



Why should we start younger with sexuality education?



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Our view on sexuality

- Sexual development starts at birth
- Sexuality means more than reproduction:
 - Body image
 - Self image
 - Gender
 - Relationship
 - Feelings, emotions
 - Skills (personal and life skills)
- Reinforce a positive view on sexuality



Preconditions for a healthy sexual development:

- Experience with love and affection and abstinence of (sexual) violence & abuse
- Positive examples of an intimate and caring relationship
- Positive messages about sexuality
- Possibility for discovering own body and the bodies of peers in a playful way
- Possibility to develop necessary life skills
- Intact anatomy (and functioning) of genitals



Features of sexual, emotional and cognitive development

- Discovery of own body (0-4 y.)
- Discovery of special feelings (0-4 y.)
- Behavior: genital stimulation, sexual play (> 1 y.)
- Development of gender-identity (3-7 y.)
- Emotional development: relationship building (> 4 y.)
- Emotional development: self-image, self awareness (>2y)
- Cognitive development: concrete thinking (> 2 y.)
- Moral development: social norms (> 3 y.)

Knowledge of reproduction is very limited



Why should we start earlier with sexuality education?

- Sexual development starts at birth
- To respect the rights of young children
- Young children show sexual behavior and have sexual feelings (at child level)
- Teaching that their feelings are normal at their age
- Teaching appropriate behavior without condemning their feelings
- Talking about this subject is not stimulating early sexual behavior
- Development of life skills may have strong positive influence on later healthy sexual behavior
- In upper primary already some sexual behavior

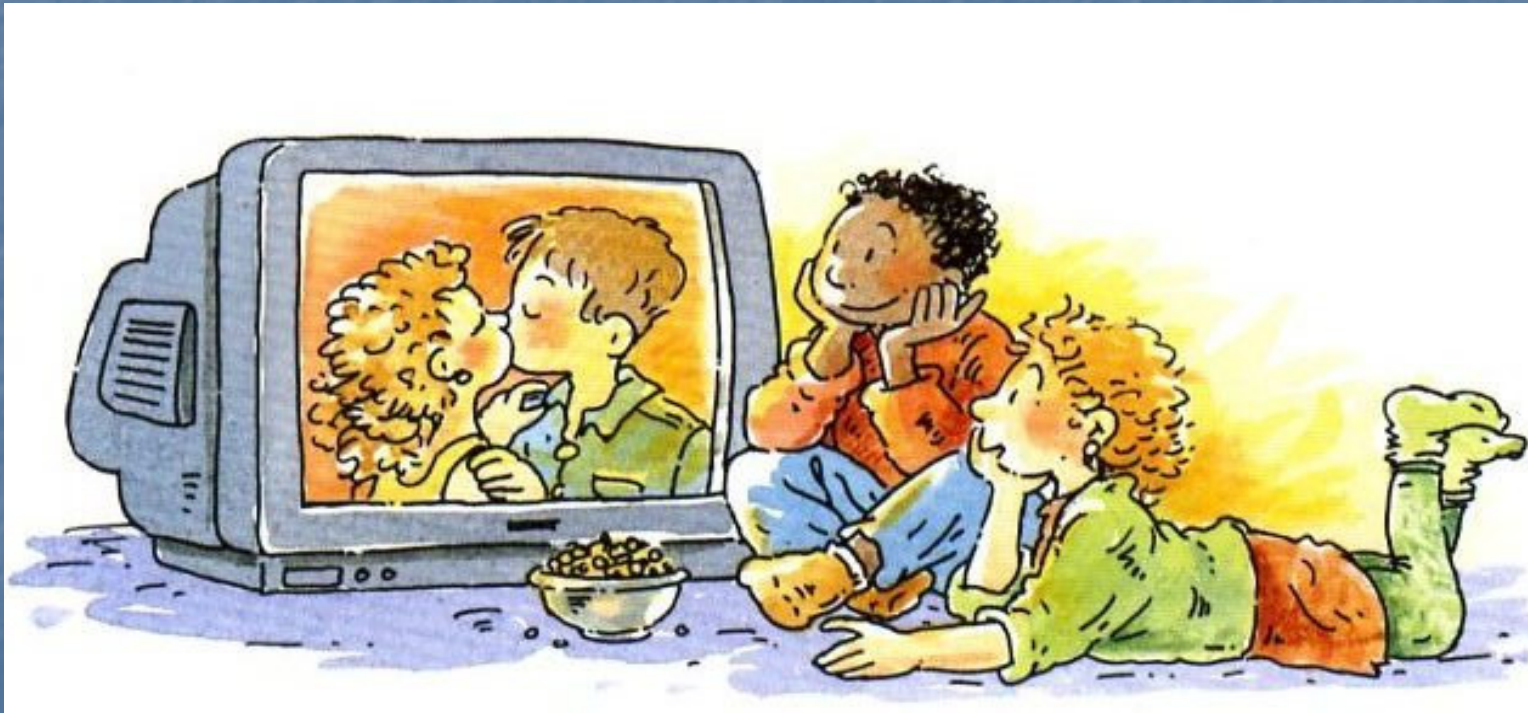


Another name for the same content

- Because sexuality education for young children is sometimes in some cultures a sensitive issue
- Let's call it different:
- In Indonesia we call it now:

A program to support the development of social life values and skills and to protect against sexual harassment.

Thank you!





Let's have a discussion

1. Should sexuality education start earlier? On primary School? At what age at the earliest?
2. What should be the content of sexuality education at different ages on Primary Schools?
3. If you think Life Skills are important to teach for Primary Schools, which Life Skills? And why these Life Skills?



Children and their Sexual Reproductive Health and Rights in Western Uganda

Experiences from Save the Children in Uganda

Warren B. Tukwasibwe
10th - 11th October 2008
Rotterdam, The Netherlands

Why the SCiUG HIV/AIDS and Sexual Reproductive health rights interventions in Western Uganda?

- Between 1996- 2002 Uganda faced the Allied Democratic Forces (ADF) rebels' war in the Western parts of the country where more than 10,000 people were displaced and lived in IDP camps, some for more that 2 years.
- During the period there were reported cases of sexual gender based violence against children, rape and abductions during the peak of the insurgency against the ADF. Important to note that some infections are reported to have occurred with from interactions with in camps and barracks' from the period during and immediately after the war.
- In conflict and post conflict Western Uganda, more than 98% of children in conflict zone reported experience of physical & emotional violence. 75.8% reported experiencing sexual violence and 74.4 % experienced economic violence (source SCiUG studies)
- In Kasese the HIV/AIDS prevalence is 11.2% and in Kabarole 14.1% against the national prevalence of 6.9% (Uganda AIDS Commission source, 2007) some of the contributing factors to this situation are;

Situation of SRH and HIV/AIDS in Western Uganda; Traditional and Cultural context.

- In Western Uganda girl children typically become sexually active, marry, and bear children under 18 which under Ugandan law is defilement, this is attributed to the cultural practices of early marriages. (34% children in Uganda under child marriages (UDHS))
- In Rwenzori region by age 15, 30% of young girls have had sexual intercourse; by 17, 43% have had their first child; and by 18, 56% have married. (UDHS)
- Many births for these young girls are neither planned nor desired. 87% of unmarried young women age 15 - 19 who become pregnant in Uganda report that the pregnancy was unintended. This pattern of early childbearing is a major contributor to Uganda's TFR of 6.9, one of the highest in the world.
- Many children and young people experience sexual gender violence in form of sexual abuse, physical, emotional, sexual and economic violence. About 34% of children in Uganda are engaged in child labour where they may also be sexually abused.
- As many as 55% of young girls report that their first sexual experience was coerced this also means that they were predisposed to HIV/AIDS infection.
- Girls are the least likely to attend post-primary education, training and access general reproductive health information.

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Kabarole is a neighbouring district to Kasese and Bundibugyo and the situation of children in the districts is similar.
wtukwasibwe; 2-11-2008

Traditional and Cultural context ; Gender Dimensions and risks to SRHR and HIV/AIDS.

- In Western Uganda societies 'sex topics' is taboo! Parents often do not feel comfortable discussing sexual health issues with their children for fear it will encourage them to become sexually active.
- In Rwenzori region societies socialisation for boys is different from girls the society encourages them to explore and prove themselves to be men. The same situation should be supportive of girl children.
- In Kabarole defilement cases was one of the highest offences against boys in 2007. Defilement was 31% of all 119 cases. In Bundibugyo out of 305 cases handled by police, 40% was defilement cases. For the year 2006, statistics for the last six month. Kasese reported 97 cases of defilement, Kabarole 70 and Bundibugyo 49. *(SCiUG reports, Kabarole is a neighboring district to Kasese)*
- Nationally only 19% of 15 to 19-year-old girls and 42% of 15 to 19-year-old boys reportedly used condoms at last sex, according to the UDHS. The lack of use of condoms is partly due to the cost of accessing them and sometimes the misconceptions about their use. For example John 18 years, in Bundibugyo had this to say:
'You can't eat a sweet which is wrapped in paper! You would not be able to enjoy the sweetness. Besides it is not easy to use those condoms when she has agreed to give' This also re-enforces the issues around safe sex.'

Overview of SciUG SRHR intervention in Western Uganda.

- The Sexual Reproductive Health and Rights interventions in Kasese and Bundibugyo are focused on ensuring that children and young people in upper primary school (ages 9-14) access SRHR information with in the school curriculum based on the World Starts With Me program.
- In Western Uganda, the project is piloted in Bundibugyo at Bundibugyo Parents Primary school and in Kasese at Kasese primary school.

- Goal:

Improved Sexual and Reproductive Health and Rights (SRHR) of young people.

- Purpose:

To Increase safe sexual behaviour among sexually active young people and delayed sexual onset among sexually inactive young people.

Approach of the SRHR implementation through the WSWM approach.

- The World Starts With Me (WSWM) guides adolescents through the processes of developing a realistic self image, building self esteem, accepting emotional and physical changes in puberty and coping with gender roles to becoming more independent and autonomous, building relationships and deciding on and negotiating sexual activity within intimate relationships by proposing alternative options for safe and consensual sexual behaviour including abstinence from sexual intercourse.
- The curriculum guides young people and supports efforts to prevent both unwanted pregnancy and STIs, including HIV. In addition, WSWM supports in helping adolescents cope with and seek support for sexual health problems, and understand, avoid and deal with sexual harassment and abuse.
- The final cluster of lessons supports young people in sharing their lessons learned with their peers and involves the community in an exhibition on products made by young people during the curriculum.
- The systemic integration of objectives on sexual and reproductive rights throughout is designed to empower adolescents in goal setting, decision making, communication, negotiation and appropriately using health services and products.

Principles of the WSWM and Expected Outputs;

- WSWM is based on evidence and facts, not on religious or political ideologies or cultural norms;
- WSWM is based on openness and acceptance of young people's sexuality, not on taboos;
- WSWM is based on a positive, non-judgmental approach towards sexuality, not on fear or control;
- WSWM is based on equality in gender and sexual orientation;
- WSWM is based on the rights of young people to accurate and correct information and to self-determination, in order to make own responsible choices;
- WSWM is based on respect for young people and trust in their own responsibility;
- WSWM is based on active participation of young people;

Expected out puts;

- The school based curriculum is effectively developed/ adapted for upper primary students.
- Young people approve the adapted curriculum, find it relevant and apply what they learn in their lives.
- Educators are capable to implement the curriculum.
- A referral system for Counselling and health services is established in the school.
- National school policy on Sexual Reproductive Health and Rights is implemented.
- Parents and wider community have positive attitude towards the program/curriculum.

Target group and approach to implementation.

- The computer based version of the WSWM programme developed by WPF, is designed for youth in the age bracket of 12-19. In working towards an adapted version for youth in upper primary level, this looks at the age bracket of 9-14.
- The project in both Kasese and Bundibugyo reaches more than 300 children in both primary schools.
- The project also targets teachers, parents and youth workers/peer educators who directly work with young people, dialogues and review of SRH situation is key.
- Leaders and technical offices at district and National level in the departments of education, social services and health are involved in the Advisory boards and working groups.
- At National level Kyambogo University and School net Uganda take lead in the WSWM adaptation and other capacity building activities for partner at district level.

Expected Changes in Children's Lives

Access to information and skills in the sexual reproductive health and rights for children will lead to many outcomes some of which are:

- Improved communication skills on SRH among children participating in this project.
- Increased Knowledge on life skills among children and openness among Parents and guardians.
- Increase in the number of Parents/ Guardians willing to take their children for VCT services and other health services.
- Improved care and quality of life among children whose SRHR are violated including affected by HIV.
- Reduced stigma among children and families affected by HIV/AIDS.
- Reduction in STI including HIV infections among children and young people.
- Increased demand for utilization of existing SRH including HIV/AIDS prevention and care services.
- Increased Knowledge and skills on SRHR including HIV/AIDS prevention among children and young people.
- Effective home based care, referral and follow up of children who have SRH problems.

Challenges of interventions targeting

children and young with regard to SRH

- SRHR interventions of a pay-off which is less clear and may take a longer period of time to produce results in the form of quality of care and support and thus there is lack of appreciation among communities and some families.
- SRH programs for young people have to achieve more diverse outcomes than programs for older people example are; good health, ability to go to school, access to good nutrition. There has been little skills and understanding of the best practices by care givers and health workers.
- Children and young people are seen as having fewer rights especially in accessing health services though the trend is changing with more health workers being trained in handling.
- Advocates have a particularly hard time getting support from decision makers on issues of SRHR because they fear a backlash this is specific in areas of lake shore communities and urban centers.
- Children and Young people have less experience and skills as advocates and in articulating their needs, the community structures of peer educators and child care givers will continue to be the vanguard for their issues to be brought to the forefront.
- Youth get older and their needs and concerns change hence their targeted

Actions and progress by partners.

- Partnerships have been developed between Save the Children in Uganda, Save the Children Netherlands, World Population Foundation, School Net Uganda and Kyambogo University on the implementation of the pilot SRHR project in Western Uganda
- Partnership with Government institutions of Education, Health and Social Services, these departments are consulted and involved in the processes
- Identification of stakeholders and holding of the first planning workshop involving schools (teachers, children and administration), in Kasese and Bundibugyo, children, World Population foundation, Kyambogo University, School Net Uganda and Save the Children in Uganda.
- Ongoing review by Kyambogo University on the existing curriculum in schools (upper primary) with regard to SRHR information and preparation of a report in February 2009.
- Selection and formation of the working groups and advisory boards composed of the key stakeholders including children to review the SRH curriculum based on the WSWM

Actions and progress by partners cont'd.

- Providing youth with a comfortable and appropriate setting to access SRH services- including linking and establishing children's centers at health service delivery units.
- Mapping and special attention to meeting the SRH information needs especially the girl children in hard to reach areas of mountains and lake shores.
- Instituting programmes at health centers that retain them for follow-up and repeat visits, in collaboration with peer educators and child care givers, including teachers and parents.
- Partnership development with Baylor College Uganda for free ART for children in Kasese and Bundibugyo. Closer consultations with the DHAC and the SHAC (Bundibugyo and later Kasese) and the H/C IV's management teams.

Implementation approach and Partnership Development

- Partnership has been developed among the following institutions which are key in the implementation process;

- Save the Children Netherlands.
- World Population Foundation.
- School Net Uganda
- Kyambogo University

Others are;

- The two primary schools of Kasese Primary school and Bundibugyo Parents primary school.
- The line departments of Education, Health and Social Services in the district local Governments of Kasese and Bundibugyo

Together!

We continue to work through processes that ensure that the sexual reproductive health and rights for children are realized and that children and young peoples lives will be better.