

# SEXUALITY EDUCATION

## Policy brief No. 2

## SEXUALITY EDUCATION: WHAT IS ITS IMPACT?

This policy brief provides an overview of the impact of good quality sexuality education on the health and well-being of children and young people. The examples in this brief are taken from Europe and Central Asia but they are also relevant to countries outside of these regions.

Sexuality education is teaching about the cognitive, emotional, social, interactive and physical aspects of sexuality. Sexuality education does not encourage children and young people to have sex. In the *Standards for Sexuality Education in Europe*, experts agreed that: “Sexuality education starts early in childhood and progresses through adolescence and adulthood. For children and young people, it aims at supporting and protecting sexual development. It gradually equips and empowers children and young people with information, skills and positive values to

*understand and enjoy their sexuality, have safe and fulfilling relationships and take responsibility for their own and other people’s sexual health and well-being.”<sup>1</sup>*

Sexuality education lays the foundation for a safe and fulfilling passage to adulthood, e.g. by encouraging understanding of emotions and feelings, teaching the principles of human reproduction, exploring family and interpersonal relationships, learning about safety, and developing confidence and communication skills.

These can then be built upon gradually, in line with the age and stage of development of the child.

This policy brief presents the available evidence describing the “hard” and “soft” aspects of sexuality education. At the same time, the authors recognize that the impact of “soft” aspects of sexuality education have not been sufficiently studied to date.<sup>2</sup>

## IMPACT OF GOOD QUALITY SEXUALITY EDUCATION ON THE HEALTH AND WELL-BEING OF CHILDREN AND YOUNG PEOPLE

Sexuality education delivered within a safe and enabling learning environment and alongside access to health services has a positive and life-long effect on the health and well-being of young people.

Studies in several European countries have shown that the introduction of long-term national sexuality education programmes has led to “hard outcomes”, as shown in Table 1:

- Reduction in teenage pregnancies and abortions
- Decrease in sexually transmitted infections (STIs) among young people aged 15–24 years<sup>3,4</sup>
- Decrease in HIV infections among young people aged 15–24 years<sup>4</sup>
- Decrease in sexual abuse<sup>5,6</sup>
- Decrease in homophobia<sup>5,6</sup>

Table 1: “Hard” outcomes of good quality sexuality education

Beyond that, by increasing confidence and strengthening skills to deal with different challenges, sexuality education can empower young people to develop stronger and more meaningful relationships (Table 2).

Social norms and gender inequality influence the expression of sexuality and sexual behaviour. Many young women have low levels of power or control in their sexual relationships. Young men, on the other hand, may feel pressure from their peers to fulfil male sexual stereotypes and engage

in controlling or harmful behaviours. Good quality sexuality education has a positive impact on attitudes<sup>7</sup> and values and can even out the power dynamics in intimate relationships, thus contributing to the prevention of abuse and fostering mutually respectful and consensual partnerships.

<ul style="list-style-type: none"> <li>• Awareness of human rights</li> <li>• Respect, acceptance, tolerance and empathy for others</li> <li>• Gender equality</li> <li>• Confidence and self-esteem</li> <li>• Skills in contraceptive use</li> </ul>	<ul style="list-style-type: none"> <li>• Empowerment and solidarity</li> <li>• Critical thinking</li> <li>• Skills in negotiation, decision-making and assertiveness</li> <li>• Parent-child communication</li> <li>• Sexual pleasure and mutually respectful relationships</li> </ul>
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**Table 2: “Soft” outcomes of good quality sexuality education**

The experience of some countries provides direct evidence for the positive behavioural changes that have occurred in parallel with the introduction of sexuality education.

### RISE IN AGE AT FIRST INTERCOURSE

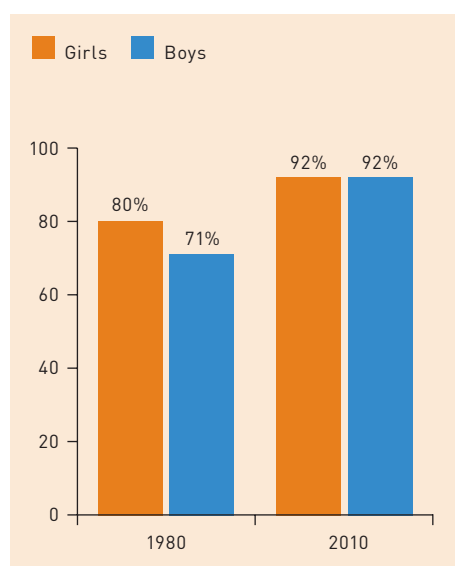
From 2005 to 2010 the percentage of sexually experienced 15-year-olds has remained stable in Western European countries and increased in East-

ern European countries.<sup>8,9</sup> However, at least four countries (Finland, Germany, Kazakhstan and the Netherlands) observed a decrease in the percentage of sexually experienced 15-year-olds.<sup>8-11</sup>

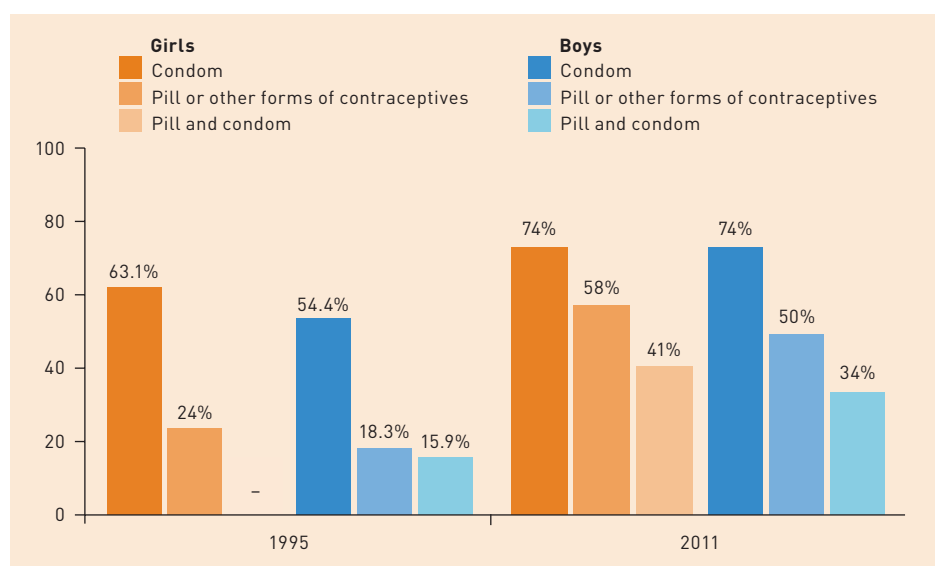
### INCREASED CONTRACEPTIVE USE AT FIRST INTERCOURSE

Over the last three decades, Germany saw a significant increase in contraceptive use at first intercourse. In 2010, 92% of young people used some form of contraception at first intercourse, compared with only 80% of

girls and 71% of boys in 1980 (Figure 1). Similarly, in the Netherlands, nine out of ten adolescents used contraceptives at first intercourse. This is not only due to sexuality education, but also to national safer-sex campaigns, good access to reliable, affordable and acceptable contraception, youth-friendly services and supportive environments. Increased condom use is particularly important as it also protects from HIV, other STIs and human papillomavirus (HPV). Figure 2 shows contraceptive use broken down by contraceptive method.



**Figure 1: Contraceptive use at first intercourse in Germany<sup>11</sup>**



**Figure 2: Contraceptive method at first intercourse in the Netherlands in 1995 and 2011<sup>12,13</sup>**  
Young people using no contraceptive have been excluded from this table

## DECLINE IN TEENAGE PREGNANCY RATES

Sexuality education is thought to decrease teenage pregnancy rates because of the specific knowledge it imparts about contraception including condoms, positive attitudes and intention to use contraception, self-efficacy in using contraception, negotiation skills when a partner refuses to use a condom, ability to seek contraceptive services and counselling, and more.

In Finland, school-based sexuality education and sexual and reproductive health services for young people were introduced in 1990, leading to an immediate decrease in teenage pregnancy rates. However, owing to budget constraints, both programmes were drastically reduced in the period

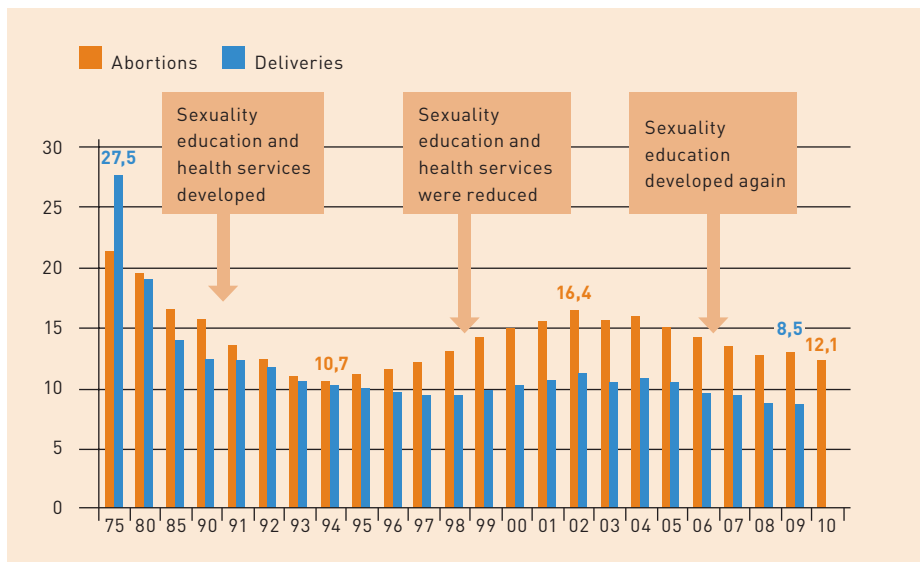


Figure 3: Abortions and deliveries in 15–19-year-old girls (per 1000), Finland, 1975–2010

1998–2006. This had an immediate impact on abortion and birth rates among 15–19 year old girls. The rates decrea-

sed again after the reintroduction of sexuality education and youth-specific health services in 2006 (Figure 3).<sup>3</sup>

## DECLINE IN SEXUALLY TRANSMITTED INFECTION RATES

In Estonia, increased knowledge about contraception and condoms, access to youth-friendly sexual and reproductive health services and a supportive policy environment are thought to be the reason for the dramatic decline in STI rates among 15–24-year-olds (Figure 4).<sup>4</sup>

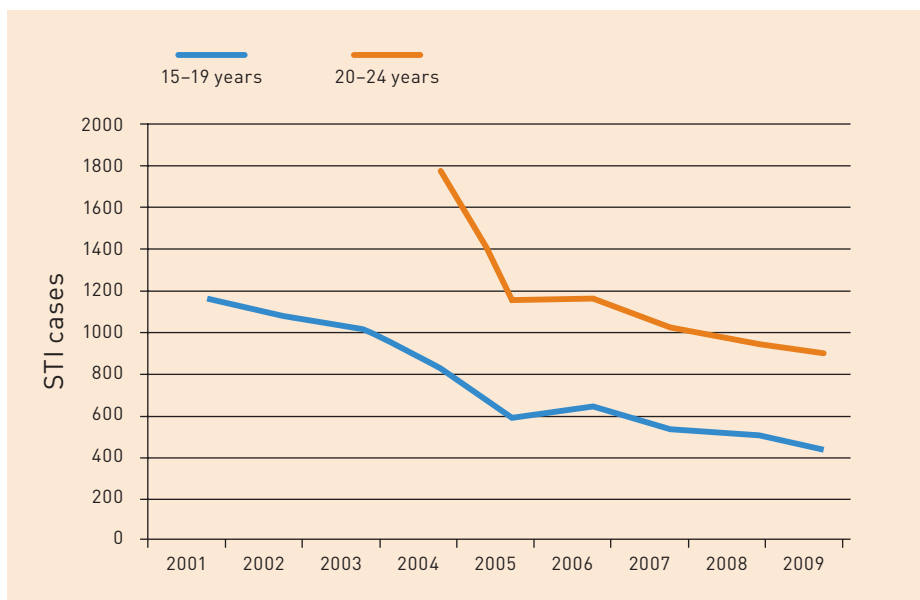


Figure 4: Decline in registered cases of three STIs (Chlamydia, gonorrhoea and syphilis), Estonia, 2001–2009

Data source: Murd, M. and A. Trummal. 2010. *HIV ja seotud nakkused arvudes 2009. aasta seisuga* [HIV and related infections in numbers in 2009]. Tallinn, National Institute for Health Development.

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This policy brief is provided free of charge.

The content of this brief was reviewed by the European Expert Group on Sexuality Education. The members of the Expert Group are representatives of the following organizations: Austrian Institute for Family Studies – University of Vienna, Contraception and Sexual Health Service – Nottinghamshire Community Health, European Society for Contraception, International Centre for Reproductive Health – University of Ghent, International Planned Parenthood Federation (IPPF), Lucerne University of Applied Sciences and Arts, Norwegian Directorate of Health, Sex Education Forum of the National Children's Bureau – United Kingdom, Sexual Health Clinic – Väestöliitto, Rutgers, SENSOA, Swiss Foundation for Sexual and Reproductive Health (PLANeS), United Nations Educational, Scientific and Cultural Organization (UNESCO), University of Uppsala, and WHO Regional Office for Europe.