COMPREHENSIVE SEXUALITY EDUCATION - FACTSHEET SERIES

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COMPREHENSIVE SEXUALITY EDUCATION FACTSHEET SERIES:

AN INTRODUCTION

In the Standards for *Sexuality Education in Europe* the concept of "holistic sexuality education" is defined as follows: 'learning about the cognitive, emotional, social, interactive and physical aspects of sexuality. Sexuality education starts from birth and progresses in a way that is developmentally appropriate through childhood and adolescence into adulthood. For children and young people, it aims to support and protect 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'.[1]

WHAT IS THE AIM OF THE CSE FACTSHEETS?

The German Federal Centre for Health Education (BZgA) in collaboration with UNFPA has produced a series of factsheets that synthesize recent international evidence on the benefits of comprehensive sexuality education (CSE) in relation to various health, development and youth-focused topics. Each of the factsheets presents the results of the most recent research on the benefits of CSE in relation to a specific topic, and provides good-practice and country examples. The factsheets aim to:

- Present evidence of the benefits of CSE to allow advocates to develop effective advocacy campaigns and materials based on evidence particularly for Europe and Central Asia;
- Showcase positive developments and country examples regarding the benefits of CSE globally, and in Europe and Central Asia specifically; and
- Contribute to scientific and technical exchange about recent evidence and good practices in the area of CSE.

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WHO ARE THE CSE FACTSHEETS FOR?

The CSE factsheets are a useful reference for anyone working on CSE globally. They have been developed for the following key groups, with a particular focus on Europe and Central Asia:

- CSE advocates within government entities and educational facilities, civil society, UN agencies, youth movements and other people striving to strengthen CSE
- Policymakers and representatives from relevant ministries, including health, youth, education and others
- Elected representatives of national/regional/local governments and parliaments
- Representatives of educator/teacher associations
- Representatives of parents, faith and community associations
- Representatives of youth and SRHR advocacy organizations
- Programme implementers working with young people
- Others who work on CSE or are interested in the topic

HOW HAVE THE CSE FACTSHEETS BEEN DEVELOPED?

The factsheets have been informed by an extensive literature review,[2] carried out by UNESCO in the process of revising its *International Guidance on Sexuality Education*,[3] and developed in consultation with the European Expert Group on Sexuality Education. Each of the factsheets has been developed as a stand-alone resource to address a specific topic; however the factsheets do include some cross-references to reflect the significant linkages between the different topic areas.

WHICH TOPICS DO THE CSE FACTSHEETS COVER?

To date, BZgA in collaboration with UNFPA developed factsheets on six topics:

1. The impact of comprehensive sexuality education on young people's sexual behaviour
2. The impact of comprehensive sexuality education on adolescent pregnancy
3. The impact of comprehensive sexuality education on sexually transmitted infections, including HIV, among young people
4. The impact of comprehensive sexuality education on youth empowerment
5. The impact of comprehensive sexuality education on addressing gender inequality and gender-based violence
6. Promoting parental involvement in comprehensive sexuality education

HOW ARE THE FACTSHEETS STRUCTURED AND WHAT DO THEY INCLUDE?

The factsheets are written in clear, accessible language and follow a similar structure, with key information highlighted through text boxes and case studies.
Each factsheet provides a short summary—between four and six pages—of the relevant evidence and best practices for CSE in relation to the given topic. This evidence and best practices are relevant globally, with a specific focus on Europe and Central Asia. Each factsheet includes:

- A short introduction to CSE as understood by **key stakeholders** including the German Federal Centre for Health Education (BZgA),[4] WHO,[5] UNFPA,[6] UNESCO[7] and the International Planned Parenthood Federation (IPPF)[8]
- A summary box of the key evidence linking CSE and the relevant topic
- Key facts and data relating to young people and the topic
- A brief discussion and analysis of the issues and linkages between the topic, CSE and adolescents and young people
- A country case study example illustrating how CSE has addressed the topic in practice; along with a list of references.

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THE IMPACT OF COMPREHENSIVE SEXUALITY EDUCATION ON YOUNG PEOPLE'S SEXUAL BEHAVIOUR

WHAT IS 'COMPREHENSIVE SEXUALITY EDUCATION'?

The international community has moved towards a consensual definition of comprehensive sexuality education (CSE), steering away from a primary focus on disease prevention to a more positive and holistic focus on well-being.[1] **Key stakeholders** including the German Federal Centre for Health Education (BZgA),[2] WHO,[3] UNFPA,[4] UNESCO[5] and the International Planned Parenthood Federation (IPPF)[6] **agree that CSE**

- is an **evidence- and curriculum-based** process of teaching about the cognitive, emotional, social, interactive and physical aspects of sexuality.[7]
- starts from birth and progresses in a way that is **developmentally appropriate** through childhood and adolescence into adulthood.
- plays a key role in ensuring young people's **safe emotional and physical development.** It gradually equips and empowers children and young people with **information, life skills and positive values** to understand and enjoy their sexuality, have safer, healthier and more fulfilling relationships and take responsibility for their own and other people's sexual health and well-being.[8]
- strengthens children's and young people's ability to exercise their **sexual and reproductive rights** to make conscious, satisfying and healthy choices regarding relationships, sexuality and their physical and emotional health.
- is based on a **respect for human rights, gender equality and diversity** that underpins individual and community well-being.
- helps young people to **reflect on, understand and challenge harmful social and gender-based norms** and the impact these have on relationships with peers, parents, teachers, other adults and their communities.
- covers a **comprehensive range of topics** beyond **biological aspects of reproduction and sexual behaviour**, including (but not limited to) sexuality, gender, different forms of sexual expression and orientation; gender-based violence (GBV); feelings, intimacy and pleasure; contraception, pregnancy and childbirth; and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV).

CSE is an integral part of the human right to health; in particular, the right to access appropriate health-related information, and is supported by a number of international agreements, including the *1994 International Conference on Population and Development (ICPD) Programme of Action* and related resolutions. Additionally, the UN Committee on Economic, Social and Cultural Rights views a failure to ensure that up-to-date, accurate information on sexual and reproductive health (SRH) is publicly available and accessible to all, and incorporated into educational curricula, as a violation of a State's obligations.[9]

In countries where CSE is integrated into schools, evidence shows that young people wait until a later age to have their first sexual experiences; have lower teenage pregnancy and abortion rates; have higher rates of contraceptive use; and report less discrimination based on sexual orientation and gender differences.[10,11,12] This is in contrast to 'abstinence-only' approaches, which have been found to be ineffective, stigmatizing and unethical.[13,14,15]

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SUMMARY OF KEY EVIDENCE: CSE AND YOUNG PEOPLE'S SEXUAL BEHAVIOUR

There is evidence that CSE has an impact on young people's sexual behaviour.

- **CSE can decrease the number of young people having sex at a very young age ('early-starters') and reduce high-risk sexual behaviour**.[16] A study in Kenya involving over 6,000 students showed that CSE decreased the number of young people having sex at a very young age and, once sexually active, it increased condom use.[17] Studies in the Netherlands[18] and Germany,[19] which have well-established CSE programmes, show that young people felt it was better to delay sex and initiated sex at a later age than their peers in countries without CSE.

- **CSE increases young people's knowledge and promotes positive attitudes in relation to sexual and reproductive health**. Nearly all CSE programmes studied in a review of evidence commissioned by UNESCO in 2016 were shown to increase knowledge about different aspects of sexuality and the risks associated with unprotected sex in terms of unintended pregnancy and STIs, including HIV.[20]

- **CSE has a positive impact on behaviour among young people, increasing effective and consistent use of contraception, including condoms**. An extensive review of 64 studies (including in the Russian Federation) involving over 87,000 young people, confirmed the positive impact of school-based CSE on increased and effective use of contraception (including condoms) during last sex; on reduced high-risk sexual behaviour; and on less frequent sex without a condom in the past three months.[21] School-based CSE, together with access to youth-friendly clinics, was also shown to increase the effective use of contraception in Estonia.[22] In Germany, there has been a significant increase in condom use at first sexual intercourse over the past three decades, which correlates with the introduction and expansion of CSE in the country.[23]

- **CSE does not increase sexual activity, numbers of sexual partners or sexual risk-taking behaviour**. This has been confirmed in research studies in Europe, including in Finland,[24] and across the most rigorous trials and systematic reviews.[25,26] Most recently, it has been re-confirmed in UNESCO's 2016 review of evidence.[27] Indeed, two thirds of the 87 global studies included in an earlier evidence review demonstrated a positive impact of CSE on behaviour, including self-efficacy related to condom use and refusing unwanted sex; reduced number of sexual partners; and fewer young people engaging in sex at a very early age.[28]

- **In contrast to CSE, abstinence-based approaches have consistently proven ineffective and potentially harmful.** A 2017 review of sexuality education policies and programmes in the United States concluded that abstinence-only-until-marriage programmes were ineffective. These programmes were found to withhold pertinent sexual health knowledge; provide medically inaccurate information; promote negative gender stereotypes; stigmatize young people who are already sexually active, pregnant and/or parenting; and marginalize lesbian, gay, bisexual, transgender, intersex, queer/questioning (LGBTIQ) adolescents.[29] Further studies demonstrate that abstinence-only approaches are not effective in delaying sexual initiation,[30] reducing the frequency of sex or reducing the number of sexual partners.[31,32] They are also more likely to contain inaccurate information about key topics such as homosexuality, masturbation, abortion, gender roles, condoms and HIV.[33]

KEY FACTS:

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND BEHAVIOUR

- **21% of adolescents aged 15 in Europe and Central Asia are sexually active**. Rates for boys culminate at 40% in Bulgaria, with rates over 30% in Albania, North Macedonia and the Republic of Moldova.[34]

- **Globally, young people have high rates of STIs,** although data on STIs is limited and inconsistent between and within regions and countries.[35] Across Eastern Europe and Central Asia, incidence of syphilis and gonorrhoea among 15 to 19 year-olds is declining, but remains very high in some countries including Belarus, Kazakhstan, the Republic of Moldova and the Russian Federation.[36] Chlamydia trachomatis infections are increasing in Europe and Central Asia.[37]

- **Worldwide, 1.8 million adolescents aged 10 to 19 were living with HIV in 2017**[38] **and young people aged 15 to 24 account for 33% of all new HIV infections among adults** (aged 15 and over).[39] Eastern Europe and Central Asia has one of the world's fastest-growing HIV epidemics[40]; HIV prevalence in the region more than doubled between 2001 and 2011 among young people aged 15 to 24.[41]

- **Around 16 million girls aged 15 to 19 give birth every year**, accounting for 11% of all births worldwide. A further 1 million girls under 15 give birth every year.[42]

- **Adolescent fertility rates remain high in countries in Eastern Europe and Central Asia**, including Bulgaria, Georgia, Romania and Tajikistan, culminating in Azerbaijan where there were 60 births per 1000 women aged 15 to 19 in 2015.[43]

- **Some 120 million girls worldwide (slightly more than 1 in 10) have experienced forced intercourse, other forced sexual acts or other forms of intimate partner violence (IPV)**.[44] In Europe and Central Asia, one in every four women is subjected to IPV during her lifetime.[45]

By the end of adolescence, many young people have initiated sexual activity.[46] In many cases young people reach this stage in their development without the knowledge, skills and access to services they need to be properly prepared. This can limit their ability to negotiate safe, consensual and pleasurable sexual activity, to prevent unintended pregnancy and to protect themselves and their partners from STIs, including HIV.

ADOLESCENT SEXUAL BEHAVIOUR

Adolescence is a period of ongoing physical, emotional and social changes, and the time when many young people start to explore their sexuality, develop intimate relationships with others and initiate sexual activity.[47] It can also be a time of risk-taking and peer pressure. Attitudes and values related to gender equality, sexuality and health behaviours are established in this period and have important implications for health and social well-being in later life. **Therefore, adolescence is a critical time to develop healthy behaviours in relation to sexual and reproductive health.**

Many young people do not have the information, access to contraception or skills they need to negotiate safe sex and to protect their sexual and reproductive health. In many settings school-based CSE is not available, and even where it is many young people—especially girls who experience child, early and forced marriage (CEFM)—do not attend school. **The world's 1.8 billion young people have the highest rates of unmet need for contraception of any age group**.[48] In addition to existing barriers such as distance and cost, young people face further restrictions to accessing sexual and reproductive health services as a result of age restrictions, need for parental consent and/or attitudes of health-care providers towards young people.

Social and gender-based norms have significant impact on girls' and boys' life choices and experiences. Gender inequality influences sexual expression and behaviour. Often gender norms dictate that girls should marry and begin childbearing in adolescence, well before they are physically or mentally ready to do so. **In many settings, adolescent girls and young women have low levels of power or control in their sexual relationships**; they may be unable to negotiate sexual activity or condom use with their partners, especially if they are in relationships with older men and/or relationships that involve the exchange of sex for money or gifts.[49] In some contexts **young men may face destructive male stereotypes and experience pressures from their peers, or society as a whole, to fulfil these stereotypes and to engage in controlling or harmful behaviours towards women and girls.** In Europe and Central Asia, one in every four women is subjected to IPV (including physical and sexual violence) during her lifetime, and IPV has remained the second leading cause of death among adolescent girls aged 15 to 19 in the region since 1990.[50]

LINKING ADOLESCENT SEXUAL BEHAVIOUR AND CSE

The 1994 International Conference on Population and Development (ICPD) Programme of Action states that CSE programmes should address SRH and sexuality, gender relations and equality, as well as violence against adolescents. Later resolutions reinforce the call for CSE as part of 'promoting the well-being of adolescents, enhancing gender equality and equity as well as responsible sexual behaviour, to protect them from early marriage and unwanted pregnancy, sexually transmitted diseases including human immunodeficiency virus (HIV)/AIDS, and sexual abuse, incest and violence'.[51]

CSE provides knowledge and life skills that are essential to enable young people to make informed, voluntary and healthy choices about engaging in sex. It supports them to exercise their **sexual and reproductive rights** and builds skills to develop healthy and fulfilling relationships and negotiate safe and pleasurable sex. This includes understanding what constitutes risky or harmful behaviours; and **developing the skills to reject unwanted sexual activity and to seek help in case of coercive sex, IPV or GBV**.

CSE that is age- and developmentally appropriate begins very early in childhood; is based on the principles of human rights and gender equality; and continues through adolescence into adulthood. Many adolescents are already sexually active, and where CSE starts in late phases of young people's development some experience problems resulting from early and unprotected sexual activity.

Increasing young people's control over when, where, with whom and how they have sex, and ensuring that when they do, they have **access to youth-friendly services including contraceptives, condoms for dual protection and testing for STIs, including HIV, is critical to protect their own and their partners' sexual and reproductive health**.

Contrary to some widespread beliefs and fears, **CSE does not encourage young people to have sex earlier, increase sexual activity or deprive them of their 'innocence'**.[52,53] Evidence supports the correlation between positive changes in behaviour and the introduction of CSE. Where CSE is integrated into schools, these countries have **lower abortion rates, higher rates of contraceptive use** and young people report **less discrimination on sexual orientation and gender differences**.[54] **CSE can delay sexual activity for very young adolescents**.[55] Evidence also shows that, once engaged in voluntary sexual activity CSE **increases consistent use of effective contraception,**[56] **including condoms, reducing the likelihood of unintended pregnancy and STIs, including HIV**.[57]

Research conducted in several European countries shows that **long-term CSE programmes can contribute to reductions in teenage pregnancy**,[58,59] **abortion,**[60] **STIs**[61],

and HIV infections[62,63] among young people aged 15 to 24[64]. Consequently, **CSE is an investment in the younger generation that provides clear benefits later, including in terms of lower health-care and social-support costs**. [65,66]

In addition to improving sexual and reproductive health and rights outcomes, the life skills developed through CSE—including critical thinking, communication, negotiation, assertiveness, critical reflection, responsibility, empathy, self-confidence and self-efficacy—**all contribute to young people's development and well-being more broadly**.[67,68]

The **behaviours and relationships developed during adolescence have a lifelong impact**,[69] and providing accurate, non-judgmental and age- and developmentally appropriate **information that covers the full range of topics in a carefully phased process benefits all individuals and can contribute to the development of healthier, more equitable societies.**[70]

Scaling-up and expanding CSE to include non-formal and community-based settings is also paramount, with the potential to reach out-of-school and most vulnerable and marginalized adolescents, especially in countries where school attendance is low, or where CSE is not provided as part of the national curriculum.[71]

EVIDENCE IN PRACTICE

Across Europe and Central Asia, countries with well-developed CSE programmes, such as the Netherlands and Switzerland, have the lowest percentages of young people initiating sexual activity by age 15—at 15% compared with, for example, a high of 30% in Bulgaria where CSE is not well-implemented.[72] CSE increases consistent use of effective contraception,[73] including condoms, reducing the likelihood of unintended pregnancy and STIs, including HIV.[74] **The impact of CSE increases when delivered together with efforts to expand access to high quality, youth-friendly services that offer a full range of services and contraceptive choices**[75,76,77] **and when legislation is in place that protects and empowers young people**.

A 2017 study of young people in the Netherlands, where CSE is well-established, found that the **numbers of young people having their first sexual experience at a very young age—between 12 and 14—decreased** from an earlier study in 2012.[78] This is important, as young people who start having sex at a very early age are more often forced or persuaded to do so and more frequently have unprotected sex. The same study found that **more young people reported using a contraceptive method when they had sex for the first time and showed a reduction in the numbers of young people coerced or forced into sex**.

COUNTRY CASE STUDY:

PROMOTING SAFER SEXUAL BEHAVIOUR AND HEALTHY PRACTICES THROUGH SCHOOL-BASED CSE IN THE NETHERLANDS

In the Netherlands, school-based CSE programmes are the main way that adolescents receive information and life skills related to safer sex, sexuality and relationships. Rutgers developed the 'Springfever' programme, which provided CSE across a third of primary schools in the country. The Municipal Health Services provided teacher training, and the programme used a school-wide approach to deliver CSE to children aged 4 to 12, and included parents.

With the aim of ensuring a continuous curriculum for children and young people of different ages, Rutgers and Soa Aids Nederland (STI/AIDS Netherlands) also developed **Long Live Love (Lang Leve de Liefde—LLL)** to support the delivery of CSE in secondary schools. This programme is one of the most successful, evidence-based CSE programmes for adolescents aged 13 to 15, and is implemented widely across half of target secondary schools in the Netherlands. First developed in 1990, it has been reviewed and updated regularly to reflect up-to-date evidence on effective approaches and changes in youth culture, and to ensure that content continues to meet adolescents' needs.

The fourth generation of the programme was launched in 2012, and includes 26 learning activities divided over six lessons of one hour. It aims to provide students with the knowledge and skills to develop healthy and respectful relationships; promote safer sexual practices; and reduce negative health outcomes, including unintended pregnancy and STIs. The revised programme also focuses on sexual, cultural and gender diversity. Elements of the programme include a student magazine, a teachers' manual, a film series of six episodes and two optional computer-based lessons.

The Netherlands has the lowest (15%) percentage across Europe of young people initiating sexual activity by age 15, and contraceptive use among those adolescents engaging in sex is very high: 90% used contraception at first intercourse.[79] This cannot be attributed solely to the implementation of CSE, as national safer-sex campaigns; access to reliable, affordable and acceptable contraception; youth-friendly services; and a supportive environment for adolescent sexual and reproductive health have all been key contributing factors. Nevertheless, **Long Live Love is recognized as having an important impact on changing adolescent attitudes and behaviours in relation to sexuality and sexual and reproductive health.**

For further information see **http://www.longlivelove.nl**

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The **Federal Centre for Health Education (BZgA)** has been a World Health Organization Collaborating Centre for Sexual and Reproductive Health (WHO CC) since 2003, with a focus on comprehensive sexuality education (CSE) in Europe and Central Asia. In this role, BZgA develops documents, resources and standards for different target groups and engages in research and the organization of seminars and conferences to promote knowledge transfer and learning in the field of CSE.

United Nations Population Fund (UNFPA)
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UNFPA is the United Nations sexual and reproductive health agency. Its mission is to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled, and it works in more than 150 countries and territories around the world. Guided by the 1994 Programme of Action of the International Conference on Population and Development (ICPD), UNFPA's work includes partnering with governments, civil society and other agencies to implement comprehensive sexuality education, both in schools and through community-based training and outreach. UNFPA promotes policies for, and investment in, sexuality education programmes that meet internationally agreed standards.

This factsheet is provided free of charge.

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THE IMPACT OF COMPREHENSIVE SEXUALITY EDUCATION ON ADOLESCENT PREGNANCY

WHAT IS 'COMPREHENSIVE SEXUALITY EDUCATION'?

The international community has moved towards a consensual definition of comprehensive sexuality education (CSE), steering away from a primary focus on disease prevention to a more positive and holistic focus on well-being.[1] **Key stakeholders** including the German Federal Centre for Health Education (BZgA),[2] WHO,[3] UNFPA,[4] UNESCO[5] and the International Planned Parenthood Federation (IPPF)[6] **agree that CSE**

- is an **evidence- and curriculum-based** process of teaching about the cognitive, emotional, social, interactive and physical aspects of sexuality.[7]
- starts from birth and progresses in a way that is **developmentally appropriate** through childhood and adolescence into adulthood.
- plays a key role in ensuring young people's **safe emotional and physical development.** It gradually equips and empowers children and young people with **information, life skills and positive values** to understand and enjoy their sexuality, have safer, healthier and more fulfilling relationships and take responsibility for their own and other people's sexual health and well-being.[8]
- strengthens children's and young people's ability to exercise their **sexual and reproductive rights** to make conscious, satisfying and healthy choices regarding relationships, sexuality and their physical and emotional health.
- is based on a **respect for human rights, gender equality and diversity** that underpins individual and community well-being.
- helps young people to **reflect on, understand and challenge harmful social and gender-based norms** and the impact these have on relationships with peers, parents, teachers, other adults and their communities.
- covers a **comprehensive range of topics** beyond **biological aspects of reproduction and sexual behaviour**, including (but not limited to) sexuality, gender, different forms of sexual expression and orientation; gender-based violence (GBV); feelings, intimacy and pleasure; contraception, pregnancy and childbirth; and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV).

CSE is an integral part of the human right to health; in particular, the right to access appropriate health-related information, and is supported by a number of international agreements, including the *1994 International Conference on Population and Development (ICPD) Programme of Action* and related resolutions. Additionally, the UN Committee on Economic, Social and Cultural Rights views a failure to ensure that up-to-date, accurate information on sexual and reproductive health (SRH) is publicly available and accessible to all, and incorporated into educational curricula, as a violation of a State's obligations.[9]

In countries where CSE is integrated into schools, evidence shows that young people wait until a later age to have their first sexual experiences; have lower teenage pregnancy and abortion rates; have higher rates of contraceptive use; and report less discrimination based on sexual orientation and gender differences.[10,11,12] This is in contrast to 'abstinence-only' approaches, which have been found to be ineffective, stigmatizing and unethical.[13,14,15]

UNFPA

World Health Organization
REGIONAL OFFICE FOR Europe

BZgA Federal Centre for Health Education

WHO Collaborating Centre for Sexual and Reproductive Health

SUMMARY OF KEY EVIDENCE: CSE AND ADOLESCENT PREGNANCY

There is strong evidence to show that CSE is effective in developing essential knowledge, skills and behaviours to prevent unintended adolescent pregnancy.

- **CSE is effective in reducing early and unintended pregnancy**. Multiple reviews and studies across a diverse range of settings in Europe, the United States, Nigeria and Mexico confirm that CSE contributes to preventing unintended adolescent pregnancies.[16,17,18,19] By providing students with knowledge, life skills and information on contraceptive options, it can decrease the number of very young adolescents who initiate sexual activity and prevent early and unintended pregnancy.[20]

- **European countries with well-established national CSE programmes have significantly lower rates of adolescent births and abortions** than those countries where CSE is under-developed or non-existent.[21,22] Both Estonia[23] and Finland[24] demonstrate a strong correlation between the introduction of mandatory school-based CSE, delivered in combination with the development and expansion of youth-friendly sexual health services, and significantly reduced rates of unintended pregnancy.

- **CSE increases effective and consistent use of contraception, including condoms, once adolescents become sexually active**. An extensive review of 64 studies involving over 87,000 young people demonstrated the positive impact of school-based CSE on effective use of contraception (including condoms) during last sex; on increased condom use; and on less frequent sex without a condom in the past three months.[25] Similarly, there was a significant increase in reported condom use at last sex in a review of 53 studies involving over 105,000 young people receiving CSE.[26] In countries with well-established CSE programmes, young people report high rates of contraceptive use. For example, in 2017, 70% of young people aged 12 to 25 in the Netherlands reported using a condom when they had sex for the first time.[27]

- **CSE that aims to prevent both unintended pregnancy and STIs, including HIV, is more effective than single-focus programmes** in increasing effective contraceptive use and decreasing reports of sex without a condom.[28]

- **CSE programmes that address gender are significantly more effective at reducing unintended pregnancy.** 'Gender-focused' programmes are substantially more effective than 'gender-blind' programmes in achieving positive health outcomes such as reduced rates of unintended pregnancy and STIs, including HIV. This is as a result of their transformative content and teaching methods that support students to question social and cultural norms around gender, and to develop gender-equitable attitudes.[29] Gender-transformative programmes can also reduce partner violence, increase female control over sex, and lead to less sexual coercion.[30]

- **Linking CSE with youth-friendly health services increases the chances of preventing adolescent pregnancies.** Results from over 40 trials involving more than 95,000 adolescents showed that providing both CSE *and* access to contraception lowered the rate of unintended pregnancy among adolescents.[31] In Estonia, the provision of school-based CSE together with visiting a youth-friendly clinic was shown to increase the effective use of contraception among young women aged 16 to 24 and contributed to a reduction in unintended pregnancies.[32]

- **In contrast to CSE, abstinence-based approaches are not effective in delaying sexual initiation, reducing the frequency of sex or the number of sexual partners**.[33,34,35] They are more likely to contain inaccurate information about topics such as abortion, gender roles and condoms, and are potentially harmful to young people's sexual and reproductive health.[36] One study in a 2017 review of US-based programmes showed higher rates of non-marital pregnancy among young women who had taken a 'virginity pledge' than among those who had not.[37,38]

KEY FACTS:

ADOLESCENT PREGNANCY

- **Globally, around 16 million girls aged 15 to 19, and 1 million girls under 15, give birth every year**.[39]

- **11% of all births worldwide are to girls aged 15 to 19** and 95% of these are in low- and middle-income countries. Across Eastern Europe and Central Asia adolescent fertility rates in countries including Bulgaria, Georgia, Kyrgyzstan, Romania and Tajikistan remain high; in Azerbaijan there were 60 births per 1000 women aged 15 to 19 in 2015.[40]

- **Early pregnancy and childbirth can have serious health consequences** and is the second cause of death for girls aged 15 to 19 globally.[41]

- **Babies born to adolescent mothers face a substantially higher risk of dying than those born to women aged 20 to 24**. The younger the mother, the greater the risk to the baby.[42]

- **Babies born to adolescent mothers are also more likely to have low birth weight**, with the risk of long-term effects.[43]

- **Every year, some 3 million girls aged 15 to 19 undergo unsafe abortions**. Unsafe abortions account for up to 20% of all deaths during pregnancy in several countries across Europe and Central Asia.[44]

- **More than 1 in 10 adolescent girls worldwide experience violence, including forced intercourse or other forced sexual acts**.[45] School-related gender-based violence (SRGBV)—in the form of sexual violence or coercion from teachers and fellow pupils—is a cause of unintended adolescent pregnancy.[46] In Europe and Central Asia, one in every four women is subjected to intimate partner violence (IPV) during her lifetime.[47]

Across Eastern Europe and Central Asia, adolescent fertility rates are generally on the decline, although the regional rate remains three times higher than in Western Europe as a consequence of the barriers that young people continue to face in accessing information and services in many countries in the Eastern Europe and Central Asia region.[48] In Azerbaijan, where adolescent fertility rates are actually rising, the rate of 60 births per 1000 young women aged 15 to 19 is over ten times higher than in many Western European countries. When compared with countries such as Switzerland (with a rate of 2.84 per 1000 young women of this age group), the Netherlands (rate of 3.88) and Denmark (rate of 3.96)—all with well-established CSE programmes—the difference is even more pronounced.[49]

ADOLESCENT PREGNANCY —CAUSES AND CONSEQUENCES

Adolescence is a period of ongoing physical, emotional and social changes, and the time when many young people start to explore their sexuality, develop intimate relationships with others and initiate sexual activity.[50] It can also be a time of risk-taking and peer pressure. In many cases young people reach this stage in their development without the knowledge, skills and access to services they need in order to protect themselves and their partners from unintended pregnancy.

Early and unintended pregnancy is a global concern affecting high-income countries as well as low- and middle-income countries. **For some adolescents, pregnancy and childbirth are planned and wanted, but for many they are not, often resulting in abortion.** Many factors contribute to young people's vulnerability to unintended pregnancy.

Many young people do not have the information, access to contraception or skills they need to negotiate safe sex and to protect themselves against unintended pregnancy. In many settings school-based CSE is not available, and even where it is many young people—especially those who experience child, early and forced marriage (CEFM)—do not attend school.

Adolescent girls may lack access to contraception because services are not easily available; are inaccessible due to age constraints; are too expensive; or require adult consent. Restrictive national laws and policies can also have a negative impact and adolescent girls also report **legal barriers** and other access-related issues, as well as health concerns and worries about side effects of contraceptives.[51] **Young people's care-seeking behaviour may also be restricted because of fear of people finding out** and other confidentiality issues that may result in violence, embarrassment, lack of knowledge, misinformation and myths, stigma and shame.[52]

Attitudes of health-care providers—particularly towards young people seeking sexual and reproductive health and rights (SRHR) services—present an important barrier to health care across many settings.[53] These factors result in the world's 1.8 billion young people having the highest rates of unmet need for contraception of any age group.[54]

Social and cultural norms have a significant impact on girls' life choices and experiences, and consequently on adolescent pregnancy. Gender inequality and gender-based discrimination result in girls in many settings being less likely than boys to get an education; to have access to health care; and to have the opportunity to grow and develop before taking on adult roles. In many parts of the world, gender norms dictate that girls should marry and begin childbearing in adolescence, well before they are physically or mentally ready to do so.

Early marriage exposes girls to a range of risks including high-risk pregnancies and births, intimate partner violence (IPV), and the transmission of STIs, including HIV.[55] In many settings, adolescent girls and young women have low levels of power or control in their sexual relationships; they may be unable to refuse unwanted sex or resist coerced sex, which tends to be unprotected. **Around 120 million girls worldwide (slightly more than 1 in 10) have experienced forced intercourse, other forced sexual acts or another form of IPV**.[56]

In addition to IPV, perpetrators of gender-based and sexual violence (GBV and SV) include peers, family members or other influential adults, such as teachers. **School-related gender-based violence (SRGBV) in the form of sexual violence or coercion from teachers and fellow pupils is a key contributing factor in adolescent pregnancy**.[57]

Adolescent pregnancy has a major impact on the lives of young people—especially girls—in terms of their health, social, economic and educational outcomes. According to the World Health Organization (WHO), 'Complications during pregnancy and childbirth are the second [leading] cause of death for 15 to 19 year old girls globally. Young girls who marry later and delay pregnancy beyond their adolescence have more chances to stay healthier, to complete their education and build a better life for themselves and their families.'[58] **Early childbearing has serious health risks for both mothers and babies, including significantly increased risks of child mortality, obstetric fistula, low birth weight and other health risks to babies**.

Pregnancy in adolescence also places some 3 million girls aged 15 to 19 at risk of unsafe abortions each year.[59] Unsafe abortions account for up to 20% of all deaths during pregnancy in several countries across Europe and Central Asia.[60,61] **Adolescent girls who have an unintended pregnancy can also face challenges that include partner abandonment and dropping out of school, limiting their chances of future employment and other life opportunities and contributing to the cycle of ill-health and poverty.**[62]

LINKING ADOLESCENT PREGNANCY AND CSE

The 1994 International Conference on Population and Development (ICPD) Programme of Action states that programmes should address SRH and sexuality, gender relations and equality, as well as violence against adolescents. Later resolutions reinforce the call for CSE as part of 'promoting the well-being of adolescents, enhancing gender equality and equity as well as responsible sexual behaviour, to protect them from early marriage and unwanted pregnancy, sexually transmitted diseases including human immunodeficiency virus (HIV)/AIDS, and sexual abuse, incest and violence'.[63]

Preventing adolescent pregnancy was the main impetus for countries in Western Europe to pioneer the introduction of school-based sexuality education during the 1960s and 1970s. Over time, sexuality education has evolved and expanded to include a more comprehensive range of topics, and to develop the values, attitudes and skills that are critical to support young people's empowerment and enable them to fulfil and enjoy their sexual and reproductive health and rights, including preventing unintended and early pregnancy. **Scaling-up and expanding CSE to include non-formal and community-based settings is also paramount, with the potential to reach out-of-school and most vulnerable and marginalized adolescents, especially in countries where school attendance is low, or where CSE is not provided as part of the national curriculum.**[64]

Adolescence is a period of transition, growth, exploration and opportunities. **CSE begins early in childhood and continues into early adulthood, and targeting early adolescence (ages 10 to 14) is crucial[65] as this period marks a critical transition between these two phases.**[66] CSE with children and young adolescents delivered *before* they become sexually active is critical in order to provide them with the knowledge and skills to develop healthy behaviours and protect their sexual and reproductive health (see Factsheet 1). **When CSE starts in late phases of young people's development, some experience problems, including unintended pregnancy**, resulting from early and unprotected sexual activity.[67]

Extensive research and evidence exists to demonstrate that CSE is effective in preventing and reducing early and unintended pregnancy.[68,69,70] CSE empowers girls to negotiate sexual relationships and can affect gender norms that contribute to early marriage and pregnancies among adolescents. At the same time, it can help boys to understand and be part of the responsibility for sexual and reproductive health, including understanding GBV, healthy relationships and issues around consent. Research also shows that **CSE does not encourage young people to have sex earlier; increase sexual activity or numbers of sexual partners; or deprive young people of their 'innocence'.**[71,72,73,74]

WHO recognizes CSE as one of the most important ways to improve adolescent reproductive health and to prevent unintended and early pregnancy.[75] **UNFPA** includes CSE as one of the five

prongs in its Adolescent and Youth Strategy.[76] **UNESCO** includes the implementation of school-based CSE programmes as a key evidence-based recommendation to strengthen the education sector's response to early and unintended pregnancy.[77]

Key stakeholders, including BZgA[78], WHO[79], UNFPA[80], UNESCO[81] and IPPF[82], also highlight the importance of CSE that begins early in childhood, well before puberty, so that adolescents fully understand the changes in their bodies and have the information and skills needed, prior to becoming sexually active, to prevent early and unintended pregnancy.[83] Understanding what constitutes risky or harmful behaviour and developing skills to reject unwanted sexual activity and seek help in case of coercive or forced sex are critical in protecting children and young people and supporting them to exercise their sexual and reproductive rights.

CSE empowers young people to make informed choices about if, when and with whom to have sex and/or a child. It can support them to enjoy their sexuality and develop healthy, respectful and fulfilling relationships, helping them to avoid the risks associated with unintended pregnancy: early childbearing, complication of potentially unsafe abortions and STIs, including HIV. **CSE empowers girls to negotiate sexual relationships and to challenge gender norms** that contribute to early marriage and unintended pregnancy. This includes understanding what constitutes risky or harmful behaviours; and **developing the skills to reject unwanted sexual activity and to seek help in case of coercive sex, IPV or GBV.** CSE that discusses the sensitive topic of abortion—which is stigmatized all over the world—can dispel myths, help to reduce silence and stigma around the topic and provide young people with factual information about health and the law that can help them to access safe services when they need them.[84]

EVIDENCE IN PRACTICE

Countries that have long-standing CSE programmes, such as Sweden, Finland and the Netherlands, have significantly lower teenage birth rates and higher rates of contraceptive use among young people. Conversely, teenage birth rates are high in countries where CSE is either non-existent or in an early stage of development. Switzerland, where CSE is well-developed and starts between the ages of 4 and 8, has the lowest teenage birth rate in Europe at less than 3 per 1,000 girls aged 15 to 19. However, across countries in Eastern Europe and Central Asia, where discussions on sexuality and sexual and reproductive health in schools remain more sensitive, rates are much higher, with the highest rate of almost 61 per 1000 girls in the same age group in Azerbaijan.[85]

Studies in several European countries, including Estonia, Finland and the United Kingdom, have shown that the introduction of long-term national CSE programmes has led to a reduction in teenage pregnancies and abortions.[86,87] Although there are challenges in attributing impact of biological outcomes to one single intervention, there is strong evidence to show that CSE increases knowledge about contraception, including condoms; develops positive attitudes and intention to use contraception; increases self-efficacy in using contraception; builds negotiation skills to engage in voluntary sexual activity and condom use; and increases ability to access contraceptive services.[88]

Estonia provides clear evidence to demonstrate the **strong correlation between the implementation of a national CSE programme, together with youth-friendly sexual health services, and the improvement of sexual health indicators among young people**. This includes significantly **lower rates of unintended pregnancy and abortion** due to sharp **increases in condom and contraceptive use** among young people, in addition to **reduced infections of HIV and other STIs.**[89]

In Finland, school-based CSE and sexual and reproductive health services for young people were introduced in 1990, leading to **an immediate reduction in teenage pregnancy rates**. When these programmes were drastically reduced from 1998 to 2006 due to budget constraints, this had an immediate impact on adolescent birth and abortion rates, with adolescent abortions rising by 50%. When CSE became compulsory again in 2006, the rates decreased once more and the numbers of adolescents initiating sexual intercourse at age 14 and 15 also reduced.[90]

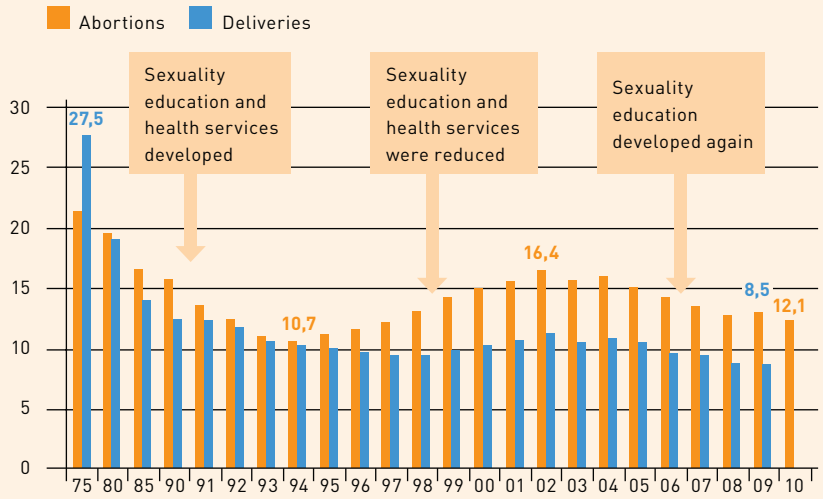

Figure 1: Abortions and deliveries per 1000 girls aged 15 to 19, Finland, 1975-2010[91]

COUNTRY CASE STUDY:

SCALING UP SCHOOL-BASED CSE TO ADDRESS EARLY AND UNINTENDED PREGNANCY IN THE UNITED KINGDOM

In most Western European countries, the rates of unintended pregnancies among adolescents have steadily declined in recent years. However, the adolescent pregnancy rate in the United Kingdom was the highest in the region, and the UK Government committed to addressing this, developing a 10-year Teenage Pregnancy Strategy for England (1999–2010). This ensured a multisectoral approach to promoting more widespread contraceptive use by expanding the provision of high-quality CSE; facilitating easier access to SRH services; and improving training for health-care providers to meet young people's needs.

Key elements of the approach included: sex and relationship education in schools; dedicated support for teenage parents, including sex and relationships education and access to contraception; scaling-up youth-friendly contraceptive and SRH services and condom programmes; and promoting access to contraception and sexual health advice in non-health youth settings. Providing training to health and other professionals (e.g. teachers) to build their confidence and skills to provide sex and relationships education, and providing advice and support for parents to discuss these issues with their children, were also critical components of the programme. As a result, England and Wales experienced a 56% reduction in the under 18 birth rate between 1998 and 2013.[92]

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The **Federal Centre for Health Education (BZgA)** has been a World Health Organization Collaborating Centre for Sexual and Reproductive Health (WHO CC) since 2003, with a focus on comprehensive sexuality education (CSE) in Europe and Central Asia. In this role, BZgA develops documents, resources and standards for different target groups and engages in research and the organization of seminars and conferences to promote knowledge transfer and learning in the field of CSE.

United Nations Population Fund (UNFPA)
Regional Office for Eastern Europe and Central Asia
Istanbul, Turkey
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UNFPA is the United Nations sexual and reproductive health agency. Its mission is to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled, and it works in more than 150 countries and territories around the world. Guided by the 1994 Programme of Action of the International Conference on Population and Development (ICPD), UNFPA's work includes partnering with governments, civil society and other agencies to implement comprehensive sexuality education, both in schools and through community-based training and outreach. UNFPA promotes policies for, and investment in, sexuality education programmes that meet internationally agreed standards.

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The content 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; European Society for Contraception; International Centre for Reproductive Health – University of Ghent, Belgium; International Planned Parenthood Federation European Network (IPPF EN); Lucerne University of Applied Sciences and Arts, Switzerland; Lust und Frust – Fachstelle für Sexualpädagogik und Beratung, Switzerland; Väestöliittoo, Finland; Russian Association for Population and Development; Rutgers, Netherlands; SENSOA, Belgium; United Nations Educational, Scientific and Cultural Organization (UNESCO); United Nations Population Fund, Regional Office for Eastern Europe and Central Asia – UNFPA/EECARO; University of Tartu, Estonia; University of Uppsala, Sweden; VL-Medi Oy Research and Sexual Health Centre, Finland; Integrated Sexual Health Service, Sherwood Forest Hospitals, NHS Foundation Trust and WHO Regional Office for Europe.**

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THE IMPACT OF COMPREHENSIVE SEXUALITY EDUCATION ON SEXUALLY TRANSMITTED INFECTIONS, INCLUDING HIV, AMONG YOUNG PEOPLE

WHAT IS 'COMPREHENSIVE SEXUALITY EDUCATION'?

The international community has moved towards a consensual definition of comprehensive sexuality education (CSE), steering away from a primary focus on disease prevention to a more positive and holistic focus on well-being.[1] **Key stakeholders** including the German Federal Centre for Health Education (BZgA),[2] WHO,[3] UNFPA,[4] UNESCO[5] and the International Planned Parenthood Federation (IPPF)[6] **agree that CSE**

- is an **evidence- and curriculum-based** process of teaching about the cognitive, emotional, social, interactive and physical aspects of sexuality.[7]
- starts from birth and progresses in a way that is **developmentally appropriate** through childhood and adolescence into adulthood.
- plays a key role in ensuring young people's **safe emotional and physical development.** It gradually equips and empowers children and young people with **information, life skills and positive values** to understand and enjoy their sexuality, have safer, healthier and more fulfilling relationships and take responsibility for their own and other people's sexual health and well-being.[8]
- strengthens children's and young people's ability to exercise their **sexual and reproductive rights** to make conscious, satisfying and healthy choices regarding relationships, sexuality and their physical and emotional health.
- is based on a **respect for human rights, gender equality and diversity** that underpins individual and community well-being.
- helps young people to **reflect on, understand and challenge harmful social and gender-based norms** and the impact these have on relationships with peers, parents, teachers, other adults and their communities.
- covers a **comprehensive range of topics** beyond **biological aspects of reproduction and sexual behaviour**, including (but not limited to) sexuality, gender, different forms of sexual expression and orientation; gender-based violence (GBV); feelings, intimacy and pleasure; contraception, pregnancy and childbirth; and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV).

CSE is an integral part of the human right to health; in particular, the right to access appropriate health-related information, and is supported by a number of international agreements, including the *1994 International Conference on Population and Development (ICPD) Programme of Action* and related resolutions. Additionally, the UN Committee on Economic, Social and Cultural Rights views a failure to ensure that up-to-date, accurate information on sexual and reproductive health (SRH) is publicly available and accessible to all, and incorporated into educational curricula, as a violation of a State's obligations.[9]

In countries where CSE is integrated into schools, evidence shows that young people wait until a later age to have their first sexual experiences; have lower teenage pregnancy and abortion rates; have higher rates of contraceptive use; and report less discrimination based on sexual orientation and gender differences.[10,11,12] This is in contrast to 'abstinence-only' approaches, which have been found to be ineffective, stigmatizing and unethical.[13,14,15]

UNFPA

World Health Organization
REGIONAL OFFICE FOR Europe

BZgA Federal Centre for Health Education
WHO Collaborating Centre for Sexual and Reproductive Health

SUMMARY OF KEY EVIDENCE: CSE AND STIS, INCLUDING HIV, AMONG YOUNG PEOPLE

Despite challenges in attributing the impact of CSE to biological outcomes, there is evidence to show that by improving knowledge and developing behaviours necessary to prevent STIs, including HIV, CSE is effective in reducing STI risks, including HIV-related risk.

- **CSE reduces the risk of STIs, including HIV, by increasing knowledge and developing safer sexual behaviours**.[16] Students who received school-based CSE had significantly greater knowledge of HIV, improved self-efficacy related to refusing sex, increased condom use and fewer sexual partners.[17]

- **CSE increases the effective and consistent use of condoms, thereby significantly reducing risks of STIs, including HIV**. A global review of 64 studies, including one conducted in the Russian Federation, demonstrated the positive impact of school-based CSE on effective use of condoms during last sex; increasing condom use; reducing high-risk sexual behaviour, and less frequent sex without a condom in the past three months.[18] There was a significant increase in reported condom use at last sex in a review of 53 studies involving over 105,000 young people receiving CSE.[19] In countries with well-established CSE programmes, young people report high rates of condom use. For example, in 2017, 70% of young people aged 12 to 25 in the Netherlands reported using a condom when they had sex for the first time.[20]

- **CSE that addresses both pregnancy prevention and STIs, including HIV, is more effective than single-focus programmes in increasing effective contraceptive and condom use and in decreasing reports of sex without a condom.**[21]

- **CSE that adequately addresses gender and is linked to youth-friendly sexual and reproductive health services is more effective at reducing STIs, including HIV. '**Gender-transformative' programmes that support learners to challenge harmful social and cultural norms around gender, and to develop gender-equitable attitudes, are substantially more effective than 'gender-blind' programmes in achieving health outcomes such as reducing rates of STIs.[22] **Rigorous evidence also demonstrates that CSE is more effective when it is linked to youth-friendly sexual and reproductive health services,**[23] **including STI and HIV counselling, testing and treatment, and provision of condoms**.

- **CSE is both cost-efficient and cost-saving in terms of its impact on preventing adverse health outcomes**. Between 2001 and 2009, Estonia's mandatory CSE programme prevented an estimated 7,240 incidences of STIs, 1,970 new HIV infections and 4,280 unintended pregnancies. A cost-benefit analysis, based on HIV infections prevented and HIV treatment costs alone, concluded that CSE would only have to be responsible for 4% of the HIV infections averted to be considered cost-effective and cost-saving.[24]

- **In contrast, abstinence-based approaches have consistently proven ineffective and potentially harmful.** A 2017 review of sexuality education policies and programmes in the United States concluded that abstinence-until-marriage-only programmes were 'ineffective, stigmatizing and unethical'. Such programmes were found to withhold pertinent sexual health knowledge; provide medically inaccurate information; promote negative gender stereotypes; stigmatize young people who are already sexually active, pregnant and/or parenting; and marginalize lesbian, gay, bisexual, transgender, intersex and queer/questioning (LGBTIQ) adolescents.[25] Further studies demonstrate that abstinence-only approaches are not effective in delaying sexual initiation, or in reducing the frequency of sex or the number of sexual partners.[26,27,28] They are also more likely to contain inaccurate information about key topics such as homosexuality, masturbation, abortion, gender roles, condoms and HIV.[29]

KEY FACTS:

STIS, INCLUDING HIV, AMONG YOUNG PEOPLE

- **Globally, young people continue to have high rates of STIs**, although data is limited and inconsistent between and within regions and countries.[30] Across Europe and Central Asia, incidence of syphilis and gonorrhoea among 15 to 19 year olds is declining, but remains very high in countries including Belarus, Kazakhstan, the Republic of Moldova and the Russian Federation.[31] Chlamydia infections are also increasing across Europe and Central Asia.[32]

- **Worldwide, 1.8 million adolescents aged 10 to 19 were living with HIV in 2017[33] and young people aged 15 to 24 account for 33% of all new HIV infections** among adults (aged 15 and over).[34]

- **Young women continue to be disproportionately affected, accounting for 19% of all new HIV infections globally among adults** (aged 15 and older). In Sub-Saharan Africa, 1 in 4 new HIV infections in 2017 were among young women aged 15 to 24, despite the fact that they represent just 10% of the population.[35]

- **In Eastern Europe and Central Asia, the HIV epidemic has grown by 30% since 2010, making it one of the world's fastest-growing HIV epidemics.[36]** In addition to sexual transmission, this is fuelled by injecting drug use. **In 2017, key populations[i] and their sexual partners accounted for 95% of new infections in this region.[37]**

- **Between 2001 and 2011, HIV prevalence more than doubled among young people aged 15 to 24 across Eastern Europe and Central Asia.[38]** One third of new HIV infections in the region occur in the 15 to 24 age group,[39] and over 80% of people living with HIV in the region are below 30 years of age.[40]

- **HIV also disproportionately affects young men who have sex with men; young people who inject drugs; young people who are transgender; young people who sell sex; and those who are already marginalized**, for example, those out of school and street children.

i UNAIDS considers gay men and other men who have sex with men; sex workers; transgender people; people who inject drugs; and prisoners and other incarcerated people as the five main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to services.

Young people often start having sex without the knowledge, skills or access to youth-friendly services they need. This, together with issues such as restrictive laws and policies, harmful cultural norms, gender inequity, gender-based violence (GBV), early marriage and stigma contributes to the fact that globally, young people experience high rates of STIs, including HIV, which can have lasting effects on their lives and their sexual and reproductive health. According to the International Planned Parenthood Federation, at least 111 million new cases of curable STIs occur each year among young people aged 10 to 24.[41]

STIS, INCLUDING HIV, AMONG YOUNG PEOPLE —CAUSES AND CONSEQUENCES

Adolescence is a period of ongoing physical, emotional and social changes, and the time when many young people start to explore their sexuality, develop intimate relationships with others and initiate sexual activity.[42] It can also be a time of risk-taking and peer pressure. In many cases young people reach this stage in their development without the knowledge, skills and access to services they need in order to protect themselves and their partners from STIs, including HIV.

Young people often lack knowledge on how to prevent STIs, including HIV. A global survey by UNAIDS across 37 countries showed that just 36% of young men and 30% of young women aged 15 to 24 had comprehensive and correct knowledge of how to prevent HIV.[43] Knowledge of specific risk factors (e.g. transmission through sexual networks or the risks associated with intergenerational sex and anal sex); of newer biomedical prevention

methods (e.g. PrEP); and of links between HIV and GBV is likely to be even lower.[44] **In many settings school-based CSE is not available, and even where it is many young people—especially those who experience child, early and early forced marriage (CEFM)—do not attend school.**

At a political level, adolescent sexual and reproductive health is often low priority, and there are often restrictive laws and policies in place, for example age of consent laws. These reinforce social and cultural norms that may create an inhibitive environment for discussion, and many societies disapprove of adolescent sexual activity, often stigmatizing the sexual health concerns of young people, in particular around STIs, including HIV.[45]

Social and cultural norms have a significant impact on girls' life choices and experiences, and consequently on vulnerability to STIs, including HIV. In some countries intergenerational sex and CEFM leave girls disempowered to negotiate safe sex, and are key drivers of the HIV epidemic. **In some settings, up to 45% of adolescent girls report that their first sexual experience was forced,[46] with condoms rarely used during forced sex**. In Europe and Central Asia, one in every four women is subjected to intimate partner violence (IPV), including both physical and/or sexual violence, during her lifetime.[47] **There is a strong correlation between GBV and HIV**.[48] Those who experience GBV are at increased risk of HIV, while those who disclose their HIV status may experience GBV as a consequence. **HIV transmission is also fuelled by injecting drug use, with many people beginning to inject during adolescence**.[49]

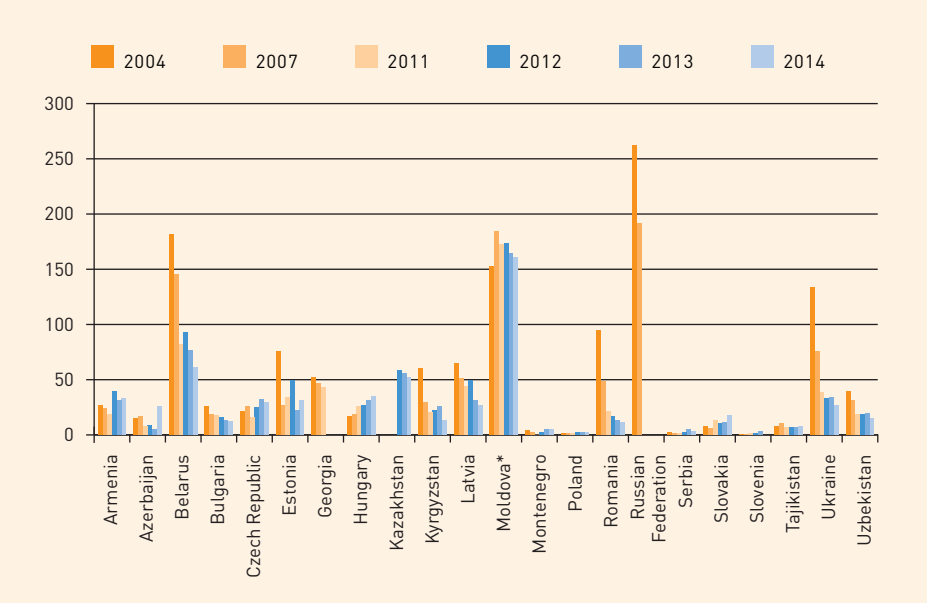


Figure 1: Total incidence of syphilis and gonorrhoea among 15 to 19 year olds (new cases per 100,000 average relevant population)

Source: TransMonEE 2016 Database, UNICEF Regional Office for CEE/CIS (released in July 2016)
*Data since 2001 do not include Transnistria

There is often an absence of youth-friendly integrated services where information and condoms are readily available. Where services do exist, other barriers may prevent young people from accessing them. These include the inability to pay; distance to services; fear of people finding out and other confidentiality issues that may result in violence; embarrassment; lack of knowledge; misinformation and myths; and stigma and shame.[50] **Health-care providers' attitudes towards young people present an important barrier to healthcare across many settings**.[51]

Untreated STIs increase young people's risk of contracting HIV and young women's risk of experiencing pelvic inflammatory disease (PID), a leading cause of preventable infertility. Children and young people are particularly vulnerable to HIV at two stages of their lives: very early in life when HIV can be transmitted from mother-to-child (also called 'vertical transmission')[52] and during adolescence when sexual activity brings new vulnerabilities to STIs, including HIV. **A combination of social and biological factors—including gender inequity, early marriage, violence and physiology—make young women twice as likely to acquire HIV as young men**.[53]

Young people who face some of the highest risks of HIV include those selling sex, young men who have sex with men, young people who are transgender and young people who use intravenous drugs. Studies indicate that HIV disproportionately affects individuals from these 'key populations': female sex workers are up to 13 times more likely to have HIV than other adult women; transgender women are up to 13 times more likely to have HIV than other adults aged 15 to 49; men who have sex with men are up to 28 times more likely to have HIV than heterosexual men; and risks of HIV infection can be up to 22 times higher among young people who inject drugs.[54]

Stigma and discrimination towards people from key populations, as well as migrants and prisoners, remains very high in many countries, particularly across Eastern Europe and Central Asia and including within health-care settings. This presents a major threat to an effective HIV response, discouraging people from accessing HIV testing and treatment.

Unlike many other regions in the world where HIV prevalence has fallen, Eastern Europe and Central Asia has one of the fastest-growing HIV epidemics. This region saw a 29% increase in new HIV infections between 2010 and 2017, with a total of 1.4 million people now living with HIV.[55] HIV transmission among people who inject drugs and their sexual partners accounts for the majority of HIV infections and is heavily influenced by the Russian Federation, which is home to 70% of people living with HIV in the region.[56] HIV infections among young people have increased significantly, with one third of new HIV infections in the region now occurring in the 15 to 24 age group.[57] Unprotected sex is now the most common route of HIV infection for young people, with sharing infected needles being the second.[58]

LINKING STI AND HIV PREVENTION AND CSE

The 1994 International Conference on Population and Development (ICPD) Programme of Action articulates that programmes should address SRH and sexuality, gender relations and equality, as well as violence against adolescents. Later resolutions reinforce the call for CSE as part of 'promoting the well-being of adolescents, enhancing gender equality and equity as well as responsible sexual behaviour, to protect them from early marriage and unwanted pregnancy, sexually transmitted diseases including human immunodeficiency virus (HIV)/AIDS, and sexual abuse, incest and violence'.[59]

Sexuality education has evolved over time in line with health and educational priorities, moving from a focus on preventing adolescent pregnancy in Western Europe in the 1960s and 1970s, to prioritizing HIV prevention from the 1980s and 1990s onwards. Over time, sexuality education has evolved and expanded to include a more comprehensive range of topics, and to develop the values, attitudes and skills that are critical to support young people's empowerment and enable them to fulfil and enjoy their sexual and reproductive health and rights (SRHR), including prevention of HIV and other STIs.

Tailoring CSE to the needs of all children and young people, including those already living with HIV and those who are marginalized and most vulnerable, is critical. Most CSE takes place in schools, but **scaling-up and expanding CSE to include non-formal and community-based settings is also paramount**, in order to reach out-of-school and the most vulnerable and marginalized adolescents, especially in countries where school attendance is low, or where CSE is not provided as part of the national curriculum.[60] Many of the factors influencing adolescent SRH lie in cultural and gender norms, therefore **engaging with parents and the wider community, including religious leaders, is important to challenge harmful cultural norms**, and to build their understanding of the issues faced by young people.

CSE supports the development of health-promoting habits from an early age, as the behaviours developed during adolescence have a lifelong impact,[61] and there is strong evidence to demonstrate CSE's contribution to preventing STIs, including HIV. This is attributed to the specific knowledge CSE imparts about STI transmission and HIV prevention;[62] its ability to build self-efficacy skills in order to negotiate sexual activity and condom use;[63] and its positive impact on safer sexual behaviours,[64] including increased condom use.

CSE is an important strategy to 'fast track' the HIV response and end AIDS. In its *Global AIDS Update 2018*, UNAIDS highlighted CSE's central role in preparing young people for a safe and fulfilling life and highlighted it as 'an important component of the HIV prevention package for young people'.[65]

EVIDENCE IN PRACTICE

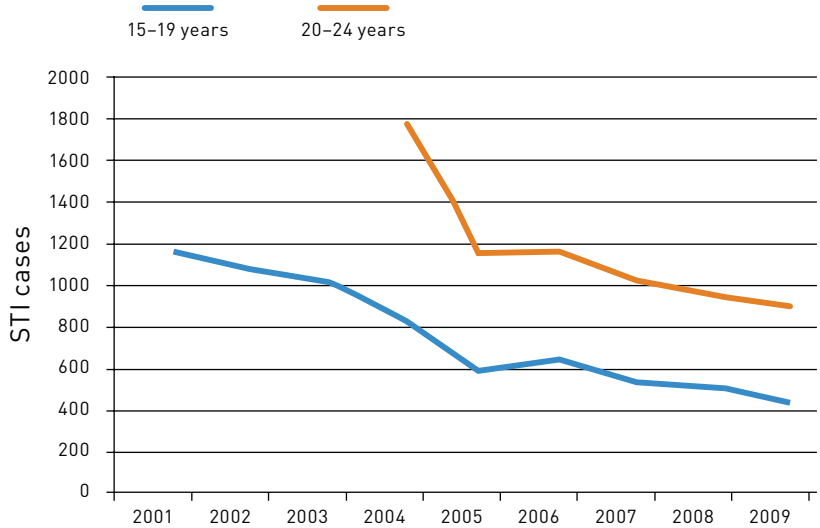
There is compelling evidence linking the introduction of CSE with a significant reduction in STIs, including HIV, in several European countries. In Finland, CSE has been linked to a reduction in STI rates,[66] while in Estonia, CSE delivered together with youth-friendly sexual health services had a demonstrated effect on reducing STI and HIV infections among adolescents.[67]

COUNTRY CASE STUDY:
CSE AND PREVENTING STIS, INCLUDING HIV, IN ESTONIA

Estonia was the first country of the former Soviet Union to introduce mandatory school-based CSE, implementing this in 1996 for 7 to 16 year olds, alongside youth-friendly sexual and reproductive health services that provide young people with free STI counselling, testing and treatment, and with counselling on safer sex and contraception. CSE was delivered primarily within the subject of Human Studies and the curriculum was updated between 2000 and 2002 to include a greater focus on HIV prevention, in response to increased HIV incidence. The curriculum was revised again in 2010 to pay more attention to the prevention of high-risk behaviours and to more clearly define the topics within health and sexuality education, with an increased number of sexual and reproductive health-related lessons.

From 2000 there was a marked improvement in youth sexual health indicators, including steep declines in STI and HIV infections and lower abortion and adolescent birth rates. This was due to sharp increases in condom and other contraceptive use among young people. The programme has been extensively evaluated, including an in-depth cost and cost-effectiveness analysis by UNESCO in 2010. This concluded that improvements in youth health outcomes from 2001 onwards are likely to be due to CSE in combination with youth-friendly sexual health service delivery.

Between 2001 and 2009, an estimated 13,490 negative health outcomes were prevented. These included 7,240 incidences of STI transmission; 1,970 new HIV infections; and 4,280 unintended pregnancies. The number of new HIV cases among 15 to 19 year olds fell dramatically, from 560 in 2001 to 25 in 2009; new cases of syphilis fell from 116 in 1998 to just two in 2009; and gonorrhoea cases from 263 to 20 in the same period.[68]



Sources: UNESCO. 2011 School-based sexuality education: A cost and cost-effectiveness study in six countries. Paris, UNESCO.

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The **Federal Centre for Health Education (BZgA)** has been a World Health Organization Collaborating Centre for Sexual and Reproductive Health (WHO CC) since 2003, with a focus on comprehensive sexuality education (CSE) in Europe and Central Asia. In this role, BZgA develops documents, resources and standards for different target groups and engages in research and the organization of seminars and conferences to promote knowledge transfer and learning in the field of CSE.

United Nations Population Fund (UNFPA)
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UNFPA is the United Nations sexual and reproductive health agency. Its mission is to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled, and it works in more than 150 countries and territories around the world. Guided by the 1994 Programme of Action of the International Conference on Population and Development (ICPD), UNFPA's work includes partnering with governments, civil society and other agencies to implement comprehensive sexuality education, both in schools and through community-based training and outreach. UNFPA promotes policies for, and investment in, sexuality education programmes that meet internationally agreed standards.

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THE IMPACT OF COMPREHENSIVE SEXUALITY EDUCATION ON YOUTH EMPOWERMENT

WHAT IS 'COMPREHENSIVE SEXUALITY EDUCATION'?

The international community has moved towards a consensual definition of comprehensive sexuality education (CSE), steering away from a primary focus on disease prevention to a more positive and holistic focus on well-being.[1] **Key stakeholders** including the German Federal Centre for Health Education (BZgA),[2] WHO,[3] UNFPA,[4] UNESCO[5] and the International Planned Parenthood Federation (IPPF)[6] **agree that CSE**

- is an **evidence- and curriculum-based** process of teaching about the cognitive, emotional, social, interactive and physical aspects of sexuality.[7]
- starts from birth and progresses in a way that is **developmentally appropriate** through childhood and adolescence into adulthood.
- plays a key role in ensuring young people's **safe emotional and physical development.** It gradually equips and empowers children and young people with **information, life skills and positive values** to understand and enjoy their sexuality, have safer, healthier and more fulfilling relationships and take responsibility for their own and other people's sexual health and well-being.[8]
- strengthens children's and young people's ability to exercise their **sexual and reproductive rights** to make conscious, satisfying and healthy choices regarding relationships, sexuality and their physical and emotional health.
- is based on a **respect for human rights, gender equality and diversity** that underpins individual and community well-being.
- helps young people to **reflect on, understand and challenge harmful social and gender-based norms** and the impact these have on relationships with peers, parents, teachers, other adults and their communities.
- covers a **comprehensive range of topics** beyond **biological aspects of reproduction and sexual behaviour**, including (but not limited to) sexuality, gender, different forms of sexual expression and orientation; gender-based violence (GBV); feelings, intimacy and pleasure; contraception, pregnancy and childbirth; and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV).

CSE is an integral part of the human right to health; in particular, the right to access appropriate health-related information, and is supported by a number of international agreements, including the *1994 International Conference on Population and Development (ICPD) Programme of Action* and related resolutions. Additionally, the UN Committee on Economic, Social and Cultural Rights views a failure to ensure that up-to-date, accurate information on sexual and reproductive health (SRH) is publicly available and accessible to all, and incorporated into educational curricula, as a violation of a State's obligations.[9]

In countries where CSE is integrated into schools, evidence shows that young people wait until a later age to have their first sexual experiences; have lower teenage pregnancy and abortion rates; have higher rates of contraceptive use; and report less discrimination based on sexual orientation and gender differences.[10,11,12] This is in contrast to 'abstinence-only' approaches, which have been found to be ineffective, stigmatizing and unethical.[13,14,15]

UNFPA

World Health Organization
REGIONAL OFFICE FOR Europe

BZgA Federal Centre for Health Education

WHO Collaborating Centre for Sexual and Reproductive Health

SUMMARY OF KEY EVIDENCE: CSE AND YOUTH EMPOWERMENT

- **CSE builds self-efficacy skills.**[i] **An extensive global review of 87 studies found that two thirds of sexuality programmes demonstrated increased self-efficacy related to condom use and refusing unwanted sex.**[16] A further high-quality trial in the United States also demonstrated greater self-efficacy to manage risky situations.[17]

- **CSE has a positive outcome on young people's confidence, self-esteem and decision-making and negotiating skills.**[18] A global review of evidence from the education sector found that CSE builds confidence.[19] Self-confidence benefits young people's well-being and is recognized as having a lifelong impact. Increased confidence can also help young people to wait until they feel prepared and ready to engage in sexual activity, and then to use contraception, including condoms, when they do.[20]

- **Building life skills through CSE empowers young people to make positive choices about their sexual and reproductive health.** CSE increases young people's capacity for critical thinking, decision-making and communication. It builds competencies and skills that empower them to fulfil their rights and make positive choices about sexuality and reproduction that are self-affirming and respectful of others.[21] The World Health Organization (WHO) reiterates that CSE builds a sense of agency, essential to equip young people to make responsible choices about their sexual health.[22]

- **Empowerment approaches to CSE are particularly effective in strengthening SRH outcomes**. Systematic reviews of a wide range of different programmes—including reproductive health interventions for married girls; interventions with men in maternity projects; and microcredit programmes for marginalized women—found that those taking an empowerment approach in order to challenge gender inequalities resulted in improved reproductive health outcomes.[23]

- **Using explicit rights-based approaches in CSE leads to positive effects on knowledge and attitudes**, including increased knowledge of one's rights within a sexual relationship; increased communication with parents about sex and relationships; and greater self-efficacy to manage risky situations.[24]

- **CSE develops life skills, providing protective factors from GBV.**[25] Evidence shows that CSE has a positive impact on life skills, including confidence, self-efficacy and decision-making. Together with improved gender relations, these skills provide protective factors against violence. An evaluation of a life-skills-based CSE programme in Nigeria showed that participating girls took on leadership roles and were more able to make informed decisions in their relationships.[26]

[i] Having the necessary information and confidence to exert control over one's behavior and social environment and to make conscious and informed decisions.

UNDERSTANDING AN 'EMPOWERMENT' APPROACH TO CSE

Adolescence is a period of ongoing physical, emotional and social changes, and the time when many young people start to explore their sexuality, develop intimate relationships with others and initiate sexual activity.[27] It can also be a time of risk-taking and peer pressure. In many cases young people reach this stage in their development without the knowledge, skills and access to services they need in order to protect their sexual and reproductive health and rights (SRHR) and that of their partners. **They often lack the information, skills and confidence to challenge harmful social norms; to take responsibility and make healthy choices; and to realize their sexual and reproductive rights.**

Empowerment is a process that encourages and supports young people to take control of their lives and achieve their full potential by having access to the necessary knowledge, skills, authorities and opportunities in order to be responsible and accountable for their actions. The aim of an empowerment approach is to maximize participation; encourage learners to question and critically reflect; enhance control through shared decision-making; and create opportunities to learn, practise and increase skills.[28,29] **Empowerment approaches are increasingly recognized as the most effective ways to deliver CSE in terms of improving SRHR outcomes.**[30]

Empowering young people supports them to become agents of change and to know and exercise their rights. This includes the right to choose with whom to develop friendships and sexual relationships; the right to refuse or delay marriage; the right to choose if, when and with whom to have a child; and the right to refuse unwanted sexual advances. Empowerment approaches can support young people to stay healthy, to challenge social norms that restrict their rights, and to become the critical thinkers of the future.[31]

The importance of youth empowerment is reflected in the goals of CSE, and in policies and strategies at both international and national levels, which have broadened to emphasize a more explicit human rights, life skills and empowerment focus.[32]

An 'empowerment' approach requires focusing on the methods to deliver CSE, in addition to the topics. **The most effective teaching methods are participatory and learner-centred methodologies**.[33] These encourage young people to explore their attitudes and values; engage with and ask questions of one another; and participate actively in their learning. They are rooted in rights-based models, promoting self-reflection and critical thinking about power and social norms around gender. Consequently, they have aspirations beyond behaviour change, and aim to create broader social change.[34] Educators' ability and comfort to discuss CSE topics and their capacity to deliver participatory approaches varies. **Continued investment in teacher training to deliver CSE is essential** to ensure that they have reflected upon their own values and attitudes before they engage in teaching, and that their messages do not conflict with the contents of a curriculum.[35,36] **An enabling school environment with policies in place to support teachers and learners is also important.**

Recognizing young people's rights and participation is key in all SRHR programmes, service delivery, CSE and policymaking. Delivering programmes that enable young people to feel that they are in charge of their lives, in addition to providing them with essential knowledge and services, is critical. Empowerment is therefore an important concept that underpins young people's SRHR programming—particularly when it comes to serving marginalized youth.[37] Engaging with young people as partners in designing and implementing CSE programmes is key. Ensuring that the content of CSE is informed by the lived experiences of young people is essential to making it applicable to their lives.[38]

Peer education approaches have been shown to have limited effects in promoting healthy behaviours and improving health outcomes when used alone, benefitting peer educators (as recipients of training and supervision) rather than their intended beneficiaries.[39] However, these approaches support

broader empowerment goals for young people, and building peer education into programming to support adolescent sexual and reproductive health recognizes the unique value that peer educators offer as a source of sensitization, and as a referral point to experts and services.[40] **Youth participation is also a right and a core value and principle in and of itself. It should not be evaluated only in terms of health outcomes and impact.**[41]

LINKING EMPOWERMENT WITH YOUTH SRHR AND OTHER DEVELOPMENT OUTCOMES

CSE has gained global recognition as a critical element in efforts to empower children and young people; enable them to improve and protect their health, well-being and dignity; and support them in developing critical-thinking skills, citizenship, equality and healthy, positive relationships.[42] Promoting and supporting the empowerment of young people is vital to ensure their health; to challenge social norms that restrict their rights; and to encourage them to become the critical thinkers of our future. Failing to do so will compromise not only their future, but also the future of generations to come.[43]

By increasing confidence and strengthening skills to deal with different challenges, CSE can empower young people to develop stronger, more meaningful and equitable relationships.[44] CSE is a continuous and lifelong process that begins from birth or very early childhood and lays the foundations for healthy future relationships with partners, family and friends, positive SRH and health-seeking behaviour. It is particularly important that young adolescents between the ages of 10 and 14 have access to CSE, as this is a key transition between childhood and older adolescence and adulthood, setting the stage for future SRH and gendered attitudes and behaviours.[45,46]

Empowerment strengthens young people's capacities for critical thinking, decision-making and communication, building competencies and skills that allow them to make positive choices about sexuality and reproduction that are self-affirming and respectful of others. Promoting empowerment approaches that develop young people's negotiation and self-efficacy skills can also increase their confidence and ability to negotiate consensual and pleasurable sex, and to ask questions that may help them to protect their health, including potentially from violence, abuse and exploitation.[47]

CSE can also contribute to promoting 'responsible citizenship'. The International Planned Parenthood Federation (IPPF) recognizes sexual rights and citizenship as one of seven core components of CSE.[48] **When young people are supported to become critical thinkers, empowered in their sexuality, and informed about their sexual and reproductive choices, the positive impact is felt across society.**[49] They become empowered to question their social context and challenge social norms and behaviours that undermine their health, well-being and rights, including sensitive cultural practices, such as child, early and forced marriage (CEFM).[50] This can encourage young people's readiness to engage in social development processes that benefit communities and nations more broadly, bringing about positive changes in culture and contributing to a healthier, more tolerant and gender-equitable society.[51]

EVIDENCE IN PRACTICE

To date, evaluations of CSE programmes have primarily focused on measuring outcomes such as age at first sex; frequency of intercourse; number of sexual partners; contraceptive and condom use; and sexual risk-taking. This links to the two main public health indicators: pregnancy and STIs. Where indicators such as 'self-efficacy' or the 'ability to communicate effectively about feelings or wishes' are used, these are usually linked to the behaviours mentioned and are not generally considered important in their own right.[52] However, the strong contribution CSE makes to wider outcomes beyond a narrow health focus is increasingly recognized. The revised UNESCO[53] definition of CSE acknowledges its wider contribution to developing 'life skills' and BZgA,[54] WHO,[55] UNFPA[56] and IPPF[57] also emphasize this in their CSE guidance.

This broader approach calls for an increased focus on 'soft outcomes' that include: awareness of human rights; respect, acceptance, tolerance and empathy for others; gender equality; confidence and self-esteem; skills in contraceptive use; empowerment and solidarity; skills in negotiation, decision-making and assertiveness; parent-child communication; and sexual pleasure and mutually respectful relationships.[58]

COUNTRY CASE STUDY:

YOUTH EMPOWERMENT AND ADVOCACY FOR CSE IN SCHOOLS IN NORTH MACEDONIA

North Macedonia has traditionally not included CSE within its national curriculum. However, in 2015 nine youth groups and organizations came together to advocate for the implementation of a national schools-based CSE programme. Catalysed by the youth group associated with Health Education and Research Association (HERA; IPPF's Member Association in North Macedonia), a Youth Platform on CSE was established. Members included the National Youth Council of Macedonia, Young European Federalists, Youth Educational Forum, Healthy Options Project Skopje, Y-PEER, Youth Can, Shadows and Clouds, HERA and Izlez. The Youth Platform was led by young people and supported by adults, particularly HERA staff working on youth and advocacy issues. These young activists lobbied the conservative government to implement CSE in schools, and the Youth Platform provided a valuable mechanism to support and coordinate their activities.

Individual youth groups had different areas of focus and experience in CSE and youth advocacy, but were united in their common purpose. Some, including Y-PEER and the Youth Educational Forum, were already receiving (and sometimes delivering) CSE in non-formal settings, which empowered them and gave them the skills to advocate for the scaling-up of CSE to reach greater numbers of young people in school settings. For other organizations, CSE was a new topic but they brought significant experience in youth advocacy and were leading the process to develop a new National Youth Strategy. The voices of vulnerable young people injecting drugs were also represented through Healthy Options Project Skopje.

In the first year, the Youth Platform on CSE developed a strategy and organized high-profile events to increase public awareness and support for CSE, including a public CSE class, to which celebrities and politicians were invited. In the second year, the group worked with political parties, and members participated in working groups established to develop the National Youth Strategy. The Youth Platform on CSE also sent a shadow report to the United Nations Committee for Economic, Social and Cultural Rights in Geneva, which resulted in tangible recommendations for the Government to improve access to age-appropriate CSE in schools. The youth advocates also worked with political parties and their youth wings during elections. As a result, two political parties added CSE to their electoral programmes, while eight pledged their support should they be elected to Parliament.

After three years of advocacy work, the Youth Platform on CSE succeeded in its mission: the conservative government recommended the introduction of CSE as one of the key objectives of the new National Youth Strategy 2016–2025. In 2018 this led the Bureau for the Development of Education and Science (working under the Ministry of Education) to establish an intersectoral working group on CSE, which is guided by WHO, UNESCO and IPPF international guidance and good practice on CSE. This working group is tasked with suggesting the most suitable model of CSE to be piloted in schools.

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The **Federal Centre for Health Education (BZgA)** has been a World Health Organization Collaborating Centre for Sexual and Reproductive Health (WHO CC) since 2003, with a focus on comprehensive sexuality education (CSE) in Europe and Central Asia. In this role, BZgA develops documents, resources and standards for different target groups and engages in research and the organization of seminars and conferences to promote knowledge transfer and learning in the field of CSE.

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UNFPA is the United Nations sexual and reproductive health agency. Its mission is to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled, and it works in more than 150 countries and territories around the world. Guided by the 1994 Programme of Action of the International Conference on Population and Development (ICPD), UNFPA's work includes partnering with governments, civil society and other agencies to implement comprehensive sexuality education, both in schools and through community-based training and outreach. UNFPA promotes policies for, and investment in, sexuality education programmes that meet internationally agreed standards.

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THE IMPACT OF COMPREHENSIVE SEXUALITY EDUCATION ON ADDRESSING GENDER INEQUALITY AND GENDER-BASED VIOLENCE

WHAT IS 'COMPREHENSIVE SEXUALITY EDUCATION'?

The international community has moved towards a consensual definition of comprehensive sexuality education (CSE), steering away from a primary focus on disease prevention to a more positive and holistic focus on well-being.[1] **Key stakeholders** including the German Federal Centre for Health Education (BZgA),[2] WHO,[3] UNFPA,[4] UNESCO[5] and the International Planned Parenthood Federation (IPPF)[6] **agree that CSE**

- is an **evidence- and curriculum-based** process of teaching about the cognitive, emotional, social, interactive and physical aspects of sexuality.[7]
- starts from birth and progresses in a way that is **developmentally appropriate** through childhood and adolescence into adulthood.
- plays a key role in ensuring young people's **safe emotional and physical development.** It gradually equips and empowers children and young people with **information, life skills and positive values** to understand and enjoy their sexuality, have safer, healthier and more fulfilling relationships and take responsibility for their own and other people's sexual health and well-being.[8]
- strengthens children's and young people's ability to exercise their **sexual and reproductive rights** to make conscious, satisfying and healthy choices regarding relationships, sexuality and their physical and emotional health.
- is based on a **respect for human rights, gender equality and diversity** that underpins individual and community well-being.
- helps young people to **reflect on, understand and challenge harmful social and gender-based norms** and the impact these have on relationships with peers, parents, teachers, other adults and their communities.
- covers a **comprehensive range of topics** beyond **biological aspects of reproduction and sexual behaviour**, including (but not limited to) sexuality, gender, different forms of sexual expression and orientation; gender-based violence (GBV); feelings, intimacy and pleasure; contraception, pregnancy and childbirth; and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV).

CSE is an integral part of the human right to health; in particular, the right to access appropriate health-related information, and is supported by a number of international agreements, including the *1994 International Conference on Population and Development (ICPD) Programme of Action* and related resolutions. Additionally, the UN Committee on Economic, Social and Cultural Rights views a failure to ensure that up-to-date, accurate information on sexual and reproductive health (SRH) is publicly available and accessible to all, and incorporated into educational curricula, as a violation of a State's obligations.[9]

In countries where CSE is integrated into schools, evidence shows that young people wait until a later age to have their first sexual experiences; have lower teenage pregnancy and abortion rates; have higher rates of contraceptive use; and report less discrimination based on sexual orientation and gender differences.[10,11,12] This is in contrast to 'abstinence-only' approaches, which have been found to be ineffective, stigmatizing and unethical.[13,14,15]

UNFPA

World Health Organization
REGIONAL OFFICE FOR Europe

BZgA Federal Centre for Health Education

WHO Collaborating Centre for Sexual and Reproductive Health

SUMMARY OF KEY EVIDENCE: CSE, GENDER AND GBV

There is a lack of robust evidence on the impact of CSE on GBV, as few interventions have measured this sufficiently as an outcome. Nevertheless, **there is compelling evidence that CSE plays an important role in transforming harmful gender norms; reducing the risk of violence; and consequently mitigating the negative effects of violence and gender inequality on adolescent sexual and reproductive health and rights (SRHR)**.

- **CSE programmes that address gender are significantly more effective.[16] Programmes addressing gender, rights and power are up to five times more effective in reducing negative outcomes including unintended pregnancy and STIs.[17]** This is due to their transformative content and teaching methods that support students to question social and cultural norms around gender; and to develop gender-equitable attitudes. More equitable power between heterosexual partners is associated with more consistent condom use, lower pregnancy rates and reduced risk of HIV infection,[18] and has been shown to reduce partner violence.[19]

- **CSE that addresses gender has a positive impact on gender-equality outcomes, including transforming harmful gender norms and attitudes towards GBV**. An evaluation of a Gender Equity Movement in Schools (GEMS) curriculum to foster more gender-equitable norms and reduce violence—critical elements of CSE—showed that participating students were more likely to support higher education for girls, openly express opposition to GBV and be champions for delaying early marriage.[20]

- **CSE's basis in human rights and gender equity reduces the risk factors related to violence and is an important entry point for violence prevention.[21]** Evidence demonstrates that CSE contributes to gender equality, school attendance, shifting harmful notions of masculinity and reductions in alcohol use and harsh parenting.[22] Addressing gender equality through CSE is an important entry point for violence prevention among children and young people, including reducing school-related gender-based violence (SRGBV)—sexual violence from teachers and fellow students.[23]

- **CSE that addresses gender equality and harmful gender norms can reduce partner violence, increase female control over sex and lead to less sexual coercion.[24] An evaluation of the well-established international curriculum** *Stepping Stones* showed a reduction in rates in intimate partner violence (IPV) in South Africa.[25] An evaluation of *Project H (Hombres)*, implemented by Instituto Promundo in Brazil, reported that a gender-focused approach led to a decline in self-reported IPV and to positive changes in attitudes and behaviour in terms of gender equity in a number of countries.[26]

- **CSE can break silences about sexual violence, sexual exploitation and abuse, and inspire young people to seek help.[27]** *The Stop Violence against Girls (SVAGs)* project coordinated by ActionAid in Ghana, Mozambique and Kenya led to changes in attitudes towards gender and violence, and to increased knowledge on how and where to report incidents. Where the girls' clubs also included discussion on intimacy and sex and relationships, reporting of violence increased.[28]

- **Interventions targeted at children and adolescents who are especially vulnerable to violence, as well as their parents, can help reduce violence, including sexual violence**. These interventions that address child maltreatment, which is a recognized risk factor for later perpetration or experience of IPV or sexual violence, show promise.[29]

KEY FACTS:

ADOLESCENTS, GENDER INEQUALITY AND GBV

- **Violence is the second leading cause of death among adolescent girls globally**; every 10 minutes, somewhere in the world an adolescent girl dies as a result of violence.[30]

- **Around 120 million girls (one in 10) under the age of 20 have experienced sexual violence.**[31]

- **Violence against women and girls (VAWG) increases the risk of adverse sexual and reproductive health outcomes**, including unintended pregnancy and acquisition of STIs, including HIV, in addition to affecting their emotional health and well-being.

- **In Europe and Central Asia, one in every four women is subjected to IPV** during her lifetime. IPV remains the second leading cause of death among adolescent girls aged 15 to 19 in this region, a figure that has not improved since 1990.[32]

- **Gender norms impact on girls' risk of child, early and forced marriage (CEFM)**. Globally, 15 million girls marry before the age of 18 each year—the equivalent of one every two seconds.[33] In countries across Eastern Europe and Central Asia, rates of officially registered marriages involving girls aged 15 to 19 are highest in Albania (27.2%), Turkey (23%) and Kyrgyzstan (19.1%), and lowest in Kazakhstan (0.9%) and Ukraine (2.2%).[34]

- **An estimated 200 million girls and women alive today have experienced female genital cutting/mutilation (FGC/M)**; the majority of girls are cut before they turn 15.[35] This figure includes approximately 500,000 women living in Europe, with a further 180,000 girls at risk every year.[36]

- **Violence in schools and other educational settings is a global problem and includes bullying, harassment and physical and/or sexual violence.** More than 246 million children experience violence in or around schools every year.[37] **School-related gender-based violence (SRGBV) may include sexual violence or coercion from teachers, school personnel and fellow pupils.**[38]

- **Violence in schools based on sexual orientation and gender identity/expression—also referred to as homophobic and transphobic violence—is a form of SRGBV and is one of the most common forms of bullying**. It includes physical, sexual and psychological violence and bullying.[39] Lesbian, gay, bisexual, intersex and queer/questioning (LGBTIQ) students report experiencing significantly higher rates of violence in schools.[40]

Gender inequality, stigma and discrimination, violence, ignorance, and some cultural and traditional practices threaten young people's SRHR, and have a life-long impact. Adolescent girls and young women in particular experience severe forms of inequalities, including sexual violence, CEFM, FGC/M and other harmful practices. Adolescent girls are especially vulnerable to IPV: in 27 of the 45 countries with recent age-disaggregated data, young women aged 15 to 19 reported a higher prevalence of recent IPV than women aged 15 to 49.[41]

'Gender-based violence against girls and women remains one of the most pervasive human rights violations of current times. It affects society as a whole, has major public health consequences and constitutes an obstacle to women's active participation in society.'[42]

GENDER INEQUALITY AND GBV —CAUSES AND CONSEQUENCES

Social and gender-based norms have significant impact on girls' and boys' life choices and experiences. Gender-based discrimination results in girls being less likely than boys to get an education and the health care they need, and to grow and develop before taking on adult roles. **In many parts of the world, gender norms dictate that girls should marry and begin childbearing in adolescence, well before they are physically or emotionally ready to do so**. Early marriage exposes them to a range of risks including high-risk pregnancies and births, IPV and the transmission of HIV.[43] Gender inequality also influences sexual expression and behaviour.

In many settings, adolescent girls and young women have low levels of power or control in their sexual relationships; they may be unable to negotiate sexual activity or condom use with their partners, especially if they are in relationships with older men and/or relationships that involve the exchange of sex for money or gifts.[44] In 2017, the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) introduced the term 'gender-based violence against women' highlighting gender discrimination as a root cause of violence against women and girls.

In some contexts, young men may face destructive male stereotypes and experience pressures from their peers or society to fulfil these stereotypes and to engage in controlling or harmful behaviours towards women and girls. As a result, **gender has a major impact on SRHR and is a key driver of the HIV epidemic, significantly affecting adolescent health outcomes, including adolescent pregnancy, STIs and violence.**

Violence starts early in the lives of many girls; perpetrators may sometimes be strangers, but are most often caregivers, family members, teachers or other influential adults or peers. This makes it harder for girls to refuse unwanted sex or to resist coerced sex. **Globally, one in three women will experience violence at some point in their lifetime, most commonly by an intimate partner.**[45] **In some settings, up to 45 per cent of adolescent girls report that their first sexual experience was forced,**[46] **with condoms rarely used during forced sex**. In Europe and Central Asia, one in every four women is subjected to IPV (including physical and sexual violence) during her lifetime, and IPV has remained the second leading cause of death among adolescent girls aged 15 to 19 in the region since 1990.[47] **Experience of IPV and sexual violence can place adolescents on a lifelong trajectory of violence, either as victims or perpetrators**.[48,49]

Rates of violence are even higher among girls and women who are particularly vulnerable, including those with disabilities, women who use drugs and women who sell sex. There is also a growing body of evidence indicating that **LGBTIQ students—often perceived as not conforming to prevailing sexual and gender norms—frequently experience physical and psychological violence on the basis of their sexual orientation or gender identity/expression.**[50]

In many countries violence may occur within or on the way to school; **school-related gender-based violence (SRGBV) is defined as '... acts or threats of sexual, physical or psychological violence occurring in and around schools, perpetrated as a result of gender norms and stereotypes, and enforced by unequal power dynamics'**.[51] Gender norms not only make such violence acceptable in society, but may also force women, girls and those identifying as LGBTIQ to bear this burden in silence by blaming and stigmatizing themselves. **Violence is a manifestation of power and control, a way to maintain gender inequalities, impacting upon the health, safety and freedom of girls and women globally and limiting their potential.**

Gender inequality also fosters harmful practices such as FGC/M, which is an extreme form of violence against girls and young women, intended to exert control over their sexuality and to deprive them of sexual pleasure. It has serious implications for girls' and women's SRHR and can be a vector for infection, including hepatitis and HIV.[52] Although there are no reliable data from Europe and Central Asia, the region is home to large numbers of migrants and refugees from countries that practise FGC/M. There is also emerging evidence of the practice among some communities, for example Avar communities in the north Caucasus region of the Russian Federation and Georgia.

ADDRESSING GENDER INEQUITY AND GBV THROUGH CSE

The 1994 International Conference on Population and Development (ICPD) Programme of Action articulates that programmes should address SRH and sexuality, gender relations and equality, as well as violence against adolescents. Later resolutions reinforce the call for CSE as part of 'promoting the well-being of adolescents, enhancing gender equality and equity as well as responsible sexual behaviour, to protect them from early marriage and unwanted pregnancy, sexually transmitted diseases including human immunodeficiency virus (HIV)/AIDS, and sexual abuse, incest and violence'.[53]

CSE's capacity to change sexual behaviours and improve health outcomes, such as a reduction in early and unintended pregnancy (see Factsheet 2) and STIs, including HIV (see Factsheet 3), is well-established. **CSE also has the potential to reduce GBV, IPV and gender-based discrimination, and to increase gender-equitable norms**.

Transforming gender norms impacts on a range of adolescent behaviours and health outcomes. For example, adolescents with more egalitarian attitudes about gender roles, or who form more equal intimate heterosexual relationships, are more likely to wait until they feel ready to begin sexual activity, use condoms and other forms of contraception. They also have lower rates of STIs, including HIV, and are less likely to be in a violent relationship.[54]

CSE's participatory methodologies can encourage young people to question sensitive cultural practices such as CEFM or FGC/M.[55] This can enable them to challenge harmful social norms and enter into informed debates with community leaders, which can benefit the wider community. CSE has a positive impact on attitudes and values and can challenge power dynamics in intimate relationships, fostering mutually respectful and consensual partnerships. **Gender-transformative CSE programmes that engage men and boys and the wider community to transform gender and other social norms—including harmful notions of 'masculinity'—also show promise.**[56] CSE is increasingly recognised as part of a holistic approach to addressing violence.[57] It helps to build the skills and knowledge of boys and girls to promote gender equality; shift harmful gender and social norms; and address power dynamics, gender-based and sexual violence, and harmful practices including CEFM and FGC/M.

There is strong evidence for investing in CSE that includes a focus on gender, rights and empowerment, which is more effective at reducing rates of STIs and unintended pregnancy, and in responding to the needs and realities of girls and young women worldwide.[58] An 'empowerment approach' to CSE supports young people, especially girls and others who may be marginalised, to view themselves and others as equal members in their relationships, able to protect their own health and to contribute actively to society[59] (see Factsheet 4). **Addressing gender inequality to ensure more equitable relationships has been shown to reduce partner violence, increase female control over sex and lead to less sexual coercion**.[60]

CSE also includes discussions about consent, essential for building healthy and respectful relationships; good sexual health; and promoting young people's well-being. Teaching young people to respect other people's personal boundaries can help create a society where no one feels ashamed to willingly engage in, or to reject, sexual activity. Taking a 'sex-positive' approach to CSE, by supporting young people to have safe, pleasurable and satisfying experiences, can help them to understand what constitutes coercive sex. It also builds skills to seek help in case of coercive sex and to reject unwanted sexual activity. This is critical in supporting young people to exercise their sexual and reproductive rights and helping them to protect their health, including potentially from abuse and exploitation.[61]

EVIDENCE IN PRACTICE

Despite global policies and good practice guidelines that increasingly emphasise the importance of CSE as an optimal entry point for violence prevention, programme evaluations have not yet caught up with the aims of policy and advocacy strategies.[62] Consequently, the existing evidence on the impact of CSE on GBV remains limited because most interventions have not sufficiently measured violence as an outcome. UNESCO states that 'There are very few systematic reviews of studies that feature violence prevention as a component or key characteristic… this is a gap that urgently needs to be addressed.'[63] UNESCO's revised International Guidance on Sexuality Education includes 'violence and staying safe' as one of eight key concepts to be addressed when developing a CSE curriculum.

Across Europe and Central Asia, a number of projects aimed at preventing violence against young people have been implemented, including the United States Agency for International Development (USAID)-supported *Safe Schools Program* to reduce SRGBV in Tajikistan. This project challenged negative gender stereotypes about girls; trained teachers and school counsellors to prevent and recognise different types of violence; and developed appropriate reporting and referral systems in cases of violence. Violence prevention is also increasingly being integrated within different subjects across school curricula in countries including Armenia, Belarus, Kazakhstan, Moldova and Ukraine.[64]

COUNTRY CASE STUDY:

PREVENTING SCHOOL VIOLENCE AND BULLYING THROUGH CSE IN CHINA[65]

In 2007, Beijing University began a pilot project that aimed to integrate CSE within China's primary education system. The project has developed curricula and resources; trained and supported teachers to deliver CSE; worked with parents to build their confidence and skills in talking to children about these issues; and monitored, evaluated and disseminated the results of CSE in order to advocate for the scaling-up of the project.

The curriculum covers grades 1 to 6 and has been updated and revised in line with international evidence and standards on CSE, specifically UNESCO's International Technical Guidance on Sexuality Education.[66] The new curriculum is progressive, sex-positive—including concepts such as sexual desire and masturbation—and takes a 'building blocks' approach to CSE, where topics are discussed in more depth as children get older.

The project explicitly addresses school violence, including bullying, to enable a more inclusive and safer school environment and to promote learning. Within the programme, school violence and bullying is recognised as an infringement of learners' rights, causing harm to children's physical health, psychological well-being and academic performance. Key topics within the CSE curriculum include: discussions on gender roles; gender equality; eliminating discrimination; children's sexual rights; preventing and coping with abuse; and asking for help and support. Pre- and post-test questionnaires for children and parents have demonstrated significantly increased knowledge on key topics. '*Cherish Life*'—a CSE booklet for primary school children—has also been developed, with accompanying guides for parents and teachers. The project has been scaled-up, reaching over 20,000 primary school children in seven provinces: Beijing, Guangdong, Guangxi, Hebei, Shandong, Yunnan and Zhejian.

Source: Laboratory of Comprehensive Sexuality Education for Children, Beijing Normal University. January 2017. *Preventing school violence and bullying through Comprehensive Sexuality Education Curriculum*

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The **Federal Centre for Health Education (BZgA)** has been a World Health Organization Collaborating Centre for Sexual and Reproductive Health (WHO CC) since 2003, with a focus on comprehensive sexuality education (CSE) in Europe and Central Asia. In this role, BZgA develops documents, resources and standards for different target groups and engages in research and the organization of seminars and conferences to promote knowledge transfer and learning in the field of CSE.

United Nations Population Fund (UNFPA)
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UNFPA is the United Nations sexual and reproductive health agency. Its mission is to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled, and it works in more than 150 countries and territories around the world. Guided by the 1994 Programme of Action of the International Conference on Population and Development (ICPD), UNFPA's work includes partnering with governments, civil society and other agencies to implement comprehensive sexuality education, both in schools and through community-based training and outreach. UNFPA promotes policies for, and investment in, sexuality education programmes that meet internationally agreed standards.

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PROMOTING PARENTAL INVOLVEMENT IN COMPREHENSIVE SEXUALITY EDUCATION

WHAT IS 'COMPREHENSIVE SEXUALITY EDUCATION'?

The international community has moved towards a consensual definition of comprehensive sexuality education (CSE), steering away from a primary focus on disease prevention to a more positive and holistic focus on well-being.[1] **Key stakeholders** including the German Federal Centre for Health Education (BZgA),[2] WHO,[3] UNFPA,[4] UNESCO[5] and the International Planned Parenthood Federation (IPPF)[6] **agree that CSE**

- is an **evidence- and curriculum-based** process of teaching about the cognitive, emotional, social, interactive and physical aspects of sexuality.[7]
- starts from birth and progresses in a way that is **developmentally appropriate** through childhood and adolescence into adulthood.
- plays a key role in ensuring young people's **safe emotional and physical development.** It gradually equips and empowers children and young people with **information, life skills and positive values** to understand and enjoy their sexuality, have safer, healthier and more fulfilling relationships and take responsibility for their own and other people's sexual health and well-being.[8]
- strengthens children's and young people's ability to exercise their **sexual and reproductive rights** to make conscious, satisfying and healthy choices regarding relationships, sexuality and their physical and emotional health.
- is based on a **respect for human rights, gender equality and diversity** that underpins individual and community well-being.
- helps young people to **reflect on, understand and challenge harmful social and gender-based norms** and the impact these have on relationships with peers, parents, teachers, other adults and their communities.
- covers a **comprehensive range of topics** beyond **biological aspects of reproduction and sexual behaviour**, including (but not limited to) sexuality, gender, different forms of sexual expression and orientation; gender-based violence (GBV); feelings, intimacy and pleasure; contraception, pregnancy and childbirth; and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV).

CSE is an integral part of the human right to health; in particular, the right to access appropriate health-related information, and is supported by a number of international agreements, including the *1994 International Conference on Population and Development (ICPD) Programme of Action* and related resolutions. Additionally, the UN Committee on Economic, Social and Cultural Rights views a failure to ensure that up-to-date, accurate information on sexual and reproductive health (SRH) is publicly available and accessible to all, and incorporated into educational curricula, as a violation of a State's obligations.[9]

In countries where CSE is integrated into schools, evidence shows that young people wait until a later age to have their first sexual experiences; have lower teenage pregnancy and abortion rates; have higher rates of contraceptive use; and report less discrimination based on sexual orientation and gender differences.[10,11,12] This is in contrast to 'abstinence-only' approaches, which have been found to be ineffective, stigmatizing and unethical.[13,14,15]

UNFPA

World Health Organization
REGIONAL OFFICE FOR Europe

BZgA Federal Centre for Health Education
WHO Collaborating Centre for Sexual and Reproductive Health

SUMMARY OF KEY EVIDENCE: PARENTAL INVOLVEMENT IN CSE

- **Parents play a key role in shaping their children's attitudes, norms and values related to gender roles and sexuality.** Favourable parental views influence children's attitudes, whether this is related to acceptance of CSE, uptake of HIV testing or use of contraceptives.[16]

- **Parental involvement in CSE improves parent-child communication on sexual and reproductive health and rights (SRHR).**[17] A trial in the United States reported greater communication with parents about sex and relationships, in addition to positive effects on knowledge and attitudes and greater self-efficacy to manage risky situations.[18]

- **Strengthening parent-child communication on CSE offers 'protective value' to young people, improving knowledge, reducing 'risky behaviours' and improving SRH outcomes.** A study in 2009 demonstrated that parent-adolescent (girl) conversations on issues relating to CSE and sexuality offer 'protective value', including having fewer sex partners, delaying sexual activity and increased self-efficacy for condom negotiation.[19] A further study conducted in the US found that when parents talked to children about sex and contraception, these young people reported fewer sexual partners and were more likely to report using contraception during their last sexual encounter.[20]

- **Involving parents makes curriculum-based CSE programmes more effective.** A study in the Bahamas found that including a parent component in existing CSE programmes improved young people's knowledge, condom-use skills and perceptions, and showed marginally significant increases in self-reported condom use.[21] An extensive review of 44 CSE programmes found that those with higher levels of parental involvement—including communication about sex, SRH information, discussion about their children's future values or plans, regulation of child behaviour and parental modelling of behaviour—showed the strongest effects.[22]

- **Involving parents of younger children—well before adolescence—through 'early years' interventions, can improve adolescent sexual health**. There is growing evidence that parent- and family-based interventions—well before children reach adolescence—may be an important strategy for improving sexual health.[23] A review of four rigorous evaluations of three schools-based CSE programmes (SHARE, RIPPLE and HEALTHY RESPECT) in the UK—where CSE programmes and the provision of SRH services were already in place—concluded that further improvements in youth sexual health outcomes could be achieved through 'early years' interventions.[24]

- **Targeted parenting interventions are effective in preventing child maltreatment**, which is a known risk factor for the later perpetration or experience of intimate partner violence (IPV) and sexual violence.[25]

PARENTAL INFLUENCE ON ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

Schools play a central role in delivering CSE by imparting knowledge, building essential skills and providing the opportunity for adolescents to talk about sex and sexuality with peers. Mandatory schools-based CSE also achieves large-scale coverage, benefitting large numbers of children. **However, there is also growing evidence that working with parents—well before their children reach adolescence—may benefit sexual health outcomes for young people.**[26] Parents and families can play a key role in supporting the development of children's sexual identity and sexual and social relationships.[27]

A BZgA survey of youth sexuality in Germany involving 3,568 young people aged 14 to 17 revealed that parents—for girls, the mother; for boys, the mother and father equally—play an important role in providing information on sex to their children. This is particularly true for girls, 64% of whom cited their mother as the most important source of information on topics of sex, sexuality and contraception. Teachers, peers and the Internet are also increasingly important sources for both German boys and girls; boys cited teachers/schools as the most important. As young people get older, parents and teachers lose their dominant position as reference people, with steady partners and doctors playing an increasingly important role in advising young people on these issues.[28]

Studies have repeatedly shown that favourable parental views influence children's attitudes to CSE, uptake of HIV testing or use of contraceptives[29] and can encourage young people to delay sex until they feel ready.[30] Parents also play an important role in facilitating adolescent access to, and use of, health information and services[31] and help to shape community norms and positive attitudes around adolescent sexuality and SRH. **Working with parents to encourage them to examine their own attitudes and values towards sex, sexuality, gender and relationships is very important to ensure that the messages that young people receive at home contribute to building a culture that supports choice, respect and responsibility.**[32]

However, many parents may feel uncomfortable and/or insufficiently prepared to provide sexuality education, lacking the confidence and skills to talk to young people about these issues.[33] As a result, many young people learn about relationships and sexuality from sources other than their parents, often citing friends or the Internet. These sources carry the risk of inaccurate information and potentially harmful messages.

ENGAGING PARENTS IN CSE

Parental and community support or resistance has been widely recognised as an important factor that enables or constrains the implementation of CSE, both in and out of schools.[34] Involving parents and caregivers in CSE initiatives is critical for a number of reasons. Ensuring their support from the outset and promoting their continued engagement can help to allay fears and prevent a backlash.[35] **Ensuring that parents and caregivers understand, support and get involved in the delivery of CSE is essential to achieve long-term results**. In addition, their participation provides **an opportunity for parents to critically reflect upon their own values, attitudes and experiences relating to sexuality, and builds their confidence, knowledge and skills around sexuality education**.

Parental resistance may directly challenge efforts to promote CSE (for example they may withdraw children from classes, or may model behaviours and attitudes that contradict the messages and values of CSE) consequently reducing its effectiveness. **CSE programmes are not intended to take over the role of parents, but rather to work with them as partners, contributing to up-to-date, appropriate and accurate information**. The chances of personal growth for children and young people are much better if teachers and parents support one other. Across Eastern Europe and Central Asia, parents' objections—often resulting from deep-rooted cultural, political and social norms or from inaccurate beliefs that CSE promotes sexual activity—contribute to the sensitivities around discussions of sexual and reproductive rights and behaviour in a classroom context.[36] Despite this, research suggests that the majority of parents do in fact support the delivery of schools-based CSE. A survey conducted by the Federal State Statistic Service (ROSSTAT) and the Ministry of Health of the Russian Federation in 2012 found that 88% of Russian women aged 15 to 44 support CSE in schools to provide knowledge about pregnancy, STIs, contraception and other SRH issues.[37] Surveys in the US show that parents want their children to be taught about delaying sexual activity until they feel ready, and to practise safer sex when the time comes.[38]

Research also indicates that parental concerns can be allayed by offering parallel programmes for parents to familiarize them with the content of schools-based CSE and their children's learning, and by providing skills-based training after school or in community settings to enable parents to communicate more openly about sexuality with their children.[39] One of the most effective ways to increase parent-to-child communication about sexuality is by providing students with homework assignments to discuss selected topics with parents or other trusted adults.[40] Parents also need to be supported to identify and address sensitive issues, including sexual violence and abuse, as children may be at risk, or be perpetrators themselves. In many parts of the world sexual violence against adolescents is widespread and many of the perpetrators are trusted adults, including family members, friends or teachers.[41] Targeted parenting interventions can help prevent child mistreatment.[42]

EVIDENCE IN PRACTICE

In response to the growing evidence base on the importance of involving parents in CSE, there are increasing numbers of interventions working directly with parents. NGOs and UN agencies have piloted effective programmes to equip parents with the information and skills to communicate effectively on these topics. In several countries in Latin America, Ministries of Education have produced materials for parents to support their children's activities at school. In eight countries in Africa, NGOs and UN agencies have developed specific tools to support community engagement in sexuality education.[43]

While schools remain the primary setting for adolescent CSE programmes, many school-based programmes incorporate a parenting component, with those with the highest level of parental involvement having the greatest effect.[44] Across Eastern Europe and Central Asia, where discussions within schools about sexuality remains a sensitive area, a review of prevention education across 10 countries included a clear recommendation to develop and expand programmes to sensitise parents and increase their support for school-based HIV prevention and SRH education.[45]

In countries where CSE is lacking in schools, the role of parents in providing correct and timely information about healthy relationships becomes even more important. In Belarus, UNESCO's Institute for Information Technologies, in partnership with the Minsk-based, adolescent-friendly health centre Doverie Trust and the Minsk Municipal Education Development Institute, has initiated a programme to deliver workshops for parents and teachers in schools across Minsk. The aim is to equip them with knowledge about key topics related to CSE and to build their confidence about 'hard to explain' and 'must know' topics. Teachers and parents also receive a booklet titled *An Open Conversation about Sexuality Education and Reproductive Health*. Feedback has been so positive that the workshops have been expanded to cover other cities across Belarus, reaching more than 80 teachers and 1,000 parents.[46]

A growing number of resources and tools are available to support parents in talking to their children about sexuality and relationships. These include examples of face-to-face workshops, such as *What should we tell the Children*? delivered in the United Kingdom.[47] Others, such as the ASK project (see case study) have developed online toolkits and in-depth training courses with input from parents and young people across Europe—including Austria, Denmark, Germany, Italy, Latvia and Lithuania. Parents can access these in their own time to build their confidence and skills in talking to their children. The Netherlands has integrated support to parents within its existing youth health-care system. Health-care workers provide parents with information, tools and training; and have face-to-face meetings with and monitor all children and adolescents between birth and the age of 19. There are dedicated guidelines to support young people's sexual development; these include providing tailored support to health workers and parents, for example through leaflets, workshops or training courses, including e-learning.

CASE STUDY:

ASK PROJECT - ASK DAD AND/OR MUM

(Parents as key facilitators: an inclusive approach to sex and relationships education in the home environment)

ASK is a consortium project involving six European partners, with the specific aim of developing material to support parents to provide better sex and relationships education to children aged 11 to 18. Project partners worked closely with parents and young people across the six European countries, conducting a series of focus groups to seek their input and ensure that the resources met their needs. Focus groups looked specifically at parents' confidence to discuss sensitive issues, including topics such as sexual violence/abuse, pornography, prostitution, puberty, sexuality in the media, sexual safety on the Internet and condoms and emergency contraception.
The vast majority of parents did not feel absolutely confident they could discuss these subjects easily with their children, for example, fewer than 25% felt able to discuss pornography.

The project went on to develop a toolkit and an online self-learning programme for parents in English, Italian, German, Danish, Latvian and Lithuanian. The toolkit includes detailed methodology and materials to help parents to give sex and relationships education to their children aged 10 to 14. It includes guidelines and practical tools for parents, including assessment and self-assessment sheets; descriptions of exercises parents can carry out with their children; tips on improving and opening communication between parents and children; and tools for planning career-guidance activities and monitoring results. The toolkit also includes a parents' informative self-help resource, containing guidance on key facts on sexuality and relationships to discuss with their children.

In addition, the project has developed an in-depth online training programme (totalling 40 hours), based on the content of the toolkit, to provide additional support for those parents who feel unable to use it as a stand-alone resource.

More information on the ASK project is available at **http://www.askproject.eu**

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GLOSSARY

The following definitions have been used in the factsheets. Many of them are based on or adapted from recommendations from the World Health Organization (WHO), the United Nations (UN) and the International Planned Parenthood Federation (IPPF).

Adolescent: A person aged between 10 and 19 years. *(UN)*

Child: A person aged under 18 years. *(UN Convention on the Rights of the Child)*

Empowerment: Developing the ability to take control of one's life and achieve one's full potential by having access to the necessary knowledge, skills, authorities and opportunities in order to be responsible and accountable for one's actions.

Equality: Treating all people equally by providing identical types, qualities or quantities of services, goods and opportunities to everyone, irrespective of differences between or among groups of people.

Equity: A notion of social justice that involves providing fair and impartial treatment, including differentiated treatment, or quality and quantity of services, goods or opportunities, with the aim of ensuring everyone is equally able to exercise and fulfil their rights.

Evolving capacities: Recognizing and respecting the increasing ability of children, adolescents and young people to make informed decisions as they grow up; and providing support and protection as they acquire the skills and experience required to take full responsibility for their actions and decisions. This happens at a different pace for different young people, and in practice means looking at young people's *capacity* rather than age when trying to strike the balance between protection and autonomy.

Gender: A range of socially constructed roles, identities, attitudes, personality traits and behaviours in relation to masculinity and femininity, intersex or sex assignment of women and men associated with gender identity. These characteristics may include biological sex, gender roles or social roles. Gender is a dynamic concept that changes over time and across different places, cultures and communities. It is not the same as 'sex', which refers only to biological differences.

Gender-based violence (GBV): All forms of violence targeted at an individual based on gender, gender role expectations and/or gender stereotypes; or based on the differential power status linked to gender that results in, or is likely to result in, physical, sexual or psychological harm or suffering. GBV includes, but is not limited to, sexual violence (e.g. assaulting or raping someone), domestic violence, community violence and emotional or psychological abuse.

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Gender equality: The measurable equal representation of women and men. Gender equality does not imply that women and men are the same, but that they have equal value and should be represented and treated equally.

Gender equity: The application of fairness or justice, and lack of discrimination based on gender. For example, in many societies it is accepted that women carry responsibility for reproductive health and bear the larger share of costs, dangers and burdens, which is not an equitable scenario.

Gender identity: A person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned to them at birth. This includes their personal sense of the body (which may involve, if freely chosen; modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms. *(UNESCO)*

Gender-transformative: Policies and practices that examine, challenge and ultimately transform structures, norms and behaviours that reinforce gender inequality, and strengthen those that support gender equality and equity.

Intimate partner violence (IPV): Any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Examples include: **acts of physical violence**, such as slapping, hitting, kicking and beating; **sexual violence**, including forced sexual intercourse and other forms of sexual coercion; **emotional (psychological) abuse**, such as insults, belittling, humiliation, intimidation, threats of harm, threats to take away children; and **controlling behaviours**, including isolating a person from family and friends, monitoring their movements and restricting access to financial resources, employment, education or medical care. *(WHO)*

Reproductive rights: Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all people to make decisions concerning reproduction free of discrimination, coercion and violence. (WHO)

Rights-based approach: A human rights-based approach is a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. It seeks to analyse inequalities that lie at the heart of development problems, and redress discriminatory practices and unjust distributions of power that impede development progress (as per the Office of the United Nations High Commissioner for Human Rights). *(UNICEF)*

School-related gender-based violence (SRGBV): Relates to threats or acts of sexual, physical or psychological violence occurring in and around schools, perpetrated as a result of gender norms and stereotypes and enforced by unequal power dynamics. *(UNESCO)*

Self-efficacy: Having the necessary information and confidence to exert control over one's behaviour and social environment and to make conscious and informed decisions.

Sex-positive: Messages and approaches within CSE that emphasize sexuality as an integral and positive part of being human, recognizing that people are sexual beings with sexual rights, regardless of their age, gender, religion, sexual orientation, HIV status or (dis)ability. Sex-positive approaches aim to achieve positive experiences, rather than focusing only on preventing negative experiences or consequences. At the same

time, sex-positive approaches acknowledge and tackle the various concerns and risks associated with sexuality without reinforcing fear, shame or taboo of young people's sexuality and gender inequality.

Sexual identity: The way a person identifies themselves in terms of various aspects of their sexuality, including their sexual attractions, desires and expressions. Sexual identity is often closely linked to sexual orientation, but also includes how social and cultural factors influence the way a person chooses to self-identify.

Sexual orientation: A person's capacity for profound emotional and sexual attraction to, and intimate and sexual relations with, other people, based on their gender. This can be someone of the opposite gender (heterosexual) the same gender (lesbian or gay) or both genders (bisexual).

Sexual rights: Rights of every human being that relate to experiencing and living their sexuality, sexual health, sexual orientation and sexual identity. For example: the right to choose a partner, the right to decide whether or not to have sex, and the right to get accurate and timely information about sexuality.

Sexuality: A central aspect of being human and how people experience and express themselves as sexual beings. It includes sexual behaviour, gender identities, gender roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Each person experiences and expresses their sexuality in a unique way.

Young person: A person aged between 10 and 24 years. *(UN)*

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