From Commitment to Action on Age appropriate, Context relevant and culturally appropriate Health education in Schools

Policy Brief

January,2022

PLAN INTERNATIONAL

FAWE Forum for African Women Educationalists
Forum des éducatrices africaines

SAT SRHR Africa Trust
GENDER EQUAL YOUTH HEALTH

FAWE Ethiopia Chapter

About the Programme

The **"Break Free!"** programme is an initiative of Plan International Netherlands, SRHR Africa Trust (SAT) and Forum for African Women Educationalists (FAWE) in collaboration with the technical partners 'The Royal Tropical Institute KIT' and 'Rozaria Memorial Trust' (RMT). It is a five-year program and started in January 2021. The Break Free! Programme will be implemented in nine countries in Africa as well as at the regional and continental levels. There will also be a component in The Netherlands.

The aim of the "Break Free!" Consortium is **to contribute to adolescents to exercise their right to live free from Teenage Pregnancy (TP) and Child Marriage (CM), supported by civil society.** The BF Program has three pathways of change leading towards the strategic programme objective:

- Pathway 1: **Adolescent girls at risk of CM/TP and FGM/C have access to quality education in a safer school environment with improved participation, retention and completion**
- Pathway 2: **Duty Bearers and decision makers at national and county level, review, resource and implement laws and policies that respond to adolescents' needs**
- Pathway 3: **Adolescent girls and boys access quality SRHR education, information and youth-friendly services.**

FAWE Ethiopia Chapter is the lead organization in Ethiopia implementing the program at the national level. As part of its implementation with the aim of providing evidence for lobby and advocacy events, after research has been conducted this policy brief has prepared to take action on Age appropriate, Context relevant and culturally appropriate sexuality and life skills education in Schools.

Executive Summary

Despite Ethiopia's remarkable progress in expanding access to education over the past two decades, adolescent and young people, particularly girls are impacted by SRH and gender related barriers that affect their health and education outcomes. Limited access to age appropriate, quality and contextualized education on puberty, SRH , gender and life skills exacerbates the dire situation. Young adolescents, especially those in rural areas, have limited access to timely information about puberty. Menstruation and menstrual management are sources of great anxiety for girls due to gendered social norms that conflate menstruation with female health, thus making it a highly stigmatized bodily function.

Studies indicated that adolescents are more likely to be sexually active outside of marriage, with significant implications for their access to SRH information and services. Amidst high rates of adolescent and youth pregnancy, many young women aged 15-24 face problems relating to unintended pregnancy resulting from pre-marital sex which is either voluntary or forced — and clandestine abortion. The higher abortion and pregnancy rates among sexually active adolescents suggest barriers to contraceptive access. Furthermore, adolescent girls vulnerability to all forms of Sexual and gender based violence including early marriage, FGM/C and socially accepted notions of masculinity regarding violence inhibit their access to, retention, transition and completion of their education. Although the government has taken several policy measures to address these challenges, implementation has been limited.

Thus, investing in educating children about puberty and engaging communities to accept the need for such education. Furthermore, adopting and integrating contextualized, age appropriate and culturally relevant life skills SRH and health education in the education curriculum and expanding access to and improving the quality of adolescent-friendly SRH services would be instrumental in reducing adolescents' exposure to pregnancy and sexually transmitted infections (STIs), and reducing the social barriers that affect adolescents health and education outcomes.

Background

Ethiopia has made remarkable progress in expanding access to education over the past two decades. With policy commitments made tangible by doubling the share of the budget allocated to education – to 27%, the government has tripled the number of primary schools across the country and the number of primary students climbs from only 3 million to nearly 21 million . However, significant hurdles remain if all Ethiopian adolescents are to access their right to a quality education. Dropout rates remain high, with only about half of young people completing grade 5 and enrolment rates at less than 10% in upper-secondary school i.e., 11th and 12th grades.

International policies, frameworks and bodies promote implementation of age-appropriate and culturally relevant health education by providing scientifically accurate, realistic, non-judgemental information . Health education is embedded in transnational commitments based on a Sexual and Reproductive Health Rights (SRHR) framework, as defined by organizations such as the United Nations Population Fund (UNPFA), the World Health Organization (WHO) and the International Planned Parenthood Federation (IPPF) . Recently endorsed international declarations and resolutions also calls for countries to give attention and commitments to adopt and to scale up scientifically accurate age- and culturally-appropriate health education. The UN General Assembly 2016 Political Declaration on HIV and AIDS on the Fast Track to Accelerating the Fight against HIV ending the AIDS Epidemic by 2030 and the Commission on the Status of Women 2016 Resolution on Women, the Girl Child and HIV and AIDS have put declarations on health education. Furthermore, under the Sustainable Development Goal (SDG), governments have agreed that achieving quality education for all and Goal 4 indicator 4.7.2 specifically focuses on health education for the purpose countries to assess the progress towards implementation of life skills-based HIV and health education in all schools .

Ethiopia has also taken key policy measures that call for integration of health education in schools. In the 2016-2020 National Reproductive Health Strategy, health education is outlined as one of the key strategic objectives, and seen as a means to promote SRH, including increasing understanding of the causes of

gender-based violence and developing attitudes to alleviate it. The Education Sector HIV&AIDS Policy and Strategy, as well as the Education Sector Development Program, acknowledge the importance of health education toward HIV prevention in preparing learners before they become sexually active . The FMoE has adopted 'life skills-based HIV and health education. Furthermore, equipping schools with the services, resources to foster a safe, healthy environment" is stated as a strategy under Component 6 of ESDP IV . The School Health and Nutrition Strategy (2012) also promotes provision of Skills based Health Education, fosters, skills based education including development of knowledge, attitudes, values, and life skills needed to make and act on the most appropriate and positive health-related decisions with respect to issues such as HIV and AIDS, early pregnancy, appropriate nutrition throughout the lifecycle, injuries, violence, and tobacco and substance use . Although these policy measures have been taken by the government, implementation has been limited. Recent studies and lessons learnt from implementation of adolescent and youth health and education programs indicate that limited access to age appropriate, quality and contextualized education on puberty, SRH, gender and life skills inhibits achievement of desired health and educational outcomes among adolescents and young people, particularly girls, in Ethiopia.

1-Ministry of Education (2018). Educational Statistics. Annual Ab- stract 2009 (2016/2017). Addis Ababa: MoE.
2- Pankhurst, A., T. Woldehanna, M. Araya, Y. Tafere, J. Rossiter, A. Tiumelissan, and K. Berhanu (2018) Young Lives Ethiopia: Lessons from Longitudinal Research with Children of the Millennium, Country Report. Oxford: Young Lives

3 - UNESCO. 2016. Review of the Evidence on Sexuality Education. Report to inform the update of the UNESCO International Technical Guidance on Sexuality Education; prepared by Paul Montgomery and Wendy Knerr, University of Oxford Centre for Evidence-Based Intervention. Paris, UNESCO". Accessed from: http://gem-report-2016.unesco.org/en/home/: Accessed on November 2021.
4 - Rahil Roodsaz (2018) Probing the politics of comprehensive sexuality education: 'Universality' versus 'Cultural Sensitivity': a Dutch–Bangladeshi collaboration on adolescent sexuality education, Sex Education, 18:1, 107-121, DOI: 10.1080/14681811.2017.1403894: Accessed from: https://doi.org/10.1080/14681811.2017.1403894; Accessed on November 2021.

5 - UNITED NATIONS 2016a. Commission on the Status of Women, Report on the sixtieth session (20 March 2015 and 14-24 March 2016), Economic and Social Council, Official Records, Economic and Social Council, Supplement No. 7. New York. (Accessed on October 2021).

6 - The 17 Goals - Sustainable Development Goals (SDGs). Accessed from: : https://sdgs.un.org/goals. (Accessed on November 2021)

7 - ibid
8 - Federal Ministry of Education. 2010. Addis Ababa. Education Sector Development. Program IV (ESDP IV). 2010/2011 – 2014/2015. 2003 EC – 2007 EC.
9 - Federal Democratic Republic of Ethiopia, Ministry of Education, October 2012. National School Health and Nutrition strategy

The Problem

- ***Limited access to timely and quality information and education about puberty inhibit adolescents and young people's educational outcomes:*** Puberty education – and support for menstrual management – remains limited in Ethiopia. Adolescent girls in particular receive limited information/advice about puberty, menstruation and menstrual hygiene. Of the younger adolescents taking part in GAGE research, only 50% of rural younger adolescents reported having a source of information about puberty, compared with 64% of their urban peers . The onset of puberty poses a risk to a girls' school attendance given that a reported 15% of girls and young women have missed school because of menstruation . In schools, classes on menstruation are primarily offered at the upper-primary level, by which time some students will have already reached puberty and many will have already dropped out of school. In addition, only 40% of primary schools have access to water to support menstrual hygiene and hand-washing, only 12% have a menstruation pad bin, and a mere 8% have a room that girls can use to change sanitary products in private . Overall, while there is evidence of recent change in urban areas, in much of Ethiopia menstruation remains a taboo topic; girls report fear of menarche (first occurrence of menstruation) because they believe their caregivers will see it as a sign of sexual activity or readiness for marriage. In general, menstruation remains stigmatized and puberty remains a marker of marriageability . Young adolescents, especially those in rural areas, have limited access to timely information about puberty. Menstruation and menstrual management are sources of great anxiety for girls due to gendered social norms that conflate menstruation with female health, thus making it a highly stigmatized bodily function .

- ***Limited access to contextualized and age appropriate health and life skills education in schools contributes to undesired SRH and educational outcomes among adolescents and young people:*** Studies indicated that adolescents are more likely to be sexually active outside of marriage. While the 2011 EDHS found that the median age at first marriage and the median age at first sex were nearly the same for women aged 25– 49 (16.6 years and 16.5 years respectively), the 2016 EDHS found that women were sexually active for six months before they are married. This has significant implications for adolescents'

access to SRH information and services . While 10% of girls are married by 15, 24% have experienced their first sexual intercourse by that age. Sixty-two percent experience it before age 18 and 76% by age 20 .

Amidst high rates of adolescent and youth pregnancy, many young women aged 15-24 face problems relating to unintended pregnancy — resulting from pre-marital sex which is either voluntary or forced — and clandestine abortion. After adjusting for levels of sexual activity, adolescents have the highest rate of abortion among all age groups (19.6 per 1,000 women) as well as the highest proportion of legal abortions compared to other age groups . The higher abortion and pregnancy rates among sexually active adolescents suggest barriers to contraceptive access. The most recent GAGE survey found that only 25% of younger rural adolescents were typically able to correctly identify any contraceptive method compared to 31% among urban respondents. In terms of disease transmission, 0.2% of young people aged 15-24 are HIV-positive. In this age group, HIV prevalence is three times higher for girls than boys (0.3% versus 0.1% respectively) . Some of the reasons for this disparity are low knowledge levels related to HIV/AIDS, power imbalances in sexual relationships, sexual violence and sex work or commercial sexual exploitation.

- ***Adolescent girls vulnerability to all forms of Sexual and gender based violence including early marriage , FGM/C and socially accepted notions of masculinity regarding violence – at home, in the community and at school; inhibit their access to , retention, transition and completion of education:*** Sexual and gender-based violence (SGBV) against adolescents , including harmful practices such as child marriage and female genital mutilation/cutting (FGM/C), as well as harassment and rape is prevalent in Ethiopia . The latest Ethiopia Demographic and Health Survey (DHS) data shows that 40% of women were married before the age of 18 and 6% of girls aged 15–19 were married before the age of 15. Recent findings from GAGE surveys also showed that 68% of young adolescents (10-12 years old) experience or witness violence in the home. In schools, 78% of boys report having experienced corporal punishment compared to 66% of girls. However, both boys and girls agree that when girls are

punished, it is more likely to be for things beyond their control such as making mistakes in the classroom or arriving late due to household duties. Outside of school, peer violence is not uncommon. Nearly half (46%) of younger adolescents have experienced peer violence in the last year, and boys are more likely to have been bullied than girls (52% versus 39%). Some 4% of girls age 15-19 report having experienced sexual violence. Girls who experience sexual violence have limited resources, and often fear telling their families out of concerns about being blamed for the violence or retaliation from perpetrators or family members . In a study of 764 secondary school girls in Eastern Ethiopia, 68% had experienced at least one instance of sexual violence victimization. By type of perpetration 52% had been victimized by least one instance of sexual offense, 56% by sexual assault, 25% by sexual coercion and 15% by sexual aggression . In a study of 10,080 adolescents and young people in seven regions of Ethiopia, 33% of sexually experienced females reported that their first sex was coerced or forced, including due to use of threats, violence, being given money or gifts or the partner not taking 'no' for an answer.

10 - Jones, N., Presler-Marshall, E., Baird, S., Hicks, J., Emirie, G., Yadete, W., Alemayehu, Y., Bekele, B. and Kifle, E. (2019) . Adolescent health, nutrition, and sexual and reproductive health in Ethiopia , Baseline Report Series, May 2019
11 - National Adolescent and Youth Health Strategy: Baseline Statistics (Rep.). (2017). Addis Ababa: Ethiopia Ministry of Health.
12 - Ministry of Education (2018) Ethiopian Education Development Roadmap (2018–30). Ministry of Education: Addis Ababa
13 - Jones, N., Tefera, B., Emirie, G., Yadete, W., Gezahegne, K., Tilahun, K., & Birhanu, K. (2017). Exploring Ethiopian adolescents' gendered experiences and perspectives (Rep.). London: GAGE.
14 - Jones, N., Presler-Marshall, E., Baird, S., Hicks, J., Emirie, G., Yadete, W., Alemayehu, Y., Bekele, B. and Kifle, E. (2019) . Adolescent health, nutrition, and sexual and reproductive health in Ethiopia , Baseline Report Series, May 2019
15 - Jones, N., Presler-Marshall, E., Baird, S., Hicks, J., Emirie, G., Yadete, W., Alemayehu, Y., Bekele, B. and Kifle, E. (2019) . Adolescent health, nutrition, and sexual and reproductive health in Ethiopia , Baseline Report Series, May 2019
16 - Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF
17 - Sully, E., Dibaba, Y., Fetters, T., Blades, N., & Bankole, A. (2018). Playing it Safe: Legal and Clandestine Abortions Among Adolescents in Ethiopia. Journal of Adolescent Health, 62(6), 729–736. doi: 10.1016/j.jadohealth.2017.12.015
18 - Jones, N., Presler-Marshall, E., Baird, S., Hicks, J., Emirie, G., Yadete, W., Alemayehu, Y., Bekele, B. and Kifle, E. (2019) . Adolescent health, nutrition, and sexual and reproductive health in Ethiopia , Baseline Report Series, May 2019
19 - HIV Prevention in Ethiopia National Road Map 2018 - 2020 (Rep.). (2018). Addis Ababa: Federal HIV/AIDS Prevention and Control Office
20 - Pankhurst, A., T. Woldehanna, M. Araya, Y. Tafere, J. Rossiter, A. Tiumelissan, and K. Berhanu (2018) Young Lives Ethiopia: Lessons from Longitudinal Research with Children of the Millennium, Country Report. Oxford: Young Lives.

21 - Jones, N., Presler-Marshall, E., Baird, S., Hicks, J., Emirie, G., Yadete, W., Alemayehu, Y., Bekele, B. and Kifle, E. (2019) Adolescent bodily integrity and freedom from violence in Ethiopia. A report on GAGE Ethiopia baseline findings. London: Gender and Adolescence: Global Evidence

22 - Bekele, A. B., Aken, M. A. G. V., & Dubas, J. S. (2011). Sexual Violence Victimization Among Female Secondary School Students in Eastern Ethiopia. Violence and Victims, 26(5), 608–630. doi: 10.1891/0886-6708.26.5.608

23 - Erulkar A, Ferede A, Ambelu W, et. al. 2010. "Ethiopia Young Adult Survey: A Study in Seven Regions," Addis Ababa: Population Council and UNFPA, September, 2019.

Recommendations

o **Invest in educating children about puberty and engage communities to accept the need for such education:** Age-tailored puberty education classes that begin with younger children need to be provided in school-based and other community settings, alongside classes for parents that help them address children's questions and concerns, while also ensuring that their own knowledge is accurate. Given the powerful role that community and religious leaders play in shaping gendered social norms, it is critical to secure parental and community buy-in to educating children about puberty.

o **Adopting and integrating contextualized, age appropriate and culturally relevant life skills SRH and health education in the education curriculum:** Lessons learned from a decade of implementation of health education programs, indicate that barriers to health education program implementation can be averted if the programs are adapted to the socio-cultural context of countries and relevant structures for promotion of advocacy for programs are in place. Equally, important is inclusion of ample participation by communities and families - particularly adolescents, young people, civil society and other community structures including faith-based organizations during design and delivery of health education and SRH programs. Communities and parents need to be actively engaged in the design and delivery of SRH, health education and life skill programs in schools.

o **Continued dialogue between actors and stakeholders for follow up and adaptation:** The government actors need to table repeated dialogues between actors and institutions at various levels to gain conceptual clarity on topics to be included in the SRH and health education curriculum, to revise to ensure that the content and delivery approaches are aligned with, and support the government health and education policy, and are incongruent with the most pressing concerns of its people, such as the norms and values that denigrate or belittle religious beliefs or values regarding sex, gender or sexuality. The continued dialogue would also be helpful to identify and exclude

the most sensitive issues such as sexual diversity, discussion of non-marital sexual relationships and sexual pleasure, and ensure inclusion of locally embedded approaches to health education and topics tailored to fit to the socio-cultural or religious affiliations of the country and that specifically emphases the health benefits to young people.

o **Expand access to and improve the quality of adolescent-friendly SRH services:** To reduce adolescents' exposure to pregnancy and sexually transmitted infections (STIs), stakeholders should take a multi-pronged approach that includes delaying sexual debut (to allow for cognitive and emotional maturity), better access to condoms, improved education and services on STIs (especially HIV), and reducing the social barriers (e.g. stigma, shame, and restrictive gender norms) that reduce contraceptive uptake.

FAWE Contact details
W/ro Roman Degefa, Executive Director

Tel: 011-667 6645
Mobile: 0911 453554
P.O. Box : 20882 code 1000
E-mail: romandegefa@gmail.com
Website: faweethiopia.com
Skype: fawe.ethiopia1994

10 Sisters Building, 3rd Floor
Gurd Shola, Next to Atletics Building
Addis Ababa, Ethiopia

FAWE
Ethiopia Chapter

FAWE-Ethiopia is one of the FAWE 34 National Chapters established in 1994 just after 2 years of the founding of FAWE- Regional Secretariat (FAWE-RS). It is registered and licensed as NGO by MoJ in 2003 and re-registered as Ethiopian Residents Charity Organization in 2010 by The Ethiopian Charities & Civil Society Organizations Agency. It was re-registered by the new Ethiopian law with a registration number of 0626 on July 1, 2019.