Promotion of Sexual and Reproductive Health in Schools and Universities in Cameroon.

Report

August 2018

This strategic briefing note was written by a multidisciplinary team from the Centre for the Development of Best Practices in Health as part of the SURe-KT project .

Audience of the Strategic Briefing Note.

Decision-makers, managers, their collaborators and other stakeholders interested in the **choice of strategies for the sexual and reproductive health of adolescents in Cameroon**.

Why was this Strategic Briefing Note written ?

This strategic briefing note was written to inform deliberations on sexual and reproductive health policies by providing an evidence synthesis on issues and relevant options for solutions to problems faced within this field.

What is a strategic briefing note ?

A strategic briefing note synthesizes **research evidence** (from systematic reviews*) and **local evidence** to inform decision making and deliberations relative to health policies and programs.

***What is a systematic Review ?**
A summary of studies that responds to a clearly formulated question that uses systematic and explicit methods to identify, select and critically appraise relevant studies. Data from different studies are extracted and can be analyzed together using meta-analysis techniques.

Executive Summary

The evidence presented in this Full Report is available in the form of a more succinct executive summary.

Authors

Dr Moustapha Moncher Nsangou, Sociologist, PhD, Researcher

Email: jordynsangou@yahoo.fr

Dr Renée Cécile Bonono Momnougui, Anthropologist, PhD, Researcher

Email: bonono2003@yahoo.fr

Pr Marie-Josée Essi, Anthropologist, PhD, Researcher

Email: mariejoseessi@yahoo.fr

Pr Pierre Ongolo-Zogo, Health Policy and Systems Analyst, Researcher

Email: pc.ongolo@gmail.com

Correspondance Address

Pr Pierre Ongolo-Zogo, Centre for the Development of Best Practices in Health

Central hospital of Yaoundé, Cameroon, Po Box 5604 Yaoundé – Cameroon

Author contributions

MN, POZ, MJE and RCB designed the approach, CDE searched for the evidence, AJ and JPO extracted important elements from the documents. MN, RCB, MJE formulated the context and the options and considerations for implementation. POZ has revised the successive versions of the document.

Conflicts of Interest

None.

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CDBPH - The Center for the Development of Best Practices in Health is a research unit created in 2008 within the Central Hospital of Yaounde. It aims to promote the application and exchange of knowledge to improve health in Africa. The mission of the CDBPH is to enable health researchers to collaborate with policy makers. This initiative aims to help researchers by collecting, synthesizing, and disseminating relevant evidence-based syntheses in a more digestible, accessible, and usable form for most stakeholders at various levels. The CDBPH also aims to support policymakers by providing capacity-building opportunities, providing evidence-based syntheses and identifying needs and gaps in the evidence base in practice. www.cdbph.org

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Context

As part of the project "Knowledge on Reproductive Health: Improving, Evaluating and Institutionalizing the Application of Evidence", a deliberative forum was organized with stakeholders including policy makers, researchers, partners and civil society organizations. The purpose of the forum was to identify priorities for adolescent sexual and reproductive health in Cameroon. The thematic analysis of the discussions showed a gap of knowledge and skills in the transmission of sex education and an unpreparedness of adolescents and young adults (10-24 years) to sexual and reproductive life on the one hand and an incapacity to protect and promote their reproductive health. It was also emphasized that the family, school, college, high school and university are formal reference spaces, where this preparation of adolescents and young adults for sexual and reproductive life should be done.

This strategic briefing note is prepared to accompany the implementation of the "learning" initiative of the national investment plan for the reduction of morbidity and maternal, infant and child mortality. It aims to provide stakeholders with evidence to optimize efforts in schools and universities to promote reproductive health and reduce reproductive health risks and issues among adolescents and young adults.

After describing the magnitude of the problem and the underlying factors, four options adapted to the Cameroonian context based on evidence from local studies and systematic reviews as well as implementation considerations are detailed.

Problem

Adolescents (10-19 years old) and young adults (20-24 years old) represent 34% of the national population according to the extrapolations of the last general census of population and housing (BUCREP 2010). Their health, a key potential for national development, is vulnerable to various factors, such as reproductive and sexual health (SRH / DROS, 2013), which are of concern because of the efforts made and the resources mobilized. Early fertility is high at a rate of 119-127 ‰ among 15-19 year olds, twice the global average in the same age group (MICS, 2014). One in four teenagers (25.6% of 15-19 year olds) have already started their reproductive life: 21% have had at least one child and 4% are pregnant with the first child. The median age at first intercourse of girls who attended school until the end of primary school is 15.9 years, compared to 18.6 years for those who have completed secondary and higher education. Seroprevalence of HIV among adolescents (10-19 years) is 1.2% and young adults (20-24 years) is 2.2% (MINSANTE, nd).

Identified reproductive health issues for this segment of the population include: early sexual intercourse, unwanted early pregnancy, sexually transmitted infections, early marriages, sexual violence and abuse, clandestine abortions, and multiple partners (World Bank, 2017). Fifty-five percent (55.4%) of sexual abuse victims are in pre-puberty and puberty (Biyong 1990, Mbassa Menick et al 2004). The average age of victims of child prostitution was 16.6 years with extremes of 9 years and 20 years (Mbassa Menick et al 2009). It is reported in a survey that 37.3% of girls and 29.9% of boys experienced forced sexual initiation in Bamenda in the North West Province (WHO Report 2002). A study by MINAS / UNICEF (2004) identified cases of sex tourism in Kribi and Limbe involving victims between 12 and 18 years old.

Sexuality at risk of adolescents and young adults. Multi-partnership (up to 49% for boys) would justify HIV prevalence estimated at 1.2% among 15-19-year olds. This vulnerability is all

the more complex because its engines are poorly documented: STIs; poor access to adolescent friendly health services; sexual violence; prostitution (diffuse or real); the trivialization of risky sexual practices (anal, oral, plural, homosexual, etc.); the consumption of various drugs, racketeering; addictions to games, etc.

These reproductive health problems result, on the one hand, from a gross lack of preparation for sexuality - lack of comprehensive education in sexuality and sexual abuse (Woog and Kågesten, 2017) - and on the other hand from the approximate identification of specific needs in reproductive health. Studies of attitudes, sexual behavior and risk factors among adolescents aged 10 to 14 are almost non-existent (UNFPA, 2012). The main underlying factors identified are: (i) inadequate level of knowledge and skills in reproductive health, (ii) inappropriate use of STI / HIV / AIDS protection methods and contraceptive methods, (iii) poor access to reproductive health services for adolescents and young adults, (iv) reliance on sources of information of questionable reliability in reproductive health, (v) sexualization of social media, (vi) depravation of morals and, (vii) the failure of school, university, family and community education related to reproductive health, even though school enrollment rates have improved and family life education curricula on population and HIV-AIDS (EVF-EMP-HIV-AIDS) have been in existence for over ten years (PSNAJ).

Manifestations of the problem in Primary Schools

In summary, the performance of the EVF / EMP / HIV-AIDS is sub-optimal with regard to the objectives set, namely:

1. The pupil will be able to acquire knowledge about sexuality and reproduction in order to develop and maintain responsible sexual behavior.

2. The pupil will be able to develop protective skills and attitudes and reject risky behaviors.

3. The pupil will be able to develop attitudes and aptitudes allowing him to appropriate human rights, to reject and to denounce the different forms of abuse and violence against children.

Sexual abuse against pre-teens and adolescents is not reported. Sexual abuse of a child / youth may be defined as "the participation of the child or young person in sexual activity that he or she is not able to understand, which is inappropriate for his or her age and psycho-sexual development."[1] "The analysis of the work done on sexual abuse has amply demonstrated the reality of the phenomenon, but it revealed that children are assaulted in all their living environments" (EIP-Cameroon, s.d.). Sexual abuse of pre-teens includes rape, sexual abuse, sexual touching, sexual harassment, child prostitution, child pornography, forced marriages, early marriages, sexual exhibition, sex tourism, pedophilia, female genital mutilation, incest. The majority of victims of sexual abuse (55.4%) are in pre-puberty and puberty (Biyong 1990, Mbassa Menick et al, 2004). One in three (29.8%) abuses occur before the age of 10 (Biyong, 1990). Rape is the most common form of aggression (Biyong, 1990).

The repercussions of sexual abuse are multifaceted. The physical consequences are multiple: injuries, fractures, bruises, scars, sleep disorders, gastrointestinal problems, migraines, respiratory problems, rashes and unwanted pregnancies. (EIP-Cameroon, nd). Gynecological complications include loss of virginity, bleeding, vaginal fistulas, vaginal irritation, painful intercourse, chronic pelvic pain, infections and sexually transmitted diseases including HIV-AIDS. Mbassa et al. (2003) found an HIV seroprevalence of 37.5% among children who were

[1] Pr. KEMPE, founder of International Society for Prevention of Child Abuse and Neglect (ISPCAN) – Chicago, USA.

raped at the age of 11.6 years with extremes of 4 and 15 years. Child sexual abuse is associated with mental illness and behavioral dysfunction in adolescence and adulthood, such as: sleep disorders, depressive syndromes, post-traumatic stress syndromes, somatic complaints, smoking common behavioral disorders, aggressive behavior, kleptomania, academic difficulties, suicides and attempted suicides. On a completely different level, the repercussions include school drop-out and the adoption of unhealthy behaviors (alcohol and other drug abuse), risky sexual behavior, self-destructive behaviors such as self-mutilation or burns, eating disorders and attempts of suicide (WHO, 2002, EIP-Cameroon).

In terms of the subsequent experience of sexuality the consequences are, among others, manifest or excessive masturbation, an exaggerated sexual curiosity and frequent exposure of the genitals, the simulation of sexual acts with the brothers, sisters and friends, inappropriate sexual behavior. (eg tendencies to touch the breasts or genitals), premature sexual knowledge, the "sexualisation" of kisses given to friends and relatives. In adolescence and adulthood, abused children continue to exhibit sexually inappropriate behaviors, dissatisfaction and negative attitudes towards sexuality. Relationally, relationships with others are disrupted. The prevalence of interpersonal problems is higher among abused children in the form of inconstancy in relationships with parents and others, family and community conflicts, some of which sometimes lead to rejection of the victim. Psychologically, sexual abuse promotes low self-esteem, identity disorders and self-rejection coupled with a loss of confidence in everything. In addition, it may induce a fear of intimacy, confinement in a victim's status or the transformation of the victim into a perpetrator reproducing the violence suffered.

Reproductive and Sexual Health Vulnerability in Colleges and High Schools.

Secondary education has about two million students (Cameroon Tribune, 2016), some of whom start at an early age. The average age of high school students is 14 years compared with the median age (16.8 years) of adolescent sexuality in Cameroon (MINSANTE, nd.). A majority of adolescents enter into sexuality without any knowledge or skill and without any preparation from their family. Most young people learn about their sexuality through their peers, media or social networks (Nsangou MM, Bonono RC, Ongolo-Zogo P. 2018). Colleges and high schools have become spaces of sexual vulnerability for adolescents.

Sex scandals involving teenagers in middle and high schools. A media observation shows a recurrence of sexual scandals in recent years like the case of the pornographic video of Bafang Technical High School (Africapresse, 2018), sexual intercourse between students at College de la Retraite (Camer24, 2017), sexual intercourse between students in the bilingual Lycée de Santchou (Camernews, 2017), the Vogt College pedophile case (Camer24, 2017), the "orgy" affair between pupils at the Lycée Classique de Bafoussam (Grand Ouest grandstand, 2015) and the case of sexual intercourse between two students at the College of Industrial and Commercial Technical Sciences (CSTI) of Etoug-Ebé (Africapresse, 2013)**.**

Abuse and sexual violence involving teenagers. A study, made in ten middle and high schools of the city of Yaounde in 1999 with 1688 students, reveals a 17% prevalence of sexual abuse before 16 years of age. The sexual abuse concerned the pre-pubertal and pubertal period (72.9%) but also the pre-adolescence (25.3% between 5 and 9 years). Girls were the main victims (72.5%). The majority of the 274 assailants identified were men (86.5%). Noteworthily, 31.4% of sexual abuse was intra-familial compared to 68.6% of extra-familial sexual abuse. In almost 15% of cases, sexual abuse occurred in a school environment and

about 30% was perpetrated by classmates. Teachers accounted for 7.9% of the extra-family abusers and home tutors accounted for 7.3%. The prevalence of sexual attacks on minors ranges from 2.05% to 9.5% and they mainly concern children during pre-adolescence and adolescence (Mbassa Menick, 2002). Halim Benabdallah (2010) reports several forms of school-based violence in French-speaking sub-Saharan Africa, including sexual, physical and psychological problems, which frequently result in girls being out of school. Sexual violence refers to touching, attempts to initiate a sexual act, using force, threat or surprise. Physical violence refers to corporal punishment, forced labor and beatings. Psychological violence refers to various forms of verbal abuse, intimidation and emotional manipulation (Halim Benabdallah 2010).

The forms of violence observed are of a sexual and psychological nature. With the advent of ICT, teenagers equipped with smartphones and tablets become spectators and / or actors of pornographic photos and videos. This situation is all the more serious when they train their comrades, who are under psychological pressure, in their games. Zobo (2017) has shown the negative impact of media hypersexuality (erotic films, pornography ...) on the construction of sexuality among adolescents in the absence of rigorous sexual education. Thus, the average age of exposure to sexuality as represented by pornographic film is 13 years and this has an impact on the early entry into active sexuality and sexual practices of young people. The school environment has become a space of adolescent sexual socialization.

Early and unwanted pregnancies and STIs / HIV-AIDS. Early and unwanted pregnancy is a global problem. It has a major impact on the adolescent's (especially the girl's) health, social, economic and educational life (UNESCO, nd.). It is often the basis of a part of complications during childbirth or even maternal and neonatal death and secondly of lack of interest in school in the girl. The Demographic and Health Survey and Multiple Indicators (EDS-MICS 2011) indicated that 60% of adolescent girls (15-19 years old) were already sexually active by the age of 16 and that 25% of them were pregnant. The analysis of the dropout profile shows that the dropout rate is higher in third grade (11.67%) and among non-academic reasons, marriage / pregnancy is the most recurrent with 17.78% (Noumba Isidor 2008). In the majority of middle and high schools, the discovery of pregnancy signifies the exclusion of the concerned by the authorities of the school.

Reproductive and Sexual Health Vulnerabilities in Universities.

Higher (post-secondary) education consists of about 500,000 students, distributed among the 8 state universities and nearly 200 private higher institutes (MINESUP, 2018), and without any age limit. In fact, more than 463,798 students were under 19 in 2014 (INS, 2010). This coexistence of generations, whether between comrades or with the teaching and administrative body is in itself a source of conflict. At university, the situation is all the more problematic because obtaining the baccalaureate is tacitly accepted as the right to sexuality for parents and adolescents (Essi, 2002). Where historically three bodies rubbed shoulders already, we find ourselves today with four: student-adolescents; adult students, teachers and administrators. Four human groups with different values and aspirations, nevertheless living together in a rigorously structural-intellectual organization, but weakly spatio-moral, and subject to the dynamic exponential of the digital. Who protects these younger and younger teens in lecture halls, of their mature and / or perverted classmates (the raped child is at risk of being a teenager rapist, Roman 2008); their teachers; or school staff?

The law of silence of ubiquitous sexual harassment. The university environment in Cameroon is characterized by the pervasiveness of sexual harassment. Typically directed towards the female sex, the sexual harassment concerns more and more the two sexes, effectively duplicating the forms of vulnerability of the sexual health of the teenagers. Harassment is defined as a set of repeated physical or psychological aggression, manifested by often insidious gestures and words aimed at destabilizing and breaking a person to the point of submission. It is described as sexual when this abuse of authority aims to obtain sexual favors.

Adolescents and young adults are very quickly dealing with sexual harassment in academia. Upon registration, they are welcomed by seniors who guide them in this new space. Due to the weakness of human resources, this task is entrusted to student associations that take advantage of new prey. "Come here, what is your name? What problem do you have? Stand here I will see with my colleague. ... Your phone number, what is it? ". If the victim does not execute: "I will see how you will file your file ... I am the airport, go up, go down, you will come to find me and there, we will see who is who". (Nsangou & Onana, 2014).

From the beginning of coursework, they undergo harassment by the substitute or the instructor. Due to a shortage of teaching staff and some disengagement from full-time teachers, a delegation of tasks is made to doctoral students, often leaving room for abuse of authority, including sexual harassment. They attach themselves to the badly summoned African proverb "the goat grazes where it is tied up". Often without real financial reward, one said to Nsangou & Onana that "there are several ways to make extensions for the ends of the month, it is necessary that one way or another I enjoy myself. The salary is not necessarily monetary ". Unsuspecting young students will fall on this fauna, which considers them as a payment in kind of the teaching service rendered. In the face of resistance, adolescents and young adults experience failure, having to repeat courses and even disciplinary action. "They are the ones who correct our copies and therefore, we must be careful. They can get us back to the level, "said a FALSH student as reported by Nsangou & Onana in 2014. Similarly, in 2016, a FSE / UYI substitute instructor had the weakness to send this SMS to a victim:" I have the copy of Fernand (victim's boyfriend) in front of me. How do we do? ". Exceptionally, this SMS served as an exhibit to the Disciplinary Council at the UYI. It is also necessary to evoke the omnipotence of the admission services. From monitoring exams to issuing transcripts, each stage of the circuit is an ideal opportunity for harassers. They use threats of eviction from class; fraud accusations; the provision of corrected exams or "water" (as locally termed); replacement of copies; falsification of minutes, the retention of transcripts, etc.

However, in the scale of actors abusing their authority to obtain sexual favors, teacher-researchers take the lead themselves (Pondi, 2011). Taking advantage of a position of power (supervision, internship, evaluation, etc.), they use all the strategies: invitations to hostels; fieldwork support; correction of homework; exhibitionism; prostitution / swapping, etc. Thus in 2014, Cameroonians were able to listen in a radio channel to these words from a teacher, recorded by a student of the Ecole Normale Supérieure of the University of Yaounde 1 "Your buttocks kill me, that's what I want ... I'll even rape you ... go eat your rules there ... ". The granting of sexual favors to the teacher is a condition sine qua non for a normal evolution. A collateral victim confided: "I went back to the same teaching unit 3 times, because I was walking with my cousin, whom one teacher thought was my girlfriend. He had told her "as you give to the bandit there, give also for me" and in the face of his refusal, neither she nor I got a rating of more than 25 out of 100 ". At the Faculty of Sciences of the

University of Yaoundé 1, it is a young student who recounted the homosexual attacks of his teacher, whose refusal ended with the SMS "it is you who wants a master's degree, not me ".

This "right of cuissage" is so anchored in the university culture that it exceeds the vulnerability of adolescents. In 2015, a teacher was described as "irreverent" because of her desire to have her degree change reviewed, without giving sexual favors to Board members. Also, a teacher from the Faculty of Science told Moncher & Onana: "I spent 7 years in the rank of assistant because my Head of Department made me advances. But since I did not want to hurt my husband, I could not go with him. I could only evolve after the death of this man." What must be understood in this verbatim is that if the lady had not been married, or had had a husband insensible to pain, she would have given in to this dishonorable sexuality. Pondi then stated in 2011 that the "right of cuissage" was the condition for an academic rise in our university system.

Non-existent management structures/services

Some adolescents and young adults arrive at the university without sexual experience. Their entry into sexuality will thus happen in this "jungle", without any knowledge and in total unpreparedness. It is therefore not surprising that the HIV rate is estimated at nearly 1%, and admitted casual sex at 37.5% (MINESUP, 2017). At the University of Maroua, only 17.70% of students had a good level of knowledge about the menstrual cycle, and none had adequate knowledge about emergency contraception. The majority (80.30%) were unaware of the time required for it to be effective, and very few possessed correct attitudes (19.30%): "If by trying to strip the egg you find yourself stripping all the way to the uterus, it will lead to harmful complications; so I cannot encourage that."(L3); "The morning-after pill causes sterility" (L1); "You can be seen as a prostitute" (L3). Logically, 90.80% of the girls had inadequate practices: "I will wait a little more than 2 weeks and take the pregnancy test before seeing how to use the morning after pill."(L1). In the event of contraceptive failure, 24.10% of female students had unabashedly admitted that abortion was the next option.

At the University of Yaounde I, 62.80% of female students said that induced abortion was a common practice, and up to 44.90% said they had already helped a loved one to do so (Kamtcheu RG, 2016). Despite a fairly low average age of participants (18.3 years), 84.5% of girls had cited at least one abortion method, the most cited was the drug method (71.3%), followed by potions and traditional concotions (65.6%); and some excitants (36.2%), "there is a whiskey that is used, at the beginning of a pregnancy, the first days" (L2 medicine). They were aware of the complications, the most frequently mentioned being infertility (93.3%) and death (77.9%): "In fact, an abortion always leaves scars and consequences, but the most serious is death, because there is sterility as she said but you can also have certain diseases ..." (economics student). The main reasons for abortions were parents' fear (74.4%), partner's denial (73.6%) and lack of money (69.2%). Half (50.3%) of girls were against the decriminalization of abortion, the main reason being religious (70.9%) "I am against the legalization of abortion because if we legalize abortion it will leave the field free for girls to no longer maintain pregnancies, she will say it is allowed so I'm doing it, it will be necessary not to legalize it, for religious reasons at least, it is a life all the same "(L1 right). However 21.5% were in favor of legalization: "Everyone does this when she wants. In each mini-city, there is the "docta" of that. We must legalize, so that people can go directly to the hospital. There they will know where to throw the fetuses that are everywhere in the gutters at Bonas"(L2, FSc). One-third of girls (38.5%) thought that abortion was a solution to unwanted pregnancy (UP), and 1/10 had admitted to recommending abortion to a classmate. Almost all (90%) of the students thought that the decision on the fate of an unwanted pregnancy was solely that of the student: "the decision is 100% the girl's, the decision can be influenced by others but

the final decision comes back to her, the others are the family, the father of her child, the society, the look of society, the school, the ambitions but it is she who must make the decision "(L2 medicine). It is important to highlight the huge public health challenge of informants' desire for discretion. Thus, 43.3% highlighted discretion as a determinant in the choice of the place of abortion, security being evoked only by 12.6% of the girls. In cases of unwanted pregnancies in the current year, 68.7% of female students were not sure of keeping it and 7% would abort unconditionally.

The situation hereby presented may come as a surprise when we know that these universities all have social health center, whose sole mission is to reduce the vulnerability of access to a complete state of well-being for students. At the UYI, these social health centers have a listening center, which is probably not equipped to address sexual health, in the sense that the WHO and BZgA (2013) specify that it requires a positive and respective approach to sexuality and sexual relations, as well as the possibility of having sexual experiences that are fun and safe, free from coercion, discrimination or violence. Sexuality is a central component of the human being, and the university must integrate it as a cognitive, emotional, social, interactive and physical learning in a useful and permanent process throughout life. It is important to address as well because of the different environments and social groups with which the teenager will interact throughout his coursework. It is an integral part of comprehensive education and helps the adolescent develop self-esteem, perception of body image and self-determination. With sophisticated knowledge and sophisticated skills, the university must complete the adolescent's training with responsible skills towards himself and others. Social health centres must therefore be the reference in case of doubt (physical, psychological and social), and can no longer consider sexuality solely through the prevention of STIs and early pregnancies.

Underlying factors of reproductive health vulnerability in schools and universities

Have schools become a place of depravation of morals or transmission of knowledge for integration into social life? How can schools contribute effectively to promoting the reproductive health of adolescents and young adults? What are the reasons for the failure of complete sex education? The analysis highlights a gap in knowledge and skills in reproductive health and insufficient training of supervisors. Observations of scenes of sexual violence demonstrate that it is a structural phenomenon (Abéga SC, 2007). It benefits from the existing lax organization of the structures of supervision which is a favorable place of emergence for this phenomenon.

The "sex education" approach in primary school today is a low-impact intervention (Irvin, 2000). Sex education in schools is therefore only one source of information among other sources. Zobo (2017), whose results confirm those of BUCREP (2015), shows that the media (television and Internet) are now a source of sexual initiation of pre-adolescents. The information disseminated is of erotic and pornographic type and has a negative impact on the construction of adolescent sexuality in the absence of rigorous sexual education.

Outside primary school, there are no other forms of learning about reproductive health because of: (i) the failure of the traditional mechanisms (initiations and stories) that accompanied the transition from childhood in adolescence (Abega, 1995) and (ii) the assimilation of the pre-adolescent to the child which induces a negation of his sexuality. Commonly an expression of interest for the sexual things of a child or a pre-adolescent causes embarrassment, mockery, repression and / or guilt of adults - the blocking of verbal

exchanges on sexuality in family between parents / guardians and children due to taboos and / or parents' fear of losing the child's innocence and inducing an early interest in sexuality - confusion induced by partial, false and contradictory information from diverse origins (media, internet, examples of information on sexuality, peers) and insufficient consideration of the specificities of youth in national policy making (World Bank, 2017) and particularly the exclusion of the young adolescents or pre-adolescent sub-category from preventive interventions for adolescents (Cissé et al, 2017). The two consequences of this failure are the low level of reporting of sexual abuse and inappropriate sexual behavior of adolescents. On the other hand, the support of the pre-adolescent, to build a balanced sexuality in such a social context, is marginal. Calvès (1998) reports that "social norms encourage adolescent sexuality so strongly that, after a certain age, those who are still virgins feel rather marginalized". Between taboos and social practices, swept back to childhood, pre-adolescent sexuality is ignored and rarely benefits from social interventions other than repression and guilt. In addition, this group is excluded from interventions for older adolescents because "peer education programs and youth centers tend to attract older youth and rarely aim to meet the specific needs of very young adolescents. Youth. "

The primary school officially welcomes children aged 6 to 11, but the reality is different because students enter school after the age of 6 and stay there well after the age of 11. In 2015, the 11-year-old age group accounted for 520,000 pupils. Most pupils are vulnerable pre-teens in terms of sexuality. Pre-adolescence is variously conceived and defined. For Aton (2011), the interval of pre-adolescence ranges from 9 to 12 years and is manifested by puerile adolescent attitudes in subjects like physical and psychological development. The next excrpt by Olano summarizes the confusion and debate surrounding this phase. "Pre-teenagers are characterized by a large difference in height and sexual maturity ... They are no longer interested in games, movies, rituals of the child, without necessarily being in teenage logic ... More than a new age of life, preadolescence is simply this time of transition between childhood and adolescence more or less long according to individuals." Finally, François de Singly who names the children of 8-14 years "adonaissant" highlights the transformations they experience. For Dounally (2011), it is a process rather than a period of 6 to 13 years and is characterized by the early onset of disorders previously attributed to adolescence. On a sexual level, this period later considered as latent (Dounally, 2011) is today associated with the production of hormonal secretions and body modifications leading to the maturation of primary sexual characteristics and the appearance of secondary sexual characteristics (Anton, 2011). On the other hand, doctors and parents notice the precocity of mensturation for girls who may start bleeding at the age of 8 (Dounally, 2011). A study conducted in South Cameroon that defines the pre-adolescent category from 11 to 14 years, highlights specific behaviors with respect to sexual prohibitions, "the youngest integrate the prohibition, the pre-teens divert, adolescents transgress it "(Sauzade, Vernazza-Licht and Abega, 2000).

While the need for reproductive health education in middle and high school is disputed by secondary school teachers (Wafo, 2012), no study is available on the perceptions of school teachers vis-à-vis this education. Upon analysis, lessons based on the EVF / EMP / HIV-AIDS teaching guide are not dispensed adequately. For the reduction of sexual risks, the theme of HIV-AIDS is approached in terms of means of transmission and tolerance from Class 2 while Class 5 and 6 study sexual reproduction. Issues relating to the rights of the child such as physical integrity and abuse are brushed over or even ignored.

The qualification of half of the teachers in the private sector is insufficient with variations between regions of 25 to 74%. The three regions of the East, Far North and North have the lowest rates and the Central, North West and South West regions have the highest rates.

According to 2014-15 statistics, 51% of the 5885 mainly rural public primary schools have multigrade classes. Overcrowded classrooms have a negative impact on the student acquisition process and the quality of the results (Glass et al., 1982). In the specific case of comprehensive sexuality education, multi-grade classes and numbers (average pupil-to-classroom ratio = 72-58 pupil in urban-rural areas) can have a negative impact on efficiency since this teaching requires adaptation of teaching to learners. The limited budget is an additional constraint since the allocated resources cover only 30% of the current expenditure of schools.

A report by UNFPA (2014) providing feedback on the process of implementation of Integrated Sexuality Education for Adolescents / Youth in Cameroon showed that only 1234 teachers and supervisors (both in school and out-of-school) and 371 peer educators were trained and 4 training centers covering 78 schools set up. On the material side, a tutorial and a training guide were offered for the trainings, 10 Multifunctional Centers for the Promotion of Youth covering the 10 regions of the country were equipped with awareness raising materials and for income-generating activities. Sixteen thousand adolescents / young people were sensitized about their reproductive health.

For decades, various actors have nevertheless tried to address this sensitive issue, but interventions for the care of adolescents in strategic documents remain approximate, both by the target (age range of 10-35 years (PSN-SRA & J 2015-2019), and by the framing of the interventions, which reduces sexual health with healthy genitality. The present form of the supply is not adapted to the demand. The majority of studies on knowledge in SRHA reveal various insufficiencies: low overall information on the sexual health of young people (Sepde, 2015); inappropriate contraceptive practices among female students (Bildi, 2015) and married girls (Sanda, 2016); Pornographic media as the main source of education on sexuality (Zobo, 2017).

Because of their transitional position, adolescents are not aware of their vulnerability (due to their lack of comprehensive information). They do not perceive the risks, nor do they have the means to control them. Addressing Adolescence as the Second Decade of Life collects age-based data for analysis of this transition period. Today, it is widely accepted that this phase is distinct from early childhood and young adulthood, which requires special attention and protection. The transition from childhood to adulthood must be accompanied, to help the young child to fully assume the independence, responsibilities, expectations and privileges associated with adulthood. In traditional societies, a rite of passage accompanies this change, and implies that childhood is lived as a space and a time separated from the rest of human life, which must be treated with care and reverence (Abega, 1995).If modernity has demonized the practice of these rites, it is imperative to rethink support during this period.

Indeed, the physical changes and the appearance of the secondary sexual characteristics are blatant changes which constitute a source of anxiety as well as excitation. Neuroscience has shown that the adolescent's brain is undergoing electrical and physiological growth, and the number of brain cells can almost double in one year, and the neural networks are radically reorganized, with a strong emotional, physical and mental impact. It is also at this time that girls and boys become more aware of their gender. They will therefore adjust their behavior and appearance to match current standards and values. They can become victims or actors of abuse, and experience uncertainties about their personal and sexual identity. There is therefore at this moment of life, a characteristic risk, where the adolescent tests adult behaviors. It is therefore imperative to offer him a safe and solid device as a safety cushion. Moreover, in a multicultural context such as Cameroon (6 different cultural spheres), where

geographical, intellectual, economical and gender-based data is scarce, the most linearly safe space in the country is indeed the institution called «School".

The analysis of highschool and secondary school curricula shows a marginal importance given to sexuality education (UNESCO, 2010a) even though a joint decree of MINEDUB and MINESEC from 8 th January 2007, integrates the curricula of EVF / EMP / HIV-AIDS in training and education programs in Cameroon. The theoretical contents of Comprehensive Sex Education (CSE) or Integrated Sex Education (ESI) are well articulated. However, the analysis of the implementation shows that it remains approximate. Classes in middle and high schools speak of reproduction in biology in the fifth class (invertebrate reproduction) and in the fourth class (human reproduction). Although this course exists, addressing issues of sexuality is sometimes embarrassing for some teachers. They approach it in a superficial or summarized way, especially since the need to teach sexuality in middle and high school is disputed by secondary school teachers (Wafo, 2012). In addition, in secondary schools of technical or vocational education, students do not have access to human reproduction classes. In some secondary schools, it is necessary to note the incompetence or the discomfort of the teachers when they approach the courses related to sexuality. They have not received adequate training and therefore cannot be good agents for transmitting this knowledge. This situation increases the chasm created by the incompetence of families in the sexual education of adolescents. The emergence of HIV and the prevalence of unwanted early pregnancies have been the subject of several interventions, notably through health clubs. These interventions focus on sensitization during AIDS Days and condom distribution. The role of school infirmaries remains invisible in reproductive health as it is confined to providing essential care and medicines. Guidance counselors are absent from the sexual education of young people.

Logical framework of action

The school and university environment are likely to make a significant contribution to the complete state of well-being of pupils and students. This is a fact now recognized by international organizations (WHO, UNICEF, UNESCO, International Union for Health Promotion and Health Education - UIPES). Despite the differences in targets and strategic objectives, the “School” strategy recognizes that health in general, reproductive health and responsible and fulfilling sexuality in particular play a fundamental role in all aspects of the school community. Beyond health education, the evidence clearly indicates the need to combine medicine-in-schools with the effective action of the parent community to achieve this (World Bank, 2003). However, sex education needs to be adapted to the development and needs of the child. According to the University of Sherbrooke in Canada, sexuality education in school promotes learning about difference, social rules, laws and common values where self-esteem, respect for others, acceptance of differences, understanding and respect for the law, individual and collective responsibility, are essential objectives of the educational process. It is to equip adolescents and young adults that UNESCO (2010) has taken a stand for comprehensive sexuality education, as it is "a way of approaching the teaching of sexuality and interpersonal relationships that is age-appropriate, culturally relevant and based on scientifically accurate, realistic information and refraining from value judgments ". Because it gives adolescents and young adults cognitive skills for better management of their reproductive health, it gives them the ability to self-protect in this environment of flouted sexuality and amplified by the absence of listening structures, interventions and adequate care.

In view of the sexual risks to adolescents and the central place of primary school, it is imperative that the teaching of EVF / EMP / HIV-AIDS be disseminated in this setting for young people to adopt healthy sexual behaviors. Primary school is the right place to develop the capacity to manage one's reproductive health, including sexuality. Preparation before an active wanted sexuality or undergone through an unpredictable sexual assault or first sexual intercourse is lacking in most youth control cases (Abega and Kouakam Magne, 2006, Woog and Kagesten, 2017). In addition, the acquisitions made in childhood are decisive for the construction of the personality of the future adult. As such, the primary school is at the crucial moment of the life of the individual where must be introduced the beginnings of knowledge on reproductive health including sexuality that will be further developed during adolescence. Because access to primary school is universal and represents the only schooling for a significant proportion, it is essential to effectively introduce the EVF / EMP / HIV-AIDS curriculum. The number of pupils is increasing; the gross enrollment rate increased by 20 points, from 102% to 122% between 2003-4 and 2013-14, and enrollments are steadily increasing (MINEDUB Report, 2015).

To target the future Cameroonian adult using the academic setting is to choose a safe and clearly defined space to manage this emotional, sexual and psychological transformation by bringing the parental and the clinical to complete education. It is widely accepted that the school and university environment can play a significant role in determining health behaviors and the health status of young and future adults (Doumont & Aujoulat, 2008). Among the factors contributing to this role of the school and university environment, we can cite: the length of the school curriculum; the fact that the child goes through three important stages of personal development; the opportunity of pedagogical sciences; the presence of trained teams; the possibility of sequencing the baggage of skills to be transmitted; and the presence of parents' associations and clinics in the school environment.

According to Maslow's pyramid of needs, sexuality is placed among physiological needs, related to survival. It is therefore a basic need, vital to all human beings, such as eating, drinking, sleeping, and breathing. It is an integral part of the child's development and does not consist solely of the absence of disease, dysfunction or infirmity. It is a central aspect of the human person throughout life and includes biological sex, sexual identity and role, sexual orientation, eroticism, pleasure, intimacy and reproduction (INEPS, 2017). Adolescents, like adults, do not live in a vacuum. They are witnesses and actors, in a community and culture in motion and where, inevitably, sexuality evolves. From early childhood appear questions relating to sexuality, depending on the different stages of psycho-emotional development of the child. WHO therefore proposes to consider the age, the stage of development and the social and cultural references of the child or the young person so as to be sure to meet the specific needs? According to the Quebec government, early childhood (before age 5) builds awareness of sexual identity; childhood (6-11 years) develops the body and awakens to its multiple functions (physical, emotional, psychological, sexual, social); and adolescence (12-18 years) develops acceptance, lover appeal, sexual desire, the feeling of invincibility and a magical thought. Promotion of reproductive health is therefore integral to learning citizenship and leadership.

The process of integrated promotion of reproductive health must inform, induce reflection and help with an integral construction. Indeed, evidence demonstrates that Integrated Sexuality Education - as advocated by UNESCO (2018)- allows learners to: (i) receive responses that are appropriate to their level of development; (ii) to have a caring attitude towards their body, including access to care; (iii) to learn about and respect

individual and social boundaries; (iv) become aware of their own limitations, express them and defend them.

Existing evidence confirms that simple and accurate information gives adolescents and young adults more confidence to address more emotional issues later on. In the same way, in order not to be the victim of external influences alone, it is important for the adolescent to be able to think about the implications of different behaviors and situations for himself. This requires teachers, supervisory staff and other adults to deliver explicit messages that take into account the context and the demand of the adolescent / young adult. The promotion of reproductive health in schools and universities is based on a model of democratic, scientific, citizenship, leadership and open competencies for the purpose of contributing to the development of personal, social and political ethics. To do this, three fields of knowledge and skills are retained to achieve a comprehensive, positive and benevolent approach to sexuality. These are the biological, psychoaffective and social dimensions. Thus health promotion programs in general and reproductive health programs, particularly in schools and universities, must: (i) provide objective information to young students; (ii) enable a better perception of risks and encourage prevention behaviors; (iii) promote information, help and support within and outside the school and university environment; (iv) communicate the relational, legal, social and ethical dimensions of sexuality; (v) support their reflection on mutual respect, rapport with others, gender equality, rules of living together, and respect for the law; (vi) develop the exercise of critical thinking, by analyzing the models and social roles conveyed by the media; and (vii) provide a comprehensive, discreet and friendly medical service to young people and adolescents.

Strategic Options for the Promotion of Reproductive Health in Schools and Universities.

Option 1: Establish a quality assurance mechanism for education to family life in terms of population and HIV / AIDS (EVF / EMP / HIV-AIDS) in primary schools, colleges and high schools.

This option aims to correct the shortcomings noted in the implementation of this teaching. It preserves the achievements of the teaching guide EVF / EMP / HIV-AIDS because the content of the knowledge and the defined methods constitute a complete sexual education. Indeed, the effectiveness of integrated sex education is proven to reduce the sexual risk of pre-adolescents and adolescents in developing countries. Integrated sex education programs have a positive impact in terms of: (i) delay or reduction of sexual relations; (ii) condom use; (iii) knowledge and use of modern contraception. Specifically in schools and universities, evidence on the effects of CSE programs at school includes: increasing condom use (Duflo et al, 2006), reducing the rate of early pregnancy (Dupas , 2006).

By introducing a Quality Assurance mechanism, the level of ownership and empowerment of all actors in the educational community will increase. Regular analysis of performance and difficulties in a perspective of continuous improvement of quality incorporating the principles of the Deming wheel: PDCA Plan Do Check Adjust will review both the resources and

processes of training of trainers, universal dispensation of the teaching of EVF / EMP / HIV / AIDS. It is a matter of investing in the acquisition of the skills required to ensure this teaching by all teachers and to encourage the support of teachers. The priority elements to consider are those listed in the table below:

Specific Obstacles	**MO**
Insufficient organizational framework	Consolidation plan of teaching EVF / EMP / HIV-AIDS Supervision / Inspection of the EVF / EMP / HIV-AIDS Monitoring and Evaluation of Teaching EVF / EMP / HIV School network and specialized services (associations, health services, sexual violence)
Inappropriate skills of teachers	Training of the EVF / EMP / HIV-AIDS in the teacher training colleges Teacher support system and continuing education on EVF / EMP / HIV-AIDS (face-to-face and / or around ICT) Mobilize support from partners (UNESCO, UNFPA, friendly countries)
Resistance from parents and teachers	Awareness and discussion about EVF / EMP / HIV-AIDS Appropriation
Funding	Integrate the activities of promoting the EVF / EMP / HIV-AIDS in the day-to-day activities Seeking funding for the consolidation of this reform with partners (UNESCO-UNFPA)

Actors of the implementation. To build capacity for integrated sexuality education for the promotion of reproductive health, several actors need to be mobilized. These are the decision-makers involved in the design chain and the monitoring of the implementation of school programs at the central and intermediate levels (MINEDUB, MINSANTE, MINJEC, MINAS). In the same vein, school clinics need to be developed and resupplied to provide the right services for young people. Secondly, teachers / health professionals / guidance counselors / social workers responsible for field implementation, i.e to deliver lessons in accordance with teaching guidelines and approaches, and advice consistent with formal education to consolidate the latter. Thirdly, parents and teachers' associations, since the parents must contribute by continuing the education received at school and agreeing to talk about the aspects considered taboo with their offspring. In the end, pupils and students must agree to follow assiduous programs of sex education without taboos and accept to benefit from the services that will be offered to them under the complete sexual health education. They must also attend school clinics to receive adequate services.

Option 2: Engage the community in the prevention of sexual harassment and abuse in schools and universities.

This option aims to create a harmonious environment and regulate in terms of norms, sexual practices and listening to protect and better supervise adolescents and young adults. Formal integrated sex education is an essential component of primary and secondary prevention against sexual abuse of children and adolescents. Primary prevention includes a set of devices to prevent sexual assault and secondary prevention aims to prevent the recurrence of aggression. Children who have received formal sex education are able to identify abuse, to denounce it more easily or even to prevent it, unlike those who have received a rigid education characterized by sexual taboos.

A systematic review shows evidence of moderate quality that school-based sexual abuse prevention programs are effective. "The impact of sex education is greatest when school-based programs are complemented by the participation of parents and teachers, training institutes and youth-focused services" (Walsh, Zwi, Woolfenden, and Shlonsky, 2018). These programs provide schoolchildren, students and students with lasting knowledge about the concept of sexual harassment and abuse, the development of protective skills, and the increased ability to expose abuse in comparison to children who are not exposed to this program.

Obstacles	MO
Resistance from parents and teachers	- Integrated communication plan for the educational community - Exchanges between parents and teachers within the parents and teachers' associations
Incompetence of the actors	- Train parents, teachers and cooperate with MINAS and local specialized associations

Option 3: Build the capacity of teachers to deliver comprehensive sexuality education (CSE) or integrated sex education (ISE) in colleges, high schools and universities

UNESCO defines comprehensive sexuality education as "a culturally relevant and age-appropriate approach to the teaching of sexuality and interpersonal relations, based on scientifically accurate, realistic information which refrains from value judgments. "(UNESCO, 2010b). CSE has a positive impact on the reproductive health of adolescents and young adults. It helps reduce STIs, HIV and unwanted early pregnancies. CSE does not precipitate sexual activity; on the contrary, it has a positive impact on healthy behaviors and can delay

the first sexual activities (UNESCO, 2009). The availability of training and support for teachers is crucial to ensure that CSE is implemented in a safe environment. CSE promotes structured learning about sexuality and relationships in a positive, affirmative and youth-centered way. The guidelines affirm the benefits of implementing quality comprehensive sexual education through programs that enable young people and adolescents to have the means to live a healthy, safe and productive life, with different actors (teachers, health educators, youth development professionals, advocates for sexual health and youth leaders). A 2014 study of school-based sex education programs showed greater knowledge of HIV, high self-efficacy in condom use, reduction in sexual partners, and later onset of sexual intercourse (Fonner VA et al, 2014).

School-based CSE, before and after puberty, is effective in preventing early and unwanted pregnancies in different national contexts. Adolescent girls who have received sexual education classes at least once a week and advice from a qualified professional increase their chances of avoiding an early or unwanted pregnancy by 40%, and 30% respectively by graduation from secondary education (Coalition for Evidence-based Policy 2015, Chandra-Mouli et al., 2013, Kohler et al., 2008, Oringanje et al., 2009, Rosenthal et al., 2009, WHO, 2011). A more recent Cochrane systematic review including 41 randomized controlled trials in Europe, USA, Nigeria and Mexico confirms this efficacy (Oringanje et al, 2016). The content of the ISE / CSE must be age-appropriate to promote the development of healthy behaviors. ISE/CSE provides a solid foundation for future healthy interpersonal relationships as well as good reproductive health and healthy behaviors (UNESCO 2017). “CSE particularly practiced on young adolescents aged 10-14 is decisive. Because this age group marks a key transition between childhood, adolescence and adulthood, strongly determining future reproductive health and sex-specific attitudes and behaviors "(UNESCO 2017). **Establishing university-adapted comprehensive sexual education,** as international guidelines on reproductive health of young adults reaffirm the position of sexuality education in the context of human rights and gender equality (UNESCO 2018) **.**

Option 4 : Make essential reproductive health services accessible in schools and universities (information, education, STI / HIV / AIDS prevention, contraceptives and care)

The package of activities of school clinics and health centers should include essential reproductive health services and care including activities of information-education-communication for development, prevention of STI-HIV-AIDS, contraceptives and basic care. This option aims to make reproductive health services easy to use near the student living space. Thus, adolescents will no longer have to miss classes to go to other health facilities where the queues are long and the presence in class attire appears stigmatizing. The young people will thus be able to benefit from the advice of health professionals at the establishment, will be more edified in their daily problems, but will also benefit from contraceptives within the establishment. This measure will enable adolescents to address sexual and reproductive health issues with health and education professionals who will provide them with the necessary supports.

Evidence supports the need for comprehensive quality sexual health services as a complement to CSE (Mazur et al, 2018, Denno D.M. et al., 2015, WHO, 2012). User-friendly reproductive health services include: (i) listening and counseling about physical, social and

emotional reproductive health challenges; (ii) address the challenges posed by complex reproductive health issues such as access to informed contraception, gender-based violence, STIs and HIV / AIDS; (iii) sensitize adolescents and young adults to primary and secondary prevention of HIV; (iv) supplement or refute the large amount of approximate information on the Internet; (v) help cope with hyper-sexualization of the media. A US study found that a school-based reproductive health program has resulted in an increase in teenage school attendance compared to previous years when these services were not offered (Griswold 2012).

Option 5 : Combat stigma and discrimination against pregnant girls and girl mothers

It is essential to act against stigma and discrimination against pregnant girls and girl mothers. The stigmatization of pregnant girls and girl mothers has negative impacts on their school performance (EPPI Center, 2006). This strategy will help young girls not to fall into despair, loss of self-esteem, or drop out of school. A UK study shows that the effects of stigma and discriminatory attitudes towards pregnant girls and teenage mothers include isolation, loss of self-esteem, depression and dropping out of school (Yadley, 2008). A revision of the texts systematically excluding pregnant girls is debatable.

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Appendix: Summary of Effective Program Characteristics.

1. Involve experts specialized in research on human sexuality, behavioral change and pedagogy in the development of school curricula.

2. Assess reproductive health needs and behaviors of young people to support the development of logic models.

3. Use a logic model that specifies the health objectives, the types of behavior that affect those goals, the risk and protective factors that affect these types of behaviors, and the activities designed to modify these factors. risk and protection.

4. Design activities that reflect cultural values and are consistent with available resources (ie staff time, staff skills, space for facilities and supplies).

5. Test the program and regularly gather feedback from learners on how the program is meeting their needs.

6. Focus on clear goals for defining the content, approach and activities of the curriculum. These goals should include prevention of HIV infection, other STIs and unwanted pregnancies.

7. Concentrate strictly on risky sexual behaviors and specific protective behaviors that are directly related to these health goals.

8. Deal with specific situations that may lead to unwanted or unprotected sex and ways to avoid and get rid of it.

9. Disseminate clear messages about behaviors that reduce the risk of STIs or pregnancy.

10. Focus on specific risk and protective factors that influence specific sexual behaviors and are likely to change through curriculum-based courses (eg, knowledge, values, social norms, attitudes and skills).

11. Use participatory pedagogical methods that promote the active participation of students and help them to internalize and integrate information.

12. Implement multiple pedagogically relevant activities aimed at modifying each of the risk and protective factors considered.

13. Provide scientifically accurate information on the risks of unprotected sex and the effectiveness of different methods of protection.

14. Address risk perception (especially predisposition).

15. Address personal values and perceptions of family and peer norms about sexuality and multiple partners.

16. Address individual attitudes and norms of peers regarding condoms and contraception.

17. Deal with both the skills and the ability to use them.

18. Cover themes in a logical order.