

Lessons learned from the adaptations to the provision of comprehensive sexuality education during the COVID-19 pandemic: Case studies from five countries

Authors

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Country / Institution

India: Family Planning Association of India (FPAI)

Philippines: Family Planning Organisation of the Philippines (FPOP)

Myanmar: Marie Stopes Myanmar (MS-M)

Namibia: Namibia Planned Parenthood Association (NAPPA)

Zimbabwe: Ministry of Primary and Secondary Education (MOPSE) in partnership with UNFPA and UNESCO

Key learning points

Organisations nimbly adapted the provision of different CSE programmes to overcome the obstacles created by the pandemic by using a variety of approaches that enabled them not only to reach the target audiences intended by these organizations, but also additional groups such as out of school adolescents.

These organisation informed adolescents and young people about available SRH and mental health services, and acted as means of referring some of them to these services.

There is a potential for these nimble adaptations to be used beyond the pandemic context, either by complementing or by substituting traditional programmes, especially in humanitarian contexts, but their effectiveness needs to be further evaluated.

Background

The COVID-19 pandemic and the actions that countries have taken to respond to it have had a profound impact on the lives of adolescents around the world. There is growing evidence about the indirect effects that COVID-19 has had and continues to have on adolescents' lives.

Early in the pandemic, service disruptions and movement restrictions led to limited access to health, education and social services, including those related to adolescent sexual and reproductive health (ASRH), and comprehensive sexuality education (CSE) programmes were among the first to be discontinued.

In this brief, we provide a synthesis of lessons learned from five countries on different adaptations employed by organisations (see the name of the organisations above) to provide CSE in the light of the challenges imposed by COVID-19.

Impact of COVID-19 on essential health services

Prior to the pandemic, the CSE programmes provided by these organisations were delivered in schools as a part of their curricula, in adolescent and youth clinics, and youth friendly spaces.

Prior to the pandemic, all of these programmes were provided in person, mostly as group activities that were led by teachers, peer educators and CSE programme facilitators. These programmes targeted school students as well as adolescents and young people not in school.

As countries imposed lockdowns, schools and community based activities -including those related to CSE- were affected. In order to resume these activities, the organisations referred to in this brief adapted their programme design and delivery processes.

What was the intervention or activity?

During the pandemic, the organisations either employed remote services or a combination of remote and facility-based approaches, wherever possible.

In terms of digital methods, these adaptations included the use of one or more of (i) asynchronous online modules, (ii) synchronous online group sessions, in addition to (iii) social media and messaging apps.

More specifically in India, a seven module CSE programme was delivered as online sessions to adolescents, both in and out of school. Similarly in the Philippines, online sessions were used to deliver CSE. This was complemented by establishing virtual groups for additional engagement with adolescents, sharing short sexual and reproductive health (SRH) promotion messages across social media apps accessed by adolescents, and by setting up a hotline to respond to their queries. In Zimbabwe, the MOPSE adapted its CSE programme to reach in and out of school adolescents through radio edutainment lessons. Teachers from different grades adapted the CSE syllabi and developed lessons scripts and scenarios for the radio lessons.

It is worth noting that in Myanmar and Namibia, in person activities were carried out while taking into account COVID-19 prevention protocols. The programme in Myanmar continued in classrooms with reduced numbers of students in each session. In Namibia, the programme involved peer education activities. In both countries, the in-person education was complemented with the use of messaging apps to provide snippets adapted from their CSE curriculum.

Curricula in most sites were adapted and included what was perceived by young people as 'hot' topics. For example, there was a focus on sexual and gender-based violence, menstrual health, and contraception, in addition to mental health and COVID-19 to provide the needed information as requested by adolescents themselves.

How did this intervention/activity contribute to the maintenance of EHS?

These adaptations were intended to improve the access of adolescents that were already targeted by these CSE programmes. However, it improved the access of additional groups such as out of school adolescents. Furthermore, it provided a chance to promote sexual and reproductive health services that were functional during the pandemic and acted as a referral pathway to some of these services.



Artwork prepared for and in conjunction with WHO. Artist: Graham Ogilvie, ogilviedesign.co.uk

What were the key challenges involved?

How were these challenges overcome?

While some of the organisations selected online approaches to deliver CSE, in other settings, access to Internet was either impeded by lack of telecommunication infrastructure or due to its high cost. To overcome these challenges, organizations either used other means or employed their use of online approaches strategically. For example, one organization used radio to provide edutainment activities as it was more fitting and enabled the organisation to reach a wider audience. On another occasion, one organisation used social media apps and messaging apps to provide CSE as they were included for free in smartphones' bundles and would not impose additional cost for adolescents who preferred this approach. Moreover, two organisations were successful in carrying out in person CSE activities with adolescents and used online resources only as a complementary component to augment their reach.

One other challenge was that the initial use of online resources had its impact on the quality of engagement with adolescents as it was unidirectional and of less interaction when compared to in person activities that were conducted prior to the pandemic. To address this challenge, organisations designed their programmes to include interactive components. For example, the CSE radio lessons in Zimbabwe were designed as interactive sessions with edutainment component plus a dialogue element as well. Additionally, organizations used social media and messaging apps to carry out discussions with adolescents, and respond to their queries. Finally, in India and Philippines, online synchronous sessions were implemented to have better engagement with adolescents.