A large volume of requests from physicians at high school clinics for talks on sexuality and responsible parenthood prompted the Centro Médico de Orientación y Planificación Familiar (CEMOPLAF), a veteran family planning non-governmental organization in Ecuador, to launch a project introducing sexuality education in classrooms. Between 1995 and 1997, the Georgetown Institute for Reproductive Health supported CEMOPLAF in implementing a Fertility Awareness and Sexuality Education pilot project in high schools in four provinces of Ecuador. The purpose of this project was to develop and test a Fertility Awareness-based sexuality education model for in-school youth, and to evaluate and document the impact of this model on adolescents. The model includes: (1) a high school curriculum and instructional support materials; (2) teacher training on use of the curriculum; (3) a tool to monitor and evaluate student progress; and (4) introduction of the curriculum to parents and school officials.

Fertility Awareness (FA), an approach successfully implemented by The Georgetown Institute in many programs worldwide, is more than basic reproductive anatomy and physiology. It incorporates understanding basic information, applying it to one’s self, and discussing it with a parent, health provider, peer or partner. What distinguishes it from more traditional sex education programs is the self-understanding, self-assessment skills, and communication skills the young person gains.

**Program Design and Implementation**

The design of the Fertility Awareness and Sexuality Education Curriculum followed the findings of an initial knowledge, attitudes, skills and practices (KASP) assessment conducted with adolescents, their parents and teachers. Based on these results, a team of CEMOPLAF physicians and educators, adolescents, and high school teachers identified 24 topics to be covered in the curriculum. Six modules (Communication, Self-esteem, Values, Fertility and Family Planning, Sexuality, and Sexually Transmitted Diseases) were then developed and packaged into a 26-hour course applied weekly during the academic year.

Ninth and tenth grade students at four intervention schools received the curriculum, and students at four other schools constituted the control groups. Schools were selected to match a particular type of student and school: coeducational, non-coeducational, urban, rural, lay, religious, public, private, indigenous, and mixed race
(mestizo). A total of 1,103 students participated in the pilot activity; 502 received the curriculum, and 601 remained the controls.

Twenty-nine teachers from the four intervention schools were trained to use the curriculum, and received implementation guides and monitoring tools. Each guide contained the theme, objectives, basic concepts, timing, materials, classroom activities, evaluation methodology, and homework modules. Getting teachers to change from a didactic to a more facilitative role posed an initial challenge, so teachers were trained not only to use the curriculum, but also in facilitation techniques and group dynamics.

**Program Evaluation**

Evaluation included documenting both the implementation process and the project’s impact. Monitors, teachers and students completed questionnaires and participated in in-depth interviews about each of the six modules. Teachers found the curriculum simple to use and the balance between content and practice appropriate. Youth rated classroom activities as interesting and engaging, and more than 80% indicated that the program had helped them clarify key concepts and concerns. Their feedback led to adjustments in the final curriculum, such as consolidation of topics, spreading topics across two academic years, and reducing contact hours.

To evaluate the program’s impact, tests were administered before application of the curriculum, at the completion of the course, and six months after course completion. The test measured knowledge of key reproductive health issues such as body awareness, family planning, and sexually transmitted diseases; attitudes regarding self-esteem, sexuality and fertility; self-observation skills; and communication skills with parents, teachers, and peers. Selected reproductive health practices, such as genital hygiene, protected intercourse, self-referral, pregnancies and abortions, and postponing sexual intercourse were also measured.

The tests showed that before the course, the intervention and control groups had very similar knowledge, attitudes, skills and practices. The test administered at the end of the course showed a statistically significant difference in knowledge and attitudes between the two groups, with participants in the intervention group having increased their knowledge and developed a positive attitude towards their fertility and sexuality. There was a moderate increase in the intervention group’s skills compared to the control group, but there were no differences in practices in either group. Two reasons may account for this limited change in practices. First, most youth aged 14 to 16 were not engaged in risky reproductive health behaviors at the start of the intervention. Secondly, the post intervention measurement was taken too early to expect gains in knowledge, attitudes, and skills to be translated into significant behavioral changes,
particularly those involving unplanned pregnancies. It was felt that the program should continue into later adolescence, when pressures for sexual activity are likely to be greater.

**Program Impact at the Institutional Level**

In addition to producing a tested educational model, the project generated significant institutional outcomes.

- **Continuation of the project in schools**

CEMOPLAF has turned the educational program over to school authorities. Centers in Quito and the four provinces where the pilot project was conducted continue to train teachers, often with the support of the original twenty-nine teachers. (CEMOPLAF continues to train teachers when requested, as time and resources allow.) Schools applying the curriculum continue to use the monitoring and evaluation tools. CEMOPLAF tries to ensure a high quality of training and support for teachers.

- **Strengthening relations between CEMOPLAF and the Ministry of Education and Culture**

CEMOPLAF was able to build on its long-standing collaboration with the Ministry of Education and Culture (MEC) to secure support for this project. Through its close collaboration with local schools during this project, CEMOPLAF further strengthened its ties with the MEC. When the project was completed, the MEC officially endorsed the curriculum as a tool for sexuality education in schools around the country. It also endorsed the teacher training package as a valid option for teachers who need training for their recertification (teachers in Ecuador must complete 30-40 hours of training every two years in order to renew their teaching license). Finally, the MEC and CEMOPLAF also collaborated in drafting congressional legislation on classroom-based sexuality education.

- **Development of youth-friendly reproductive health services**

The project helped sensitize CEMOPLAF staff to the need for specialized reproductive health services for adolescents. After the pilot project, CEMOPLAF developed proposals for a youth-friendly clinic model. A participatory approach was used to secure the support of the communities where the clinics operate and the active involvement of young women and men and their parents. Realizing the need to incorporate new services and/or make existing services more acceptable and accessible to youth, five CEMOPLAF clinics remodeled the clinics, trained personnel, adjusted schedules and fees, and hired specialized personnel. Adolescent-only clinical
services, counseling, and education are now delivered in four CEMOPLAF clinics. CEMOPLAF is closely monitoring this new experimental project and plans to replicate it in its sixteen other clinics in Ecuador.

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