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School-based Sexual and Reproductive Health Education and Its Challenges to Adolescents in Ethiopia; A Qualitative Study

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ABSTRACT

Background & aim: Sexual and Reproductive Health Education (SRHE) helps adolescents avoid risky sexual behaviors such as unintended pregnancies and sexually transmitted infections. However, it is frequently said that school-based SRHE is insufficient and uneven. This study aimed to investigate the perceptions of teachers, students, and healthcare workers regarding the current delivery of school-based sexual and reproductive health education and the challenge it faces in Ethiopia.

Methods: The study was conducted using conventional content analysis of qualitative approach in Arsi Zone, Ethiopia. Overall, 36 participants were involved in the study. Among these, 24 were students took part in focus group discussions and 12 key informants who participated in in-depth-interview. The data were collected using pretested and semi-structured interview guides. All the interviews were recorded and transcribed exactly as spoken. Guba and Lincoln (1985) criteria were used to achieve trustworthiness. The data were analyzed simultaneously with data collection using ATLAS.ti 8 software.

Results: The main themes emerged included: 1) Current school-based Sexual and Relationships Health Education consisted of sub-themes of curriculum contents, teaching approach and students' knowledge of SRHE., 2) Implementation obstacles of SRHE including subthemes such as teachers' confidence, lack of resources/reading materials, cultural and religious barrier sand discomfort with sexual health terminology and 3) Suggestion to improve SRHE comprising subthemes of health promotion policies, creation supportive environments and avoiding obstacles.

Conclusion: The status of school based SRHE is insufficient due to various factors. Policymakers and program managers are advised to incorporate comprehensive SRHE within the normal school curriculum and work on capacity building of teachers through training.

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Introduction

Adolescents Sexual and Reproductive Health Education (SRHE) will help teenagers to make informed decisions and choices regarding their sexuality (1). The goals of Comprehensive Sexual Education (CSE) programs, which are taught in schools in countries with low or middle incomes, are to advance gender equality, human rights, and the prevention of teenage risky sexual conduct (2).

Sexual and Reproductive Health (SRH) is defined by the World Health Organization (WHO) as a complete condition of mental, emotional, physical, and social well-being in

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connection to sexuality, rather than just the absence of illness, dysfunction, or infirmity (3). Thus, every person has the freedom to choose a lifestyle and conduct that will eventually safeguard and advance their SRH (4). In particular, teens have the right to CSE, counseling, access to variety of contemporary contraceptives, safe abortion services, treatment for the consequences of unsafe abortion, protection from sexual and gender based violence, and prevention of sexually transmitted infections (STIs) including HIV/AIDs (5).

The people, groups, institutions (such as schools and hospitals), legislators, and other stakeholders are all accountable for advancing SRHE. Students must receive the SRH instructions listed in curriculum and policy papers from their schools (2). Focusing on the individual as a whole and expressing sexuality as a good aspect of life, sexuality education emphasizes a wide approach to sexuality. From biological to psychological to social to economic, it encompasses all facets of being and being a sexually gendered individual. With an aim to promote SRH, it examines values and cultivates social skills. In order to prevent harmful sexual behavior and because attitudes toward sex are typically formed (6).

Numerous young people are utterly excluded from school-based SRHE both domestically and abroad as a result of inconsistent and frequently inadequate SRHE implementation and interpretation of curriculum and policy guidelines (7). Because of this, a lot of young men and women start their early adult lives without realizing the importance of SRH to general health and welfare (8). One persistent and problematic issue is the inconsistent and/or insufficient delivery of school-based SRHE. Multiple research studies indicated that students' understanding of sexual health and contraception was much increased by school-based SRHE in addition to information from parents, peers, clinics, and technology (8-9). This could therefore contribute to a decrease in Ethiopia's high incidence of adolescent pregnancies and unsafe abortions. Furthermore, it helps to develop effective school-based SRHE and to understand both health care workers and teachers' views on the existing sexual health education. However, there are no studies conducted on school based SRHE among school-going adolescents in Ethiopia. Hence, the study was intended to explore the school teachers, adolescent students and HCWs opinions on the status of school based SRHE and Its challenges in Arsi zone, Ethiopia.

Materials and Methods

Using a conventional content analysis approach, this qualitative study was carried out in the Arsi zone of Ethiopia between April and May of 2021. The goal of applying content analysis was to produce reliable and valid findings from the pertinent data in order to offer the study's new perspective and body of knowledge (10). In five secondary schools and four health centers, purposeful sampling was employed to choose participants with the greatest possible diversity. Before starting data collection permission was obtained from the Arsi zone education office and Health office of Research Centre Scientific Review Committee. Also, the University of South Africa (UNISA) approved the study (REC 0127 14-039 (NHERC)). Twelve key informants (teachers and healthcare professionals) participated in individual in-depth interviews (IDIs), and four focus group discussions (FGDs) with secondary school students (six participants in each group) were used to gather data. We kept sampling until the point of data saturation was achieved. When more sampling is no longer possible for the researcher to gather fresh data, the data saturation point is reached. The individuals were chosen to represent the widest possible range of characteristics, including location, sex, field of study, and kind of institution (public). The subjects for the study were residents of the Arsi zone, free from mental diseases, and gave their consent. Then, data collection was performed using a semi-structured interview guides adapted from previous studies (1, 8,11). Finally, with the participants' consent, the in-person interviews were conducted. All the interviews were tape-recorded and transcribed verbatim. The interviews were performed in a suitable place, in which the participants felt comfortable.

During the interviews we asked the following questions:

- In your opinion, how important is school based SRHE for the health of adolescents?
- What is your opinion about the current SRHE for adolescent?
- What are the challenges of providing SRHE for adolescents?
- What do you suggest to improve school based SRHE for adolescents?

The approximate duration of the interviews for IDIs and FGDs was 45-60 minutes. Four FGDs were held with students. It was performed during break time at private class to collect valuable information. The groups included a total of 24 secondary school students. The conversations were taped after getting the participants' consent. In the course of the interviews, the researcher acting as a mediator addressed questions, and the assistant researcher oversaw the interviewing process and took notes when necessary to ensure that nonverbal data was not lost. To safeguard the study participants' ethical concerns, participants were told of the study's purpose and their freedom to discontinue participation at any time. Regarding the privacy of their data, they received guarantees. Before the interviews, the subjects gave their informed written consent.

The data were analyzed using the conventional content analysis method using Atlas.ti 8.1 software. The key codes that were related to a certain phenomenon were grouped together and classified into several groups based on their shared characteristics. At last, the concepts were developed.

Guba and Lincoln's (1989) credibility, dependability, confirmability, and transferability criteria were applied to make sure this study was trustworthy. Data credibility was achieved through long-term interaction with the participants, immersion in the data, participant verification of the findings, supervisor evaluations, and a high degree of participant diversity. Transferability was facilitated by preparing the study's setting and culture, participant requirements, data collection techniques, data analysis methodology, and sample participant statements, allowing others to access the study's methodologies and population. Dependability was ensured as the researchers attempted to avoid introducing their assumptions into the data gathering and analysis process enhancing reliability. Additionally, the data analysis process utilized code-recode and external auditing techniques. Conformability was enhanced by incorporating the perspectives of experienced SRH researchers who were not part of the research team at every level of the investigation, including data collection, analysis, interpretation, and sampling.

Results

A total of 24 adolescent students in four FGDs and 12 IDIs with (teachers=6 and HCWs=6) participated in this study. The age range of students was 14-19 years where the teachers and HCWs were between 30-50 year (Table 1).

Table 1. Demographic Characteristics of Participants

Variable	Number	Age	Education	Marital status	Total
Teachers					
Male	4	30-50	Msc=3, Bsc=1	Married	6
Female	2	27-40	Bsc=2	Married	
Health workers					
Male	3	33-45	MSc =3	Married	
Female	3	28-40	Msc =1, BSc =2	Married	6
Students					
Male	12	14-19	Grade 9-12	All single	
Female	12	14-19	Grade 9-12	Single=10, Married=2	24

BSc (Bachelor of Science), MSc (Master of sciences).

According to this study, school-based reproductive health education is associated with improved reproductive health outcomes, such as postponed sexual initiation, fewer sexual partners, and higher usage of contraceptives.

Increasing risk awareness and knowledge about STIs and pregnancy, values and attitudes toward sexual topics, self-efficacy (managing condom use or refusing unwanted sex), and intentions to abstain or limit the number of sexual partners are just a few of the positive effects that many programs have had on the factors that determine risky sexual behaviors.

Theme1: Current school-based SRHE

As described in table 2, the first theme consisted of three sub-themes: curriculum contents, teaching approach and students' knowledge of SRH. The study provides an overview of an incomplete list of subjects taught in the curriculum. Majority of teachers and HCWs stated that the implementation of SRHE is neither mandatory nor comprehensive as other subjects in normal public secondary schools.

Table 2. The Main and Sub-themes emerged from data analysis

Sub-themes	Main themes
• Curriculum content • Teaching approach • Students' knowledge on SRH	**Current School-based SRHE**
• Teachers' confidence to provide SRHE • Lack of resources and training materials • Discomfort sexual health with terminology • Cultural and religious barriers	**Implementation Obstacles of SRHE**
• Health promotion policies • Creating supportive environments • Avoiding obstacles	**Suggestion to Improve SRHE**

1.1 Curriculum content

Teachers disclosed during IDIs that the curriculum did not cover topics such as the anatomy and physiology of the reproductive system, preconception, physical and psychological changes associated with puberty, family planning and contraception, infertility, and SRH rights. Thus, they were obliged to teach the limited contents of SRH lessons which were only taught in biology or natural science. Additionally, It was reported that the time given and content lesson were insufficient to SRH lessons.

One of schoolteacher confirmed as:

"In our curriculum, the SRH contents are very limited and non-compressive. For example, in our school students unable to learn about menstruations and contraceptives methods detail."[Female, teacher]

One HCW participant reflected as:

"I think the access to SRHE at school is limited. This may be either limited content of subject or teachers' ignorance in delivering the lesson." [Female, HCW]

All the participants suggested that the curriculum should emphasize the integration of sexuality education into various year-level curricula and in primary or secondary schools.

1.2 Teaching approach

The study found that none of schools offered CSE separately as an independent subject. There were some contents (HIV/STIs) integrated in biology subjects and delegated to biology (natural science) teachers. Additionally, both male and female students were taught without gender separation. This may create discomfort to teachers and students during discussion openly. The majority of participants recommended that the Ethiopian health policies should support and encourage classroom discussions and teaching of SRHE.

As expressed below:

"As the biology teacher, we focused more on the main subject [biology] since the SRHE is not given adequate time as a separate subject. I think it's also not focused by government and most of us ignore it."[Male teacher]

"It is mandatory to teach adolescents CSE in school separately as one subject and the curriculum should be revised in this way" (Male, HCW).

1.3 Adolescent knowledge of SRH

Research has demonstrated that teenagers, particularly girls, are a susceptible group dealing with a number of severe issues related to SRH, such as unwanted pregnancy, gender inequity, sexual abuse, and STDs including HIV/AIDs (2, 13). These problems are caused due to the limited knowledge adolescents possess of SRH. SRHE for adolescents are of utmost significance to prevent any sexual risks (9). However, the findings revealed that adolescents had limited knowledge of SRH services and choices. In FGDs, the majority of adolescents in selected schools were unable to list contraceptives methods and emergency contraceptives. The only thing they know is about delaying sexual intercourse or abstinence.

The following quotes illustrate their understanding what reproductive health services are all about:

"As a student [adolescent], all I know is not to having sex until we get married. We have no knowledge or skills on how to use and choose the contraceptive methods that would prevent us from becoming pregnant" [Female, students].

Even though the students eager to know about the reproductive health system, the study revealed that they couldn't gain the adequate information.

As stated by one of school student:

" I want to know about all human reproductive anatomy and systems but no one taught us. I didn't know that in adolescence a boy can make a girl pregnant." [Male, Student]

Overall this study shows that SRHE is a neglected subject in school as confirmed by students:

"In the past, we used to hear a lot about HIV, but I haven't heard much about STIs, contraceptives, and other topics. I'm not exactly sure how to protect ourselves against STIs and unintended pregnancies.''[Female student]

Moreover, schoolteachers confirm that:

''We have seen many adolescent girls dropout of school because of unplanned pregnancy and early marriage. I think this is because of they had lack of knowledge about their sexuality and pregnancy prevention methods.''[Male, Teacher]

When we asked teachers and HCWs during the IDIs they reported that most of the students had limited knowledge of SRH issues. It is clear that they did not get adequate information about it both in school and out of it. Also, the participants believed as if CSE lessons are delivered to students they can understand body changes and keep their personal hygiene, enabling them to handle these changes during puberty.

Theme 2: Implementation obstacles of SRHE

The second theme, challenges in delivering of SRHE, included four subthemes: dealing with teachers' confidence, lack of resources/reading materials, culture and religious and discomfort with sexual health terminology.

2.1 Teachers' confidence to provide SRHE

The finding shows that the majority of school teachers are not confident to provide SRHE. This could be the result of ignorance and unfavorable attitudes on sex education. The majority of teachers had not received formal CSE training, and their ability to teach sex education depended on their level of expertise.

One teacher said,

''It seemed to me that I lacked the confidence to impart the SRH lessons. We have limited knowledge and skill about it.''[Male teacher]

They expressed similar thoughts when students questioned if the lecturers were confident enough to convey the teachings on sexual health. Numerous pupils expressed their dissatisfaction with the lecturers' lack of confidence in their ability to honestly discuss the lessons.

One student stated,

''I noticed most of the time our teachers afraid to openly discuss with us and rush when the content in other subject linked it.'' [Male, student]

2.2 Lack of resources and training materials

Teachers at the schools stated in the interview that they have not yet received official training. Also, they have been complaining the lack of reading material and special training on the subject.

"A handbook or reading materials for SRHE was not found in our library." [Female Teacher]

Health professionals gave similar answers when asked if the instructors had sufficient training and experience to impart the sessions on sexual health. They believed that the lesson should be taught by qualified educators or specialists.

One health worker stated that:

"I think well trained teachers should teach the lesson, and they must get trusted reading materials to refer to" [Male, HW].

Furthermore, students reported that none of them trusted reading materials or books found in their library to refer. But they read some times from internet or learn from peers, this may not be trusted and could negatively affect their life.

2.3 Discomfort with sexual health terminology

During individual interviews several school teachers stated how it was difficult to teach the sexual health terminology (language for the female and male anatomy) in terms of emotional reactions from the students. When talking about the appropriate sexual health terminology, teachers have experienced students' immature behavior, reaction and discomfort.

One schoolteacher reflected as:

"Students know them differently than their scientific term. They [students] thought it funny and offensive because of the language or the words is culturally taboo" [Male teacher]

According to other health care workers, societal norms and the local setting still view sexual content as a sensitive topic. It was uncomfortable to discuss openly about sex education with teachers, students, and healthcare workers.

" I think not only students but also some teachers and HCWs fear using scientific terminologies appropriately. Influenced by their culture, maybe some of them might have found it funny and offensive word to discuss openly" [Female teacher]

2.4 Cultural and religious barriers

We identified that religion and social norms may be the cause of teenagers' inability to learn about sexual health, have conversations about it, or receive services that encourage high-risk behavior.

One of the health workers said:

"Many people were embarrassed to talk about their sexual problems. So, government and NGOs should focus on to create awareness in community."[HCW, Female]

Theme 3: Suggestions to improve SRHE

The third subject, which emerged from the three sub-themes (health promotion policies, creation supportive environments, and Avoiding obstacles) were the identified sub-themes. All participants suggested that several places where health promotion can be carried out, including community centers, schools, and health posts. Remembering that various young people require varied methods and messages based on their age, living and family arrangements, and educational standing is crucial in all circumstances.

3.1 Health promotion policies

Effective school health programs are one of the key tools for addressing significant health risks among teenagers and including the education sector in efforts to alter the social, cultural, and educational environments that place adolescents at risk. Accordingly, most of the key informants suggested that the curricula should be comprised and revised to deliver the following contents: reproductive anatomy and physiology, fertility, family planning, pregnancy and childbirth and STIs/STDs including HIV as one subject independently. Adolescent health promotion can take many forms, such as family life education, peer education, community dialogue, and school-based instruction. Promotional events can be held at the health post, in the community, and in schools.

3.2 Creating supportive environment

During IDIs and FGDs majority of the participants regarded the development of religious, community and family involvements as the essential components to improve school based SRHE. In order to influence good behavioral changes, we must actively train or raise awareness of SRH among elected officials, kebele officials, religious leaders, and

community leaders. This will enable adolescents to support access to services and information. It was suggested that educators should be supported by special training and accessing resources/ materials that support them. Additionally, it was suggested that an instructor should be able to build rapport with the pupils, grab their interest, and inspire trust in him.

3.3 Avoiding obstacles

According to this study school-based reproductive health education was affected by misperception and misunderstanding the risks of SRH issues. Therefore, various stakeholders- community members, parents and religious leaders– along with government and NGO support, should be involved in supporting adolescents' SRHE both in schools and outside of them.

Discussion

This study aimed to explore the school-based sexual and reproductive health education and its challenges among adolescents in selected five secondary schools and four health centers in Arsi zone, Ethiopia. Based on the study's findings, nearly all participants thought that providing school-based SRHE would improve the sexual health of teenagers. Furthermore, some of the participants pointed to age-appropriate education that takes personal values and views into account. To enable teenage students to preserve and promote, SRHE that is customized based on age, knowledge and skill demands, and cultural and religious values is required. However, the study showed that the CSE was not introduced to the curriculum to address sexual health problems for adolescents. Findings from the Iran and Chile studies (quoted above) demonstrate that age related SRHE is essential to prevent adolescents from any sexual risk behaviors(11,12). The present study showed that the existing curriculum had not included pertinent lessons like contraceptive methods, anatomy and physiology of SRH in detail. This result is in line with other studies where participants felt that anatomical and physiological aspects of the genital organs should be considered as crucial components of SRHE. They felt that a lack of understanding about sexual and reproductive health, specifically the structure of the reproductive organs, could encourage situations that harm these organs and jeopardize people's health (11). Studies reveal that condoms and hormonal birth control are not permitted to be provided in schools by several school-based health programs because they focus on abstinence for adolescents (13).

According to the study's findings, every participant said that SRHE needed to address the psychological and physical changes that come with puberty. Specifically, every health care worker came to the conclusion that describing the physical and mental changes that happen during this time is essential when teaching adolescents about puberty. Further, the majority of the key informants reported the necessity of teaching about high-risk behaviors for adolescents and revising the curriculum content. School teachers explained that in the Ethiopian education system, SRHE is not adequately delivered and offered to students. These findings are similar to previous studies conducted in India(14). In the sub theme of current school based SRHE, the approach of teaching, curriculum content and students' knowledge were justified by the participants as being essential. The effectiveness of SRHE was found to be significantly influenced by education, brainstorming, discussion, and idea sharing among the participants. This is similar with the previous studies conducted in India and Fiji (14,15). However, it is suggested by several literature that the key focus of the SRHE should be comprehensive and strategic (11,16,17).

In this study the theme was extracted as implementation obstacles in SRHE. There are several factors that influenced the delivery of SRHE like lack of teacher's confidence and knowledge, lack of resources, discomfort with terminology, cultural and religious barriers were identified as sub-themes. This is also in line with the study conducted in different countries using systematic review and meta-analysis (2).

The school-based reproductive health education is associated with improved reproductive health outcomes, such as postponed sexual initiation, fewer sexual partners, and higher usage of contraceptives.

Increasing risk awareness and knowledge about STIs and pregnancy, values and attitudes toward sexual topics, self-efficacy (managing condom use or refusing unwanted sex), and intentions to abstain or limit the number of sexual partners are just a few of the positive effects that many programs have had on the factors that determine risky sexual behaviors (4,16,18). However, the study described more barriers in the providing of SRHE and teaching approach factors. The key barriers were the availability of guidebooks and syllabus for teaching, lack of teachers knowledge and skill on the subject matter(19). Further obstacles to the implementation of SRHE include the topic not being required, teachers' discomfort delivering SRHE since they are not well-trained, a lack of resources, parents' fear of a bad reaction, and the fact that the subject is not examinable. These obstacles are comparable to those in other nations with low and medium incomes. According to a different systematic review and meta-analysis study on school-based SRHE, successful CSE begins in primary schools (18).

This study used a diverse group of study participants including school teachers, students and HCWs to explore the school based SRHE and its challenges for adolescents. It contributes to the richness and integrity of data. One drawback of the current study was that it did not take into account the opinions of parents, civil society organizations, the ministry of education, or policy makers. Another of this study's shortcomings, similar to previous qualitative research, is the non-generalizability of the findings.

Conclusion

This study showed that school-based reproductive health education improves reproductive health outcomes, such as delayed sexual initiation, fewer sexual partners, and higher contraceptive use. It increases awareness and knowledge about STIs and pregnancy, values and attitudes toward sexual topics, self-efficacy, and intentions to abstain or limit sexual partners. However, the current SRHE is neither compulsory nor comprehensive. Its implementation is hindered by structural and individual factors, such as lack of appropriate curriculum, teachers' confidence and knowledge, teaching aids /resources, and cultural and religious beliefs. Further studies should focus on curriculum analysis and community perceptions to enhance SRHE practices.

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Conflicts of interest

Authors declared no conflicts of interest.

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Ethical approval

Permission to conduct the study was obtained following ethical approval from the Higher Degrees Committee of Department of Health Studies at the University of South Africa (UNISA) (Ethics Code:REC 0127 14-039 (NHERC)). All ethical aspects were adhered to, and the Arsi zone Education and Health Office. Zonal Department of Health and Education Research Directorate granted permission to conduct the study. Strict conditions of confidentiality were maintained. To assure confidentiality, trained data collectors were sourced from the university. Higher Degrees Committee of Department of Health Studies at the University of South Africa approved the protocol of this study (code number REC 0127 14-039 (NHERC).

Authors' contribution

All authors contributed to the conception and design of study. DB drafted the first version of the manuscript. HD revised the manuscript and critically reviewed the manuscript for important intellectual content. All authors read and approved the final manuscript and agreed to be accountable for all aspects of the work.

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