United Nations
Educational, Scientific and
Cultural Organization

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EDUCATION 2030 BRIEFING
November 2016 | VOLUME 3

Strengthening Education in West and Central Africa by Improving Learners' Sexual and Reproductive Health

SUMMARY

West and Central Africa (WCA) is the region of the world with the largest percentage of young people (32%, UNFPA, 2016) and the highest gender disparity in education. Upper secondary school completion rates are 35% for boys and 25% for girls (UNICEF, 2016). A number of factors are responsible for the persistent gender disparities in education. Among them, early and unintended pregnancy, which is often linked to child marriage, poor sexual and reproductive health (SRH) including HIV infection, and school-related gender-based violence (GBV) have a marked impact on the education and future prospects of young people (UNESCO, 2016).

Few young people in the region receive adequate preparation for their sexual lives. Fortunately education itself can be harnessed to give young people the knowledge and skills to make informed decisions about their SRH, and to develop attitudes and values which support human rights and gender equality.

The growing population of young people in the region requires that ministries of education and local education authorities in WCA countries improve and scale up comprehensive sexuality education (CSE), which is defined as an age-appropriate and culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information (UNESCO, 2009). To be effective, CSE needs to fully integrate gender and human rights (UNFPA, 2014) and to be paired with adolescent-friendly SRH services.

CSE is best delivered in safe and healthy learning environments, where school-related GBV is also addressed at the level of rules and regulations, links with communities, and reporting and referral mechanisms. Addressing issues surrounding both health and gender equality, as recommended in global commitments (Box 1), will contribute to achieving SDG4 – to "ensure inclusive and quality education for all and promote lifelong learning" – as well as to realising the demographic dividend.

[1]In this document young people are defined as persons between the ages of 10 and 24 years old.

COMMITMENTS TO EDUCATION AND HEALTH

Sustainable Development Goals (SDGs)

Target 4.7: all learners acquire the knowledge and skills needed to promote [...] human rights, gender equality [...] and non-violence

Target 3.7: ensure universal access to sexual and reproductive health-care services, including for family planning, information and education

Empower young women and adolescent girls: Fast-Track the end of the AIDS epidemic in Africa (UNAIDS & the African Union, 2015)

Recommendation 4 "Strategies to keep girls in school and provide comprehensive sexuality education": Education confers higher knowledge about HIV and sexual and reproductive health and rights and leads to better health outcomes for young women and adolescent girls. It lowers exposure to gender-based violence and increases women's and girls' chances of being financially secure and independent. (p.21)

Other relevant global and regional commitments include the Programme of Action of the International Conference on Population and Development, the Maputo Protocol, and the Education 2030 Incheon Declaration.

SN/ED/2016/PI/H/1

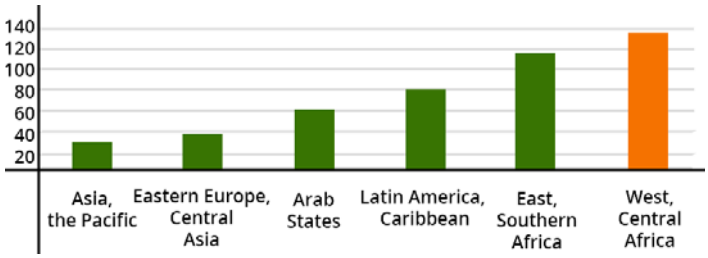
MAJOR HEALTH CHALLENGES CONTRIBUTING TO EDUCATION DISPARITIES

Considerable challenges remain with gender disparities widening in each cycle of the education system. Net enrolment ratios in secondary education across WCA are 37% for males and 30% for females (UNICEF, 2016). Early and unintended pregnancy, HIV infections and school-related GBV are among critical issues which hinder access to education and the academic success of students in the region.

1. Early and unintended pregnancy

In WCA two out of five young girls are married before the age of 18. It is also the region with the largest percentage (28%) of women between the ages of 20 and 24 who reported a birth before age 18, the largest percentage (6%) of reported births before age 15, and the highest unmet need for family planning among married (29.3%) and unmarried (41.7%) women aged 15 to 24 years old (MacQuarrie, 2014). Pregnancy-related complications are among the leading causes of death for girls aged 15 to 19 years old in Sub-Saharan Africa (WHO, 2016). Nearly all adolescent girls who have ever been pregnant are out of school in Sub-Saharan Africa (Birungi et al., 2015).

Adolescent birth rate per 1000. Women aged 15-19
Source: UNFPA (2015)



2. HIV and AIDS

Girls and young women are most at risk of exposure to HIV through sexual intercourse. In some WCA countries, HIV prevalence among them is as much as seven times that of their male counterparts. Only 33% of men and 22% of women aged 15 to 24 years old have comprehensive knowledge about HIV prevention (UNAIDS, 2015). Additionally, girls with no education are twice as likely to acquire HIV and do not seek help in cases of intimate partner violence, which also increases the risk of HIV exposure (UNAIDS, 2015).

3. School-related gender-based violence

Several reports on WCA draw attention to levels of school-related GBV (e.g. Devers et al., 2012; UNICEF et al., 2010), which is defined as acts or threats of sexual, physical or psychological violence occurring in and around schools. Boys are more likely to experience frequent and severe physical violence, while girls are at greater risk of sexual violence, harassment and exploitation, including student and teacher sexual assault, sexual harassment, and rape (UNGEI, 2012).

A lack of gender-sensitive sanitation measures and infrastructure to manage menstrual hygiene further affects the health, well-being, and success of girls at school.

THE ROLE OF THE EDUCATION SECTOR IN PROMOTING SRH

The education sector has a critical role to play in preparing children and young people to face SRH challenges through effective implementation of quality CSE programmes and to ensure that they all have access to safe, inclusive, health-promoting learning environments (UNESCO, 2016). There is clear evidence that CSE has a positive impact on SRH, notably contributing to a reduction in sexually transmitted infections, HIV and unintended pregnancy. CSE improves knowledge and self-esteem, changes attitudes and gender social norms, and builds self-efficacy. Contents on gender and rights, and access to a full range of high-quality, youth-friendly SRH services and commodities, makes it even more effective (UNESCO, 2015a; UNFPA, 2014).

In many countries, young people have their first sexual experiences while they are still attending school, making the setting even more important as a space to provide education on SRH. Schools provide a practical means of reaching large numbers of young people from diverse backgrounds in ways which are replicable and sustainable (UNESCO, 2009). Existing infrastructures and teachers make for very cost-effective CSE programmes. Besides, school authorities have the power to regulate many aspects of the learning environment to make it protective and supportive, and schools can also act as trusted institutions that can link children, parents, families and communities with other services such as health services (UNESCO, 2009).

BARRIERS IN IMPLEMENTING EFFECTIVE CSE PROGRAMMES

Despite clear and compelling evidence for these benefits, many children and young people in WCA are not given access to good quality CSE. There are many reasons for this, including resistance from parents, teachers or decision makers resulting from misunderstandings about the nature, purpose and effects of sexuality education. As regards the education sector itself, major barriers in the successful implementation of CSE programmes stem from shortcomings in sector-wide analysis and planning, teaching and learning, learning environments and coordination between sectors.

1. Vertical analysis and planning of health issues in education

There is increasing recognition that health and gender issues affect educational outcomes. Inspite of this, in cases where sector wide analysis shows that health or GBV have an important impact on education, the data is rarely taken into account when defining priorities for the sector. National governments need appropriate strategies to integrate CSE and responses to school-related GBV into education sector plans and to reduce gender disparities.

2. Gaps in teaching and learning

Analysis of curricula across the region shows that more needs to be done to integrate skills and critical thinking for young people to address SRH challenges. Beyond cultural taboos and social norms, large classes, rote learning and teachers' level of comfort with talking about sexuality all inhibit effective CSE delivery. Teachers are not be sufficiently trained to deliver CSE effectively.

3. Unsafe and unhealthy learning environments

Available evidence shows that gender-based emotional, physical or sexual violence occurs in and around schools in WCA, often with consequences for students' SRH and academic achievement, attendance or access to school. The curriculum itself can implicitly be a vector of violence and contribute to the environment by perpetuating stereotypes or harmful gender norms. Lack of safe water and sanitation facilities, inadequate teacher training, the absence of mechanisms to report abuse and a culture of impunity can also contribute to girls dropping out of school (UNESCO, 2014, 2015b).

4. Lack of coordination and partnerships between sectors

While the education sector has a key role to play it cannot address HIV, SRH and other issues affecting children and young people in isolation. Collaboration with other sectors is needed to address harmful gender norms, to ensure that children and young people have access to appropriate, quality and adolescent-friendly services, and to promote a supportive environment for CSE. However, there remains limited coordination between the education sector and other sectors including health, youth, child protection, social protection, justice, water and sanitation.

RECOMMENDATIONS

Education and health are two pillars of the demographic dividend that will better position WCA countries on the path towards economic development. For this to happen there is a need to enable young people to improve their SRH, promote gender equality and build healthy relationships, all of which can positively affect education outcomes.

1. Ensure that all children and young people benefit from good quality CSE

CSE is a critical intervention in efforts to end AIDS as an epidemic. Representatives of Ministries of Education and Health from 24 countries, regional economic communities, civil society, UN agencies and other development partners gathered in October 2015 and established a call for action to promote CSE in WCA. The following are some recommendations from this call.

Policy and planning. Technical assistance and capacity building should be provided for national education ministries to develop policies and plans that support CSE, safe and inclusive learning environments and school health. Training for policy makers, planners and managers is necessary to create an enabling environment for CSE programmes.

Teaching and learning. Ensuring that comprehensive curricula, including teaching and learning materials, are developed, that CSE is allocated adequate time in the school timetable, and that teachers are trained and supported to deliver it will be critical. More attention must be paid to ensuring that pre-service and in-service training provides teachers with the requisite active, student-centred pedagogical approach, and to assessing how they are delivering CSE in order to improve delivery. Furthermore, technology can facilitate new ways of teaching and learning, and some countries are already implementing internet-based sexuality education courses for educators and learners.

Strengthening partnerships between sectors. Education must be complemented by improving young people's access to friendly, non-judgmental, confidential SRH services which can provide appropriate advice, care and commodities, including free or affordable condoms and contraceptives to both married and unmarried adolescents. Collaboration between the education and health sectors is therefore essential. This issue was also emphasised elsewhere: working together, these two sectors 'have enormous potential to promote the good health and well-being of all individuals and communities and to prevent early and unintended pregnancy, transmission of HIV and other sexually transmitted infections'. (Eastern and Southern African Commitment on CSE and SRH Services for Adolescents and Young People, 2013).

Addressing cultural and religious resistance. Evidence suggests that many people who could deliver CSE are not convinced of the need to provide it, or are reluctant to. Educators or service providers may believe that sexuality education leads to early sex, deprives children of innocence, is against their culture or religion, is a role for parents or that parents will object. Meaningfully engaging key stakeholders including young people, teachers, communities and religious leaders is integral to addressing the challenges presented in implementing effective CSE programmes (UNESCO, 2010).

2. All children and young people have access to safe, inclusive, health-promoting learning environments

The education sector needs to adopt and implement measures to prevent and address school-related GBV. This entails improving codes of conduct for

educators and students, reviewing curricula, teacher training, and teaching materials, involving communities, creating mechanisms to report cases of violence and links with other services (health, justice, social protection), and creating spaces free of GBV. When implemented holistically, these measures promote gender equality and respectful relationships in the school setting.

3. Monitoring and Evaluation

Strengthening national monitoring and evaluation of the coverage, quality and impact of comprehensive sexuality education is important across these policy recommendations. This can be done by building the capacity of national Education Management Information Systems to use the guidelines for the construction and use of core indicators (UNESCO, 2013), which some countries already use in WCA. Relevant short-term and long-term global M&E indicators include:

Quantity and coverage – the percentage of schools that provide life-skills based HIV and sexuality education in the previous academic year; percentage of schools with teachers who received training, and taught lessons, in life skills-based HIV and sexuality education in the previous academic year;

Knowledge acquisition – percentage of students, aged 15-24, who demonstrate desired knowledge levels and reject major misconceptions about HIV and AIDS;

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Behavioural changes – percentage of young people, aged 15-24 years, who have had sexual intercourse before the age of 15; percentage of women and men, aged 15-49, who had more than one partner in the past 12 months who used a condom during their last sexual intercourse.

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This brief was prepared by Xavier Hospital and Christiana Kallon. The authors would like to thank Jenelle Babb, Gwang-Chol Chang, Mbarou Gassama, Hortense Gbaguidi, Patricia Machawira, Anandita Philipose, Eline Versluys and Akemi Yonemura for their critical review and invaluable input.