within and between ministries and with non-governmental partners. Ministries of education are often responsible for implementing CSE, given their mandate, and are assisted by other key ministries, such as the ministries of health and youth, as well as other stakeholders. Despite variations in each country’s institutional context, units responsible for CSE require relevant skills, adequate staff and financing for its efficient implementation.

To ensure that CSE is implemented in schools, units need the backing of ministerial decrees on the responsibilities of these establishments regarding sexuality education. In Côte d’Ivoire, the Ministry of the Interior and Security supported the multisectoral Zero Pregnancies in Schools campaign, issuing a circular that urged its regional and departmental services to participate. The Ministry of Education also issued a circular calling for practical life skills lessons to be taught in schools.

3.3 Coordination and collaboration

Coordination and collaboration within and between sectors, and with the support of non-governmental partners, are vital to CSE implementation and essential at the national, district and operational levels. Without them, scaling up will be ineffective or impossible.

The high number of adolescents and youth, as well as distance and geographical access barriers, require effective coordination and collaboration between the various stakeholders. Stakeholder objectives can only be attained if they work together. However, coordination and collaboration are often the weak links in a scaling-up strategy, due to the complexity and large number of stakeholders working in the areas of CSE and AYSRH. Weak coordination and collaboration can result from a lack of understanding of the role that they play and their poor implementation. The review conducted in the four countries highlighted the need for:

- effective coordination
- consultations between stakeholders to avoid a duplication of efforts and lack of harmonization (of the training curricula, for example)
- increased collaboration with the Ministry of Health
- streamlining of each ministry's activities
- improved coordination between technical and financial partners.

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A lack of stakeholder coordination results in fragmented advocacy and implementation, which in turn affects scalability and long-term sustainability. The role of every stakeholder should be understood, with each responsible for their own actions. Coordination and collaboration are essential for horizontal scaling up, to ensure that the same teaching and training modules are used, that stakeholder interventions do not overlap or duplicate those of others, and that the scaling-up plans cover the entire country.

The identification of the roles and responsibilities of each stakeholder through an official document (for example, a national CSE scaling up strategy) can mitigate this risk. Coordination and collaboration mechanisms should also be introduced at various levels. In Benin, the CSO *Association Pour l'Education, la Sexualité et la Santé en Afrique* [Association for Education, Sexuality and Health in Africa] coordinated the development of the integrated sexuality programme, with assistance from stakeholders including UNFPA, and in collaboration with a multisectoral technical committee comprising officials from the three levels of the education system. This committee was established following two ministerial decrees. Depending on existing mechanisms in the country and their mandates, technical working groups or a steering committee may be used to oversee the coordination process. Côte d'Ivoire identified different platforms to oversee the CSE process, including a national steering committee to identify priority actions, a technical working group, a technical secretariat and various mechanisms at the regional and operational levels.

Many countries already have several coordination mechanisms in place for HIV, social protection, gender and human rights or health groups, which generally include adolescents and youth. Having multiple mechanisms with similar themes wastes time and resources. It is therefore important to analyse the context before creating a new structure that could be a burden for stakeholders.

Collaboration between sectors could also be facilitated by drafting a memorandum of understanding between key ministries. These agreements will determine the roles and responsibilities, implementation methods and financial obligations. If necessary, a joint action plan can be developed to support the implementation of these agreements. Joint programmes, such as the Muskoka Initiative on Maternal, Newborn and Child Health, also represent opportunities for collaboration and coordination.

National and international partners also need to coordinate and collaborate on CSE programmes. Technical and financial partners affect the funding of development projects. This review identified several cases of duplication among technical and financial partners and United Nations organizations, which can waste resources and create a heavier burden on national governments. Partners therefore need to coordinate at the national, regional and global level.

Box 3

Senegal

In Senegal, the Coalition for Adolescent and Youth Reproductive Health, established in late 2012, comprises the Ministry of Education, United Nations organizations and relevant CSOs (such as the *Association Sénégalaise pour le Bien-être Familial* [Senegalese Association for Family Well-being], OneWorld, *Groupe pour l'Étude et l'Enseignement de la Population* [Group for the Study and Teaching of the Population] (GEEP), *Réseau Africain d'Education en Santé* [African Health Education Network] (RAES), African Medical and Research Foundation (AMREF), Oxfam, Save the Children, *Fédération Nationale des Associations de Parents d'Elèves et d'Edudiants* [National Federation of Parent–Teacher Associations], Forum for African Women Educationalists (FAWE). The coalition assists the education sector with integrating CSE into curricula.

One of the strengths of the coalition is that it involves all key stakeholders. In addition, low staff turnover in member organizations has improved efficiency and facilitated the development of a common understanding of issues and the most appropriate way to move forward. The coalition has also:

- coordinated advocacy efforts to strengthen the provision of CSE in schools
- pooled technical and financial resources to support the Ministry of Education in its provision of CSE in schools
- helped develop an action plan and map of partners and their activities
- coordinated the identification of strategic areas for implementing and scaling up CSE (for example, identifying the seven CSE components).

The CSO Senegalese Association for Family Well-being chairs the coalition and the Ministry of Education approves its actions. Using a CSO as chair allows for flexibility and timely actions that would not be possible if the position was held by a ministry or a technical and financial partner.

Although the coalition has achieved a great deal, the situation is far from perfect. The country has several coordination and collaboration platforms on AYSRH (including the Coalition for Adolescent and Youth Reproductive Health and a Ministry of Health platform, among others), resulting in an increased workload for partners and the creation of divisions between organizations, as understaffed organizations are unable to fully participate.

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3.4 Integration with other sexual and reproductive health projects

Access to adolescent and youth sexual and reproductive health services

To be effective, CSE should be linked to accessible sexual and reproductive health services that are adapted to the needs of adolescents and youth. Demand creation interventions are also required to ensure utilization of these services. In the countries under review (and in most countries in the region), there are insufficient health centres that offer AYSRH and family planning services, though these are identified as a priority in every country. Consequently, countries are trying to make existing health centres adolescent and youth-friendly by offering SRH services that are responsive to their needs Countries such as Benin, Côte d'Ivoire, Senegal and Togo have school clinics (see Box 4), but these are often unsuitable due to a lack of adequate infrastructure, equipment, qualified human resources and services. In the countries under review, the Ministry of Health oversees school clinics, which experience similar challenges and constraints to those of the health system.

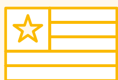
Infrastructure is not the only issue – the services are of equal importance. For the past several years, the Ministry of Health in Côte d'Ivoire has been integrating reproductive health, family planning and HIV services into school and university health services.

As of 2015, these services had been integrated into almost 97 per cent of school and university health services, school clinics and other related facilities. This integration had a very positive impact on the use of family planning services. From September 2012 to December 2013, the number of new users of family planning services increased from 262 to approximately 135,310, and 32,277 people were tested for HIV (272 seropositive cases).[32]

The Togo and Côte d'Ivoire models are not necessarily reproducible, but lessons can be learned from them. In Togo, a situation analysis and an assessment of health centres helped to identify what currently existed, what the weaknesses were and how to best address needs. After the assessment, the country entered into discussions with the private sector, which resulted in partnerships to improve certain school clinics.

Due to health system constraints, clinics cannot be developed in all schools. Existing facilities in the community should therefore be adapted to meet the needs of young people. The World Health Organization (WHO) has developed criteria that should be implemented in all health facilities that receive adolescents and youth, including schools and existing health centres.

Box 4



Togo

School clinics are an opportunity to make SRH services accessible to adolescents and youth, and ensure that services meet their needs. In 2012, a situation analysis highlighted the lack of school clinics in Togo (37) and identified inadequate infrastructure, equipment and qualified human resources as the main stumbling blocks, as well as the limited services on offer.

To support the government in responding to the SRH needs of adolescents and youth, a public-private partnership was forged with North Star Alliance and UNFPA to set up Blue Boxes (prefabricated school clinics) in secondary schools with at least 1,000 students.

The specific goals of the Blue Box project include:

- setting up a functional health unit in schools with a large student body
- providing a package of primary health-care services, including reproductive health and HIV services in clinics
- improving knowledge and behaviour of students regarding hygiene and SRH, using information, education and communication (IEC) or BCC activities
- improving SRH education, including HIV prevention in teaching programmes
- introducing early prevention practices in schools
- reducing health-related absences
- ensuring better monitoring of students presenting chronic pathologies or with disabilities.

In some schools, existing clinics have been improved, while in others, the project acquired containers specifically designed for this purpose, fitting them with medical equipment, furniture and a stock of medical supplies. The composition of the health team (paid by the state and parent–teacher associations) depends on the number of students in the school:

- one medical assistant or registered nurse
- one auxiliary nurse.[33]

Service providers underwent specific AYSRH training and offer a package of services, including:

- IEC or BCC activities (counselling service, educational discussions, films)
- medical consultations and first aid
- daytime observations
- reproductive health and HIV services (contraception and STI management).

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WHO criteria require services to be:

accessible to adolescents, so that they can access the services

acceptable, meaning that health services are delivered in a way that is appealing to adolescents

equitable, so that all adolescents, and not only certain groups, can access the health services they need

appropriate, meaning that health services respond to adolescents' needs

efficient, so that appropriate health services are delivered and contribute positively to adolescents' health.[34]

Most health strategies for young people, and national youth policies, such as those implemented in Côte d'Ivoire and Togo, prioritize adapting health services to meet the needs of these populations. In this regard, a key component of AYSRH is training providers, which helps them to adopt the best clinical decisions and develop a positive and welcoming attitude towards their customers. Although important, training alone is not enough.

Overall experience has shown that, in the long-term, short training courses that do not have ongoing supervision and support do not improve the quality of services. Given that supervising and supporting providers (such as teachers) is key to successful AYSRH services, these activities should be incorporated into Ministry of Health monitoring systems.

Links between schools and AYSRH

Most schools do not have clinics, so they will need to create links and referral systems with their local health centres. To supplement these links, demand must be created for AYSRH services. Creating such demand will require

- information about the services offered
- information about where to access services
- elimination of any sociocultural barriers to using these services.

Countries in the region are piloting various activities to strengthen links and create demand for these services, such as:

- class visits to health centres for students to familiarize themselves with, and receive information on, services offered
- visits from health-care providers to schools
- joint training of health-care providers and teachers from the same area, and the development and implementation of a joint activity plan by those trained
- a coupon system for free access to health services (in certain countries, scaling up this activity is difficult and expensive)
- establishing transport systems (with the support of a local CSO in most cases) to make it easier to access health centres.

Information on services offered and where to access them can be disseminated through various activities. School clubs existing in the four countries reviewed are often used to share information, organize events and raise awareness, sometimes with support from health-care providers. In Togo, a module was developed to guide, plan and facilitate activities carried out within school clubs related to the environment, population and reproductive health for sustainable human development.

In 2013, the Ministry of Health in Côte d'Ivoire sent a circular to all head teachers encouraging them to create school clubs and associations and to appoint a coordinator. The circular stated that school clubs and associations should be involved in the Zero Pregnancies in Schools campaign, and that they should organize at least five awareness-raising and training activities throughout the school year. From 2014 to 2016, SRH capacities in the area of GBV were strengthened for 489 supervisors of school clubs, 1,967 peer educators and 300 social workers and preschool teachers. In each school, four student members of the health club and the club supervisor attended a three-day training course, which comprised 12 modules on physiology, adolescent pregnancies and contraceptive methods, among others. This strengthened the capacity of school and university health services, enabling them to develop SRH activities within schools and clubs. Moreover, 56 new adolescent pregnancy clubs were established, which raised awareness of SRH, hygiene and STIs among nearly 33,000 girls. Since peer education has proven to be less effective in changing behaviours, it should focus on awareness-raising and advocacy.

Overcoming sociocultural barriers

Sociocultural barriers, along with the fact that sexuality is considered taboo, can make it challenging to discuss or debate these issues, which could impede access to, and use of, AYSRH services.

A behaviour-change communication (BCC) campaign can be used to challenge negative societal norms and attitudes, as can an awareness-raising campaign among parents and the community on AYSRH. Campaigns can use the media (radio, television, social networks, etc.) as well as more personal interventions, such as community discussions, school-based activities with parents and activities to improve communication between parents and children. The four countries in this review have initiated activities with community and faith-based leaders. In Senegal, the Islam and Population Network developed arguments in favour of family planning, identifying verses in the Koran and hadiths of the Prophet that support family planning and sexuality education, as well as counterarguments to those who oppose these.

In Côte d'Ivoire, the National Gender Equality Observatory (ONEG) raises awareness and strengthens capacities of leaders to promote gender equality and young people's access to SRH education and services. ONEG trained 225 faith-based and traditional leaders, among others, who made a solemn commitment to not perform child marriages. Also, with the support of faith-based and traditional leaders, ONEG developed a public communication campaign on child marriage, since these are responsible for a large number of adolescent pregnancies

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and their consequences. The messages of these leaders are broadcast through various media outlets, including audio and video channels, and are also displayed on billboards. The project aims to change the sociocultural environment.

Overall experience shows that involving parents, guardians, the community and leaders in developing and implementing programmes on CSE and AYSRH services helps to overcome obstacles and increases programmes' impact. As it is impossible to involve everyone in one awareness-raising campaign, several should be carried out, hence the wide variety of activities being implemented by different countries in the region. For example, school management committees in Côte d'Ivoire, the Federation of Parent–Teacher Associations in Togo, and the National Federation of Parent–Teacher Associations in Benin received CSE training, after which they developed awareness–raising activities that targeted parents and the community. A "school for parents" and other activities (see section 3.5) carried out by schools and CSOs also contribute to sociocultural change.

Change can only be achieved when parents, guardians, the community and leaders participate in and approve of the provision of CSE. All elements of a CSE programme need to be in place and work together to reduce:

- the rate of adolescent pregnancies (often related to a decline in child marriages)
- prevalence rates of HIV and other STIs
- rates of GBV.

3.5 Out-of-school programmes

Context

While school is the ideal place to reach many adolescents and youth, in West and Central Africa, many do not attend school, particularly the most vulnerable and marginalized young people. The region has the lowest school enrolment rate on the continent, with only 78 per cent of boys and 69 per cent of girls in primary education.[35] These rates are even worse for secondary education, with only 38 per cent of boys and 31 per cent of girls enrolled. It is important for CSE to cover all schools in a country, but it is also important to implement such education outside of schools. This will ensure that all adolescents and youth have access to the appropriate information and services, enabling them to protect themselves and make informed decisions on their SRH.

How?

Out-of-school CSE can be delivered in a number of different ways, including through communities, mobile clinics, parents and families and technology.

Community-based programmes and extracurricular initiatives are often small in scale, but are more likely to reach those most vulnerable, such as out-of-school girls. The variety of target populations highlights the importance of adapting the content and teaching activities, as SRH and learning needs tend to be diverse.

To reach out-of-school adolescents and youth, different strategies are used, such as the Healthy Youth, Protect Yourself roadshow in Côte d'Ivoire. This roadshow is facilitated by health-care providers, including midwives and SRH educators, who travel across the country providing information, support and services. In 2013, an assessment of the activities found that 207,235 adolescents and youth, including 40.8 per cent of girls, were reached through the roadshow and that 84,557 young people (9.7 per cent of the target population) were reached after two days of activity in each of the localities visited.[36]

Since midwives ran the mobile clinics, young people also benefited from health services, such as family planning, HIV

Out-of-school programmes are able to introduce content and other elements that would otherwise not be possible in a school environment, such as workshops, health services, social support activities, free telephone helplines and joint parent and child activities.

testing, STI diagnosis and treatment, and had access to male and female condoms.

Various interventions may ensure expanded coverage of CSE. These include after-school clubs, the integration of CSE into informal education, and community-based or AYSRH projects often carried out by CSOs.

Youth centres

In Senegal, *centres conseils adolescents* [youth guidance centres] (CCAs), developed by the Ministry of Youth, provide:

- prevention services (e.g. through talks, personal interviews, beach activities, telephone helplines, films, theatre productions, brochures and posters)
- psychosocial support
- medical services (provided by a mid wife)
- voluntary testing services.

Peer educators supplement the services delivered at the CCAs with home visits. These act as a link between young people in the community and the CCAs, providing them with information on the CCAs' services.

CCAs face similar issues to school clinics, as they also rely on the availability of staff, contraceptives and other supplies from the Ministry of Health (certain CCAs receive external support, such as that of UNFPA for family planning). Although CCAs and other youth centres are an option for out-of-school CSE, they cannot be considered a replacement for health facilities that provide services adapted to the needs of adolescents and youth. Experience shows that services delivered through youth centres are not necessarily used by those who need them the most, and few are effective at improving SRH outcomes.[37]

Information and communication technologies

Information and communication technologies (ICTs) are becoming increasingly important in the lives of adolescents and youth. Most have access to social media (through mobile telephones) and other media (television, radio, etc.). These are often the only easily accessible sources of information, but they do not always disseminate accurate information. Social media can often be a source of positive information, as well as negative information, prejudice and a vehicle for harassment. Often, young people cannot tell the difference.

Increasingly, governments and CSOs are using ICTs to reach young people "physically" and using a "language" they understand. Each of the countries reviewed have set up free hotlines for AYSRH issues, children in distress or GBV. For the Zero Pregnancies in Schools campaign, Côte d'Ivoire developed a website integrated with social media to allow young people to discuss issues. The Ministry of Education also manages an SMS messaging service. Other projects, such as Take Control of Your Life, use community radio stations (see Boxes 5 and 6 for more details on ICTs and the Zero Pregnancies in Schools campaign).

Another example is the Senegalese organization *Paroles aux Jeunes* [Young People's Voices], which is conducting an AYSRH digital campaign via Facebook, Twitter, blogs and other digital media outlets, and with support from rappers and other leading figures in the country.

Paroles aux Jeunes organizes various events and competitions, including the Red Card to Child Marriage campaign conducted in the form of a "tweet-up" in collaboration with other countries in the region.

Box 5

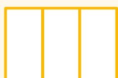
ICTs are also used by regional programmes and various CSOs. The *C'est la Vie* (That's Life) project,[38] a BCC initiative focusing on maternal and child health, reproductive health, quality of care and GBV, was broadcast in 44 countries in sub-Saharan Africa. The initiative consists of "edutainment" (educational entertainment), in the form of a television series and a multimedia campaign on radio, social media, the Internet and through community-based communication activities. Guides on specific themes – one per episode – are developed to facilitate both screenings and debates on each episode, whether they take place in the community, school or health-care settings, or on the radio. This approach has been successful, as once the 60 episodes of the televised series Tushauriane were broadcast, use of family planning services in Kenya increased by 58 per cent and the desired family size decreased from 6.3 to 4.4 children.[39]

To enable young people in the different regions of Senegal to access SRH information, a telephone service named Gindima, which means “enlighten me” in Wolof, was launched in 2016. By the end of 2017, more than 200,000 calls had been made to this automated hotline, which is available in French and Wolof 24 hours a day, seven days a week. The hotline provides information on seven main themes: the menstrual cycle, STIs and HIV/AIDS, anatomy and puberty, contraception, pregnancy, violence, female genital mutilation and abuse, and sexuality. To counter false information on SRH present on the web, the organization trains young people on how to talk about SRH and safely use social media and the web. In addition, in each region, a *Paroles aux Jeunes* club has been established, with its own Facebook page. These clubs also work with the CCAs’ peer educators.

Coordination, collaboration and standardization

Out-of-school programmes are implemented by several stakeholders, including ministries of youth, gender and families, technical and financial partners and CSOs working in SRH, education, health, adolescent and youth, gender, development and ICT, among others. To scale up CSE effectively, linkages and synergies should be identified between the formal and informal sectors, and also between the various stakeholders. The number of active stakeholders highlights the need to conduct a mapping exercise, to identify their geographic location and the curriculum used. Out-of-school CSE programmes in many countries in the region, including the four countries under review, are implemented in an ad hoc manner and often depend on technical and financial partners. Content is often not harmonized or low quality, projects often overlap and duplicate the work of others, and some areas lack any activity. Harmonization, of content in particular, is key to ensuring quality and a modular teaching approach. The content of out-of-school CSE programmes should be aligned as much as possible with school curricula and should be based on the eight key concepts of the 2018 edition of the UNESCO "International Technical Guidance on Sexuality Education". The experience of UNFPA makes it well suited to helping countries develop standards. It is only through strong collaboration and coordination of out-of-school CSE that a country can ensure that no young person is neglected and that a harmonized approach is implemented.

Box 6



The Zero Pregnancies in Schools campaign in Côte d'Ivoire – a multi-pronged approach

The Zero Pregnancies in Schools campaign uses several out-of-school strategies to broaden the coverage of the programme. To reach adolescents and youth who do not attend school, community-based strategies have been rolled out, and ICTs are being used:

- The Healthy Youth, Protect Yourself roadshow is touring the country providing SRH information and services led by health providers, such as midwives and SRH educators. In 2013, the roadshows reached 207,235 adolescents and youth with their awareness messages.
- Counselling and youth centres, among other social settings for youth, are used to broadcast messages and raise awareness of issues such as adolescent pregnancies and their prevention, sexuality and condom use.
- The Ministry of Youth collaborated with the Ministry of Education to produce visual aids, brochures, banners and kakemono, to ensure that the content is standardized and harmonized with in-school CSE.
- To harmonize the out-of-school content, the CSO *Association Ivoirienne pour le Bien-être Familial* is developing a CSE manual, a teacher's guide and a participant's guide.
- Arts, culture and sports are used to raise awareness about SRH and adolescent pregnancies.
- The main themes for the 2013 national arts and culture festival for schools were SRH and GBV, using poetry, storytelling and drama to get these messages across.

- A multimedia campaign was developed, comprising six posters and one flyer on adolescent pregnancies and means of prevention, five audio commercials, three video commercials and hundreds of SMSs.
- A website connected to social networks was developed to allow young people to discuss issues.
- An SMS system on SRH was activated.
- A free and confidential SRH hotline (107) receives 90 to 120 calls a day.
- The *Agence Ivoirienne de Marketing Social*, in partnership with the Ministry of Education, developed Take Control of Your Life, an annual campaign on adolescent pregnancies that is broadcast on TV, radio and billboards. Radio plays are also broadcast four to five times a day for a week on community radio stations. A special programme at the end of the campaign allows individuals to call in with their questions or opinions on the weekly theme. A host presents the weekly play and opens discussions with young people on its content.

To overcome barriers to accessing AYSRH or family planning information and services, various stakeholders have been working to raise awareness among community and faith-based leaders, parents and the wider community. Other interventions to break down these barriers, such as activities to improve parent–child communication, are also being implemented.

4

Recommendations

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Based on global experience, we can now identify the key contents of a quality CSE, the best teaching methods and the most promising interventions. However, CSE is most effective when it is combined with other complementary actions in the area of adolescent and youth sexual and reproductive health (AYSRH). Each country in this review has initiated a CSE development process that could be stepped up. Some are at a more advanced stage, but all require the technical and financial assistance of partners to ensure that scaling up is high-quality and effective. UNFPA, along with other United Nations agencies and technical and financial partners present in each country, has a key role to play.

Advocacy

Many positive initiatives have been launched, but policy priorities and sociocultural barriers call for continued advocacy actions. The first step is to develop **arguments** and the **rationale** for **sexuality education** and identify **entry-point activities**. Entry-point activities may include a national campaign on adolescent pregnancies or the demographic dividend. Various priorities fit into UNFPA's mandate, including assistance to:

- **develop and implement an advocacy strategy**
- **review policies and the legal framework**
- **revise SRH legislation (where necessary).**

Creating a favourable context for AYSRH does not require new CSE-specific policies, strategies or legislation.

CSE can be integrated into existing policies, strategies and legal frameworks (or those that are in development), such as a national education policy/plan or an SRH law. UNFPA is well positioned to lead the dialogue with the different stakeholders (politicians, ministries, other technical and financial partners, CSOs, among others) and build consensus. Advocacy is not an isolated effort – it requires long-term action and should keep pace with a changing environment. Governments, ministers and other stakeholders can change, as can their priorities. Advocacy for CSE should be responsive to these changes and be prepared for all possibilities – positive or negative.

Technical considerations

UNFPA has the technical expertise to support countries in developing CSE that could be scaled up. Most countries have chosen to integrate CSE into existing school curricula and hope to benefit from planned education reforms to ensure this integration. As previously mentioned, certain risks will have to be addressed by UNFPA and other technical and financial partners to ensure that the implementation process runs smoothly.

Certain countries have already developed a base upon which they can scale up CSE, while others are in the early stages of developing a CSE programme. In both cases, it is essential to select a model that can be scaled up. All too often, pilot projects are launched without considering the difficulties in scaling up the model. The first step is therefore to test a model with the potential to be scaled up, which will require many technical decisions to be made.

UNFPA can help analyse the various components of a CSE programme (integrated or stand-alone contents, training methodology, supervision and teacher training, among others) to help develop a national CSE scaling-up plan, curricula and learning materials and support their implementation.

A mandatory and examinable CSE programme has a better chance of providing adolescents and youth with the knowledge, skills, attitudes and values needed to protect themselves and make informed decisions about their SRH.

UNFPA can support partners to:

- analyse the many technical considerations
- develop a national plan to scale up CSE
- meet human and financial resource needs.

To be effective, the institutional environment must also be considered. Ministries often lack adequate human and financial resources to effectively implement the scaling-up process. UNFPA can help these ministries assess their needs and coordinate with other partners to address these needs.

Coordination and collaboration

In most countries, coordination and collaboration are often the weak links in a scaling-up strategy. This is often due to the complexity and number of stakeholders working in the areas of CSE and AYSRH. Each stakeholder should understand their role and be responsible for their own actions. Coordination and collaboration are essential for horizontal scaling up, to ensure that the same modules are used across the board, stakeholder actions do not overlap and the entire country is covered. Coordination and collaboration should occur at two levels:

- **Technical**: with those responsible for CSE development, implementation and scaling up.
- **Advocacy**: with all stakeholders who should be informed or invited to participate throughout the process (for example, religious leaders, parliamentarians and other figures).

Coordination and collaboration can be improved in a number of different ways. UNFPA is well positioned to support and facilitate the following actions:

- review existing coordination and collaboration platforms and identify and support the best platform for scaling up at all levels – national, regional/district and operational
- identify and achieve consensus on the roles and responsibilities of each stakeholder
- draft a memorandum of understanding between key ministries
- develop coordination mechanisms within sectors to improve planning, especially within the education sector
- map stakeholders, covering geographic areas of focus, activities and learning materials used
- standardize and harmonize the materials used.

Integration with other sexual and reproductive health projects

To protect themselves, adolescents and youth need quality in- and out-of-school CSE linked to AYSRH services. Global experience has highlighted the importance of access to, and use of, AYSRH services to improve SRH outcomes. A CSE programme must therefore create links and referral systems between schools and local health centres and services. However, these links must be supplemented with the generation of demand for AYSRH services. Nonetheless, demand cannot be generated if the services on offer fail to respond to the needs of adolescents and youth. This requires, for example, the Ministry of Health to develop standards for AYSRH services, and training, supervision and support for health-care providers.

UNFPA has extensive experience in implementing SRH projects. This experience allows it to identify needs, as well as the best solutions. A close link between CSE and AYSRH services is essential to achieve the desired outcomes, but too often this is not the case and efforts to bring these two areas together are often fragmented. UNFPA has ties with the health and education sectors, which will enable it to facilitate collaboration between the sectors. Close collaboration at the national and operational level is vital to any CSE strategy. Through its various national programmes, UNFPA experiments with the best options for strengthening collaboration and creating referral systems between schools and health centres. This global experience will be important when scaling up at the country level.

National policies or strategies and a legal framework for CSE and AYSRH are essential for their implementation (see Section 3.1.1 and the Advocacy section on an earlier page). SRH legislation could either facilitate or impede implementation of CSE and delivery of AYSRH services. The global experience of UNFPA in this area enables it to support countries with revising their legislation and national strategies.

Out-of-school comprehensive sexuality education

As many adolescents and young children do not attend school, out-of-school CSE is a critical component of the whole programme. Several stakeholders can implement out-of-school programmes, including the Ministries of Youth, Gender and Family; technical and financial partners; and CSOs working in the various related fields (for example, SRH, education, health, adolescents and youth, development, ICTs). For effective scaling up of CSE, possible linkages and synergies between the formal and informal sectors and the various stakeholders should be identified.

CSE is often implemented outside the school environment in an ad hoc way and depends on the priorities of the technical and financial partners. Its contents are not harmonized and are sometimes of low quality, and the projects often overlap and duplicate the work of others, while other geographic regions are devoid of any activity. Harmonization of the contents – based on the 2018 edition of the UNESCO "International Technical Guidance on Sexuality Education" – and of the training programmes, are key to ensuring quality and a modular pedagogical approach.

UNFPA can support out-of-school CSE programmes in several ways:

- helping at the technical and financial levels
- harmonizing and standardizing programme content and training
- ensuring linkages between in-school and out-of-school programmes
- improving coordination and collaboration.

Long-term support

Scaling up CSE with access to good-quality AYSRH services is a long-term effort, which entails institutional and societal changes at all levels. Existing projects should continue while CSE is being integrated into government systems, to ensure that young people continue to receive some form of sexuality education, even if it is not aligned with the international standards for CSE. This is because scaling up high-quality CSE at the country level requires time and resources.

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In addition, certain risks could slow down the implementation of a CSE programme, such as:

- a change in priorities
- inadequate human and financial resources
- lack of political will.

Thus, partners should help countries identify and mitigate these risks.

UNFPA can provide technical assistance by bringing various sectors and multiple stakeholders (the government, CSOs and technical and financial partners, among others) together, to link sectors and support countries to mobilize resources for financing.

Most governments do not currently have the domestic resources to fully finance the scaling up of CSE. In addition to costs associated with developing the curricula and learning materials (which are usually financed by partners), there are also costs such as teacher training and printing and distributing materials to schools nationwide. These costs can be high and are often the responsibility of governments that may not have the financial resources or the inclination to make these activities a priority.

However, the challenges of CSE implementation are offset by its long-term positive impact on the health and education of adolescents and youth, and thereby on the development of their country.

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Recommendations for UNFPA

UNFPA country offices, with the support of the Dakar-based regional office, have a key technical role to play in helping governments develop, implement and scale up quality CSE.

- **Coordination and collaboration** are often poorly understood and implemented. UNFPA can provide technical assistance to improve platforms; identify the **roles and responsibilities of key stakeholders**; and identify **mechanisms for intrasectoral and intersectoral collaboration** that could have a significant impact on CSE scaling up.

- To develop and implement a CSE programme, a country must **consider the technical aspects**. UNFPA can help identify the **advantages and disadvantages of the various technical decisions** to be made in each country. Moreover, drawing on its global experience, UNFPA could **identify and share promising practices** from other countries in the region.

- Understanding of how to integrate CSE into other SRH projects and how to strengthen the links between the two is often poor and/or weak. Yet a CSE without access to AYSRH services leaves young people vulnerable. UNFPA can support countries to review options for strengthening links between CSE and AYSRH services by sharing experiences from other countries and by helping governments generate country-specific recommendations on effectiveness, feasibility and cost.

- UNFPA WCARO reviewed the **policies, strategies and laws** affecting adolescents and youth in selected countries in the region. The review covered child marriage, adolescent and youth's sexual health, education, employment and youth empowerment. This review can be replicated in other countries in the region.

5

Conclusion

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The current CSE programmes in Benin, Côte d'Ivoire, Senegal and Togo are based on earlier education projects focused on life skills, HIV and population, in many cases supported by UNFPA. For several decades, UNFPA provided technical assistance to these countries through projects on family life and population education; environment; and population and reproductive health for sustainable human development.

Among other issues, these projects focused on:

- population dynamics
- reproductive health
- gender
- child trafficking
- nutrition
- the culture of peace.

Depending on the country, these projects were integrated into various school curricula such as life and earth sciences, and civic education. The themes discussed in these earlier programmes overlapped with the new CSE guidance, but often missed certain crucial topics. Therefore, they did not provide adolescents and youth with all the necessary information and skills to maintain their health, welfare and dignity. The countries are now in the process of developing high-quality CSE programmes that are aligned with the latest guidance and evidence. The programmes showcased in this report are all at different stages of development, but have a common set of strengths, weaknesses, opportunities and risks:

Strengths

- Quality learning materials have been developed.
- Processes to develop projects and materials are inclusive.
- Good use of data has led to effective advocacy in certain countries.

Weaknesses

- Certain actors in the education sector questioning the role or responsibility of the Ministry of Education in CSE.
- Existing challenges in the education sector, such as lack of teachers and infrastructure.
- Inadequate teacher training.
- A sociocultural environment that could create obstacles.
- Insufficient funding.
- Inefficient coordination and collaboration.

Opportunities and risks

- Awareness of the impact of adolescent pregnancies provides an opportunity to build consensus on CSE.
- Interest in the demographic dividend is an opportunity to integrate CSE into the Government's agenda and justify its implementation by the various Ministries.
- Education reforms planned in certain countries provide an opportunity and an entry point for CSE, but also constitute a risk – CSE could be weakened or neglected if other priorities arise.

Experience in Côte d'Ivoire, Benin, Senegal and Togo reveals five key elements to a successful CSE programme and scaling up:

- advocacy
- technical considerations
- collaboration and coordination
- linkages between CSE and other SRH projects
- establishment of out-of-school CSE programmes.

Most governments in the region currently do not have the required human or financial resources to scale up CSE. Support from partners and CSOs is therefore essential.

A CSE scale up coupled with access to quality AYSRH services is a long-term project that involves institutional changes at all levels, as well as societal changes. Existing projects should therefore continue while CSE is being integrated into government systems. Any scaling-up strategy should therefore plan for both the short and long term, to ensure that adolescents and youth receive at least a minimum level of CSE so that they are able to protect themselves. The challenges of implementing and scaling up CSE are offset by its long-term positive impact on the health and education of adolescents and youth, and thus on the development of their country.

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Comprehensive sexuality education (CSE) projects implemented in Benin, Côte d'Ivoire, Senegal and Togo have produced promising practices and lessons learned. This annex outlines these lessons.

Advocacy

- Significant **advocacy** efforts are required to develop a common understanding of CSE among key stakeholders.
- **Effective use of data**. Studies on adolescent pregnancies could provide proof that urgent action is required. Stakeholders could seize the opportunity offered by a published study to draw national attention to the problem and to advocate for CSE as an effective strategy to reduce adolescent pregnancies.
- **Effective advocacy**. Using evidence-based advocacy (for example, data on adolescent pregnancy rates) and creating media awareness of the issue could help people understand the effects of sexual and reproductive health (SRH), on girls in particular, and generate the political will to make changes. This, in turn, could help scale up CSE.
- **Interest at the highest political level** helps open up the discussion on adolescent and youth sexual and reproductive health (AYSRH) and create a sense of shared responsibility.
- **Entry-point activity**. A study on adolescent pregnancies or a Zero Pregnancy campaign could lay the groundwork for discussions about developing a CSE programme.
- **Dissemination of arguments in favour of CSE reduces obstacles to its successful implementation**. Examples include compiling a compendium of legal and non-legal texts, and activities involving faith-based and traditional leaders.
- **Building a common understanding of CSE** involves activities that raise awareness among community and faith-based leaders, parents and members of the wider community.
- **Sociocultural barriers persist in some contexts**, where better advocacy is required. A needs assessment and landscape analysis could identify entry-point activities aimed at addressing issues such as adolescent pregnancy and could also identify allies who could help reduce sociocultural opposition.
- Projects cannot be scaled up without long-term financing. To ensure sustainability, governments, not just external donors, must contribute to the programmes.

Technical considerations

- Though likely to slow down progress, an **inclusive process** is essential to building a common understanding of CSE and its importance. Therefore, key stakeholders must be involved, including the Ministries of Education, Health, Family and Youth; parent–teacher associations; technical and financial partners, faith-based leaders; civil society organization (CSO) representatives; youth representatives; consultants; and experts in education and sexual health.
- A **CSE development process** that clearly defines each stage of development (consensus-building workshops and development of materials, among others) ensures that all key stakeholders are involved and creates ownership.
- To ensure seamless **integration with national education systems**, the team in charge of developing the learning materials should include SRH experts and members with experience of the national education system.
- All key stakeholders should review and validate the materials developed, which could improve shared understanding and ownership. This process could also improve content quality, and ensure that it is acceptable to teachers, school principals and parents.
- The **development of an education sector plan and/or a curriculum review are possible entry points for CSE programmes**. They allow CSE to be integrated into education systems, but can be risky, as they require priorities to be set, which might not include CSE.
- Stakeholders should ensure that CSE is neither weakened nor neglected – but rather consolidated and integrated into the education system.
- The advantage of **teaching CSE within several subjects** is that it will become part of the curriculum without adding to an already overcrowded timetable. However, teachers may not feel responsible for teaching CSE or make it a priority.
- **Continuity between primary and secondary education, and harmonization** of in- and out-of-school content is important.
- A **short (for example, three-day) teacher training session is not enough** to ensure ownership of the CSE contents and teaching methods. As a result, even after training, some teachers do not feel comfortable discussing or teaching certain CSE themes.

Coordination and collaboration

- Coordination and collaboration platforms are more effective if they **include all key stakeholders** (the various Ministries, United Nations agencies, other partners and CSOs).

- **Rapid progress may be made when a CSE programme is managed by a CSO, but this affects the government's ownership of the programme**.

- Having a **non-governmental organization (NGO) lead a CSE project** has its advantages and disadvantages. An NGO can be a lot more flexible, allowing the project to be rapidly adapted to changing needs, but national coverage and ownership could be higher under the leadership of the Government, which could affect scaling up.

- **NGO leadership cannot be replicated in all countries** and depends on the particular NGO. For example, in Senegal, members of *Le Groupe pour l'Étude et l'Enseignement de la Population* [Group for Population Studies] come from the education sector and are well respected within the education system. In addition to their expertise on AYSRH, they can identify what can be integrated, where and how; and identify the opportunities and obstacles to CSE implementation in schools.

- **Low turnover rates among staff from member organizations on a coordination platform** contributes to improved efficiency, a shared understanding of challenges and agreement on a way forward.

- **A Zero Pregnancies in Schools multisectoral campaign**. In Côte d'Ivoire, different sectors identified possible activities for the campaign, which led to a shared sense of responsibility. Circulars from several ministers supported the implementation by urging their regional departments to participate in the campaign.

Integration with other sexual and reproductive health projects

- **Integration of reproductive health, family planning and HIV services into school and university health facilities** can significantly affect family planning use.
- **School clinics** can reduce some of the barriers to accessing AYSRH services by bringing services closer to users. They can also help strengthen the links between CSE and AYSRH services.
- Having **contraceptive products available at school clinics** facilitates access, and is a positive development and a practice to be emulated.

Out-of-school programmes

- Although the school environment is the ideal place to reach many adolescents and youth, many of them – often the most vulnerable and marginalized – do not attend school. It is therefore **important to implement CSE in- and out-of-schools**.
- **Enhanced coordination is necessary.** Certain CSOs deliver quality CSE outside of the school environment, but coverage is fragmented, and it depends on the CSO, its geographic focus and the availability of funding.
- **The variety of teaching and learning materials used prevents standardization and harmonization.**

Notes

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