COMPREHENSIVE SEXUALITY EDUCATION:
THE CHALLENGES AND OPPORTUNITIES OF SCALING-UP

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ACRONYMS

AHI	Action Health Incorporated
AIDS	Acquired Immunodeficiency Syndrome
AMREF	African Medical and Research Foundation
ASRHR	Adolescent Sexual Health and Rights
BZgA	German Federal Centre for Health Education
CfBT	Centre for British Teachers
CSE	Comprehensive Sexuality Education
DFID	Department for International Development (UK)
FHI	Family Health International
FLEHI	Family Life and Emerging Health Issues
FLHE	Family Life and HIV Education
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HALIRA	Health and Lifestyles Research Programme
HIV	Human Immunodeficiency Virus
IATT	Inter-Agency Task Team
ICPD	International Conference on Population and Development
ILO	International Labour Organization
IPPF	International Planned Parenthood Federation
ITGSE	International Technical Guidance on Sexuality Education
KIE	Kenya Institute of Education
MDG	Millennium Development Goal
MkV	MEMA kwa Vijana (Tanzania)
MoE	Ministry of Education
MoH	Ministry of Health
NACO	National AIDS Control Organization
NGO	Non-Governmental Organization
OVEC	Office of the Vocational Education Commission (Thailand)
PAHO	Pan American Health Organization
PATH	Programme for Appropriate Technology in Health
PSABH	Primary School Action for Better Health
SE	Sexuality Education
SIECUS	Sexuality Information and Education Council of the United States
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YP	Young people

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EXECUTIVE SUMMARY

Despite significant investment and programmatic interventions, levels of HIV prevention knowledge among young people have changed relatively little. This is particularly the case in countries that are most affected by HIV and AIDS. Comprehensive sexuality education is a long way from being institutionalized in most low- and middle-income countries where the HIV epidemic poses a disproportionate burden. Even in countries with the highest HIV rates, there are relatively few examples of scaled-up, sustainable programmes within educational curricula. Existing generations of schoolchildren are not receiving the information they need for their healthy development. Unless things change, future cohorts of children will be similarly disadvantaged.

Although there is an increasing body of evidence underpinning arguments about the need for in-curriculum sexuality education programmes and their effectiveness in improving knowledge and some reported behaviours, there is less clarity about how to implement these programmes and how to scale them up in diverse contexts. Good quality sexuality education needs to be delivered at scale on a sustained basis to make a significant impact, and it needs to become institutionalized within national systems of education.

Coverage alone is not a sufficient measure of scaling-up. The quality of programmes offered is critical if young people are to gain the knowledge they need, as well as the skills and values necessary to prevent HIV and lead healthy and fulfilling lives. Institutionalization of sexuality education on a sustained basis is a key contributor to social change by influencing social and gender norms, which may ultimately benefit not only population-level public health indicators, but crucially the well-being and development of adolescents.

The lack of focus on scaling up these programmes is taking its toll. Interviewees for this report expressed frustration about the proliferation of pilot projects – so-called 'islands of success' – that have little chance of being scaled up or adopted nationally. These pilot projects typically draw down greater resources than is affordable on a larger scale. This inevitably leads to inequities that benefit some regions or schools while leaving others neglected.

The United Nations Educational, Scientific and Cultural Organization (UNESCO) convenes the education sector response to the HIV epidemic within the Joint United Nations

Programme on HIV/AIDS (UNAIDS) Division of Labour. Central to the response is the need to develop adequate levels of HIV prevention knowledge among children and young people through schools and other education programmes.

This report builds on a programme of work on sexuality education for young people initiated in 2008 by UNESCO. It is also informed by several other past and ongoing initiatives related to scaling up sexuality education, as well as drawing on case studies presented at the Bogota international consultation on sexuality education, convened by UNFPA in 2010.

The report emphasizes the challenges for scaling-up in terms of integrating comprehensive sexuality education into the formal curricula of schools. It aims to:

- Provide conceptual and practical guidance on definitions and strategies of scaling-up, given the specificities of sexuality education.
- Illustrate good practice and pathways for successful scale-up in light of diverse contextual parameters.
- Provide some principles of scaling up sexuality education that are of relevance internationally.

Methods

Research for the report included a review of the published literature and relevant publications by international organizations on sexuality education as well as country-specific material. The author also drew on extensive semi-structured interviews with international and national experts. In all, 21 experts working for UN agencies, non-governmental organizations (NGOs) and research institutions were interviewed, in addition to 11 UNESCO staff dedicated to HIV at headquarters and regional level.

Documentation about particular scaling-up experiences in sexuality education was collected for a variety of countries from different regions of the world. Six case studies were chosen for in-depth analysis – Finland, Kenya, Nigeria, Tanzania, Thailand and Uruguay. Together they provide contrasting contexts and exemplify the challenges of scaling up sexuality education in these different contexts. Examples from other countries are provided in the text.

The perspective taken in this report is a national and long-term one. Rather than focusing on what individual governments or organizations can do to contribute to scaling up, the question being addressed is what can be done at a national level, with multiple players working together, to promote scaling-up of sexuality education that is sustainable over the long term, and is not limited by donor timeframes or funding.

This report is divided into four major sections. The first section discusses different conceptual approaches for analysing scaling-up generally and sexuality education specifically. The second section focuses on strategies of scaling-up. The third section summarizes the report by providing ten basic principles of scaling up sexuality education and implications for the players involved. Finally, the fourth section includes six country case studies of programmes in Finland, Kenya, Nigeria, Tanzania, Thailand and Uruguay that have been deliberately scaled up.

Conclusions

Based on the literature reviewed and the insights provided by the interviews on sexuality education and scaling-up, ten key principles for scaling up sexuality education have been identified:

1. Choose an intervention/approach that can be scaled up within existing systems.
2. Clarify the aims of scaling-up and the roles of different players and ensure local/national ownership/lead role.
3. Understand perceived need and fit within existing governmental systems and policies.
4. Obtain and disseminate data on the effectiveness of pilot programmes before scaling up.
5. Document and evaluate the impact of changes made to interventions on programme effectiveness.
6. Recognize the role of leadership.
7. Plan for sustainability and ensure the availability of resources for scaling up or plan for fundraising.
8. Plan for the long term (not donor funding cycles) and anticipate changes and setbacks.
9. Anticipate the need for changes in the 'resource team' leading the scaling-up process over time.
10. Adapt the scaling-up strategy with changes in the political environment; take advantage of 'policy windows' when they occur.

The author concludes that institutionalizing sexuality education within schools is not only cost effective but it is a right of current and future cohorts of young people. However, scaling-up requires a plan and a methodology, including a budget and a division of roles and responsibilities. Moreover, scaling-up needs to incorporate strategies for garnering and sustaining political commitment over time, as well as for building implementation capacity.

The consultation concludes that a lack of planning (including budgeting) for coordination across players — 'bringing the diverse pieces of the puzzle' together – has been the main obstacle to scaling-up. Governments with a pro-active scaling-up strategy that are

committed to institutionalizing sexuality education and ensuring it is delivered appropriately at scale should be in the driving seat, rather than being subject to the diverse agendas of different interest groups (including funders). This would ensure that all players conform to national priorities developed through partnership with key stakeholders, including young people themselves.

INTRODUCTION

Background

There are strong arguments for investing in and implementing comprehensive sexuality education programmes and for scaling these programmes up. According to the 2011 UN Millennium Development Goals Report (UN, 2011), nearly 23 per cent of people living with HIV globally are under the age of 25. Young people aged from 15 to 24 account for 41 per cent of new infections among those aged 15 and older. Women represented a slight majority (about 51 per cent) of people living with HIV in 2009.

There is evidence about the importance of sexuality education in terms of preventing unintended pregnancy and pregnancy at an early age (WHO, 2011). The World Health Organization (WHO) convened an international consultation on this topic that concluded that comprehensive sexuality education should be expanded in order to provide accurate information and education about contraceptives to adolescents (WHO, 2011).

Sexuality education offers protection against unintended pregnancy and prevents sexually transmitted infections (STIs), including HIV and AIDS. These are the key health outcomes on which many programmes are focused. However, if taught appropriately, curriculum-based sexuality education can also help young people to develop communication skills, as well as enhancing their self-esteem and capacities in making decisions. It can also help them to forge positive and equitable relationships (Gordon, 2007).

There is growing awareness about the importance of sexuality education in terms of increasing gender equality and reducing gender-based violence, as well as its critical role in contributing to young people's development and evolving capacities (Rogow and Haberland, 2005). As citizens, young people have a right to this education and internationally they are becoming increasingly vocal in claiming this right.

Sexuality education also acts at a broader social level, with the potential to change social norms by influencing adults (for example, teachers and parents), the social environment and subsequent generations of young people.

There is an increasing body of evidence underpinning arguments about the need for in-curriculum sexuality education programmes and their effectiveness in terms of improving knowledge and some reported behaviours. However, there is less clarity about how to implement these programmes and how to scale them up in diverse contexts. To achieve the goals mentioned above, good quality sexuality education needs to be delivered at scale on a sustained basis. It needs to become institutionalized within national systems of education.

Schools and the educational process offer the best possibility of reaching a large number of young people with knowledge, skills and values that will stay with them when they leave school. Moreover, educational enrolment is increasing worldwide. Children and young people of school-going age (typically 5 to 18) are expected to attend school every day. Most students are at least in primary school before they become sexually active (Mavedzenge, Doyle and Ross, 2010). WHO argues that schools are a critical venue for education on health-related issues, for improving health outcomes (in terms of imparting health-promoting knowledge and skills) and for providing opportunities for referrals to health services (WHO, 2009).

Within the Joint United Nations Programme on HIV/AIDS (UNAIDS) Division of Labour, the United Nations Educational, Scientific and Cultural Organization (UNESCO) convenes the education sector response to the HIV epidemic. Central to the response is the need to develop adequate levels of HIV prevention knowledge among children and young people through schools and other education programmes. This report builds on a programme of work on sexuality education for young people initiated in 2008 by UNESCO with the following main priorities:

- ◢ Development of international standards on sexuality education, which resulted in the *International Technical Guidance on Sexuality Education: An evidence-informed approach for schools, teachers and health educators (Volume I and II)* (UNESCO, 2009).
- ◢ Documentation of good practice examples of sexuality education programmes, which resulted in the publication of *Levers of Success: Case studies of national sexuality education programmes* (UNESCO, 2010).
- ◢ Assessing the cost and cost-effectiveness of school-based sexuality education programmes, which analysed the costs of different scale-up scenarios and recommended strategies for expansion of school-based sexuality education (UNESCO, 2011).
- ◢ Convening an international technical consultation on scaling up sexuality education in March 2012 leading to this report, which provided the basis for discussion to identify the challenges, opportunities and pathways to scaling up school-based sexuality education in different socio-cultural and epidemiological contexts.

Scope and aims

This report coincides with and is informed, where possible, by several other past and ongoing initiatives related to scaling up sexuality education. These include work by the International Planned Parenthood Federation (IPPF) on scaling up advocacy for comprehensive sexuality education; various curriculum guidance documents including *It's All in One Curriculum*, which has been translated and used in a number of countries; a review by the United Nations Population Fund (UNFPA) on sexuality education; as well as the newly developed *Standards for Sexuality Education in Europe* by WHO and the German Federal Centre for Health Education (WHO/BZgA, 2010). This report also draws on the case studies presented at the Bogota international consultation on sexuality education, convened by UNFPA in 2010.

The focus of this report is not on reaching out-of-school youth with information and education, either through their peers or through adults. Rather, it emphasizes the challenges for scaling-up in terms of integrating comprehensive sexuality education into the formal curricula of schools. The logic of this focus is two-fold. First, it reflects the comparative advantage of UNESCO in this area, building upon the above programme of work. Second, there is considerable research (for example, Ross, Dick and Ferguson, 2006; Mavedzenge, Doyle and Ross, 2010) showing that the evidence on HIV prevention strongly supports curricula-based, adult-led sexuality education, when combined with other types of prevention interventions. Finally, there are now strong arguments that scaling up through the formal curricula of schools is the best and most cost-effective way of mainstreaming sexuality education (for example, UNESCO, 2011).

Specifically, this report focuses mainly on:

- education offered within the public sector,
- school-based activities around the curriculum,
- primary and secondary educational levels.

This focus does not intend to ignore the often considerable contributions of tertiary education institutions, for example, in assisting the scaling-up of school-based sexuality education at lower levels of education. Links with health services for adolescents have been a necessary complement to scaling up sexuality education.

However, this report aims to:

- Provide conceptual and practical guidance on definitions and strategies of scaling-up, given the specificities of sexuality education.

- Illustrate good practice and pathways for successful scale-up in light of diverse contextual parameters.
- Provide some principles of scaling up sexuality education that are of relevance internationally.

The report starts from the premise that there is no single trajectory or magic bullet for scaling up sexuality education, but that good practice should be informed by an analysis of approaches that have been used in a range of countries and contexts and the challenges they have faced.

Methods

Research for this report included a review of relevant publications by international organizations on sexuality education. A search was then undertaken of the following:

1. The published and unpublished literature on the search term 'scaling-up' in development, public health and education broadly in the field-specific electronic databases.
2. The published and unpublished literature on scaling up sexuality education specifically, using electronic database search engines and internet sources.

The report also drew on extensive semi-structured interviews with international and national experts. These individuals were identified from the literature review and by UNESCO programme staff working on sexuality education internationally and regionally. Initial consultations occurred with UNESCO programme staff in November 2011 in Paris and subsequently with UNESCO regional advisors by telephone. In addition, interviewees were asked to identify other relevant individuals for interview. Interviews were conducted by telephone or Skype and lasted between half an hour and one hour each. In all, 21 experts working for UN agencies, non-governmental organizations (NGOs) and research institutions were successfully interviewed, in addition to 11 UNESCO staff dedicated to HIV at headquarters and regional level (see Appendix 1).

Documentation about particular scaling-up experiences in sexuality education was collected for a variety of countries from different regions of the world. However, due to limitations of time and available documentation, six case studies were chosen for in-depth analysis – Finland, Kenya, Nigeria, Tanzania, Thailand and Uruguay. It should be noted at the outset that these examples were selected because their deliberate scaling-up has useful lessons for other countries that are aiming to scale up sexuality education. They were also chosen because sufficient documentation was available in English about the scaling-up strategies adopted. Together they provide contrasting contexts and exemplify the challenges of scaling

up sexuality education in these different contexts. Examples from other countries are provided in the text.

The perspective taken in this report is a national and long-term one. Rather than focusing on what individual governments or organizations can do to contribute to scaling-up, the question being addressed is what can be done at a national level, with multiple players working together, to promote scaling-up of sexuality education that is sustainable over the long term, and is not limited by donor timeframes or funding.

This report is divided into four major sections. The first section discusses different conceptual approaches for analysing scaling-up generally and sexuality education specifically. The second section focuses on strategies of scaling-up. The third section summarizes the report by providing ten basic principles of scaling up sexuality education and implications for the players involved. Finally, the fourth section includes six country case studies of programmes in Finland, Kenya, Nigeria, Tanzania, Thailand and Uruguay that have been deliberately scaled up.

I. CONCEPTUALIZING AND DEFINING SCALING-UP

The need for scaling-up and the rationale behind 'designing for scale'

Despite significant investment and programmatic interventions, levels of HIV prevention knowledge among young people have changed relatively little. This is particularly the case in countries that are most affected by HIV and AIDS (UN, 2011). Comprehensive sexuality education is a long way from being institutionalized in most low- and middle-income countries where the HIV epidemic poses a disproportionate burden. Even in countries with the highest HIV rates, there are relatively few examples of scaled-up, sustainable programmes within educational curricula. Existing generations of schoolchildren are not receiving the information they need. Unless things change, future cohorts of children will be similarly disadvantaged.

As discussed below, coverage alone is not a sufficient measure of scaling-up. The quality of programmes offered is critical if young people are to gain the knowledge they need, as well as the skills and values necessary to prevent HIV and lead healthy and fulfilling lives. Institutionalization of sexuality education on a sustained basis is a crucial contributor to social change by influencing social and gender norms, which may ultimately benefit not only population-level public health indicators, but crucially the well-being and development of adolescents.

The lack of focus on scaling up these programmes is taking its toll. Interviewees for this report expressed frustration about the proliferation of pilot projects – so-called 'islands of success' – that have little chance of being scaled up or adopted nationally. These pilot projects typically draw down greater resources than is affordable on a larger scale. This inevitably leads to inequities that benefit some regions or schools while leaving others neglected.

Although the process of piloting an intervention on a smaller scale is a critical component of any scaling-up strategy (see ExpandNet/WHO, 2011), pilot projects with no scale-up strategy have limited usefulness, as will be discussed below. As one commentator (formerly

affiliated with the Primary School Action for Better Health (PSABH) Programme in Kenya) said, there is a need for 'designing for scale' from the start. This reinforces the recommendations made by researchers on a WHO-initiative on scaling up programmes in sexual and reproductive health.[1] They argue for "beginning with the end in mind" (ExpandNet/WHO, 2011). Programme staff or researchers need to design pilot programmes that incorporate pathways towards scaling up. All six case studies presented in this report provide examples of settings where achieving national scale and institutionalization within governmental systems was the intention from the beginning.

The lack of attention to scaling-up and the proliferation of pilot projects are due to an inter-related set of factors, including the short-term horizon of international donors and the lack of commitment or capacity by governments. In many countries, governments have not yet been fully convinced of the value and benefits of sexuality education and therefore do not make serious efforts to take it to scale. International donors reinforce a short-term, project focus by setting expectations of results and impact in projects with very short timeframes that do not adequately consider the prerequisites for scaling-up. Pilot programmes with little chance of national scaling-up are often introduced by NGOs. However, often there is little focus by either the NGOs or their funders on handover to government authorities for long-term sustainability and scale. NGOs also often pride themselves on their community responsiveness and participatory approaches that are best achieved at a micro level. They frequently lack the funding and capacity to deliver larger-scale programmes.

Renju *et al.*, writing about an experience of scaling up sexuality education in Tanzania, are critical of what they describe as pervasive donor dependence and project mentality (Renju *et al.*, 2011). Researchers also tend to focus on analysing the effectiveness of small-scale projects for reasons of feasibility and the timeframe of funding.

The evidence base on scaling up sexuality education

A significant amount of evidence now exists to argue for school-based sexuality education for HIV prevention in terms of conveying information and developing skills among young people. Two systematic reviews (Ross, Dick and Ferguson, 2006; Mavedzenge, Doyle and Ross, 2010) summarize the available evidence on the effectiveness of sexuality education.

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1   See www.expandnet.net for more details.

The 2006 review, which covered developing countries, recommended adult-led interventions that include the so-called 'Kirby characteristics' (Kirby, 2005) about effective sexuality education, with or without the involvement of peers.

The 2010 review focused on sub-Saharan Africa and reinforced this finding. However, it also added a word of caution: recent trials that assessed the impact of school-based interventions on biological outcomes have not shown an impact in terms of reduction in HIV incidence, STIs or early pregnancies, despite beneficial effects on knowledge and some reported behaviours (Mavedzenge, Doyle and Ross, 2010). This evidence suggests that sexuality education is necessary for effective HIV prevention but needs to be combined with other interventions, including accessible and youth-friendly health services.

There is now, however, an accumulation of studies showing that school-based sexuality education is effective in improving young people's knowledge and some reported sexual risk behaviours (see, for example, Kirby, Laris, Rolleri *et al.*, 2007; Kirby, Obasi and Laris, 2006). Nevertheless, as Mavedzenge, Doyle and Ross point out in their systematic review of interventions to prevent HIV in sub-Saharan Africa (Mavedzenge, Doyle and Ross, 2010), limitations in the knowledge base remain. Relatively few studies have assessed long-term impact (which is both expensive and methodologically challenging). Moreover, reported sexual risk behaviour is subject to reporting biases and this is likely to be the case for unmarried adolescents in particular (see Plummer *et al.*, 2004; Mavedzenge, Doyle and Ross, 2010). More studies are needed to assess the impact of scaled-up sexuality education combined with other adolescent sexual and reproductive health interventions that include biological outcomes such as HIV, other STIs or unwanted pregnancy.

From the point of view of scaling up, there are two further limitations in the existing knowledge base. First, the studies to date are much more numerous in well-off countries than in low- and middle-income countries. Few are adapted to low-resource implementation settings. Second, many studies are based on small-scale, controlled settings. While this evidence is critical to inform which interventions to invest in over the long term, there is much less evidence on effectiveness in terms of behavioural change, reduction of HIV or other sexual and reproductive health indicators of scaled-up programmes as opposed to small-scale interventions.[2] As a recent article on implementation challenges to sexuality education programmes in the US states:

> While sex education curricula are developed and evaluated under ideal conditions, their implementation occurs in real-world settings in which the conditions such as location, programme exposure and student exposure, vary. Anecdotal reports suggest that many community organizations adapt curricula ...

2 Telephone interview with Doug Kirby, 23 February 2012.

presenting a challenge, because for science-based programmes to maintain their effectiveness, adaptations need to be made without compromising the core content, pedagogy, or implementation." (Ott *et al.*, 2011, p. 170)

Spontaneous changes made as programmes are adapted to diverse contexts need to be evaluated for their effects on programme fidelity, quality and effectiveness. Mixed research methods are needed to study the many domains, processes and levels. There needs to be a stronger focus on programme content and delivery, supporting long-term effects relating to a variety of outcomes and linkages between education and health services.

There is relatively limited published literature available in English about the specifics of scaling up sexuality education.[3] Scaling-up processes for school-based sexuality education themselves have not been the subject of extensive research. Most evaluations of sexuality education focus on the content, outcomes or effectiveness, rather than processes of implementation (Renju *et al.*, 2011). Even in the case of Europe, with its long history of sexuality education in different forms, experts note that much of the documentation is in diverse languages and is therefore not necessarily accessible to an international audience.[4] Detailed process evaluations are not always readily available as published documents.

The lack of published literature, however, does not indicate a lack of expertise and experience on these issues. As a much earlier report on skills for health by WHO makes clear, existing materials that have been evaluated need to be distributed, disseminated and used more effectively to avoid 'reinventing the wheel' (WHO 2003). More explicit focus by international organizations and by research institutions to encourage documentation of these experiences would facilitate international sharing of the lessons learned.

The team that designed the MEMA kwa Vijana trial in Tanzania calls for an international repository of materials to help teams that do not have the resources to document such experiences and to make these evaluations available internationally (Plummer *et al.*, 2011). The current report also represents a step in that direction.[5]

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3 Some notable exceptions include the WHO initiative, coordinated by Dr Ruth Simmons, that culminated in a series of publications available on the ExpandNet website, as well as case studies of scaling up captured in the case studies in this report.

4 Telephone interview with Evert Ketting, 29 November 2011.

5 See the Interagency Youth Working Group as one source of information on youth adolescent sexual and reproductive health (http://www.iywg.org/).

Scaling-up in development, public health and education literature

The literature on scaling up development and public health interventions is relatively new and limited (see Mills and Hanson, 2003; Mangham and Hanson, 2010). As noted, much of it has focused on the content of interventions in specific fields, rather than the process of scaling-up (Simmons *et al.*, 2007).[6] Although these two elements are closely related, each deserves analysis in its own right. Moreover, authors writing on scaling-up often use different definitions of the term, adding to conceptual confusion. Part of the confusion lies in the fact that the word 'scale' is both a relative and an absolute concept.[7] Therefore it may indicate reaching a greater number of people, or a notion of a particular size of population, activity or particular measure of interest. The actual unit of measurement is also a source of confusion. Even within the concept of coverage there is a difference between coverage of absolute numbers of people, and coverage as expressing a percentage of a total population or particular groups.[8]

In the development literature, scale has been used to refer to what could be described as both the 'input' and the 'output' aspects of scaling-up. That is, on the one hand, it refers to organizational size or type of activity engaged in and, on the other, to 'outputs' such as scale of coverage of people or geographic area (see Table 1.1). Prevailing definitions of 'scaling-up' in development literature denote the process both of expanding the scale of activities with the ultimate objective of increasing the numbers of people reached and the *impact* on the problem at hand. As Myers reminds us, a preoccupation with increasing scale in terms of increasing numbers reached (which is the typical basis on which costs are calculated – see, for example, UNESCO, 2011) while important, needs to be combined with an understanding of impact (Myers, 1992). A programme that increases its scale may well lose in terms of its impact as the intensity of effort is necessarily reduced. A larger programme may no longer be able to provide the individual attention that may account for the high quality of a small programme or organization and may be less effective. The goal of increasing coverage – while critical to scaling-up – is clearly insufficient in and of itself. Any scaling-up exercise needs to include provision for measuring quality and monitoring when dips in quality occur.

In the education literature, a similar quantitative focus on numbers – of teachers, schools and districts – has also tended to predominate. However, Coburn argues, based on the experience of reform in US schools, "definitions of scale must include attention to the nature

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6   All references to publications by Simmons and colleagues are available on the ExpandNet website – www.expandnet.net.

7   Myers, R., Going to scale, in Cooperson, W. (ed.), *The twelve who survive*, London, Routledge, (1992), pp. 369–96.

8   Myers, op.cit.

of change in classroom instruction; issues of sustainability; spread of norms, principles, and beliefs; and a shift in ownership such that a reform can become self-generative" (Coburn, 2003: 3).

Table 1.1 Various definitions of scaling-up used in the development literature

Input	Output
- Expanding organizational size - Increasing the scale of activity engaged in - Integrating other activities (either unrelated activities or a different level of related problems) in order to reach more people	- Reaching more people - Expanding geographic area(s) reached - Reaching other 'target groups' - Increasing the volume of outputs - Increasing intensity of impact within given geographic area/social group

Source: DeJong, 2003, p. 48

Definitions have depended on the sector being addressed and from which perspective. ExpandNet focuses on scaling-up interventions within the health sector and gives many examples from the sexual and reproductive health field. The ExpandNet approach defines scaling-up as follows: "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" [ExpandNet/WHO 2009, p. 2].

Writing on scaling up NGO action in HIV, DeJong defines scaling-up as follows: "The process of expanding the scale of activities with the ultimate objective of increasing the numbers of people reached and the impact on the population at hand" (DeJong, 2003).

Writing about scaling-up from a management perspective in development (across sectors), Cooley and Kahl note that many definitions have been used. They explicitly avoid providing a definition but instead note that a crucial step in scaling-up is defining what is being scaled up, how, who will undertake it and where (Cooley and Kahl, 2006).

Lack of clarity about definitions of scaling-up characterizes both the literature and existing programmes on the ground. Simmons *et al.*, in their review of scaling-up strategies, stress the importance of initiating a participatory process to define the objectives of the scaling-up from the beginning and among all stakeholders involved. Moreover, they argue that scaling-up is far from a technical process of expanding the reach of given interventions: "As a multidimensional process, scaling-up pertains to much more than technology transfer and

the dissemination of information. It is a social, political and institutional process that engages multiple actors, interest groups and organizations..."[9]

As Renju and colleagues, in one of the few academic publications analysing the scaling-up process for sexuality education, put it: "Programme scale-up is complex: it is not simply a large-scale replication of a 'blue print' but the product of an interaction between an ideal intervention and the cultures, priorities and capacities of the structures through which it is scaled up" (see Renju *et al,* 2010b, p. 1).

There is a need for some consensus about aims before embarking on scaling up to avoid problems later. As O'Malley observed in relation to the global response to HIV by NGOs: "The [International HIV/AIDS] Alliance was founded within a rhetoric of 'scaling up community responses to AIDS'. What did this mean to different stakeholders? If more attention had been paid to the phrase, more contradictions in approach amongst and within different sets of stakeholders would have been identified" (O'Malley quoted in DeJong, 2003, p. 151).

Adenike Esiet of Action Health Incorporated (AHI) also points out that the picture is complicated in a large country like Nigeria where many donors are involved in funding sexuality education programmes and each donor may have a different conception of scaling-up. To avoid confusion, the government should have its own clear strategy that will serve as a guideline for all stakeholders.

Specificities of scaling up in sexuality education: a complex intervention

Simmons *et al.* observe that, even when programme managers are committed to scaling-up, the experience, know-how and resources are often lacking (ExpandNet/WHO, 2010, p. 1). They argue that planning needs to take into account the nature of the innovation that is to be scaled up, the capacity of the implementing organizations, the characteristics of the environment and the resources able to support the process. Figure 1.1 illustrates their conceptual model of scaling-up and the relationship between the so-called 'resource team' underpinning the scaling-up effort, the 'user organization' in which the innovation would be integrated and the wider environment.

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9 Practical Guidance for Scaling Up Health Innovations, ExpandNet website, www.expandnet.net

Figure 1.1 ExpandNet's conceptual framework for scaling-up
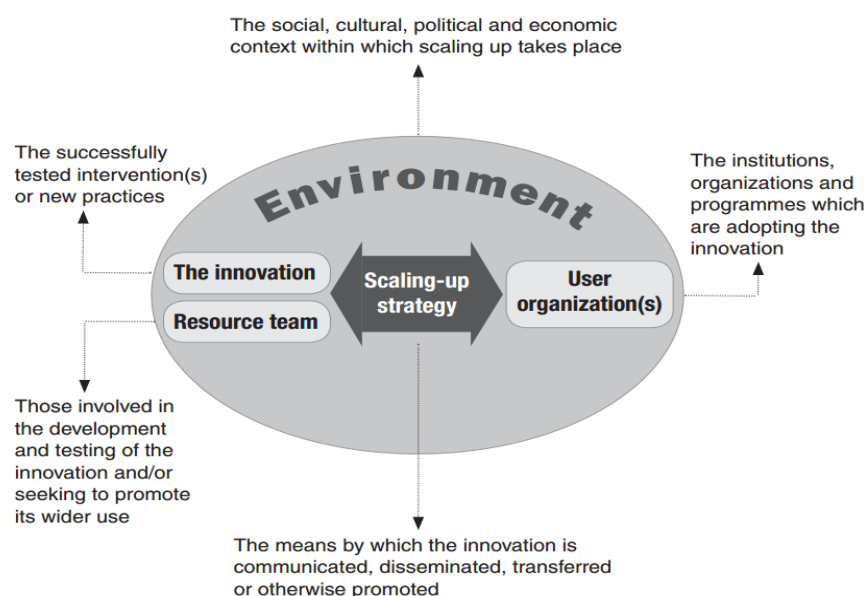
Simmons *et al.* also underscore the fact that the scaling-up process becomes more time-consuming and challenging as the innovation that is to be scaled up becomes more complex.

Sexuality education can be considered a complex intervention in several respects:

' It is an area imbued with moral values and judgements, since it addresses one of the most sensitive aspects of human experience – sexuality. Teaching about sexuality to young people before marriage is acutely sensitive in many cultures.

' Second, its scaling-up requires buy-in and commitment from key stakeholders such as parents and teachers – both of which are often difficult to achieve.

' Third, scaling up sexuality education requires complex bureaucratic changes and coordination between different sectors/ministries, including education, health and often youth. Each of these may have several related decision-making bodies and different levels of administration.

' Finally, implementing sexuality education requires curricular change and more participatory pedagogic methods, which are often new to the modus operandi of educational systems. Teaching sexuality education is challenging for teachers, since it requires imparting skills and values as well as knowledge.

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[10] Reproduced, with the permission of the publisher, from Simmons R, Fajans P, Ghiron L, eds. Scaling up health service delivery: from pilot innovations to policies and programmes. Geneva, World Health Organization, 2007:1–30.
http://www.who.int/reproductivehealth/publications/strategic_approach/9789241563512/en/index.html, accessed 10 April 2014.

In these respects, scaling up comprehensive sexuality education differs from that of many other interventions or domains because political support for and social consensus about the need for scaling-up is not always present and may be variable over time.[11] Thus, building political support – at school, community and national level – is needed as scaling-up proceeds and affects the scaling-up strategy adopted. For these reasons, scaling up sexuality education needs to be seen within a longer timeframe than many other areas.

In the two regions of the world where sexuality education has perhaps its longest history – Europe and Latin America – the processes of building political commitment and implementation capacity in sexuality education has taken several decades. In Latin America, early efforts began in the 1960s and 1970s.[12] Europe's longer history has given time to experiment with different modalities and approaches to sexuality education (as the case study on Finland below illustrates). Even in Europe, however, not all countries have comprehensive sexuality education and barriers remain.[13] The WHO Regional Office for Europe, BZgA and a team of experts on sexuality education has been addressing this inconsistency by working on standards for sexuality education in the countries of the European WHO region (53 countries including Central Asia).

Scaling up sexuality education: to what end?

In keeping with the national perspective of this report, the objectives of scaling-up are not pre-defined. A number of tensions are evident between different perspectives and even geographic regions concerning the overall social, educational and health objectives that sexuality education serves. Variations were in large part due to areas of expertise, conceptual and philosophical positions, as well as different historical contexts of sexuality education. Some see sexuality education as a means of preventing public health problems such as HIV, other STIs and unintended pregnancy. Others focus more strongly on the rights/gender and adolescent development arguments. Despite these variations, most have one common characteristic – the lack of clear indicators to measure success.

For the purposes of discussion here, however, the salient point is the importance of specific discussion at the outset about what outcomes of scaling-up of sexuality education are

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11 A point underscored by Jane Ferguson of WHO, telephone interview 12 January 2012.

12 Telephone interview with Esther Corona, 11 January 2012.

13 Telephone interview with Christine Winkelmann, 24 January 2012; see also the SAFE Report by IPPF (http://www.ippfen.org/en/Resources/Publications/Sexuality+Education+in+Europe.htm) and the Country Case Studies by WHO and BZgA (http://www.sexualaufklaerung.de/index.php?docid=1039).

desired in specific contexts, and for some degree of consensus to be achieved both in terms of the strategy and methodology of scaling-up as well as its expected outcomes.

Scaling up sexuality education as a dynamic process: trade-offs between coverage and quality/fidelity

As discussed above, scaling-up needs to be seen as a dynamic process with tensions and trade-offs as it proceeds. Objectives of scaling-up may vary over time both because of a changing policy context or new opportunities presented by the environment in which the programme operates, or because of the learning by the programme team itself about how to be effective. At certain stages of the scaling-up process, the aim may be to increase coverage, while at other stages it may be to raise the quality of an initiative that is already operating at greater scale, or to increase efficiency. In the context of the specific objectives of each programme, there may be a conflict between the dimensions of scale, quality, coverage and impact. As illustrated by Korten's 'programme learning curves', different stages of scaling-up may be associated with different types of learning – learning to be effective; learning to be efficient; and, finally, learning to expand, and there are likely to be trade-offs between effectiveness, efficiency and expansion which will lead to some loss of effectiveness as efficiency increases, and to losses in both effectiveness and efficiency during expansion (Korten, 1980).

As scaling-up proceeds, many programme teams are confronted with th e dilemma as to whether increasing coverage will compromise quality. At the outset, clear measures of quality need to be agreed. As several interviewees put it, so do the 'non-negotiable' elements – or the minimum standards of content and quality that cannot be compromised. This requires establishing systems of monitoring and evaluation that will identify such dips in quality.

The example of the MEMA kwa Vijana project in Tanzania (described in the case study below) illustrates the recognition that, in scaling up the intervention, the resources available at a pilot level are typically not available at a greater scale. Moreover, in Tanzania as often elsewhere, there was a desire for governmental structures to take over the programme to achieve greater scale and to ensure sustainability. Therefore, there was a paring down of the intervention and a reduction in the intensity of training and supervision to make it amenable to government sustainability. The team deliberately assessed the impact of this modification and found that it did not affect the quality of the intervention, at least in the medium term.

The Tanzanian example also illustrates well the need for a scaling-up strategy to be informed by and adapted to the changing policy environment. The NGO involved in that intervention also needed to adapt. As an organization more used to implementing programmes, it was increasingly in the role of supporting and handing over to government.

II. SCALING-UP STRATEGIES

Simmons and colleagues describe 'scaling-up strategies' (in health) as the 'plans and actions necessary to fully establish the innovation in policies, programmes and service delivery' (ExpandNet/WHO, 2010). They note that developing such strategies requires devoting attention *a priori* to the type of scaling-up, advocacy, the organizational processes, costs and resource mobilization, as well as monitoring and evaluation.

Writers on scaling-up have developed a number of typologies of scaling-up strategies. Simmons and colleagues, for example, distinguish between **horizontal scaling-up,** such as expansion or replication, and **vertical scaling-up** or institutionalization through policy, political, legal, budgetary or other changes (ExpandNet 2009). Scaling up sexuality education typically requires predominantly vertical scaling-up, particularly at the beginning stages, but horizontal scaling-up also becomes relevant as the scaling-up proceeds.

Translated to the field of sexuality education, examples of horizontal scaling-up would include:

- **Extending from one level of education to another**. For example, a recent UNESCO report on the state of sexuality education in Asia (UNESCO, 2012) notes that most sexuality education to date is confined to secondary level; extending it to primary level would constitute horizontal scaling-up.
- **Extending to different geographic areas** not already reached would also represent horizontal scaling-up. This often requires tailoring the intervention and approach to a new population group with different social and perhaps health dimensions (for example, urban to rural; high HIV to lower HIV; higher education capacity to lower, etc.)
- **Reaching other populations** is also a form of horizontal scaling-up. Extending programmes to indigenous populations or under-served groups would be such an example.
- **Extending teacher training** to new subject areas, teachers of different levels of education or types of schools, or in different geographic areas would be another example.

Examples of vertical scaling-up in sexuality education would include:

✐ Formalizing institutional processes of implementing sexuality education, such as making sexuality education examinable, is one such example.
✐ Integration within governmental systems, such as budgeting, planning, supervision, monitoring and evaluation is critical for long-term sustainability.

Inter-related dimensions of scaling up sexuality education

Given the nature of sexuality education, for this report, strategies for scaling up sexuality education are grouped into two, inter-related categories:

1. building and sustaining political commitment at national, community and school level; and
2. building implementation capacity (including capacity for monitoring and evaluation) so that coverage and institutionalization can be achieved.

Adequate scaling-up requires both aspects, as one is insufficient without the other. However, the degree of emphasis each receives will likely be determined by contextual starting points and the strategic directions adopted for the scaling-up process. Figure 2.1 illustrates these inter-related dimensions. Without any of these dimensions – coverage of the intervention (in terms of locations, schools and student population), political commitment and institutionalization of programmes – the scaling-up effort would not succeed.

The two mutually reinforcing dimensions for scaling up sexuality education can create a virtual cycle. The more scale is achieved, the more visible the scaling-up becomes, and therefore the more political commitment is achieved and resistance is countered; building implementation capacity strengthens political commitment in this respect. Drawing on the Latin American experience, where there is a long tradition of focusing on public policy and legislation underpinning sexuality education, these demonstrate political commitment but are also a great support for teachers in implementing programmes.[14] They can also be used for advocacy from one country to another to encourage them to invest in implementation capacity.

On the other hand, emphasis on one of the two dimensions can detract from the other, and therefore both need to be emphasized simultaneously. During the period of political dictatorships in Latin America, the possibility of comprehensive sexuality education virtually

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14 Telephone interview with Esther Corona, 11 January 2012.

'closed down'. However, during this time many countries continued to invest in building the capacity of teachers to teach sexuality education. This proved to be important when political openings emerged with democratization, because the countries were ready to rise to the opportunities presented. However, in the current political context, "so much energy is going into protecting modest victories (such as particular pieces of legislation), that it detracts from implementation."[15]

These examples illustrate the importance of understanding the context in which sexuality education is to be scaled up, which is the focus of the next section.

Figure 2.1 The inter-related dimensions of scaling up sexuality education: both vertical and horizontal scaling-up requires political commitment
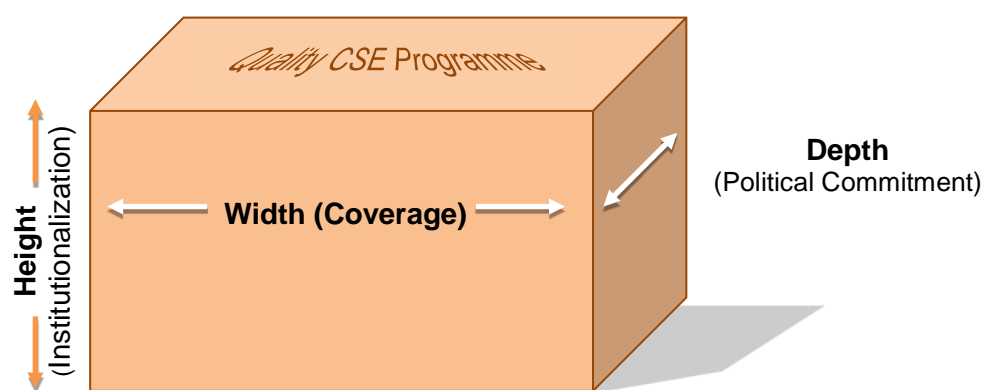
Planning for scaling up

Assessing contextual parameters and how they affect scaling-up strategies

Although many scaling-up processes take place spontaneously, the focus of this report is on deliberate scaling-up for which detailed planning is required. As Simmons *et al.* state, scaling-up cannot be successful if planning is *ad hoc* and limited to broad goals that have not been worked out (ExpandNet/WHO, 2010). A first step is assessing key contextual parameters and existing structures before planning for scaling up. Scaling-up strategies need to be tailored to existing structures/systems and therefore contextual parameters will affect which strategies to adopt.

Political will and public administration

As Simmons *et al.* point out, it is vital to consider the political environment in which scaling-up occurs, and the scaling-up strategy itself will need to respond to this changing context

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15 Telephone interview with Mary-Guinn Delaney, 5 January 2012.

over time (ExpandNet/WHO, 2010). Experts who have worked on scaling-up in the Latin American context, for example, describe the reality as one of political volatility, with frequent changes of educational administration that have major implications for implementation strategies. In Thailand, similarly, over the last eight years there have been eight different education ministers. If scaling-up is to entail transfer from NGO- or research-led programmes to governmental authorities, which it typically does, there is a need to understand the 'perceived need' for the programme, or political commitment to its integration within governmental systems, which in turn requires a detailed knowledge of those systems (Renju, 2011, p. 38).

As Pick, Givaudan and Reich conclude, based on experience of an NGO–government partnership in Mexico to scale up sexuality education, "Often it is *political opportunity and implementation feasibility* that determine what can be scaled up, rather than a systematic assessment of whether a programme operates well or what provides the greatest number of benefits" (Pick, Givaudan and Reich, 2008, p. 166).

The level of governmental political commitment to comprehensive sexuality education varies widely across settings, reflecting such factors as the degree of public resistance to the field as well as the extent to which pressures for implementation are government-driven or driven more by external funding agencies. In some countries, young people have become a major driver for change, stimulating demand for sexuality education 'from below' and advancing new forms of accountability. India's YP Foundation provides one such example (see Box 2.1).[16]

Box 2.1 The YP Foundation's Know Your Body, Know Your Rights Programme

The Know Your Body, Know Your Rights programme of The YP Foundation (TYPF) in India is an unusual example of scaling up youth demand for sexuality education and for building accountability with policy-makers involved in sexuality education to take account of young people's needs and perspectives. The assumption behind their work is that without an articulated demand by young people for sexuality education – who are its primary stakeholders, a fully "comprehensive" sexuality education that is rights-based in its approach may not be implemented or operationalized in India. Founded in 2002, TYPF is a youth-run and -led organization that promotes, protects and advances young people's health and human rights including their right to CSE. It therefore aims to provide both ground level support as well as monitoring of sexuality education programs. TYPF works to build leadership, and strengthen youth-led initiatives and movements, working with youth groups and networks in 18 states across India. Over the past 10 years, TYPF has worked with 2,000 young people to set up projects that have reached 300,000 young people in India, through a model that supports and enables young people to create programmes and influence policy in the areas of gender, sexuality, health, the arts and governance. TYPF ensures that youth leadership is handed over to subsequent generations by a policy whereby young people do not serve more than a period of 1 year at community leadership levels, and then transfer their existing programmes to a younger generation.

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16 See the website http://knowyourbodyknowyourrights.com.

Beginning in 2002 with peer-to-peer youth-led and run workshops in communities with young people that focused on addressing sexuality education through HIV prevention, the programme advanced its approach in 2006 to directly focus on young people's sexual and reproductive health and rights, particularly focusing on CSE. This was done as a response to young people's evaluations of the programme that highlighted the need to address issues relating to sex and sexuality at the heart of HIV prevention workshops. The initiative, entitled "Know Your Body, Know Your Rights is a national bi-lingual programme and campaign that works with young people in both in school- and out-of-school, community settings. Its aims to link the voices of young people to policy and decision makers to ensure the accessibility and availability of comprehensive sexuality education and to consolidate networks of young people working across India on sexuality education and adolescent health. Additionally, to share best practices on what works in tailoring services to young people and engaging them and to empower young people to address and articulate what their needs are (in the different stages of their lives) and have these reflected in national and state level policies. Finally it endeavours to document innovations (both successes and failures) being implemented by young people and share the relevant findings with policy makers and technical agencies addressing young people's right to sexuality education and youth-friendly health services. Currently in its pilot phase (2011–2013), the project is focusing on increasing young people's awareness and understanding of their sexual and reproductive health and rights and to advocate for the implementation of sexuality education in three states (Uttar Pradesh, Maharashtra and the National Capital Region). It is working with developing the leadership capacities of 50-60 existing youth leaders in these states who are currently providing sexual and reproductive health information and services to their peers in communities. Advanced skills and technical capacity building training on understanding and addressing CSE is enhanced by supporting these youth leaders, who are democratically selected through a self-selection process at district level, to design and lead community led campaigns with young people at village level. The campaigns also address gatekeepers, including religious leaders, panchayats and district level advocacy meetings with key policy implementers, government agencies and district officials addressing ARSH[17.]

The programme culminates in state and national level learning, bringing together nodal officers, policy makers and young people, to share best practices, challenges as well as to advocate for the need for and design of Sexuality Education. TYPF has produced some of the first youth-led publications on young people's needs and voices for policy makers on Sexuality Education in India and has a clear input to the policy process. In 2011, TYPE, in partnership with Plan India, conducted a set of youth-led consultations with adolescents and young people to obtain their inputs and recommendations on HIV prevention, AIDS Education and sexuality education provided under National AIDS Control Organization (NACO)'s guidance in schools.

Recommendations from the consultations have also been submitted as part of the Youth Alliance for Planning, a formal committee of youth organizations that assist the Planning Commission of India with drafting the approach paper for India's 12th Five Year Plan, under the input area of 'Decentralization of Information and Services' on the approach to youth-friendly health services for young people. Lessons from 10 years of the Know Your Body, Know Your Rights programme model have also been provided as expert input to the Supreme Court Constituted Committee to study the psychological impact of violence, harassment and bullying in-schools and suggest remedial measures.

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17 Adolescent Reproductive and Sexual Health (ARSH) Strategy, Government of India.

Degree of centralization/decentralization

An important contextual parameter for scaling-up of sexuality education is the nature of the political system and how decentralized or centralized the public administration is, including the education system. A centralized system can be a strong facilitator for scaling-up, as in the case of Mongolia, since directives and commitments from the centre can be relatively smoothly translated to national scale. At the same time, where there is strong resistance to sexuality education at a national level, this can also be a disadvantage, as is the case in some Middle Eastern countries.

Decentralized systems, however, also have strong advantages. In principle, decentralization allows for adapting programmes and tailoring curricular messages to the diversity of need and prevailing norms across regions and sub-populations. Nevertheless, decentralized systems may lead to a situation where there is strong leadership for sexuality education at the national level but this does not translate into political commitment and strong implementation capacity at state level. This is the case, for example, in countries in Latin America such as Argentina, Brazil and Mexico.[18]

Where education is highly decentralized, as in these settings, building alliances at all levels becomes critical. In practice, this amounts to building consensus almost on a person-by-person basis and political volatility undermines progress. In Thailand, for example, educational decision-making is decentralized even down to the school level; as school boards are playing a role in some larger schools and have an influence on school management, TeenPath (see case study) has recognized the need to build their capacity in issues concerning sexuality education and has begun to do this, where possible.[19]

Scaling up sexuality education becomes all the more complex in highly populous countries such as Nigeria (see case study) and India, which both have highly decentralized systems. The case study on scaling up sexuality education in Nigeria illustrates how challenging it has been to develop a national curriculum that is acceptable to all states within a population that is highly diverse (ethnically and religiously) and given resource differences across states.

Defining key stakeholders

Planning for scaling-up requires an understanding of the role and decision-making structures and processes of key stakeholders in sexuality education. In many countries, particularly those with a high level of decentralization, the institutions involved may be many and the layers of administration may be multiple. All interviewees for this report were asked about the key stakeholders in their contexts. Surprisingly, teachers' unions were only mentioned

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18 According to Mary-Guinn Delaney, UNESCO Regional Advisor in Latin America.

19 Telephone interview with Pawana Wienrawee, 23 January 2012.

rarely. Teachers and teachers' unions are notably absent in international sexuality education discussions.[20] This is despite the fact that, in many countries, including Ghana, teachers' unions have played a critical role in supporting teachers living with HIV.[21] In Latin America, where teachers' unions are unusually strong, they have generally been supportive of sexuality education.

Budgeting systems and funding trends

Government commitment to funding is critical to its potential for scaling up sexuality education. Moreover, it is important to understand the government budgeting processes to argue for its integration. Many programme implementers stated clearly that there was no earmarked budget for sexuality education in their settings. In the MEMA kwa Vijana (MkV) experience in Tanzania, documented in the case study, only one out of four districts actually committed funds for teacher training, although all four initially committed to earmarking funds as the scaling-up proceeds and government handover took place (Renju *et al*, 2010b, p. 7). If included in district budgets, funds for sexuality education would be safeguarded and could weather political change.

Several interviewees cited the restrictions on funds in the current economic climate as a key constraint to scaling-up. The cancellation of Round 11 of the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) was cited as a major setback after some countries had drawn up ambitious plans for scaling-up.

Education context

Scaling-up cannot assume a 'blank slate' in terms of sexuality education. As Ketting[22] points out, almost every country has existing structures and programmes that touch on issues relating to sexuality education and therefore it is important to assess and build on these. A major process of curricular review, for example, has taken place with the support of UNESCO in east and southern Africa. Similarly, the coverage/enrolment at different levels of education and transition between levels is important to understand. In countries with a large out-of-school population, school-based sexuality education is likely to be less effective (Mavedzenge, Doyle and Ross, 2010).

Population health

Planning for scaling-up also needs to address the question: what does assessment of the public health situation (in terms of HIV, adolescent sexual and reproductive health, etc.) tell us about the need for scaling up sexuality education? For example, in South Asia, given

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20 Telephone interview with Jan Eastman, 12 December 2011.

21 Helene Awurusa, Ghana National Association of Teachers, personal communication, 15 March 2012.

22 Telephone interview with Evert Ketting, 29 November 2011.

that HIV prevalence is not high, some have argued that comprehensive sexuality education for all is not cost effective (see UNESCO, 2012) and that the focus should be on the most at-risk populations. Investing in school-based sexuality education is arguably most important in high HIV-prevalence settings such as east and southern Africa; in these contexts, pregnancies that are unintended or too early may be a particular burden.[23] In settings where HIV prevalence is much lower, there may be different health rationales for sexuality education.

Within countries, there are variations in HIV prevalence and this may determine where the programme should be piloted and scaled up first. For example, the Primary School Action for Better Health programme in Kenya (see case study) chose to run a pilot in Nyanza, where the HIV prevalence was particularly high. They then deliberately expanded it to areas of diverse populations and lower HIV prevalence to test its applicability. Age at sexual initiation is also critical since, as Mavedzenge, Doyle and Ross point out following their 2010 systematic review, school-based sexuality education is most effective when it is offered **before** young people become sexually active. The European standards for sexuality education (see WHO/BZgA Standards, 2011) emphasize that issues pertaining to sexuality education need to be addressed before people actually start experiencing them.

Ultimately, the potential for scaling up sexuality education depends strongly on community and public understandings of adolescent sexuality and adolescent sexual and reproductive health needs. The team that designed the Primary School Action for Better Health programme in Kenya (see case study) describe how it was not until data were provided on the extent to which young people were sexually active that policymakers became more receptive to the intervention. For community members and teachers, however, qualitative data in the words of young people were most convincing (Maticka-Tyndale, Wildish and Gichuru, 2007).

Piloting and assessing effectiveness with scalability in mind

A clear prerequisite for scaling up programmes is to generate rigorous evidence at the pilot level to identify the appropriate intervention, develop its implementation strategy and to evaluate its impact in relation to the desired programme goals. As Simmons and colleagues point out, pilots are essential for testing both the concept and implementation of scaling-up; however, whereas testing new concepts may require external resources, testing

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23 The author is grateful to Shanti Conly, USAID, for emphasizing this point.

implementation needs to occur within the resource constraints likely to prevail at scale (ExpandNet/WHO, 2011).

Despite the methodological challenges in the field, there is now considerable guidance on effective strategies for evaluating sexuality education programmes. Mavedzenge, Doyle and Ross describe the criteria used to evaluate the strength of evidence in this field (Mavedzenge, Doyle and Ross, 2010). From the point of view of scaling-up, it is critical that the interventions chosen have potential for scaling up within existing governmental systems. Yet, a 2004 review of sexuality education interventions in Africa by Gallant and Maticka-Tyndale (2004) found that very few evaluations considered the potential for scaling-up or sustainability of the interventions. In 2006, a review by Ross, Dick and Ferguson similarly found that most HIV prevention programmes for young people remained small in scale (Ross, Dick and Ferguson, 2006). Examples are provided in the case studies of a contrary approach of focusing only on interventions that have potential for scale. For example, in the MkV initiative in Tanzania, the programme team investigated which interventions had the highest potential for governmental adoption, and they ruled out alternative interventions that would require intensive levels of supervision and thus were not sustainable. In the case of Kenya, the Primary School Action for Better Health programme developed their intervention on the premise that it should be deliverable in the lowest resourced school in Kenya.

Dissemination of pilot data on effectiveness has also proved to be an effective strategy for garnering political support for larger scale implementation (Pick, Givaudan and Reich, 2008). In reality, however, often pilot data are not disseminated or used for advocacy purposes.[24]

Other than data about the effectiveness of the pilot programme, the case studies in this report have also provided examples of how other types of research, some of a more qualitative nature, inform scaling-up efforts. For example, the MkV programme team in Tanzania conducted detailed evaluations of the process of implementation, and focused both on the perspectives of teachers and the process of handing over the programme to government. In both Tanzania and Kenya, detailed qualitative research was also undertaken on social and cultural norms influencing adolescent sexual behaviour that informed the design and implementation of the scaling-up strategies. Case studies also provide examples of where national data is collected on a regular basis regarding adolescent sexual and reproductive health indicators; as the case study on Finland clearly shows, such governmental data can be used to investigate the relationship between trends in the provision of sexuality education and other adolescent health interventions and population-level health indicators in a country where education is universal.

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24 Telephone interview with Margarita Diaz, 22 February 2012.

Building and sustaining political commitment at national/community/school level

As discussed above, a crucial dimension of scaling up sexuality education is to generate political commitment. Scaling-up requires strong leadership at school/community and national levels. This is not merely an initial prerequisite, but needs to be sustained throughout the scaling-up process because commitment wanes over time and new individuals/institutions enter the field. This is particularly the case where turnover of key personnel is an issue. Examples of some strategies that have been used in this respect are as follows:

1. **Capitalizing on regional/cultural similarities.** Countries are often profoundly influenced by policy developments in neighbouring countries. Generating commitment at a regional level can be critical to sustaining progress, as the high-level ministerial meeting and declaration in Latin America and the Caribbean illustrates. Capitalizing on linguistic and cultural similarities also makes it possible to develop a pool of expertise to train sexuality education teachers, as Latin America has done. This is particularly important where there are human resource constraints in the field.

2. **Building policy/legal commitment through advocacy for specific legislation** has been a strong strategy in Latin America and the Caribbean, but also in some other contexts cited by interviewees for this report, such as Ukraine, Belarus and Mongolia. Moreover, as the Latin American and Caribbean experience shows, progress on legislation in one country can be used for advocacy in other countries.

3. **Development of 'standards' or guidelines for implementation.** Internationally, there have been a number of examples of regions that have endeavoured to establish a consensus on standards or guidelines for the implementation of sexuality education. The European region, led by WHO Europe, for example, has recently drafted standards for sexuality education in Europe (WHO Europe and BzGA, 2010) and is currently drafting a document to inform their implementation. Similarly, Nigeria, as a highly populous, diverse and decentralized country, found that implementation across states was uneven and varying in quality; they therefore drafted national guidelines for implementation (Federal Ministry of Education, Nigeria and AHI, 2008). Interviewees explain that such guidelines are not only a form of advocacy to build commitment for sexuality education, but also help individual countries to think through the process of implementation, foster the sharing of experience as well as challenges, and thus help to raise standards of quality.

4. **Building support and leadership at school level and beyond for sexuality education** (parents/teachers/administration, etc.) is a critical element of scaling-up. NGO-led initiatives such as the TeenPATH Project (see case study), funded by the Global Fund and implemented by PATH Thailand, have played a pivotal role in raising

the legitimacy of sexuality education, and showing how it can be done at a micro level. Raising awareness among head teachers and parents about the content and benefits of sexuality education is part of the scaling-up strategy in the Ukraine where the Global Fund, European Commission, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and UNESCO support the Ministry of Education and the All-Ukrainian Association of Teachers and Trainers to develop necessary political support, social consensus and technical capacity for universal health and sexuality education. The case studies provided in this report also illustrate examples of how involving head teachers and community representatives (parents of the schools involved) in teacher training on sexuality education can strengthen their commitment. The literature on scaling-up in any domain illustrates the need for key leaders and role models, but these are arguably more necessary than ever when dealing with a topic as sensitive as sexuality education. As Renju and colleagues underscore: "Effective leadership and motivated individuals are essential factors in the transfer of ownership from one entity to another" (Renju *et al.*, 2010b, p. 38).

5. **Use of 'policy windows'.** In the health policy field, there has long been awareness of the potential raised by 'policy windows' – these are openings or opportunities for policy change that emerge and are often short term in nature. Typically these emerge in response to an event or increasing media coverage on a particular issue, and thus heightened public awareness. One such example is the recent discussion about teenage pregnancy in Thailand, which has created an opening for discussion about the importance of sexuality education. Policy windows can potentially be stimulated. For example, a process of curriculum review in countries may raise awareness and provide an opening for curricular reform.

6. **Scaling up 'demand'.** Although there are relatively few documented examples, young people's mobilization to articulate their need for sexuality education can be a powerful driver for sexuality education. The YP Foundation in India (see Box 2.1) has effectively been 'scaling up demand' from the perspective of young people through campaigns, peer education and lobbying for greater accountability from policymakers concerning sexuality education. This has included in-person monitoring within the classroom of how sexuality education is actually provided in schools.

The advocacy processes for scaling-up need careful planning and resources. This is particularly the case if they engage the media, which – while highly effective – can be expensive. Some countries have 'mapped the resistance' in terms of understanding the arguments used by those opposed to comprehensive sexuality education. A presentation on the Egyptian experience at the Bogota consultation stressed the need to find sympathetic voices among the so-called 'opposition' (UNFPA, 2010). In Latin America, civil society organizations played a major role from the outset when sexuality education was introduced

and lobbied for a rights-based, gender-focused approach, which is now officially endorsed by governments (see for example the case study on Uruguay).

Setbacks and opposition must be anticipated along the way, at the level of schools, the community and also nationally (see for example the recent setback in Uruguay documented in the case study). The costs of setbacks to the momentum for scaling-up cannot be underestimated. In the former Soviet republics, for example, during the second half of the last decade, elements of sexuality education were significantly reduced or removed from the obligatory and optional parts of the curriculum in Moldova, Russia, Belarus and other former Soviet republics. This was due to objections from parents and religious leaders who portrayed sexuality education as being Western-influenced and against the national interest. This compromise not only undermined scaling-up but also led to problems years later when trying to restart the programme.

Building implementation capacity for scale-up

The second dimension of scaling up sexuality education is building sufficient implementation capacity at a national level to develop and implement sexuality education. Some examples of strategies that have been used in this respect are:

1. **Formation of in-country or regional expert group/supportive 'policy community'** – with vested interest, expertise and national perspective. In Latin America, for example, building up a regional pool of sexuality education experts and trainers reinforced national implementation strategies (see the case study on Uruguay for example). In Eastern Europe, the All-Ukrainian Association of Teachers and Trainers – which includes experts in sexuality and health education as well as in teacher post-graduate training – has been the main driving force for advocacy and capacity building for obligatory health and sexuality education in schools. The Scientific Association of Medical Students of Armenia plays a pivotal role in scaling up sexuality education as part of an obligatory 'Healthy Lifestyle' course by facilitating teacher training country wide. Similarly, countries in Western Europe have developed a working group of experts that drafted the European guidelines already described above (WHO Europe/BZgA, 2010). In the ExpandNet framework of scaling-up, there is useful discussion of the 'resource team' being the group of experts – from one or several institutions – that are committed to and undertake the planning for the scaling-up process. As they conceptualize it, such a team would be involved in the design and testing of the innovation, developing the scaling-up strategy,

training, resource mobilization, research and evaluation, as well as dissemination and advocacy.

2. **Curriculum development process with attention to scalability.** Developing an appropriate curriculum is critical for implementation at any scale, but is also relevant to scaling-up because of the need for the curriculum to be scalable and adaptable to the diversity of needs (varying levels of public health, educational and social development indicators) across the country. Thus fundamental questions need to be analysed with scale in mind such as: whether the sexuality education curriculum is standalone or integrated; if integrated, within which subjects; whether it is mandatory or voluntary; what age groups and levels of education are involved; as well as learning objectives and how to keep the curriculum updated. The case studies provided below give examples of the need to comply with national directives (such as scaling up the directive that HIV education is taught by science teachers in Tanzania at the time of the MkV project). They also provide examples, however, of how such efforts can inform a revision of national policy guidelines. Kirby argues that one critical approach to scaling-up is offering detailed, scripted curricula to teachers so those who are uncomfortable teaching sexuality can rely on clear guidelines. He observed that, from his experience with those working in Africa, learning objectives and curricula were often quite broad, giving teachers little detailed guidance as to how to teach sensitive subjects.[25]

3. **Involvement of different players in curriculum development** is critical to scale because it is important to sustainability and acceptability in the long run. Thus involving tertiary educational institutions where there is expertise, young people themselves, building advocates among teachers and securing parental buy-in are all critical components of scaling-up strategies.

4. **Making decisions about whether and how sexuality education will be assessed** is needed for scaling up in that it is key to both teachers' and students' motivation. For example, Renju *et al*. (2010a) note that the fact that sexuality education was assessed in Tanzania gave teachers an impetus to implement it. International experience has shown that, where it is not assessed, sexuality education typically lacks resources and attention (UNESCO, 2011). A teacher perspective points to the importance of developing formative and summative assessment approaches that are appropriate to the subject and not 'antithetical to learning.' Apter observes from the long history of sexuality education in Finland, however, that even there it is mainly the cognitive/knowledge aspects of sexuality education that are assessed at school level; finding ways to assess the less measurable but critical aspects of sexuality education relating to skills and values has been more challenging.

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25 Doug Kirby, telephone interview, February 23, 2012.

5. **Linking within curriculum and other school-based, extra-curricular activities and health services.** Although not the focus of this report, it is clear that, in many settings, activities beyond the formal curriculum such as school-based clubs and other student activities have been critical to understanding adolescents' needs, involve them and gain acceptance of sexuality education. As the early history of Nigeria demonstrates (see case study) and in conservative settings such as the Middle East, galvanizing extra-curricular activities may be the main strategy for scaling-up in the absence of opportunity for curricular change.[26]

Similarly, links with health services either through school nurses (who are often involved in sexuality education as well as provision of services) or named school doctors is a critical component to scaling up sexuality education. Indeed, interviewees affirmed that it is unethical to teach young people sexuality education without adequate referral to youth-friendly health services being available[27]. Both the Estonian and Finland examples (see Finland case study) illustrate that scaling up sexuality education went hand in hand with the development of youth-friendly services. When sexuality education was first introduced in Finland, it was combined with central government public health directives for municipalities to make contraceptives available for all, including young unmarried people.

Teacher preparation

Teacher selection, training and supervision

Central to achieving both the coverage and quality of sexuality education is the question of teacher training. Ultimately, the success of any sexuality education programme depends on teachers and whether they are adequately prepared to handle the cognitive, emotional and relational dimensions of sexuality education. Integrating sexuality education in the pre-service training of teachers is the most cost-effective and sustainable system for scaling up sexuality education, complemented by in-service training as needed. Nevertheless, many interviewees for this report pointed out that pre-service training is expensive, often difficult to achieve if political commitment to sexuality education is not strong, and that dilemmas remain regarding which teachers to train so that scale can be achieved while maintaining fidelity of the program. Therefore in the interim, until pre-service training is institutionalized, many countries have relied exclusively on in-service training. Even if pre-service training exists, there is often a need for in-service training on specific issues, or bringing in specific expertise. Some interviewees, however, complained that *ad hoc* in-service training (often provided by NGOs funded on a short-term basis and often with expensive materials that are difficult to sustain at a larger level of implementation), even if filling a short-term gap and

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26 Telephone interview with Montasser Kamal, November 2011.

27 Telephone interview with Jane Ferguson, November 2011.

raising awareness, does not enhance the sustainability of national sexuality education programs in the long term.

The example of sexuality education in Finland (provided in the case study) is instructive in this regard. Over its long history of sexuality education since the 1970s, it has experimented with a variety of methods of teacher training and the selection of teachers for sexuality education. According to the Family Federation of Finland, which has been extensively involved, the current system is the most effective. Finland has now mandated that 'health education,' a standalone academic subject, will be taught in all Finnish schools and that it must have dedicated teaching staff. This effectively means that, during the in-service training of teachers, education student teachers effectively self-select to study health education. This in turn ensures that they are interested and able to teach it. Kirby notes that there are arguments in the US that health education teachers are often effective in applying participatory methods to sexuality education that they use in other aspects of their work, such as in preventing smoking or violence. In studies in Finland about teachers' motivation to teach sexuality education, only 4 per cent of teachers report being uncomfortable teaching the topic (Apter, 2011), which may reflect this pattern of self-selection of teachers in Finland. Previous systems of teacher training in Finland – whereby sexuality education was included in all topics – meant that it was not sufficiently covered in reality. Where it was integrated in a few 'carrier subjects', it fell prey to problems of curriculum overload and the reluctance of some teachers to teach sexuality education.

The 2010 Bogota consultation on sexuality education notes that most programmes taught sexuality education as a 'transversal subject' (UNFPA, 2010, p. 28). While it is beyond the scope of this report to analyse the pedagogical merits of this approach, its implications for scale are important. For example, the fact that Thailand incorporates sexuality education in so many subjects raises practical and cost challenges in terms of scaling-up. Moreover, the Global Fund project for scaling up sexuality education stipulates a target number of teachers to be trained; but in reality this means that only 35 per cent of schools can be covered because of budget constraints. Implementers advocate that it is more realistic to integrate sexuality education in smaller schools where one teacher teaches a larger number of subjects. Ketting argues that, even where education systems have multiple teachers involved in teaching different aspects of sexuality education, from a management/ coordination perspective there is a need for one focal teacher.

Principles for selection of teachers for training need to be carefully thought out as part of the scaling-up strategy. Many countries have opted for a geographic system of increasing coverage of training (e.g. India, Nigeria), while some have added additional criteria such as HIV prevalence (e.g. Nigeria at the encouragement of the Global Fund). Two useful and related lessons emerged from the examples given by interviewees. First, the need for a

critical mass of teachers to be trained at school level so that teachers are not isolated in their efforts to introduce a controversial subject and, second, that there should be some mechanism for trained teachers to interact and share experiences across schools. For example, in Nigeria at the level of Lagos State, trained teachers were convened to discuss their experiences, comment on the curriculum and share techniques. TeenPath offers similar four-day 'coaching sessions' for trained teachers at the provincial level and gets coaches to visit other schools in a form of peer-teacher reinforcement. In the US, according to Kirby, the best and most motivated sexuality education teachers are those who participate in professional exchanges and conferences and share material.

Another consideration about the selection of teachers is the issue of the relationship between trained and non-trained teachers. In Tanzania, there was some degree of animosity between them in Tanzania, and although not planned to be part of the intervention, the idea that trained teachers could provide training to non-trained teachers was not realistic.[28] Where this subsequent training does occur, the quality of each round of training is likely to decrease.[29]

Finally, selectivity needs to account for potential loss or transfer of trained teachers, particularly in high HIV-prevalence settings. For example, in Kenya, 22 per cent of trained teachers were lost to the intervention schools during the first two years following training due to death, retirement or transfer (Maticka-Tyndale, Wildish and Gichuru, 2010).

Given the predominant technique for achieving scale in teacher training called the 'cascading approach' – whereby teachers are selected for training who will in turn assume a training role – some critical reflection on the limitations of this approach is useful. In a recent Latin American report on teacher training, the authors pose the question whether teachers trained on a short-term basis can in turn train others:

> The most used strategy on Sexuality Education and HIV prevention has been the cascade training method, i.e. to train elements that shall act as multipliers, and shall replicate among their peers, the training received. This strategy has proved to lose its core concept along the process, as well as the methodology. Therefore, those who have been trained in short-term seminars are not able to develop the necessary competencies to assume functions as trainers. On the other hand, the competences that Sexuality Education demands are not acquired in a short time, for it has already been said that such competences are part of a gradual and methodical process, achieved in formal and non-formal education. To receive information and to internalize such information are quite

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28 Telephone interview with Jenny Renju, January 11, 2012.
29 Telephone interviews with Doug Kirby, 23 February 2012, and Margarita Diaz, 22 February 2012.

different things, because internalization deals with emotions and socio-cultural representations, transforming processes through reflection, and with the construction of new knowledge, expressing attitudes and behaviours. (Restrepo and Corona, 2010, p. 16)

In the US, an alternative approach is to have professional institutions, supported by government funds, which train teachers in sexuality education as a career[30]. It may not achieve the same coverage level but Kirby argues it is likely to provide higher quality training. The costs, however, are no doubt substantial. In many former Soviet republics, a well-established government supported system of teachers' post-graduate education still exists and plays an important role in advanced teacher training as well as in refresher training and retraining. However, preparation of teachers for HIV prevention, health and sexuality education in these institutions can be effective, efficient and sustainable only if such courses or subjects are part of an obligatory curriculum. Otherwise, teachers opt for other areas for advanced training.

Supervision, monitoring and evaluation

Whether a country relies on pre-service teacher education, in-service training or ideally both, supervision is critical to ensure the content of a programme is delivered with fidelity and is implemented correctly. A study in South Africa found through a process evaluation that supervision, a prescribed programme and training to increase teacher capacity and confidence facilitated the implementation of their intervention (Renju, 2011, p.115 citing Ahmed *et al.*, 2009). Yet often supervision systems are weak, which affects all aspects of education but is at the same time a critical constraint to scaling up sexuality education and ensuring programme fidelity. In Nigeria, for example, implementers report that some supervisors are resorting to using their personal cars because of a lack of financial support for monitoring and supervision, and are only visiting nearby schools.

Scaling-up, by definition, requires increasing coverage of both teachers and learners. As noted above, however, as scaling-up proceeds, many programme teams are confronted with dilemmas as to whether increasing coverage will compromise quality. Tailoring interventions for scale requires making them adaptable to scale and typically reducing resource intensity so that the intervention can be delivered without substantial additional resources. Even in developed countries, this is happening on an *ad hoc* and non-evaluated basis (Ott *et al.*, 2011).

A necessary but often missing component of scaling-up strategies is to establish systems both of internal quality assurance and quality improvement, as well as of monitoring and

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30 Telephone interview with Doug Kirby, February 23, 2012.

evaluation that will identify such dips in quality and assess impact. Clear measures of quality need to be agreed at the beginning and a feasible method of implementing whether they are maintained over time, whether programmes maintain their fidelity and whether desired outcomes are achieved. This is as true for advocacy efforts to build commitment as it is in efforts to build implementation capacity including teacher training.

From the point of view of achieving scale and accountability, the best place is to integrate monitoring and evaluation of sexuality education within routine governmental systems. All the case studies illustrated in the report, however, reveal difficulties in doing so and the need for the investment of resources to achieve this end.

Educational system constraints to scaling-up

The case studies and interviews collected for this report have indicated that many of the barriers to scaling up sexuality education reflect issues within the broader educational system that are not unique to this field. These have included:

- The **philosophy of education,** whereby sexuality education and adolescent development are seen as subordinate to more 'cognitive' subjects.
- **Teacher and curriculum overload**.
- **Teacher absenteeism/illness** (particularly in high HIV-prevalence settings) **and transfer**.
- **Distribution of teachers** (in Tanzania, for example, the fact that the density of teachers is low in rural areas and female teachers in particular are lacking in rural areas has implications for the sexuality education programme).
- **Class size** within some settings is very high. UNESCO (2011) cites examples of an average class size for sexuality education classes being as high as 75 to 150 students, as opposed to an average of 40 in Orissa State, India and 18 in Estonia. Class size clearly affects the quality of implementation.
- **Reduction in educational funding** translates into difficulty in securing resources to establish curricula, train teachers and provide materials.
- **Weak systems for monitoring and evaluation/supervision**.

III. TEN PRINCIPLES OF SUCCESSFUL SCALING-UP OF SEXUALITY EDUCATION

Based on the literature reviewed and the insights provided by the interviews on sexuality education and scaling-up, here are ten key principles for scaling up sexuality education:

1. Choose an intervention/approach that can be scaled up within existing systems (see all case studies).
2. Clarify the aims of scaling-up and the roles of different players and ensure local/national ownership/lead role (see all case studies).
3. Understand perceived need and fit within existing governmental systems and policies (see case studies, particularly Kenya PSABH; Tanzania-MkV).
4. Obtain and disseminate data on the effectiveness of pilot programmes before scaling up (see all case studies).
5. Document and evaluate the impact of changes made to interventions on programme effectiveness (see the case studies on Kenya PSABH; Tanzania-MkV).
6. Recognize the role of leadership (see the case studies, particularly Kenya-PSABH; Nigeria).
7. Plan for sustainability and ensure the availability of resources for scaling-up or plan for fundraising (see the case studies particularly Kenya-PSABH, Tanzania-MkV; Nigeria, Thailand).
8. Plan for the long term (not donor funding cycles) and anticipate changes and setbacks (see all case studies, particularly Thailand and Uruguay).
9. Anticipate the need for changes in the 'resource team' leading the scaling-up process over time (see all case studies).
10. Adapt the scaling-up strategy with changes in the political environment; take advantage of 'policy windows' when they occur (see case studies, particularly Finland and Thailand).

Partnerships for scaling up

Given the long-term nature and complexity of deliberately scaling up sexuality education, the respective roles of the different players involved need to be explicitly discussed and actively negotiated. These include governmental bodies (typically those bodies involved with education and health, but often including others such as youth, planning and sports); NGOs and international NGOs – whether engaged in advocacy or implementation, youth-led or sectorally defined; research institutions; and donor/international organizations. Professional associations such as teachers' unions are also in principle key players. The challenges of coordination between these bodies are enormous, not least because they often operate on different budgetary timetables and scaling-up timeframes, as well as having different objectives in terms of scaling-up. They also operate operating along different lines of accountability.

The experience of the scaling-up of sexuality education in Mwanza, Tanzania is instructive in that it points to the need for all players not only to coordinate but also to adapt and change through the scaling-up process. For example, Renju and colleagues (2010b) discuss the need to overcome governmental capacity constraints and the role of supportive technical assistance provided by NGOs in scaling up sexuality education. NGOs can also support the advocacy, awareness-raising aspect of sexuality education among stakeholders including parents and they can provide the linkages with services. They note, however, that NGOs have to adapt to a facilitating, rather than implementation, role.

Based on the experience of an NGO–government partnership in Mexico to scale up education, Pick, Givaudan and Reich conclude that the following strategies were effective in building NGO–government partnerships: creating political support; developing personal lines of communication and trust; negotiating with opposition groups; assuring programme ownership; and preparing for changes in government personnel (Pick, Givaudan and Reich, 2008, p. 166).

A recurring theme in interviews for this report was the tensions often observed between education and health personnel. Some concerns were, for example:

- As a result of the 'remedicalization of HIV', health experts do not invest in seeing how the education system functions or in considering what discourse and arguments educational experts use.
- The lack of coordination between these sectors is a major obstacle to scaling up; staff from these ministries need to sit together more often to work out their differences.
- A lack of dialogue between education and health ministries leads to contradictions in policy at national level.

The case studies provide some examples about how such barriers were addressed. For example, the Primary School Action for Better Health programme in Kenya found that they surmounted some of these miscommunication problems by incorporating staff from both the Ministry of Health and Ministry of Education in their training for teachers. Evidence presented by interviewees, such as the Tanzanian MkV example, illustrate that sexuality education may have a 'spill over' effect in terms of other aspects of education; a third of trained teachers and a quarter of ward education coordinators reported increasing their use of participatory techniques both in MkV classes and in other sessions (see case study). This should be a strong argument for education ministries to support sexuality education.

Implementers' experience from Asia underscores the importance of finding honest brokers and choosing governmental partners carefully. In some settings, the Ministry of Planning can play a convening role, bridging differences between sectorally aligned ministries of health and education. Meanwhile, in the European region, international organizations have provided a key platform to negotiate differences and help develop common strategies.

Conclusion

Given persistent gaps in adolescent development and sexual and reproductive health indicators worldwide, there is now an emerging consensus that the proliferation of pilot projects in the absence of 'designing for scale' in sexuality education is no longer acceptable.

Institutionalizing sexuality education is not only cost effective but it is a right of current and future cohorts of young people. However, scaling-up will not happen on its own; it requires a plan and a methodology, including a budget and a division of roles and responsibilities. Moreover, scaling-up needs to incorporate strategies for garnering and sustaining political commitment over time, as well as for building implementation capacity.

This report emphasizes that lack of planning (including budgeting) for coordination across players in this field – 'brining the diverse pieces of the puzzle' together – has been the main obstacle to scaling-up. As Simmons *et al.* argue, the idea is not to overburden the already squeezed public sector with additional demands but to help foster strategic planning across the health sector that could rationalize the use of scarce resources (Simmons *et al*, 2007). Governments with a pro-active scaling-up strategy that are committed to institutionalizing sexuality education and ensuring it is delivered appropriately at scale would be in the driving seat, rather than being subject to the diverse agendas of different interest groups (including funders). This would ensure that all players conform to national priorities developed through partnership with key stakeholders, including young people themselves.

IV. CASE STUDIES

	Finland	Kenya PSABH	Nigeria FLHE	Tanzania MKV	TeenPath Thailand	Uruguay
Rationale	Youth development, PH, citizenship	HIV/SRH	HIV/SRH	HIV/SRH	HIV, unintended pregnancy	Youth development, citizenship, gender, adolescent health
Geographic scope scaling up	National	National (pilot Nyanza)	National across states	Mwanza region	43 out of 77 provinces	National
Public admin.	Decentralized	Centralized	Decentralized	Somewhat decentralized	Decentralized	Decentralized
Led by	Government	NGO (gov) + 1 key donor	NGO (gov + donors)	Research/ NGO (gov + donors)	NGO with support from Global Fund for AIDS, Tuberculosis and Malaria	Ministry of Education, Ministry of Health with civil society involvement
Curriculum	Health education stand-alone	Infused across subjects	FLHE transversal - national states adaptation	Designed as stand-alone	Transversal: integrated into up to 8 carrier subjects	Integrated into the institutional matrix of the country with specific governing policies

Finland: Learning from history

Finland has a long history of sexuality education. The subject first became compulsory in schools in 1970. In 1972, the Public Health Law stipulated that local municipalities should provide free contraceptive counselling. Sexuality education was scaled up nationally in partnership with health services for young people. School health nurses played a key role in sexuality education, but also provided referrals to health services. In some cases, they were permitted to provide contraceptives. The health and education sectors were generally well coordinated at the national level. From the 1970s to the 1990s, government data (school health surveys) indicated that adolescent abortion and delivery rates had declined and this trend continued until the 1990s (see Figure 4.1).

Figure 4.1 Abortions and deliveries (per 1,000) in 15-19 year old girls in Finland, 1975-2010
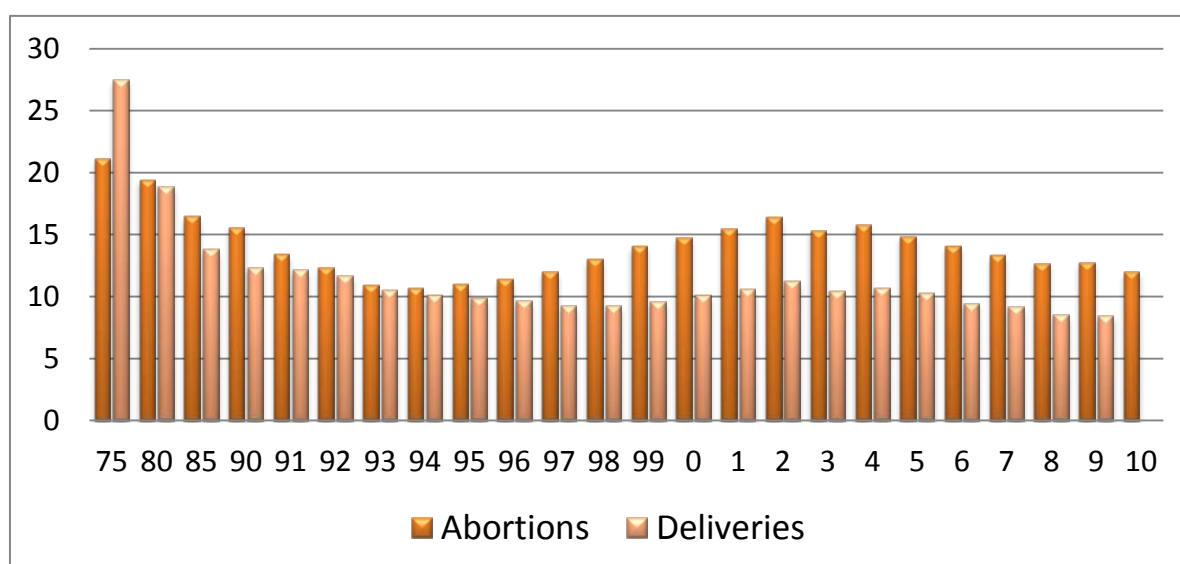
In the 1990s, owing to a recession in Finland partly caused by the collapse of the Soviet Union and the contraction of exports, the government made extensive cuts to social welfare services, particularly in preventive health care, including school health. Education also became more decentralized. In 1994, sexuality education was made optional, and each school had the power to decide whether and how to teach it. The result was a decrease in both the coverage and quality of sexuality education in Finland. Population health data show that, from the late 1990s in Finland, the rates of girls reporting having had intercourse at age 14 and 15 started an upward trend (to 2002) as did the proportion of girls who reported using no contraception. This was in direct correlation with the increase in the abortion rate (see Figures 4.2 and 4.3).

As Apter describes it, "Slowly conclusions were made and education changed" (Apter, 2011). In 2004, a new subject was introduced in most schools – health education, which includes sexuality education. As of 2006, it became compulsory. One teacher in each school is responsible for the coordination of teaching on this topic. Although Finland remains quite decentralized (with 300 municipalities for a population of five million people), the national core curriculum is the basis on which local curricula are developed, ensuring some consistency nationally. Moreover, sexuality education is assessed. Apter notes, however, that it is mainly the knowledge aspects of sexuality education that are assessed.

After 2002, the proportion of adolescents who had had intercourse by the age of 14 and 15 decreased, as did the percentage of those not using contraception. The adolescent abortion and delivery rates also decreased.

Figure 4.2 Percentage of girls in Finland who have had intercourse, Grades 8 and 9, 1998-2010 (STAKES school health survey)
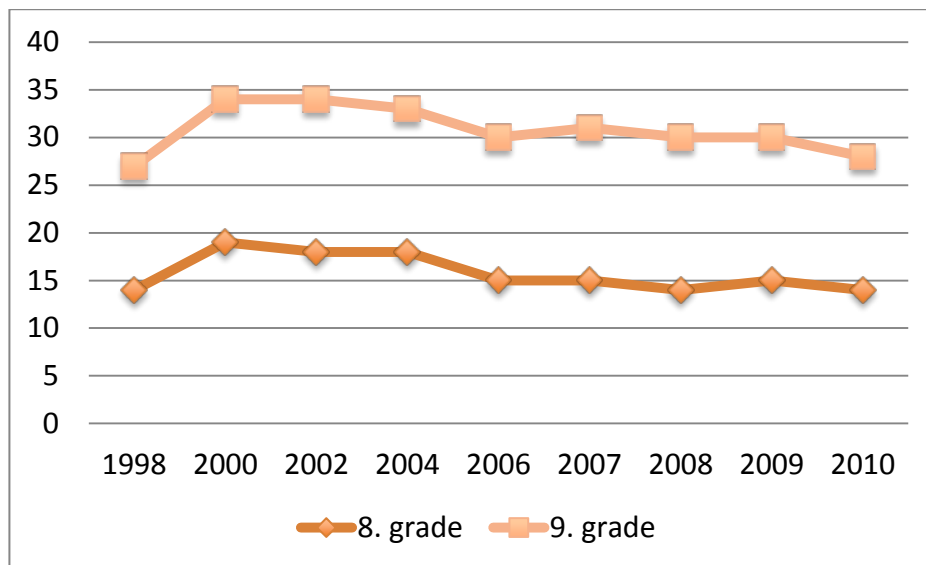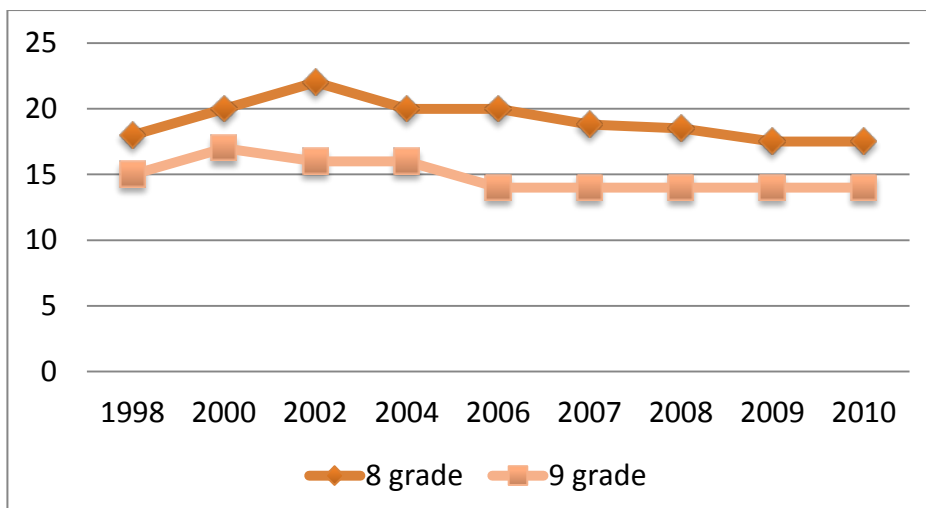

Figure 4.3 Percentage of girls in Finland who did not use contraception at last intercourse

Prior to this time, Finland had already experimented with two other approaches to selecting and training teachers involved in sexuality education. Before 1994, sexuality education was a standalone subject, but it was an addition to the workload of teachers teaching other subjects. Although Apter perceives that it worked acceptably well, teachers were not necessarily well trained or interested in sexuality education.

From 1994 to 2001, sexuality education was integrated in all topics taught at school, but there was a lack of focus and accountability. Apter concludes that the most recent approach in Finland – having dedicated teachers for health education, including sexuality education – is the best approach. As he puts it: "It is large enough to have teachers of its own, who are trained, able to do planning and development, and take responsibility." Apter attributes this approach to the observed high level of comfort among teachers in teaching sexuality education; in one study, only 4 per cent of teachers reported not feeling comfortable or finding it difficult to teach sexuality-related topics. Effectively these teachers are self-selected from the time of their pre-service training in that they opted to teach health education. He notes, however, that this is occurring with the backdrop of a long history. The legitimacy of sexuality education in Finland is widely accepted, even by the church.

Acknowledgements

Reference

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Kenya: Primary School Action for Better Health (PSABH)

Primary School Action for Better Health (PSABH) is the name given to an intervention provided in upper primary school grades in Kenya using regular classroom subjects and co-curricular activities. Initially piloted in Nyanza Province, it was up scaled to national coverage using the existing Ministry of Education (MoE) infrastructure for teacher training, programme delivery and monitoring. The programme was designed to use resources typically available in Kenyan primary schools. Rather than being introduced as a standalone topic, HIV instruction was 'infused' or integrated within all primary school subjects with no limited timeframe during the school year and requiring no additional time commitment from teachers.

At the time PSABH started, UNAIDS estimated the national HIV prevalence rate in Kenya to be 15 per cent (UNAIDS, 2002). HIV was included in the national education curriculum in Kenya from 2001 but was not an examinable topic. No specific teacher training had occurred to support it, and therefore implementation in the classroom was uneven (Jukes and Zuilkowski, 2009). In 2002, the MoE made HIV and AIDS examinable within national primary school examinations. In 2004, a revised national curriculum was introduced with HIV included in a more explicit and structured manner (Jukes and Zuilkowski, 2009).

PSABH was piloted in one district of Nyanza Province in 1998 within a wider HIV prevention and care programme agreed between the Ministry of Health (MoH) and the UK Department for International Development (DFID). It was a province with high HIV prevalence and high levels of poverty. PSABH itself was implemented as a collaborative initiative between the MoE and the British NGO, Centre for British Teachers (CfBT), also funded by DFID. Key CfBT programme staff had had previous experience with national scale programmes in the Kenyan primary education sector. The programme was not initiated as a research project, but an evaluation component came to be integral to the project. It was evaluated at nine and 18 months in Nyanza by Eleanor Maticka-Tyndale of the University of Windsor in Canada. Based on these results, it was expanded to five additional areas in Kenya, chosen to reflect diverse settings so as to test the applicability of the programme. The programme was evaluated again at 30 months and was later delivered across the whole country.

The intervention

The government and PSABH team achieved high coverage by selecting teachers for training using a strengthened training cascade. They brought trainers from different levels, sectors and regions together in a planned manner to maintain common standards across training workshops. The team assumed that there needed to be a critical mass of trained teachers

within each school, so three teachers were selected in addition to a head teacher. A community representative, who was a parent at the school, was also chosen by each head teacher according to agreed selection criteria to participate in the training in an effort to build community support and awareness about the programme.

The components of PSABH can be summarized as follows:

1. Teacher training by a combined team of trainers from the MoE and the MoH using materials designed for PSABH by the CfBT; participants were trained in a two-cycle residential programme (participants are brought back for training after spending a semester in school after the first cycle). Teachers were trained to train colleagues in their own schools, to integrate HIV education throughout classroom subjects and to provide guidance and counselling to students on HIV-related topics. Participants were provided with full-board accommodation during training and their travel costs were reimbursed.
2. Establishing student health clubs and question boxes within schools.
3. Training of a community representative (one per school attended the two-week training).
4. Peer supporter training.
5. Training of MoE Quality Assurance Officers to monitor HIV and AIDS education in schools.
6. Training of deans of curriculum and students from pre-service teacher training colleges.

Teaching and learning materials, largely generated by the Kenya Institute of Education (KIE), were provided to schools after they attended the training programme. Monitoring was conducted through the regular annual monitoring by the Kenya MoE.

Evaluations

Separate models of teacher training were developed and evaluated; based on the results, a "Basic Model" was refined and scaled up to all primary schools in Kenya. This included training of the head teacher or deputy, one resource or senior teacher and one community representative in two week-long training sessions.

In the 18-month evaluation, 160 schools in Nyanza were selected as intervention and control sites using cluster randomized sample selection. Surveys covered:

- 6,700 Standard 6 and 7 students and 289 teachers at baseline data collection in November 2001,
- 6,400 students and 210 teachers at 9-month follow up in February to March 2003,
- 6,152 students and 212 teachers at 18-month follow up in October 2003.

This evaluation found that the programme was being effectively delivered at scale in Nyanza. Target schools had a statistically higher level of comprehensive, sustainable HIV

and AIDS programmes integrated throughout school activities. It also found gains in knowledge and reported self-efficacy and reported student sexual behaviours. (For details of the evaluation findings, see the PSABH website and the articles by Maticka-Tyndale cited below).

A year after the programme was initiated in Nyanza, and even before the above evaluation results were received, the MoE encouraged the team to expand activities to the Rift Valley where it was rolled out to 1,200 schools within two years. Evaluation of impact in Rift Valley schools showed results that paralleled those in Nyanza.

A 30-month evaluation was conducted at 20 of the original intervention sites in Nyanza to assess whether the improvements noted in the 18-month evaluation were sustained. In this case, because of the ethical requirement and governmental request that the initial control areas should be provided with the intervention, the research design lacked a control (thereby meaning that environmental influences cannot be ruled out) and was based on pre-and post-test design. This evaluation found that teachers continued to deliver the programme three years after training, and indicators of pupil knowledge, attitudes and reported sexual behaviours showed that gains demonstrated for the cohort evaluated at 18 months were replicated for the cohort evaluated 30 months after programme initiation in the schools.

Data were also collected from secondary school students in six of Kenya's eight provinces in December 2005 and January 2006. The aim was to compare students who had attended schools where teachers had benefited from PSABH training with those from schools where teachers had not been trained by the programme. It found that gains witnessed among primary school students were maintained and enhanced into the secondary school years.

Facilitators to achieving scale

According to interviews with the team members, achieving scale was helped by a number of factors. First, based on their previous programme experience in running scaled up national educational programmes, the PSABH team 'designed for scale'. That is, they asked themselves what an MoE would need to do if sexuality education were to be scaled up nationally to 25,000 schools. As Janet Wildish, formerly of CfBT, put it: "You can't give the MoE a programme that can only be delivered in 300 schools. This is their world – they need to think about reaching the 25,000 schools in a realistic timeframe." To do so, however, meant that the programme had to be feasible in the least resourced school in the country, not just the best, most well-off or most accessible. Moreover, the team describes their training philosophy as including the 'best and the rest' – that is, they aimed not only to focus on the best trainers or best teachers, since that would not allow the programme to reach scale, but rather to integrate mechanisms to improve all those who enter (e.g. trying to develop a 'chalk and talk teacher into an interactive facilitator' – Wildish).

Above all, then, the aim of the programme was to use existing resources and educational infrastructure, recognizing differentials across the country. A case study on the programme quotes its planners as saying: "PSABH was designed by people who knew how Kenyan schools ran; we intentionally designed the strategies to build on what was either already being done at school, or what the MoE had instructed should be happening in the delivery of the curriculum" (Jukes and Zuilkowski, 2009, p. 9).

Second, strong data by an independent evaluator provided evidence and arguments for education policymakers to address controversial issues. The training content and approach were adapted to address these research findings as the scaling-up proceeded.

Third, high-level political commitment facilitated the scaling-up process. The Kenyan government had declared HIV and AIDS a national disaster and was committed to scaling up sexuality education. Moreover, in a political system that is not highly decentralized, national directives could be translated more easily into national implementation than in a more decentralized setting. The fact that the programme chose to combine staff of both the MoE and the MoH in the training of teachers and community representatives also fostered collaboration between the ministries.

The donor, DFID, was committed to achieving national coverage and required that the proposed programme should be integrated within existing structures of the Kenyan educational system for long-term sustainability (Jukes and Zuilkowski, 2009). Although it was never able to provide long-term funding, the donor was clearly committed to and supportive of the process. Evaluation data gave it the evidence needed for this support. In general, there was a high level of trust and concurrence of vision between the government, DFID and the NGO, given long experience of working together.

Strong local leadership among the programme team was also critical to the programme's success.

According to interviewees, the late Mary Gichuru, a teacher who had risen up the ranks of the MoE, knew the context of schools in Kenya well and commanded a strong moral authority that was important in view of potential resistance on cultural or religious grounds in Kenya. This meant also that she could lead and manage a large team of trainers, stimulate interest and enthusiasm among teachers, could relate their activities to 'the national interest' and could negotiate among the many, varied interests.

Constraints to scaling-up

One obstacle to achieving impact was teachers' evident discomfort with discussing condoms. The MoE did not provide any formal guidance on the discussion of condoms in the classroom, but did allow that teachers had a responsibility to answer pupils' questions on

sexuality and health issues. This led to a compromise whereby teachers did not plan lesson material to teach about condoms but could provide factual information when asked by students.

One main constraint to scaling-up was the loss or transfer of trained teachers: 22 per cent of trained teachers were lost to the intervention schools during the first two years following training due to death, retirement or transfer (Maticka-Tyndale *et al.*, 2010). To the team, the turnover of teachers, educational administrators or local government officials who had become allies in the programme was a constraint to scaling-up. They followed a strategy of 'managing for succession', a concept that was common to MoE officers, to overcome this.

Lastly, variations in infrastructure across schools presented challenges for scaling-up. As noted above, this meant that the 'lowest common denominator' the programme was dealing with was quite low.

Conclusion and lessons of the PSABH experience for other settings

An approach of 'designing for scale' – aiming for national coverage within a period of five years – was ambitious. However, the result was that teacher training, the delivery of an infused sexuality education approach, and monitoring and support for a behaviour-change focused approach to HIV prevention in Kenya's primary schools became integrated within the infrastructure of the MoE, through the HIV and AIDS Investment Plan. As the 2009 case study on the programme noted: "In contrast with most other school HIV prevention programmes, PSABH is not only still present in schools but has been enveloped into the national educational system." (Jukes and Zuilkowski, 2009) Moreover, the programme was able to weather substantial changes in education policy as well as extended periods of teacher strikes.

Institutions involved

Ministry of Education (MoE); Ministry of Health (MoH); Centre for British Teachers (CfBT); Department for International Development, UK (DFID); Steadman Research Services, Inc. (data collection for evaluation); University of Windsor (Canada).

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Nigeria: Family life and HIV education

Background

Nigeria illustrates the complexity of adopting a national scaling-up strategy for sexuality education in a populous country with a highly decentralized system and an ethnically and religiously diverse population. Nigeria has a population of more than 158 million people and is governed by a federal political system with 36 semi-autonomous states.

The country's education system mirrors this complexity, and scaling-up of sexuality education has needed to roll out both at federal and state level. Although educational policy and provision is largely the responsibility of Nigeria's states, the federal government is also involved in provision of education at state level through Federal Government Colleges. In each state, Federal Government Colleges (two to three in each state) cover approximately 10 per cent of enrolment. Since these colleges are highly subsidized, they are less expensive and have some of the best teachers. Conversely, state schools account for more than 90 per cent of enrolment.[31]

The prevalence of HIV in Nigeria increased from 1986 to 2001 (to 5.8 per cent) but has started to decrease since 2001. However, since Nigeria is the most populous country in Africa, the number of affected people is extremely high (Federal Ministry of Education *et al.*, 2010). From the beginning, the rationale of scaling up sexuality education used by the government was to assist HIV prevention.

In 1995, a coalition of 80 organizations adopted guidelines for comprehensive sexuality education in Nigeria for use as an advocacy tool led by Action Health Incorporated (AHI) (Esiet, 2010). In 1999, the country's National Council on Education approved a policy to integrate sexuality education into the curriculum of all Nigerian schools. In 2001, a national curriculum was developed and advocacy proceeded to encourage implementation at the state level. Consistent with the system of governance in Nigeria, the curriculum had to be approved at state level. However, the curriculum faced religious opposition in some states, particularly in northern Nigeria. As a result, the content and the name were changed in 2003. The result was the renamed Family Life and HIV Education (FLHE) curriculum. Individual states were given room to tailor it to suit their own contexts. The National Policy on HIV/AIDS for the Education Sector was finalized in 2005.

In 2004, teaching of the FLHE curriculum started in 320 lower secondary schools in Lagos State with technical assistance from AHI and funding from the Ford Foundation, MacArthur

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31 Interview with Oladeji Adeyemi, Association for Reproductive and Family Health, Nigeria.

Foundation and Lagos State Government. By June 2005, 1,700 teachers had been trained and provided with teaching resource materials across the state. In 2009, the Global Fund approved funding for scaling up FLHE at national level in its Round 9 funding. The goal was to train 48,440 teachers in five years – 20,880 teachers in the first phase and the remaining teachers in the second phase of the grant, with the long-term aim of securing budgetary commitment from the government. To do so, a Project Advisory and Advocacy Committee was inaugurated in each state of the federation including religious and traditional leaders, representatives of heads of schools' associations, parents' associations and teacher unions (which are very strong in Nigeria), as well as selected politicians.

Intervention and scaling-up

Nigeria has made significant progress in scaling up sexuality education over the past 10 years.[32] For many years, the country was reluctant to accept sexuality education, despite high levels of unprotected sexual activity, unwanted pregnancies, abortion-related deaths and STIs and HIV. AHI and other organizations were actively involved in advocacy to secure governmental commitment. By necessity, they started with extra- and co-curricular activities before there was any willingness to incorporate sexuality education into the curriculum.

The scaling-up of sexuality education was rapid in Nigeria, which itself has posed problems (as discussed below). Starting out in less than eight states in 2005, the FLHE curriculum was being delivered in schools in 34 out of 36 states in the country by 2008 (Esiet, 2010). Currently, the FLHE curriculum is available for primary, secondary and tertiary levels, but most implementation is concentrated at the junior secondary level (with very little at primary level).

At state level, implementation has mainly proceeded through collaboration with NGOs and state educational authorities. This typically consists of training sessions for master trainers and then introductory sessions for carrier-subject teachers. Given the diversity within individual states, selection of teachers for training on FLHE sometimes do not follow the criteria.[33] With encouragement from the Global Fund, they gave preference to zones where HIV is higher and selected schools where the head teacher lent support to sexuality education.

In 2008, noticing the variations across states in acceptability of sexuality education and in the quality of implementation, the Federal Ministry of Education published *Guidelines for Implementing the National Family Life and HIV Education Curriculum* to serve as a quality assurance tool for stakeholders. Recognizing the need to foster exchange among trained teachers, AHI has also organized refresher meetings for them – with support from the Ford

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32 Interview with Adenike Esiet of AHI.

33 Interview with Oladeji Adeyemi, Association for Reproductive and Family Health, Nigeria.

Foundation – on issues such as the content of the curriculum, lessons learned, training needs and, importantly for a populous country such as Nigeria, how to use participatory techniques given large class size.

Most recently, out of recognition that reliance on in-service training is not sustainable, pre-service training in sexuality education has been initiated through collaboration between the National Commission for Colleges of Education and AHI to ensure that the 94 colleges of education across country can generate a national supply of teachers. In these teacher training colleges, Family Life and Emerging Health Issues (FLEHI) is a general studies course and therefore it is compulsory and examinable. Also, FLEHI quality assurance tools have been developed and lecturers are being trained in monitoring and assessment methodologies to facilitate effective and standardized delivery of the curriculum.

Facilitators for scaling up

In summary, the scaling-up strategy in Nigeria has had elements of vertical (institutionalization) as well as horizontal scaling-up. According to Esiet, key elements of scaling-up have been: national policy that provided political backing; funding from diverse donors; development of resource materials; provision and pre- and in-service training; community mobilization and parental support (Esiet, 2010).

Today in Nigeria, according to Esiet, there is a large range of actors interested in working on sexuality education and it is important to recognize the importance of institutionalization. Some states have implemented the curriculum consistently to a large extent and there has been positive change in indicators of adolescent sexual health in those states.

Challenges for scaling up

At the same time, those who have been working on sexuality education in Nigeria admit that the rapid scale-up without sufficient dedication of funds by government created 'logistical and management problems'. Provision of funds both from state and federal budgets has been insufficient and as a result, often conflicting priorities and scaling-up strategies of donors have tended to dominate. There are also several instances where some donors do not comply with the agreed standards for training duration, depth and methodology, as published in the national guidelines for curriculum implementation. As Esiet explains, there would be greater coverage of teacher training, better distribution of teacher and learner resource materials and routine monitoring of classroom implementation if more governmental support existed. Advocacy is therefore essential to ensure that governments uphold their financial commitments.

The rapidity of the scaling-up process has also raised many issues, including the difficulty of building commitment at state level while simultaneously ensuring teachers are trained, and

making sure that there are enough resources to ensure monitoring covers the FLHE curriculum.

Experts on the sexuality education programme in Nigeria cite constraints to scaling-up that are not specific to sexuality education but pertain to the weakness of the education system as a whole, such as low teacher morale, lack of sufficient supervision and support, large class sizes and consequent shortage of materials. In addition, they comment that the monitoring and evaluation system is very weak, and the support from the Global Fund included minimal funding for this aspect. Before support from Global Fund, the HIV Unit of the Federal Ministry of Education (the unit charged with responsibility for coordinating the implementation of FLHE) lacked reliable data from states even on basic indicators such as numbers of teachers trained and students reached with FLHE information.[34] There are efforts to integrate supervision of the FLHE teaching into routine school inspections systems but since these are not funded adequately, it has been very challenging.

Esiet also notes that there is a high turnover of officials at the government level, even after investments in their capacity building; there is therefore a risk that, with limited institutional memory, newly-assigned officials may adopt different approaches without reference to the existing guidelines for implementation.

It is believed that the critical constraint to scaling-up is the sheer population size of Nigeria, and the fact that organizations supporting the effort are restricted in their own coverage.[35] Sustaining momentum in different states (which are so populous) becomes a major challenge. He identified the following further constraints:

1. weak political will in some states, because the government does not see the added benefit of the curriculum; although the Global Fund expects states to scale up, this has not yet been done;
2. social opposition in some states; and
3. resistance from teachers who, in some respects, see the FLHE as extra work that challenges their methods of teaching.

Lessons of the Nigeria experience for other settings

The Nigerian experience illustrates the challenge of scaling-up in a populous country that is at the same time highly diverse with many layers of administration. The rapidity of the scaling-up process raised many logistical and other challenges. The experience illustrates the importance of ensuring that sufficient resources are in place and shows that systems for

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34 Interview with Oladeji Adeyemi, Association for Reproductive and Family Health, Nigeria.

35 Interview with Oladeji Adeyemi, Association for Reproductive and Family Health, Nigeria.

monitoring and evaluation need substantial support. As Esiet says, it also "…underscores the importance of ongoing advocacy, even when a favourable policy environment exists" (UNFPA 2010).

Figure 4.4 Diagram showing efforts to scale up sexuality education in Nigeria
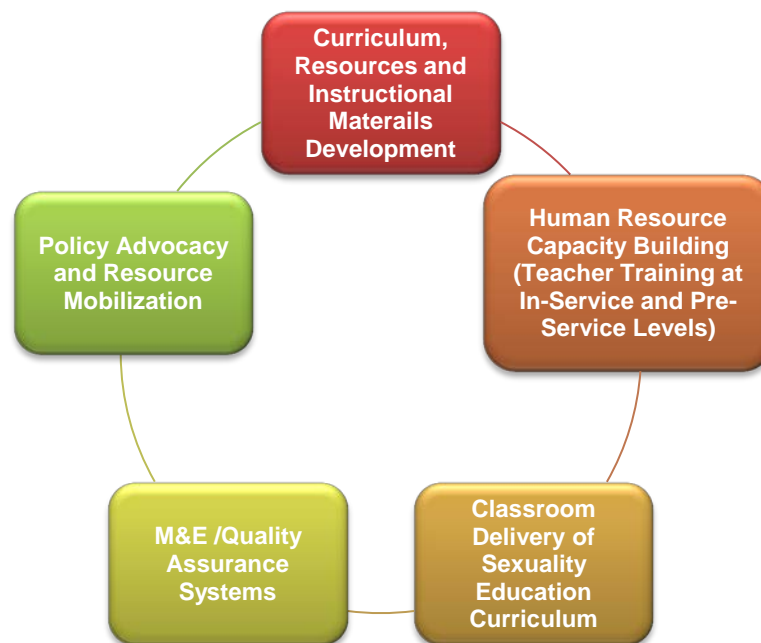
Key Intervention Areas for Sexuality Education Institutionalization

Source: Esiet, 2010 (reproduced with permission of author)

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Tanzania: MEMA kwa Vijana

Background

MEMA kwa Vijana (MkV) (Swahili for 'good things for young people') was designed as a multi-component adolescent sexual and reproductive health intervention in Mwanza, Tanzania. It involves school-based, teacher-led lessons, provision of youth-friendly services and community mobilization and awareness-raising sessions. Further details of both the intervention and its evaluation and related research are available at www.memakwavijana.org. This case study focuses on the school-based components only.

There are very few similar interventions in sub-Saharan Africa that have been evaluated through a community randomized trial to take into account knowledge, behavioural and biological outcomes. MkV is one of even fewer examples of a rigorously pilot-tested sexuality education intervention that has been deliberately scaled up. In this case, there was a 10-fold scale-up to all schools (from 62 in the pilot to 649 schools) and health units (from 18 in the pilot to 179 health facilities) in four out of eight districts of the region of Mwanza in Tanzania. Furthermore, the intervention and its evaluation were informed by an extensive qualitative research programme, which formed part of the Health and Lifestyles Research (HALIRA) Programme among adolescents that was run in parallel with the first phase of the MkV project from 1999 to 2002 (see Plummer and Wight, 2011). Moreover, the project is unusual in that a detailed evaluation and documentation of the scaling-up process was undertaken, using mixed methods, as appropriate to this multi-faceted intervention. This latter research identified facilitating and constraining factors to scaling up as well as analysing how large-scale implementation affected the quality of the programme delivered (see Renju, 2011). Both of these key aspects of scale-up are severely under-researched.

The MkV initiative is also exceptional for its deliberate effort to integrate the evaluated intervention within existing local governmental systems. Although its initial impetus was a research effort, careful groundwork allowed the team to deliberately develop an intervention that could be scaled up by government without significant additional resources. It ruled out an alternative, peer-led intervention because it was decided that this could not be scaled up without intensive resources for supervision. Moreover, the buy-in of the education and health ministries in Tanzania was critical to its implementation at scale. It became evident that the ministries were more likely to invest in a teacher-led intervention than a peer-led programme, as well as youth-friendly services.

Tanzania has a population of about 34 million and Mwanza is the second most populous region. The majority of the population lives in rural areas. When scaling-up began in 2003, HIV prevalence was 7 per cent among 15 to 49 year olds, and 60% per cent of new infections were among young people – defined in Tanzania as 15 to 35 years old (Renju, 2011, p. 12). The approach was to test the feasibility of scaling-up the initiative in a defined geographic area, rather than to aim initially for national coverage.

Due to concern over the HIV epidemic, the Tanzanian Ministry of Education was committed to offering HIV education. In 2004, the government issued guidelines on HIV education in schools. However, it did not have a clear strategy for doing so. Moreover, it recognized its own limitations in implementation, particularly as a large country moving towards increasing decentralization of core programme activities. It was therefore open to collaboration with NGOs in rolling out sexuality education. The African Medical and Research Foundation (AMREF) had long experience in the field and working relationships in the study areas. It supported implementation in partnership with governmental and research institutions (see below).

The intervention

As shown in the timeline below, the intervention was developed from 1997 to 1999 and evaluated initially from 1999 to 2002, as part of a community randomized trial (see Ross *et al.*, 2007). During the trial, the intervention was implemented in 62 primary schools in 18 health facilities in 10 randomly selected intervention 'communities', with 10 comparison communities. The 1999 to 2002 trial evaluation was conducted on a total of 9,645 adolescents. The programme was evaluated for longer-term outcomes (including biological outcomes) again in 2007 to 2008 in the 10 trial intervention and 10 comparison communities (see Doyle *et al.*, 2010).

The results of the randomized controlled trial on evaluating the impact of the intervention showed significant benefits to students' knowledge of sexual and reproductive health (SRH), but revealed no impact on HIV sero-incidence and herpes simplex virus type 2 (HSV-2) sero-prevalence at three years (2001/02). In the longer term (nine years), there was significant sustained and positive impact on knowledge. A lower proportion of males reported having more than four sexual partners in their lifetime, and there was increased reported condom use at last sex with non-regular partners among females. However, there was no significant impact on reported attitudes to sexual risk, reported pregnancies or other reported sexual behaviours or on the biological outcomes tested (HIV and HSV-2), (Doyle *et al.*, 2010).

Scaling-up

The intervention that was scaled up consisted of:

1. Orientation of three days for head teachers and guardian teachers.
2. Intensive training of ward education coordinators and science teachers teaching in the last three years of primary for 12 days.
3. Mobilization activities – one-day meetings took place with the ward development committees to increase awareness of the programme and to encourage key community level support.
4. Health education awareness days – one day in each school was intended to be set aside to conduct community level health education activities. The awareness-raising took place once in each community throughout the whole project. Each community refers to the ward level, which had about six schools in each.

The scaling-up process took place formally between 2004 and 2008 when four districts commissioned a scale-up to cover all wards within the four districts. This was led by local government with assistance in implementation provided by eight AMREF staff. Specifically during this MkV Phase 2 stage (MkV2), scaling-up entailed: assisting the districts in the AIDS response; scaling up MkV into 649 schools and 179 health facilities; conducting a process evaluation to assess implementation and integration at the district level; developing and evaluating complementary community interventions; and conducting policy research and advocacy for national uptake.

The MkV team recognized that they would need to tailor the intervention to make it manageable and affordable at a greater scale, and they were interested in monitoring and documenting the impact of such changes. For example, implementing at scale called for a decreased level of supervision. In the short term (three years), this was not found to have any detrimental impact on the knowledge gain of the students. However, it did lead to a reduction in the fidelity and coverage of the intervention implementation. By design, the supervision of the teaching of sexuality education was integrated within routine supervision systems, but the team identified that these were weak and needed strengthening if the programme were to be sustained at scale.

Teacher preparation and selection

The MkV team acknowledged that, if sexuality education were to become institutionalized in Tanzania, there was a need for pre-service training of teachers. However, in the absence of pre-service training, in-service training was needed and the criteria for selection of teachers for training would be critical to the programme's success. In order to achieve high coverage of teachers for such training, the MkV team developed a 'supported cascade system' for

selecting teachers for training. This was designed to favour the selection of female teachers, as well as encouraging those selected for training to return to their schools and conduct training within their individual schools.

After 2000, the government developed the policy that only science teachers should teach about HIV. This created some difficulties in that science teachers tended to focus more on the biological aspects rather than life skills. Moreover, since teachers often change subject every year at primary level, the fact that mainly science teachers were selected for training created some jealousy among teachers. MkV was designed as a standalone sexuality education programme, but subsequently policy in Tanzania has evolved to promote an integrated approach. Subsequent to the scaling-up, government policy has changed again in that the subject of 'personality development and sport' was introduced, which might have been a better channel for teaching life skills.[36]

The MkV team paid careful attention to how the intervention and its scaling-up was perceived by teachers and their motivation for offering sexuality education. They conducted a detailed evaluation of the training of teachers, analysing coverage, attendance, selection, motivation and attitudes, among other factors. The study found that teachers were able to implement the intervention on a large scale. Although there was some erosion of intervention fidelity, the quality of key aspects of its delivery was maintained. Furthermore, the trained teachers were more likely to consider adolescent sexual and reproductive health as a priority in schools and less likely to link teaching it to the early initiation of sex than non-trained teachers. There was also some evidence of a 'spill-over effect' to other aspects of education; a third of trained teachers and a quarter of ward education coordinators reported increasing their use of participatory techniques in other sessions in addition to MkV sessions.

To assess the quality of implementation, the team also analysed exercise books of students and found that 16 to 30 months after the intervention had been started, 89 per cent (989) of these contained some MkV notes.

As noted above, the team conducted a detailed process evaluation and analysis of the scaling-up process, identifying facilitators and barriers to scaling up. These results, as well as insights provided by members of the programme team, are described below.

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36 According to Mathias Hermann (UNESCO Tanzania), the SRH/HIV/AIDS life skills component has now been integrated in the revised primary (2004), secondary ordinary level (2005), secondary advanced level (2008) and teacher education (2007/08) curricula as a cross-cutting issue. For primary education, the SRH/HIV/AIDS life skills components have been mainstreamed in social studies, civics, personality development & sports and science. For secondary school, it is now taught in civics/general studies and biology and in teacher training in civics/general studies and biology. According to the Education and Training Policy of 2009, HIV/AIDS is to be included as a cross-cutting issue.

Facilitators to scaling-up

Facilitators to the scaling-up process included a strong perceived need for the programme among the community at large, as well as by national policymakers who were committed to delivery of sexual and reproductive health education but did not know how best to do so. For teachers, the examined nature of the material and the structured nature of the intervention also encouraged implementation. The fact that the programme was incorporated as far as possible within existing governmental systems maximized its chances of achieving scale. Finally, rigorous evaluation data, as well as process evaluation data, convinced policymakers of its importance and also of its feasibility at scale.

Barriers to scaling-up

Among the barriers to scaling-up was the low teacher density in Tanzania, especially in rural areas, and in particular the lack of female teachers in rural areas. There was also the problem of the transfer of trained teachers (although, as team members point out, if national scale were achieved, this would be less of an issue). The turnover of key staff within local government also proved an obstacle, as new negotiations and induction had to be initiated. As discussed below, there was also lack of a district governmental commitment to the budgetary contributions that were initially envisioned.

Lessons of the MkV experience for other settings

A number of instructive lessons drawn by the team emerge from the MkV experience of relevance to other countries' scaling-up efforts.

The first concerns the need for careful attention to NGO–government relations in the handover of projects to government. As Renju and colleagues (2010b) note, capacity constraints are often a clear impediment to scaling up, and NGOs may be able to fill that gap. They argue that scaling-up typically requires changes in both sides of the government–NGO relationship. In this case, for example, the NGO was more experienced in and comfortable with implementation themselves rather than facilitating the local government authorities to do this. On many occasions the NGO staff felt the need to step in and take over the implementation tasks so as to be sure the scale-up continued as planned, rather than standing back and encouraging the local government to take on the programme activities themselves. They suggest that, although embedding NGO technical assistance within the government had many positive short-term effects, it may have also delayed or hindered integration of the programme into governmental systems in the long term. As they put it: "Whilst NGO assistance at local government level was successful in supporting operational scale-up, our research suggested that psychological and financial integration were hampered by high rates of senior staff turnover, persistent strategic and financial control by the NGO and limited understanding and acceptance of the overarching policy

framework at the local government level" (Renju *et al*, 2010, p. 39). Despite extensive efforts to hand over the programme, the project was still perceived by governmental authorities as NGO-led.
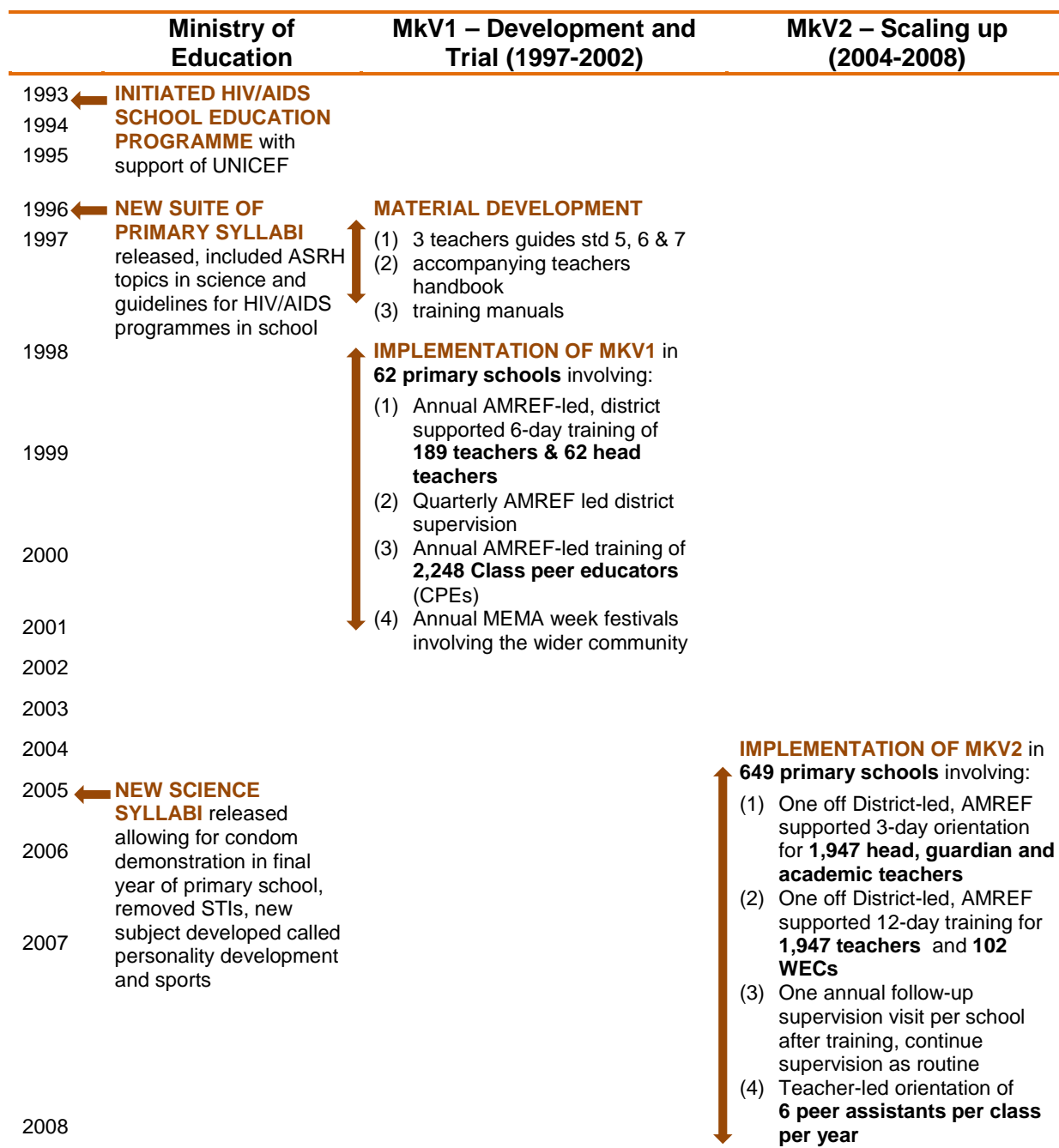
Second, having deliberately focused on one region of the country provided an opportunity for the programme to learn from and integrate itself within local government systems. This was important in a setting of 'incomplete decentralization' such as that of Tanzania. As the programme team describes it, "The MkV intervention was developed through local partnerships in line with national guidelines and with input from national bodies and initiatives" (Renju, 2011, p. 39). Nevertheless, team members point to the challenge of working at a regional (sub-national) level while simultaneously trying to stay informed about and in turn inform policy changes at the central level of government. The team engaged government directly in the project from the outset (for example, on its Senior Advisory Committee) but nevertheless the central Ministry of Education still perceived it as a project that was not under their jurisdiction.

Third, the team also faced challenges in relation to the scale-up timeline of four years with a one-year no-cost extension imposed by donor funding, as well as trying to achieve governmental ownership of the project within that period of time (see Figure 4.5). The initial understanding was that districts would increasingly invest money from their own budgets in the project, but the reality was that districts did not do so (only one district out of four allocated any funds for teacher training). Nevertheless, the NGOs involved continued to work to achieve the deliverables despite this budgetary deficit, because of the need to produce agreed outputs. Team members recommend that some sort of fund-matching or conditionality would be needed in future to facilitate this process. They note that, once districts integrated sexuality education financially within their budget, the line item tends not to be changed often and thus is protected, making it more likely that implementation will occur.

Conclusion

This MkV experience has contributed to a wider understanding of both the impact and process of scaling up school-based interventions. It has also shed light on how the realities of the cultures within and relationships between NGOs and government agents can interact in unexpected ways to affect outcomes. The MkV2 programme is still widely known and referred to within schools in Mwanza. However, lack of ongoing financial commitment has meant that this scale-up was not extended further.

Figure 4.5 Timeline of MkV1 and MkV2 (scaling up) in relation to timeline of relevant governmental policy

	Ministry of Education	MkV1 – Development and Trial (1997-2002)	MkV2 – Scaling up (2004-2008)
1993	**INITIATED HIV/AIDS SCHOOL EDUCATION PROGRAMME** with support of UNICEF		
1994			
1995			
1996	**NEW SUITE OF PRIMARY SYLLABI** released, included ASRH topics in science and guidelines for HIV/AIDS programmes in school	**MATERIAL DEVELOPMENT** (1) 3 teachers guides std 5, 6 & 7 (2) accompanying teachers handbook (3) training manuals	
1997			
1998		**IMPLEMENTATION OF MKV1** in **62 primary schools** involving: (1) Annual AMREF-led, district supported 6-day training of **189 teachers & 62 head teachers** (2) Quarterly AMREF led district supervision (3) Annual AMREF-led training of **2,248 Class peer educators** (CPEs) (4) Annual MEMA week festivals involving the wider community	
1999			
2000			
2001			
2002			
2003			
2004			**IMPLEMENTATION OF MKV2** in **649 primary schools** involving: (1) One off District-led, AMREF supported 3-day orientation for **1,947 head, guardian and academic teachers** (2) One off District-led, AMREF supported 12-day training for **1,947 teachers** and **102 WECs** (3) One annual follow-up supervision visit per school after training, continue supervision as routine (4) Teacher-led orientation of **6 peer assistants per class per year**
2005	**NEW SCIENCE SYLLABI** released allowing for condom demonstration in final year of primary school, removed STIs, new subject developed called personality development and sports		
2006			
2007			
2008			

Source: Renju *et al.*, 2011, p. 81 (reproduced with permission from the authors)

Involved institutions

Tanzania National Institute for Medical Research, the African Medical and Research Foundation (AMREF), Liverpool School of Tropical Medicine, the Social and Public Health Sciences Unit of the UK Medical Research Council, the London School of Hygiene and Tropical Medicine in partnership with the Tanzanian Ministry of Health and Social Welfare and the Tanzanian Ministry of Education and Vocational Training.

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See also the MkV website: http://www.memakwavijana.org

Thailand: TeenPath

In 2003, TeenPath became a project implemented by the Programme for Appropriate Technology in Health (PATH), Bangkok office. Funded by the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), through the Ministry of Health, its goal was to promote the scaling-up of sexuality education in Thailand. The project team worked in collaboration with the Ministry of Education and other NGOs and the project is called: Comprehensive Sexuality Education (CSE) and HIV prevention among young people (2003–2014). Its goal is for each school to include sexuality and HIV education in the curricula of Grades 7–12, as well as in vocational schools.

Policy background

Sexuality education has been included in Thailand's basic educational curriculum for secondary school since 1978. However, there has not been any formal training for teachers on this subject. Since 2002, sexuality education has been officially incorporated into physical health and physical education for basic education, although its content has been heavily focused on the bio-medical aspects of sexuality. Comprehensive sexuality education is considered a core strategy in the National AIDS Plan 2007–2011 in which the Ministry of Education is expected to play a major role. Both governmental and non-governmental organizations are involved in HIV and AIDS education in Thailand.

Scaling-up strategy

The TeenPath project developed three main objectives in its scaling-up strategy. First, to develop a foundation of human resources and skills among adults to provide comprehensive sexuality education in school settings and to promote youth involvement. Second, to create a supportive policy and community environment for sexuality education and sexual health. Third, although not the focus of this case study, to build model youth-friendly sexual health services and to strengthen links from schools to health services. The project promotes comprehensive sexuality education by integrating it within secondary/vocational schools on a regular basis and by promoting participatory learner-centred educational methods. The aim is that sexuality education should be covered for no less than 16 hours per academic year.

Given the restrictions on funding, the GFATM project could only cover 35 per cent of schools. This is partly due to the fact that sexuality education is a transversal subject in Thailand. It is included in several subjects in the core curriculum and therefore the numbers of teachers involved in teaching sexuality education is high. Teachers expected to teach elements of sexuality education receive a four-day course. Trained teachers are also

exposed to refresher workshops that focus on specific topics, such as improving facilitating skills, how to design learner-centred lesson plans, the positive youth development approach, sexuality and the media.

In addition, TeenPath developed a teacher coaching approach, whereby trained 'coaches' support teachers in other schools. Two-day training courses on coaching are held in schools for school administrators in charge of technical aspects of the curricula or teachers who serve as sexuality education coordinators. These can also include public health officers, university lecturers or NGO personnel who are willing to serve as coaches. These sessions are conducted at the provincial level in order to create a network of sexuality education coaches who can help each other. After the two-day training on coaching, the coaches are encouraged to conduct coaching sessions three or four times per semester, depending on each provincial plan. TeenPath also piloted a system of peer teacher observation sessions, but this was only possible in 20 per cent of schools. When funding permits, they bring teachers together at the provincial level to help motivate them and refresh their training.

The basis for choosing schools changed as the project progressed. Initially, the Ministry of Education selected schools, but over time, TeenPath learned that it was important to select schools with the strongest support for sexuality education. Therefore, TeenPath project staff meet with heads of schools, explain the process and then teachers are selected. The focus is currently on health education teachers and those who are clearly assigned to teach sexuality education in those schools.

Given the highly decentralized nature of the educational system in Thailand, TeenPath has learned that school boards can be important; they recognized the need to build the capacity of school boards in understanding and promoting sexuality education, which they are doing where possible with limited resources. The project also reaches out to parents and the wider school community on issues concerning sexuality education. Seeking additional support from the local administration level, PATH encouraged schools and health workers to organize training for parents to improve communication with their children on issues related to sexual matters. PATH designed a one-week training (eight modules) and trained health workers, teachers and NGOs as well as people living with HIV and AIDS as trainers to deliver this 12-hour training to parents. Many schools decided to include the parent training in their sexuality education in schools, as it has been shown to increase parental support for teaching sexuality education to students.

In terms of coverage, TeenPath (now in year nine) has focused on 43 (out of 77) provinces in the country, reaching 1,889 schools in the Year 1 through eight levels. They expect to reach 300 schools for Year 9 to Year 11. For secondary schools, they have reached 1,304 out of 8,000 and they have covered 354 out of 415 public vocational schools and 200 out of

400 private vocational schools. Twenty-nine out of 41 teacher colleges/universities were included in the project as well. This scale, if reached, should create a critical mass that might be the impetus for the entire education system to incorporate comprehensive sexuality education into the curriculum with optimal hours to affect behavioural change among the students.

In terms of progress towards policy commitment to sexuality education in Thailand, the Office of the Vocational Education Commission (OVEC) announced that comprehensive sexuality education would be included as a subject in the OVEC curriculum in 2004 and private vocational schools echoed this commitment in 2011. In 2008, the new Basic Education curriculum included sexuality education within health education. At least four universities have already included sexuality education in their pre-service teacher training.

Evaluation

PATH commissioned an external evaluation team during year four and year five to evaluate student outcomes at schools that incorporate sexuality education in the core curriculum, compared to non-teaching schools. Although the scale was quite limited (16 schools, including eight intervention and eight control schools), it was found that the student scores on knowledge, attitude to and practice of condom use and more partner communication among those already sexually active, were significantly higher among students in intervention schools. However, the study also found that the number of hours allocated to teaching sexuality education remains low at only four to six hours per year.

Recently, PATH commissioned another study comparing schools teaching comprehensive sexuality education with 16 hours, compared to those with lower hours or non-curricular activity. The preliminary results clearly revealed a superior score among those with 16-hour learning.

Challenges to scaling up

The challenges to scaling-up exemplified here relate to the fact that the scaling-up strategy was NGO-led, and thus faced the challenge of both translating pilot interventions to programmes delivered on a wider scale but also to the challenge of institutionalization within governmental structures. A number of structural obstacles have impeded this effort, including high turnover of staff at the Ministry of Education; during the last eight years, there have been five changes at the level of Minister of Education, for example. Moreover, the NGO PATH had more extensive experience in public health programmes in Thailand, and therefore working in the education area was new.

According to TeenPath staff, one of the key constraints has been the vision and commitment of Ministry of Education at all levels, and of schools themselves. One important challenge

has been the philosophy of education whereby the focus is on academic excellence -many administrators and teachers do not see the relevance of sexuality education. Therefore, it is not clear who has the mandate for developing a long-term, systematic and strategic plan for building the capacity for sexuality education among teachers through in-service training. However, clearer policy signals from the central level could reduce this constraint, as this quote from an educational superintendant at provincial level illustrates:

> Today we already have sexuality education curriculum, thanks to Path, but it is still unclear for who are the main responsible person in school. Should that be health education teacher? Or should it be guidance teacher? Then who or which unit of the education superintendent to be responsible for ensuring schools are implementing it and keep improving teacher skills? Who will be responsible to produce new teachers for this subject area. I have not heard any clear signal from policy level up above….

> Somnuek Boonpanya, Education Superintendent, Srisaket (Quote from Pawana Wienrawee presentation, Bogota Consultation, 2010)

The fact that the educational system is very decentralized also means that there is a high level of autonomy for individual schools to decide how to approach sexuality education. The decentralized nature of the system posed a dilemma between developing a standardized package with clear lesson plans as opposed to more flexible approaches. Ultimately the extent to which sexuality education is actually taught, despite teacher training, is up to the motivation of individual schools and teachers to teach the subject.

Moreover, a further constraint to scaling up sexuality education in Thailand is the fact that there is no government earmarked funding for sexuality education and that the resources of sthe GFATM project are limited.

Lessons learned for other settings

The challenges TeenPath faced in Thailand have relevance to scaling-up strategies elsewhere. The team identified the need to work simultaneously both on increasing coverage while maintaining a quality sexuality education programme. Yet the deliverables in terms of accountability to donors have tended to focus more on increasing coverage.

Given that sexuality education is a transversal subject in Thailand, the team found that it was often easier to integrate it within smaller schools where one teacher teaches multiple subjects. Finally, the link to adolescent sexual and reproductive health services was an important element of the scaling-up strategy. This is particularly the case as Thailand's policymakers become increasingly concerned with problems of unplanned pregnancy in Thailand. This became a 'policy window' to address sexuality education in schools.

Planned next steps

TeenPath plans to take advantage of the new 2008 curriculum and the revision of the content and framework of the health and physical education curriculum to promote the scaling-up of sexuality education. The project will be extended to 2014. TeenPath plans to secure local funding for this work in order to expand the programme to 34 new provinces. The project also aims to include sexuality education in the indicators established in Thailand to set school standards.

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Uruguay: Building a National Sexuality Education Programme

Until 2010, Uruguay – a country of 3.2 million people in the southern part of Latin America – had one of the most extensive sexuality education programmes on the continent. The programme was developed by sectoral experts and civil society groups working in alliance with the Ministry of Education (National Administration of Public Education) and the Ministry of Health. As in other parts of Latin America, sexuality education in Uruguay is supported by national legislation (most notably Act 15 of December 2005 and the General Education Law 18437 of August 2009), as well as the country's commitments subscribed in international conventions, including the International Bill of Human Rights, the Convention on the Rights of the Child and the Convention for the Elimination of All Forms of Discrimination against Women. The sexuality education programme in Uruguay is premised on three pillars:

- the importance of sexuality in the development of individual identity and social relations;
- sexuality education as an educational process crucial to both citizenship and democracy; and
- the promotion of health in childhood and adolescence.

Background

During the twentieth century, several initiatives relating to sexuality education were initiated in Uruguay. However, they faced resistance from conservative social and political forces. When democracy was restored in 1986 (after a period of military rule), the National Sexuality Education Programme was created with support by the Pan American Health Organization (PAHO). However, in 1996 the new education authorities suspended the programme as part of their opposition to the inclusion of issues considered to be sensitive, namely gender and sexual orientation. In 2005, with the first progressive government in the history of the country, the new education authorities incorporated sexuality education as one of five strategic policies of the education system.

The 2006–2010 period saw a process of construction of social consensus on sexuality education and the fostering of political commitment to its implementation. Political commitment was generated by engaging teachers through their technical and labour unions, academic centres, public and private institutions working with young people and other civil society groups (women's groups; people living with HIV, etc.). Data from opinion polls were also important in raising awareness within the Ministry of Education about the importance of sexuality education.

The steps taken towards scaling up implementation capacity can be summarized as follows:

First stage (February–December 2006): This period included the development of the proposal for sexuality education in the country. Its programmatic content was developed by a working group with members from all sub-systems of the education sector and representation from the Ministry of Health. The levels and modalities of implementation were discussed through a process of broad consultation with all levels of society (public and private; institutional; civil society; and young people). The government authorities approved the proposal and moved towards its implementation beginning in November 2006.

Second stage (February 2007–June 2008): Sexuality education committees were formed in each of the educational sub-systems (pre-school; primary; secondary; technical; Pedagogical Institute). This period also saw the development of a sexuality education curriculum adapted to different levels of the education system, and teacher training then followed. By March 2008, the curriculum was extended into secondary and vocational institutions with the support of international organizations such as UNFPA, UNESCO, UNICEF, UNAIDS and the German Agency for International Cooperation.

This period also witnessed increased involvement of Uruguayan programme planners in sexuality education with their counterparts in other countries in Latin America. A project called 'Harmonization of Public Sexual Education Policy and HIV Prevention in the School Environment' (supported by GTZ, UNAIDS and the Brazilian Agency for South-South Cooperation) was initiated. It included Argentina, Brazil, Chile, Paraguay, Peru and Uruguay. These six countries agreed on core principles, as follows:

- The education sector must assume the lead role in the definition and implementation of public sexual education policies based on the human rights perspective.
- Prevention of HIV and AIDS must be approached through an inter-sectoral approach based on the frameworks of sexual education and comprehensive health promotion.
- The systematic inclusion of sexual education in the studies and continuous training of all teachers is a fundamental requirement to assure the quality of the thematic issue.
- The contents of Comprehensive Sexual Education must be integrated in all levels of education.
- The sustainability of public policy of Comprehensive Sexual Education requires policy decisions and budget allocations.

Involvement in this regional initiative helped to strengthen the programme in Uruguay.

Final stage (July 2008 ─ June 2010): This period saw expansion of the programme throughout the country and its institutional consolidation. By 2010, the sexuality education programme was completely integrated into the Education Planning Directorate. This scaling-up was achieved through greater institutionalization and a clearer division of responsibilities into a) curriculum implementation and b) teacher training. It also led to the creation of a

National Centre of Reference and Documentation on Sexuality Education, which combined written and online materials, making it a valuable resource at local, national and regional levels.

Within each of the 19 geographical departments of Uruguay, strong interdisciplinary groups were created to ensure sustainability and to collect information on the local and regional needs so as to tailor sexuality education more closely to the lives of children and adolescents in the country. These combined teachers from different levels of the educational system with members of civil society to promote sexuality education. The programme also organized workshops with the pre-school and primary education system on the implications of new laws pertaining to sexuality (e.g. same sex unions, change of sexual identity and the adoption of children). The programme commissioned an external evaluation during 2009 with the objective of evaluating the quality of the action taken, the satisfaction of the 'target'population, and the achievements and difficulties that teachers encountered approaching sexual education in the classroom and at the level of their institutions.

Challenges to scaling up

As is the case elsewhere in Latin America, the education system in Uruguay is highly decentralized. Therefore, the scaling-up of sexuality education to national level meant having to navigate through difficult and complex relationships with autonomous bodies in the various educational sub-systems. Moreover, sexuality education does not receive an earmarked budget incorporated within the governmental system, making it vulnerable to financial cutbacks.

Scaling up sexuality education has also encountered many cultural and ideological obstacles. For example, teachers tend to treat sexuality as a cognitive subject or behaviour rather than viewing sexuality as part of the construction of personal identity. Moreover, teachers have difficulty fostering personal autonomy among students and often prescribe their own or other 'established' values and norms concerning sexuality and sexual relationships. Certain issues continue to be sensitive, including premarital sex and abstinence, contraception and emergency contraception, sexual diversity and the provision of condoms in school settings for HIV prevention.

Political setbacks

Despite the progress described above in the institutionalization of comprehensive sexuality education within the educational system and in garnering social consensus about its importance, political setbacks have occurred. Although there was a progressive party coalition in power, in July 2010 the new educational authorities closed the national Sexual Education programme. They transferred a limited number of its components to a new

Programme of Healthy Living Together. Various public and media protests ensued. As a result, financial support from the UN system ended and no specific national budget was secured.

As of 2012, curricula activities continue but neither the programme team nor the reference centre continues to operate, and no specific studies or evaluations are being undertaken. This removal of elements of the former sexuality education programme related to knowledge production, communication and exchange among teachers were the very factors that favoured the growth and strength of their training and ensured creative management within the system. The lack of resources to sustain the various established strategies and research that enriched and supported curriculum implementation disrupted collaboration with universities and research centres.

Arguments used to close the sexuality education programme have referred to a supposed need to focus primarily on operational criteria in a perspective of a strictly biological orientation (avoidance of risky behaviours including violence and the need for health care). Consistent with other measures taken by the current administration, the education system is focusing on employment training in line with new economic opportunities in Uruguay. The government is aiming to produce more qualified workers that the economy needs, ignoring rights-based education, citizenship and the development of critical thinking. In this scenario, sexual education is no longer a priority as very conservative ideas of gender and sexuality persist 'underground'. Some also consider that sexual education could contribute to an already low birth rate that has long been a feature of Uruguayan demography.

Lessons learned of relevance to other settings

Uruguay's experience points to the critical need to ensure continuous political support. Even when extensive effort is made to achieve social consensus about its importance, this does not guarantee its sustainability. In the case of Uruguay, the absence of continuous national funding made it vulnerable to politically motivated cutbacks.

Sexual education needs to be developed from the outset with the participation of public and private sectors, but also including young people themselves, and with leadership of the governmental education sector. There is also a need for continuous updating of the knowledge base about changes in the everyday life of young people in the country. Moreover, continuous dialogue and exchange is needed between programme staff and the families of students as well as within the educational community. Ongoing evaluations to determine if the quality of the programme is being sustained and whether it is having an impact are also critical.

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SAFE II for Europe: http://www.ysafe.net/safe/

Sexuality education in Europe:
http://www2.hu-berlin.de/sexology/BIB/SexEd/SexEd.html

TeenPath (Thailand): www.teenpath.net

The YP Foundation (India): http://www.theypfoundation.org

Interagency Youth Working Group: http://www.iywg.org/

APPENDICES

Appendix 1: List of Interviewees

The author is grateful to the following experts (listed in alphabetical order by last name) who were consulted in preparation of this draft for their insights and for directing me to relevant documentation and stakeholders in this field:

- Oladeji Adeyemi (Programme Manager, FLHE/NYSC, Association for Reproductive and Family Health, Abuja, Nigeria)

- Dan Apter (Family Federation of Finland, Finland)

- Doortje Braeken (IPPF Youth Advisor, London, UK)

- Emma Braithwaite (Nossal Institute, University of Melbourne, Australia)

- Chris Castle (UNESCO HQ, Paris, France)

- Ishita Chaudhry (YP Foundation, India)

- Dhianaraj Chetty (UNESCO HQ, Paris, France)

- Esther Corona (Mexico)

- Mary-Guinn Delaney (UNESCO regional advisor, LAC, Chile)

- Margarita Diaz (Reprolatina, Brazil)

- Jan Eastman (Education International, Brussels, Belgium)

- Adenike Esiet (Action Health Inc., Nigeria)

- Jane Ferguson (Child and Adolescent Health Dept., WHO, Switzerland)

- Nicole Haberland (Population Council, New York)

- Joanna Herat (UNESCO HQ, Paris, France)

- Doug Kirby (ETR Associates, USA)

Appendix 2: Topic guide for consultations with in-country stakeholders[*]

1. Who (types of organizations) are the main stakeholders in sexuality education in your context?

2. How scaled-up would you describe sexuality education for HIV prevention in the country or countries where you work?

3. What have been the main driving forces for scaling up in this context – governments, NGOs or others?

4. Are there linkages between sexuality education/schools and health services?

5. In your context, what would you characterize as the best domains for scaling-up (e.g. curriculum; teacher training, etc.)

6. Are there any examples of successful scaling-up in your context in your view? Is there documentation of these?

7. What scaling-up strategies, if any, has worked in your context?

8. How would you describe the main a) opposition or barriers and the b) opportunities to scaling-up in your context?

9. Are there explicit plans for scaling up? If not, why not?
   What arguments or evidence, in your context, persuades education policymakers about the importance of scaling up sexuality education?

10. What would be useful to people like yourself working at a country level in terms of this report?

11. Can you recommend further stakeholders, especially in government, with whom it would be useful to consult?

12. Recommendations of key documents?

[*] specific tailored questions depending on context

Appendix 3: Topic guide for consultations with experts working at international level[*]

1. How would you characterize the work and approach of your organization in the field of sexuality education for HIV prevention?

2. What geographic regions do you focus on or do you work in globally?

3. Are there any examples of successful scaling-up in your context in your view? Is there documentation of these?

4. What scaling-up strategies, if any, have worked that you are aware of?

5. How would you describe the main a) opposition or barriers and the b) opportunities to scaling up sexuality education?

6. What arguments or evidence, in your experience, persuades education policymakers about the importance of scaling up sexuality education?

7. What would be useful to people like yourself working at a global level in terms of this report?

8. Can you recommend further stakeholders with whom it would be useful to consult?

9. Recommendations of key documents?

* specific tailored questions depending on organization, etc.

This publication is part of an ongoing programme of work initiated by UNESCO in 2008 to provide technical guidance and implementation support for sexuality education programmes, as a platform for HIV prevention, treatment and care.

It emphasizes the challenges and opportunities for scaling up comprehensive sexuality education in school settings. Building on in-depth interviews with key informants involved in past and ongoing work on sexuality education, this publication provides conceptual and practical guidance on definitions and strategies for scaling-up. Though well developed as an area of research and analysis in the health sector, there is a need to translate experience and lessons learned on scaling-up for use in the education sector. Using case studies, the publication also draws on the experience of six country examples (Finland, Kenya, Nigeria, Tanzania, Thailand and Uruguay) which scaled up sexuality education through different modalities illustrating good practice and pathways for successful scale-up.

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