



United Nations
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EMERGING EVIDENCE, LESSONS AND PRACTICE IN
COMPREHENSIVE
SEXUALITY
EDUCATION

A GLOBAL
REVIEW

2015

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome	LAC	Latin America and the Caribbean
BZgA	German Federal Office for Health Education	M&E	Monitoring and evaluation
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women	NGO	Non-governmental organization
CPD	Commission on Population and Development	PCB	Programme Coordinating Board (UNAIDS)
CSE	Comprehensive sexuality education	POA	Process-oriented approach
DHS	Demographic and Health Survey	SADC	Southern African Development Community
EECA	Eastern Europe and Central Asia	SERAT	Sexuality Education Review and Assessment Tool
EMIS	Education Management Information Systems	SRH	Sexual and reproductive health
ESA	Eastern and Southern Africa	SRHR	Sexual and reproductive health and rights
EVA	Education as a Vaccine	STI	Sexually transmitted infection
GBV	Gender-based violence	UN	United Nations
HIV	Human Immunodeficiency Virus	UNAIDS	Joint United Nations Programme on HIV/AIDS
ICASA	International Conference on AIDS and STIs in Africa	UNESCO	United Nations Educational, Scientific and Cultural Organization
ICPD	International Conference on Population and Development	UNFPA	United Nations Population Fund
ICT	Information and communication technology	UNICEF	United Nations Children's Fund
IPPF	International Planned Parenthood Federation	WCA	West and Central Africa
ITGSE	International Technical Guidance on Sexuality Education	WHO	World Health Organization
		YWCA	Young Women's Christian Association

EXECUTIVE SUMMARY

This report provides an overview of the status of comprehensive sexuality education (CSE) implementation and coverage on a global level. It draws on specific information about the status of CSE in 48 countries, generated through analysis of existing resources and studies. The report examines the evidence base for CSE and its positive impact on health outcomes, takes stock of political support for CSE, and examines how the various global and regional commitments have had an impact at national levels on the delivery of CSE in practice. The current review represents the first in a series of periodic reports that aim to monitor the global implementation of CSE.

Comprehensive sexuality education is recognized as an 'age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, non-judgmental information' (UNESCO, 2009). Across the world there are many different names for, and approaches to, comprehensive sexuality education. The objective of CSE is to ensure that young people are receiving comprehensive, life skills-based sexuality education to gain the knowledge and skills to make conscious, healthy and respectful choices about relationships and sexuality. Core elements of CSE programmes share certain similarities: CSE's firm grounding in human rights – including the rights of the child, and the empowerment of children and young people – and a reflection of the broad concept of sexuality as a natural part of human development. Effective sexuality education starts early in childhood and progresses through adolescence and adulthood, building knowledge and skills that are appropriate for each stage through a carefully phased process over time, like any other subject in the curriculum.

There is clear evidence that CSE has a positive impact on sexual and reproductive health (SRH), notably contributing towards reducing sexually transmitted infections (STIs), the Human Immunodeficiency Virus (HIV) and unintended pregnancy. CSE has demonstrated impact in terms of improving knowledge and self-esteem, changing attitudes and gender and social norms, and building self-efficacy. This is particularly critical during adolescence, as young people make the transition into adulthood. Integrating content on gender and rights, and delivering CSE together with efforts to expand access to a full range of high-quality, youth-friendly sexual and reproductive health services and commodities, makes sexuality education even more effective (Haberland, 2015). Evidence has confirmed that sexuality education does not hasten sexual activity but has a positive impact on safer sexual behaviours and

can delay sexual debut and increase condom use (UNESCO, 2009; Fonner et al, 2014).

Global momentum around CSE has resulted in increased political commitment worldwide. In 2008, ministers of education and health from Latin America and the Caribbean signed the *Preventing through Education Declaration*¹ committing to delivering sexuality education and health services. Similarly, in 2013, 20 countries across Eastern and Southern Africa (ESA) endorsed a Ministerial Commitment on CSE and SRH services for adolescents and young people, setting specific targets to ensure access to high-quality, comprehensive life skills-based HIV and sexuality education and appropriate youth-friendly health services for all young people. UNAIDS and the African Union have recently cited comprehensive, age-appropriate sexuality education as one of five key recommendations to fast track the HIV response and end the AIDS epidemic among young women and girls across Africa. Many countries in the Asia-Pacific region, West Africa and Europe are also revising their policies and approaches to scale up sexuality education.

Young people are increasingly demanding their right to sexuality education, as evidenced by the 2011 Mali Call to Action; declarations at the 2011 International Conference on AIDS and STIs in Africa (ICASA); the 2012 Bali Global Youth Forum Declaration; the 2014 Colombo Declaration on Youth; youth delegates' inputs to the post-2015 development agenda through the 'Have you seen my Rights?' coalition; as well as the advocacy efforts of the PACT coalition of youth organizations.

The political momentum has led many governments to scale up delivery of CSE and to seek guidance on best practice. Ministries of education are working in collaboration with ministries of health and departments responsible for child protection and youth well-being. Partnerships with civil society and private institutions have been critical in key elements of scale-up such as teacher training and the development of teaching and learning resources.

However, a gap remains between the global and regional policies in place and the actual implementation and monitoring on the ground. Across the world, sexuality education may be delivered as a stand-alone subject – with the advantages of providing opportunities for specialized teacher training and being easier to monitor. Alternatively, it may be integrated across relevant subjects within the school curriculum, making

¹ See: <http://www.unesco.org/new/fileadmin/MULTIMEDIA/FIELD/Santiago/pdf/declaration-preventing-education-english.pdf> (accessed 4 May 2015).

it less likely to be cut to reduce pressure on an overcrowded timetable. CSE may be mandatory or it may be delivered through optional courses. However, where sexuality education is non-compulsory, extra-curricular or only partially compulsory, a large number of students will not reap its benefits.

CSE content must respond appropriately to the specific context and needs of young people in order to be effective.

This adaptability is central to culturally relevant programming, and includes understanding the messages that cultures convey around gender, sex and sexuality. This may include a concerted focus on topics such as gender discrimination, sexual and gender-based violence, HIV and AIDS, child marriage and harmful traditional practices. As with all curricula, CSE must be delivered in accordance with national laws and policies.

There has been increased focus recently on strengthening curricula in numerous countries, although this remains a critical need. Reviews of curricula show that increased attention is required to promote the development of key competencies, as well as to examine how gender norms, religion and culture influence learners' attitudes and behaviour. Although CSE content must be adapted to reflect local contexts, there are certain core topics that are essential to maintaining quality and meeting international standards. Indicators have been developed to measure whether sexuality education programmes meet 'essential' and 'desirable' criteria (UNESCO, 2013). Too often, topics are taught too late, for example, after young people have already experienced puberty or menstruation or initiated sexual activity. Recent assessments show that **gender and rights should be consistently strengthened across curricula, and address the needs of young people living with HIV and other key populations.**

Effective CSE has to be both inclusive and non-stigmatizing, addressing sexual and gender-based violence and promoting gender equality, as well as ensuring the needs and rights of all young people, including those living with HIV (UNESCO and GNP+, 2012).

Delivering high-quality CSE requires adequate training and capacity. Teacher training remains limited in scope, and, if provided at all, is usually delivered only through in-service training. Consequently, teachers often feel uncomfortable and avoid discussing sensitive issues like sexual behaviour, sexuality, and how students can access contraception and obtain referrals for SRH services. They also do not consistently use participatory methodologies to engage pupils fully in health and life skills education.

Engaging parents and communities in the implementation and scale-up of CSE is critical, both to ensure that there is support for the subject among the school community, and to enhance overall understanding of the issues facing adolescents and young people. Strategies and tools for community engagement, including work with faith communities, have been developed in all regions of the world reviewed for this study. Despite some reports to the contrary, most parents are supportive of school-based sexuality education and many parents report feeling uncomfortable discussing sex or relationships with their children. While young people often seek information about sex, sexuality and relationships from their peers, the internet or other sources, sexuality education that is delivered by trusted and trained adults is proven to be more effective in promoting healthy sexual behaviour.

This report demonstrates that a majority of countries are now embracing the concept of CSE, informed by evidence and international guidance, and are engaged in strengthening its implementation at a national level. This includes specifically ongoing attention to curricula revision, integration of CSE into the national curriculum, investment in monitoring systems, the engagement of communities and the scale-up of effective teacher training. In concert with national governments and civil society, development partners – including the UNAIDS Joint Programme – are supporting countries in their efforts to develop age-appropriate, evidence-informed curricula that reflect the country context and that will have a direct, beneficial impact on the HIV response and more widely on adolescent and young people's health.

CASE STUDY 1: STRENGTHENING THE NATIONAL PROVISION OF CSE IN SCHOOLS IN ZAMBIA



The government of Zambia is spearheading a major project that aims to strengthen the delivery of CSE to young people from ages 10 to 24, including those living with HIV and with disabilities. By increasing access to high-quality, age-appropriate sexuality education and services, the project ultimately seeks to contribute to improved SRH outcomes for Zambian adolescents and youth.

Since 2014, a revised curriculum with integrated CSE has been rolled out in Grades 5 to 12 in all schools across the country. CSE has also been successfully integrated into pre-service training for primary teachers. In-service teachers also receive capacity building in effective delivery of CSE.

By December 2014, a total of 12,852 in-service teachers had been trained in effective delivery of CSE at classroom level, and a further 25,017 will be trained by the end of 2015. Teaching and learning materials have also been produced by the Ministry of Education for all grades, and National and Provincial Standards Officers have been trained to monitor the quality and delivery of CSE at school level.

A baseline survey examined knowledge levels among teachers and students, as well as their attitudes. It also provided a picture of the current status of CSE provision in the education sector, and the degree to which it facilitates access to SRH services for adolescents and young people.

The new curriculum is expected to be rolled out in all schools in the country with certain 'champion schools' identified for enhanced programming. In addition to the standard teacher training, curriculum and materials that are consistent across all schools, these 'champion schools' also offer peer-education programmes and clear links to health services. This variation will also provide opportunities for comparison and analysis of outcomes between the two types of programming.

Building ownership that uses evidence, particularly the baseline survey results, has proven essential to the implementation process. Considering the project's scale and level of ambition, the engagement of multiple sectors – including ministries of health, education, development, youth and sport, as well as non-governmental organizations (NGOs) and other partners – has likewise proven vital in enhancing both ownership and sustainability.

Source: Presentation to World Education Forum, May 2015 by the Deputy Minister of Education of Zambia, (Alice Saili, UNESCO Zambia, personal communication, 10 June 2015).



1

INTRODUCTION

Comprehensive sexuality education (CSE) has attracted growing interest and attention over recent years. This is demonstrated and reinforced by increased political commitment globally and the development of expert guidance, standards, curricula and other tools to strengthen the implementation of CSE in practice. Across the world, there are a wide range of different approaches to delivering sexuality education; at this stage in the evolution of the field, it is timely to take stock of the evidence, practice and lessons learned to date.

This report provides an overview of the status of CSE implementation and coverage on a global level, drawing on specific information about the status of CSE in 48 countries, generated through analysis of existing resources and studies. Best practice in terms of providing CSE continues to develop. The

current report examines the evidence base for CSE and, through a series of case studies from every region, explores initiatives that are setting the standard and pioneering new practices in the delivery of CSE. It represents the first in a series of periodic reports that aims to monitor the global implementation of CSE.

Comprehensive life skills-based sexuality education helps young people to gain the knowledge and skills to make conscious, healthy and respectful choices about relationships and sexuality.

1.1 DEFINING COMPREHENSIVE SEXUALITY EDUCATION

The *International Technical Guidance on Sexuality Education (ITGSE)* – published by UNESCO with UNAIDS, UNFPA, the United Nations Children’s Fund (UNICEF) and the World Health Organization (WHO) – provides a comprehensive review of the goals, objectives, outcomes, content and implementation approaches for planning and delivering CSE programmes as part of an HIV response. The ITGSE is voluntary and defines CSE as an ‘age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, non-judgmental information’ (UNESCO, 2009). This definition builds on the original wording provided by the International Conference on Population and Development (ICPD) that references sexuality education as an approach to promoting the wellbeing of adolescents that should be ‘age appropriate, begin as early as possible, foster mature decision-making and specifically aim to ameliorate gender inequality’ (UNFPA, 2014a). Both definitions rely on WHO’s working definition of human sexuality as a broad concept that is a natural part of human development through every phase of life and includes physical, psychological, spiritual and social components (WHO Europe, 1999/2001).

As part of the growing movement and support for CSE globally, and as the field evolves and develops, the international community – including UNFPA (2014), WHO Europe and the German Federal Office for Health Education (BZgA) (2010) and International Planned Parenthood Federation (IPPF) (2010) – have all built on this with complementary working definitions, with varying emphases that reflect their own organizational mandates and priorities (see Annex 2 for further details). What is consistent throughout their approaches is CSE’s firm grounding in human rights^{2,3} and the empowerment of children, adolescents and young people, promoting the fundamental principles of a young person’s right to education about their bodies, relationships and sexuality.

2 See Commission on Population and Development. Resolution 2009/1. http://www.un.org/en/development/desa/population/commission/pdf/42/CPD42_Res2009-1.pdf (accessed 14 May 2015).

3 See Commission on Population and Development. Resolution 2012/1. http://www.un.org/esa/population/cpd/cpd2012/Agenda%20item%208/Decisions%20and%20resolution/Resolution%202012_1_Adolescents%20and%20Youth.pdf (accessed 14 May 2015).

BOX 1: GROUNDED IN HUMAN RIGHTS

Young people's access to CSE is grounded in internationally recognized human rights, which require governments to guarantee the overall protection of health, well-being and dignity, as per the Universal Declaration on Human Rights, and specifically to guarantee the provision of unbiased, scientifically accurate sexuality education.

These rights are protected by internationally ratified treaties, and lack of access to SRH education remains a barrier to complying with the obligations to ensure the rights to life, health, non-discrimination and information, a view that has been supported by the Statements of the Committee on the Rights of the Child, the Convention on

the Elimination of all Forms of Discrimination Against Women (CEDAW) Committee, and the Committee on Economic, Social and Cultural Rights.

The commitment of individual states to realizing these rights has been reaffirmed by the international community, in particular the Commission on Population and Development (CPD), which – in its resolutions 2009/12 and 2012/13 – called on governments to provide young people with comprehensive education on human sexuality, SRH and gender equality.

Sources: Universal Declaration of Human Rights; Commission on Population and Development (CPD).

One of the main challenges in defining sexuality education, and particularly the elements that comprise comprehensive programming, may stem from the different terminologies used across national policies and curricula. Many different names are used, reflecting an emphasis on various aspects of CSE by different countries. These include: prevention education, relationships and sexuality education, family life education, HIV education, life skills education, healthy lifestyles and the basics of life safety. However, core elements of these programmes bear similarities, and incorporate some or many aspects of CSE.

Throughout this document, the term CSE is used to describe all of these programmes, understanding that CSE encompasses more than just sex education, HIV education and general life skills and health education, where each is taken in isolation.

CSE that is scientifically accurate, non-judgemental, age-appropriate and gender-sensitive in a carefully phased process from the beginning of formal schooling is something that all children and young people can benefit from. Comprehensive life skills-based sexuality education helps young people to gain the knowledge and skills to make conscious, healthy and respectful choices about relationships and sexuality.

BOX 2: YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH

- ▶ More than 40 per cent of the world's population is under the age of 25, which represents the largest generation of young people the world has ever seen.
- ▶ Young people account for almost 50 per cent of new HIV infections.
- ▶ In sub-Saharan Africa, young women from 15 to 24 years old are twice as likely as young men to be living with HIV.
- ▶ Globally, only 34 per cent of young people can demonstrate accurate knowledge about HIV prevention and transmission.
- ▶ Worldwide, more than 15 million girls from 15 to 19 years old give birth every year, with 19 per cent of young women in developing countries becoming pregnant before they turn 18.
- ▶ Adolescent girls and young women make up 40 per cent of all unsafe abortions worldwide, and 2.5 million unsafe abortions occur every year among this age group.
- ▶ A significant proportion of adolescent pregnancies result from rape, and most births take place in the context of early marriage.
- ▶ An estimated one in three women and girls worldwide report surviving physical and/or sexual abuse, most often at the hands of an intimate partner, making gender-based violence one of the most widespread human rights violations.
- ▶ Pregnancy and childbirth are the leading cause of death among adolescent girls between the ages of 15 and 19 in low-income countries.

1.2 EVIDENCE FOR THE BENEFITS OF CSE

There is clear evidence that CSE has a positive impact on sexual and reproductive health (SRH), notably in contributing to reducing STIs, HIV and unintended pregnancy. Sexuality education does not hasten sexual activity but has a positive impact on safer sexual behaviours and can delay sexual debut (UNESCO, 2009). A 2014 review of school-based sexuality education programmes has demonstrated increased HIV knowledge, increased self-efficacy related to condom use and refusing sex, increased contraception and condom use, a reduced number of sexual partners and later initiation of first sexual intercourse (Fonner et al, 2014). A Cochrane review of 41 randomized controlled trials in Europe, the United States, Nigeria and Mexico also confirmed that CSE prevents unintended adolescent pregnancies (Oringanje et al, 2009). A

study in Kenya, involving more than 6,000 students who had received sexuality education led to delayed sexual initiation, and increased condom use among those who were sexually active once these students reached secondary school compared to more than 6,000 students who did not receive sexuality education (Maticka-Tyndale, 2010).

Sexuality education does not hasten sexual activity but has a positive impact on safer sexual behaviours and can delay sexual debut (UNESCO, 2009).



CASE STUDY 2: REDUCING UNINTENDED PREGNANCY IN THE UNITED KINGDOM

In most Western European countries, the rate of unintended pregnancies among adolescents has steadily declined in recent years. However, the adolescent pregnancy rate in the United Kingdom was the highest in the region, and the UK Government resolved to address this.

England and Wales experienced a 56 per cent reduction in the under-18 birth rate between 1998 and 2013 (Office for National Statistics, 2015). This success is attributed to the National Teenage Pregnancy Strategy, which aimed to promote more widespread contraceptive use by expanding the provision of high-quality sexuality education, easier access to services and improved training for health-care providers to meet young people's needs.

Source: UK Teenage Pregnancy Independent Advisory Group final report, 2010 and personal communication (Roger Ingham, University of Southampton, 11 June 2015).

UNAIDS and the African Union have recognized CSE's impact on increasing condom use, voluntary HIV testing and reducing pregnancy among adolescent girls and have included comprehensive, age-appropriate sexuality education as one of five key recommendations to fast track the HIV response and end the AIDS epidemic among young women and girls in Africa (UNAIDS and the African Union, 2015).

As the field of sexuality education develops, there is increasing focus on addressing gender, power relations and human rights in order to improve the impact on SRH outcomes. Integrating content on gender and rights makes sexuality education even more effective (UNFPA, 2014a). A review of 22 curriculum-based sexuality education programmes found that 80 per cent of programmes that addressed gender or power relations were associated with a significant decrease in pregnancy, childbearing or STIs. These programmes were five times as effective as those programmes that did not address gender

or power (Haberland, 2015). CSE empowers young people to reflect critically on their environment and behaviours, and promotes gender equality and equitable social norms, which are important contributing factors for improving health outcomes, including HIV infection rates. The impact of CSE also increases when delivered together with efforts to expand access to a full range of high-quality, youth-friendly services and commodities, particularly in relation to contraceptive choice (UNESCO, 2011a).

A global review of evidence in the education sector also found that teaching sexuality education builds confidence (Unterhalter et al, 2014), a necessary skill for delaying the age that young people first engage in sexual intercourse, and for using contraception, including condoms. CSE has a demonstrated impact on improving knowledge, self-esteem, changing attitudes, gender and social norms, and building self-efficacy.

CASE STUDY 3: A GENDER-FOCUSED APPROACH IN BANGLADESH

BALIKA, a recent Population Council initiative, sought to evaluate the impact of the *It's All One Curriculum* on adolescent girls in Bangladesh. In a context where a significant proportion of girls are married before the age of 18, the evaluation aimed to generate specific data about what is effective in delaying the practices of early, child and forced marriage.

The BALIKA study explored values and attitudes regarding gender and rights awareness among rural adolescent girls from 12 to 19 years old. It asked questions about gender equality, literacy, necessity of education, a woman's role in the family, masculinity, marriage and violence.

The findings revealed the need for education on gender rights for all adolescents irrespective of age, marital status or level of schooling. In particular, adolescent girls who were married, not in school, and who had lower educational attainment appeared to be less aware of their gender rights, including autonomy and freedom from violence. Awareness of these rights is instrumental in changing attitudes and empowering adolescents to deal with and transform harmful cultural norms and practices.

Indicators demonstrated the demand for comprehensive and effective programmes to address the needs of particularly marginalized girls in terms of optimizing their health and well-being. Key findings enabled the programmes to improve teacher training and support, involve parents and roll out complementary counselling programmes for both girls and their teachers.

Sources: UNFPA. 2015. The Evaluation of Comprehensive Sexuality Education Programmes: A focus on the gender and empowerment outcomes. New York, UNFPA; Population Council. 2014. From evidence to action: Results from the 2013 baseline survey for the BALIKA project; personal communication (Sajeda Amin, Population Council, 11 June 2015).



1.3 YOUNG PEOPLE CALL FOR CSE

While there is increased recognition at a global level regarding young people's need for sexuality education, progress has been uneven in translating this recognition into nationally implemented programmes. Young people are often denied even the most basic information about their sexual and reproductive health and rights. Implementing and resourcing CSE programmes continues to be a challenge in many parts of the world. However, a global movement has galvanized around ensuring universal access to CSE, with youth-led movements in particular calling for stronger responses, sustained commitment and the up-scaling of resources.

As a result, sexuality education and SRH services for young people feature prominently in the post-2015 development agenda. Young people themselves are increasingly demanding their right to sexuality education, as evidenced by the 2011

Mali Call to Action; declarations at the 2011 International Conference on AIDS and STIs in Africa (ICASA); the 2012 Bali Global Youth Forum Declaration; and the 2014 Colombo Declaration on Youth. The UN Major Group on Children and Youth also continues to highlight CSE as one of its top priorities for the Sustainable Development Goals and in related UN processes.

Within the consultations on the post-2015 development agenda, young people have advocated consistently for sexuality education, notably through the 'Have you seen my Rights?' youth coalition. The PACT, a coalition of youth organizations working on HIV, has highlighted the need for sexuality education in the consultation process on the update and extension of the UNAIDS strategy.



2

SITUATING CSE WITHIN DIFFERENT CONTEXTS

SITUATING CSE WITHIN DIFFERENT CONTEXTS

2.1 AGE-APPROPRIATE CONTENT FOR THE DEVELOPMENT OF HEALTHY BEHAVIOURS

Effective sexuality education responds to the needs and capacity of children and adolescents through a building-block approach, which develops knowledge that is appropriate to each age group and developmental stage. Age-appropriate content is a prerequisite for CSE that is effective in developing and strengthening young people's ability to make conscious, healthy and respectful choices about relationships and sexuality.

International standards and guidance recommend that sexuality education starts early in childhood and progresses through adolescence and adulthood (WHO Regional Office for Europe and BZgA, 2010; UNESCO, 2009) building knowledge and skills through a carefully phased process over time, like any other subject in the curriculum. Too often, topics are taught too late – for example, after young people have already experienced puberty or menstruation. Sexuality education must begin before the onset of sexual activity, should respond to young people's evolving needs and develop their knowledge, attitudes and skills to prepare them appropriately for all stages of their development and capacities. The *International Technical Guidance on Sexuality Education* (UNESCO, 2009) proposes an age-appropriate set of topics and learning objectives that constitutes a CSE programme for ages 5 to 18+. The *Standards for Sexuality Education in Europe* recommend starting CSE education from birth.

Developing positive self-esteem and healthy behaviours and relationships during adolescence is recognized as having a lifelong impact. Sexuality education contributes to laying the foundation for healthy future relationships, as well as good SRH and health-seeking behaviour. CSE with very young adolescents between the ages of 10 to 14 years is critical as this age marks a key transition between childhood and older adolescence and adulthood, 'setting the stage for future SRH and gendered attitudes and behaviours' (Igras, 2014).

CSE with very young adolescents between the ages of 10 to 14 years is critical as this age marks a key transition between childhood and older adolescence and adulthood, 'setting the stage for future SRH and gendered attitudes and behaviours' (Igras, 2014)

Primary education is now compulsory in almost every country, making this an important vehicle for reaching a large number of children in a cost-effective manner (UNESCO, 2014). Starting sexuality education in primary school allows children to identify and report inappropriate behaviour (including child abuse) and develop healthy attitudes about their own body and relationships.

2.2 REGIONAL COMMITMENTS TO CSE

Different regions have shown leadership in the development and implementation of CSE, from demonstrating increased political will, to developing and investing in CSE programming.

Western Europe pioneered the introduction of school-based sexuality education programmes 50 years ago. Countries such as Sweden, Norway and the Netherlands, with long-standing sexuality education programmes in schools, have significantly lower adolescent birth rates than countries in Eastern Europe and Central Asia (EECA), where open discussion of issues related to sexuality and sexual and reproductive health and rights (SRHR) in schools remains more sensitive. In Estonia, for example, several research results demonstrate the strong correlation over time between the development of sexuality education and the steady improvement in sexual health indicators among young people from 2001 onwards. These recent improvements are attributed to the development of a mandatory sexuality education programme in schools, in combination with the evolution of youth-friendly sexual health service delivery (UNESCO, 2011a). Within Europe, the WHO Regional Office produced *Standards for Sexuality Education in Europe*, which provides a framework to support policy-makers, education and health authorities, and other stakeholders, in implementing quality standards for sexuality education across the region.

In Latin America and the Caribbean, ministers of health and education declared their commitment to sexuality education through the *Preventing through Education Ministerial Declaration*

signed in 2008. Governments committed to integrating strategies and ensuring interdepartmental coordination and agreed to implement and strengthen 'multi-sectoral strategies of comprehensive sexuality education and promotion of sexual health, including HIV/STI prevention' (UNAIDS, 2009). Countries including Argentina, Uruguay, Colombia, the Dominican Republic, Cuba, Peru and Mexico have also developed national legislative frameworks, making the delivery of CSE compulsory.

Similarly, in Eastern and Southern Africa, the political will to ensure access to CSE has been affirmed at the decision-making level, as evidenced by the Ministerial Commitment on CSE and SRH services for adolescents and young people. This key outcome explicitly prioritizes, 'ensuring access to good quality, comprehensive, life skills-based HIV and sexuality education (CSE) and youth-friendly sexual and reproductive health services for all adolescents and young people', and adopts a culturally relevant approach (UNESCO, 2013c).

The Asia-Pacific region has traditionally had a highly favourable policy environment towards implementing HIV education, with most countries integrating broader sexuality education into national HIV strategies (UNESCO, 2012a). The commitment from the Asian and Pacific Population and Development Conference in 2013 focused on ensuring SRHR for all, particularly the poorest and most marginalized populations.

CASE STUDY 4: COST EFFECTIVENESS IN ESTONIA

A study of the cost effectiveness of CSE highlights the potential cost savings of rolling out a national, mandatory sexuality education programme. In Estonia, a mandatory programme was rolled out for 7–16 year olds, alongside youth-friendly sexual and reproductive health services. The cost of rolling out the programme was \$5.6 million.

Between 2001 and 2009, an estimated 13,490 negative health outcomes were prevented, including 4,280 unintended pregnancies, 7,240 incidences of STI transmission and 1,970 HIV infections. In a cost-benefit analysis, based on HIV infections prevented and on HIV treatment costs alone, sexuality education would only have to be responsible for 4 per cent of all HIV infections averted to be considered as not only a cost-effective intervention but a cost-saving one too.

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



2.3 ADAPTABILITY OF CSE CONTENT

CSE content must respond appropriately to the specific context and needs of young people in order to be effective. This adaptability is central to culturally relevant programming, and includes understanding the messages (sometimes positive, sometimes negative) that cultures convey around gender, sex and sexuality. This may include a concerted focus on topics such as gender discrimination, sexual and gender-based violence, HIV and AIDS, child marriage and harmful traditional practices. As with all curricula, CSE must be delivered in accordance with national laws and policies.

While some adaptability of content is clearly important, the fundamental principle of a young person's right to accurate and timely education about their bodies, relationships, sexual behaviour and health is paramount. There are therefore certain core topics that are essential to maintaining quality and meeting international standards (UNESCO, 2013a; UNESCO, 2011b).

The indicator framework in Box 3 in Section 3.4, developed by UNESCO in consultation with the UNAIDS Inter-Agency Task Team on Education, is one tool that can be used to help adapt content to suit specific national and local contexts. Although this tool focuses specifically on HIV and AIDS, the majority

of the criteria – particularly those categorized as 'desirable' – are highly relevant for addressing broader SRH and gender outcomes, including unintended pregnancy.

While CSE should reflect national legal frameworks, there is still a need for national efforts to review and reform harmful laws and policies that might have a negative impact on adolescent health and well-being, such as those that sanction discrimination – including criminalization in some instances – based on gender, age, health status, pregnancy or other grounds. Equally, it is important to address the legal and policy barriers that prevent adolescents and young people from accessing services, information and education. South Africa's Children's Act, for instance, passed in 2005, lowered the age of consent for HIV testing and contraceptives to 12 years, thereby expanding access to sexual and reproductive health care for adolescents in a country where an estimated 11 per cent of young men and 6 per cent of young women become sexually active before the age of 15 (UNICEF, 2011). This decision by the South African Law Commission was informed by the need to both recognize the realities of the HIV epidemic and to acknowledge the evolving capacity of adolescents. A reported result of the change was increased access to HIV testing (UNAIDS, 2013b).

2.4 WORKING WITH COMMUNITIES AND PARENTS

Parents and families play a key role in shaping attitudes, norms and values related to gender roles, sexuality and the status of adolescents and young people in the community (Svanemyr et al, 2015)

Parents can play an important role in communicating with their children about sexuality, relationships and well-being, particularly among younger age groups. Studies have repeatedly shown that favourable parental attitudes influence children's attitudes, whether this is related to acceptance of sexuality education, uptake of HIV testing or contraceptives. Parents and families play a key role in shaping attitudes, norms and values related to gender roles, sexuality and the status of adolescents and young people in the community (Svanemyr et al, 2015).

Values related to the centrality of the family, life-affirming approaches and solidarity are also central tenets in faith-based sources of learning for young people. Faith-based approaches in the response to the HIV epidemic have demonstrated considerable power, innovation and value. Similarly, faith-based support for sexuality education as a way of promoting and protecting human dignity has been expressed throughout the evolution of sexuality education. For example, in 2003, the World Young Women's Christian Association (YWCA) Council adopted a resolution on Reproductive Health and Sexuality, that calls on the YWCA movement to promote and work towards the provision of extensive access to quality education, resources, information, discussion and counselling for women and girls regarding their reproductive rights.

However, young people indicate that they generally learn about relationships and sexuality from sources other than their parents. Many parents may feel uncomfortable and insufficiently

prepared to provide sexuality education, and therefore support schools taking on this role as a supplement to any discussions within the family (WHO Regional Office for Europe and BZgA, 2010). Parental and community support or resistance has been widely recognized as an important factor that enables or constrains the implementation of CSE for young people both in and out of schools.

Despite existing opposition to sexuality education by some political or religious groups who may have certain influence over public attitudes towards CSE, parents in many parts of the world support school-based sexuality education. A recent online poll of parents in China indicated that 90 per cent of those questioned were in favour of incorporating sexuality education into school curricula, including information about family planning and how to cope with inappropriate sexual advances (UNESCO, 2014). Similarly, 88 per cent of Russian women aged 15–44 support sexuality education in schools to provide knowledge about pregnancy, STIs, contraception and other SRH issues (Federal State Statistic Service (ROSSTAT)/Ministry of Health of the Russian Federation, 2012). Surveys in the United States

show that parents want their children to be taught both about delaying sexual debut, and having safer sex when the time comes (Advocates for Youth, 2008). Demographic and Health Survey (DHS) data from countries in Eastern and Southern Africa show that, in a large majority of countries, over 60 per cent of adults agree that children aged from 12 to 14 years old should be taught about condoms (UNESCO, 2013c).

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 – including Argentina, Uruguay and Peru – ministries of education have produced materials aimed at 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. Parents’ involvement in school health education committees – as members of school boards, or as advocates during community controversy – is vital to making sure that young people receive accurate information and that answers to their questions are not censored.

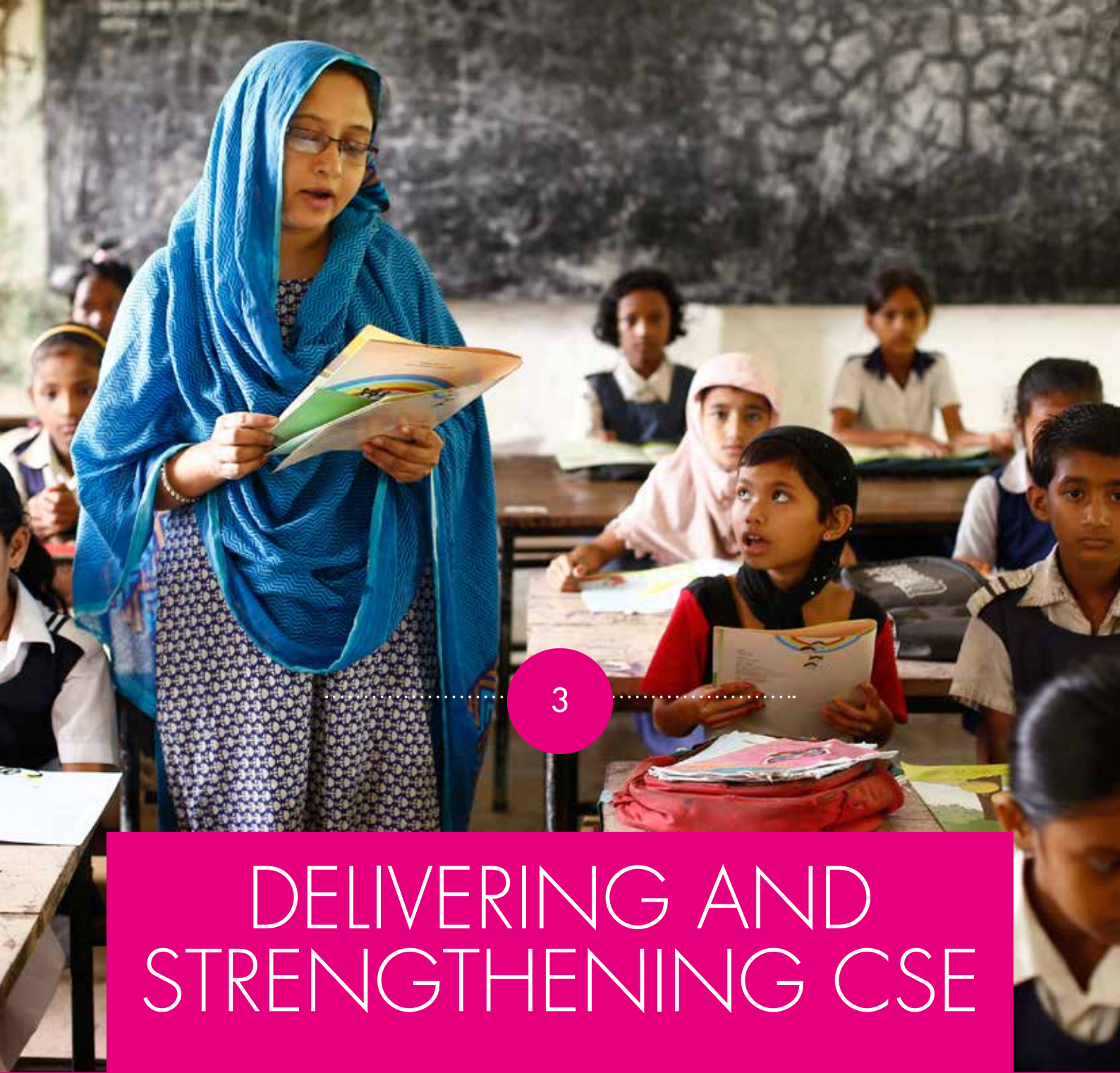
CASE STUDY 5: ENGAGING PARENTS IN PAKISTAN

The Pakistani NGO *Aahung* develops culturally relevant strategies to respond to the community’s SRH needs. *Aahung* succeeded in integrating its life skills-based education programme into public and private schools in Sindh province. As part of the organization’s work to engage a broad range of stakeholders, it explored ways of engaging with parents and community leaders. *Aahung* works closely with the school administration and community members to ensure local support for the project. The organization invites parents to a meeting where they can ask questions about the curriculum and raise any concerns they may have. They discuss where young people will access sexuality information in the absence of CSE programmes.

Parents recognize the benefits of *Aahung*’s programme, which is evidence-based, accountable and delivered by trained professionals, particularly when compared to the alternatives, such as young people receiving information from their peers or the media. *Aahung* has found that involving parents in this way increases support for the programme and results in fewer barriers for the project’s implementation.

Source: Website of the NGO *Aahung*: www.aahung.org and personal communication (Sheena Hadi, *Aahung*, 19 May 2015).





3

DELIVERING AND STRENGTHENING CSE

DELIVERING AND STRENGTHENING CSE

3.1 PLACEMENT IN THE CURRICULUM

As CSE gains momentum and interest at international, regional and national levels, governments are increasingly putting in place measures to scale-up their delivery of some form of life skills-based sexuality education, as well as seeking guidance on best practice, particularly regarding placement within the school curriculum. Sexuality education may be delivered as a stand-alone subject or integrated across relevant subjects within the school curricula. These options have direct implications for implementation, including teacher training, the ease of evaluating and revising curricula, the likelihood of curricula being delivered, and the methods through which it is delivered.

Within countries, choices about implementing integrated or stand-alone sexuality education are typically linked to national policies and overall organization of the curricula. The country summary table in Annex 1 reveals a fairly even division in terms of approach. The evidence base on the effectiveness of stand-alone vs. integrated sexuality education programming is still limited. However, there are discernible differences for policy-makers to consider when deciding the position of CSE within the curriculum.

The pedagogical approaches promoted through sexuality education [...] are increasingly being recognized as transformative approaches that impact on learning and education more widely

As a stand-alone subject, sexuality education is set apart from the rest of the curriculum, whether on its own or within a broader stand-alone health and life skills curriculum. This makes it more vulnerable to potentially being sacrificed due to time and budget constraints, since school curricula are typically overcrowded.

However, a stand-alone curriculum also presents opportunities for specialized teacher training pathways, and the use of non-formal teaching methodologies that aim to build learners' critical thinking skills. The pedagogical approaches promoted through sexuality education – such as learner-centred methodologies, development of skills and values, group learning and peer engagement – are increasingly being recognized as transformative approaches that impact on learning and education more widely. As a standalone subject, it is also significantly easier to monitor, which is crucial in terms of evaluating the effectiveness of programming, and revising curricula where it is not delivering the desired learning outcomes.

When sexuality education is integrated or infused, it is mainstreamed across a number of subject areas, such as biology, social studies, home economics or religious studies. While this model may reduce pressure on an overcrowded curriculum, it is difficult to monitor or evaluate, and may limit teaching methodologies to traditional approaches.

3.2 MANDATORY VS. OPTIONAL

In order to maximize the effectiveness of sexuality education, it must be comprehensive in the information and skills it imparts, and it must also have broad coverage. Where sexuality education is non-compulsory, extra-curricular or only partially compulsory, a large number of students will not reap its benefits (UNESCO, 2012a). A cost-effectiveness study of CSE concluded that, in order to reach a critical mass of young people and use resources effectively, CSE programmes should be mandatory and scaled-up through state schools (Kivela et al, 2014, p1–13; UNESCO, 2014).

NGOs have been critical in developing and piloting curricula and innovative delivery methods, but they generally lack the capacity to deliver programming on a national scale. National governments, particularly ministries of education and health, are best placed to coordinate the implementation of sexuality education in a way that maximizes available resources, and strives towards universal access.

3.3 TEACHER TRAINING

The question of whether CSE should be compulsory or optional also impacts on the number of teachers available who are equipped to deliver it, since delivering CSE requires adequate training and capacity. In the absence of CSE as a compulsory subject within teacher training programmes, or compulsory quotas for CSE teachers in schools, effective delivery cannot be guaranteed.

The availability of training and support to teachers is crucial to guaranteeing that CSE is delivered in a safe environment. Research from ten countries in ESA found that most curricula did not mention access to guidance, supervision or reporting requirements for teachers who encountered disclosure of sexual abuse during delivery of sexuality education programmes (UNESCO/UNFPA, 2012), pointing to a critical lack of supervision and support.

CASE STUDY 6: BUILDING TEACHERS' CAPACITY TO DELIVER QUALITY SEXUALITY EDUCATION ACROSS AFRICA

Save the Children in South Africa led the implementation of a Pan-African Comprehensive Sexuality Education and Information project across 15 countries in Southern, Eastern and Western Africa. The programme piloted the process-oriented approach (POA), a unique teacher-training methodology recognizing that anyone who delivers sexuality education will be influenced by their own personal attitudes, beliefs and values.

Teachers were encouraged to examine their own attitudes and values to issues relating to sex, sexuality, gender and relationships to consider how these might influence their delivery of CSE and to reflect on their responsibility to deliver information that is technically accurate and unbiased. This included participating in activities that explored personal values and attitudes from the perspective of both learners and teachers. Teachers were also given the opportunity to practice delivering sexuality education sessions – particularly those parts of the curriculum that they found most challenging – and to receive feedback to build their confidence and skills.

Source: Save the Children training manual and personal communication (Yumnah Hattas, Save the Children, 10 June 2015).



3.4 ASSESSING CSE

Monitoring the impact of sexuality education can be challenging. Monitoring knowledge levels – for example, HIV knowledge through DHS indicators – does not necessarily reflect the impact on attitudes or translate into behaviour change. Evaluating sexuality education according to health indicators such as adolescent pregnancy or HIV incidence may confound the impact of education with access to services and other important contextual factors (UNESCO, 2014).

A variety of monitoring and evaluation tools have been developed in recent years. Tools such as the *Sexuality Education Review and Assessment Tool* (SERAT) (UNESCO, 2011b) and IPPF's *Inside and Out*, give a framework for assessing the scope, content and delivery of sexuality education both, and out of school.

As part of its support to national ministries of education to scale up sexuality education, UNESCO and the Inter-Agency Task Team on Education developed the following indicator to examine the quality, comprehensiveness and coverage of life skills-based HIV and sexuality education. As part of a larger monitoring framework for education sector responses to HIV and AIDS, this has been field tested in several African and Caribbean countries. UNESCO and partners are supporting its roll out for the education sector through existing education management information systems (EMIS).

The indicator measures the extent to which certain 'essential' or 'desirable' criteria have been included in school-based sexuality education. The essential topics are those that have the greatest direct impact on HIV prevention and include: life skills such as communication and negotiation; sexual and reproductive health information; and, HIV-specific information. 'Desirable' topics are those that have an indirect impact on HIV prevention but that are important as part of an overall sexuality education programme. Although this focuses primarily on HIV outcomes, it does nevertheless capture many broader concepts of CSE such as pregnancy, gender equality and human development.

This indicator is in the process of being integrated in the EMIS of approximately 18 countries in the ESA region. By 2016, all Southern African Development Community (SADC) countries are expected to integrate the global monitoring and evaluation framework indicators into EMIS. A similar process is expected in West and Central Africa (WCA), where UNESCO has provided training to 11 countries on the integration of indicators into their annual school census.

Further indicators and evaluation tools have been used in individual countries, or for specific programmes (such as those managed by civil society organizations). In recent years, tools have been refined to specifically take note of gender and rights within CSE (UNFPA, 2015). While collectively agreed sets of indicators could offer CSE providers and supporters the means to collect strategic information to inform programme and planning,

CASE STUDY 7: BUILDING THE EVIDENCE BASE WITH A STRONG EVALUATION FRAMEWORK IN COLOMBIA

The Ministry of Education of Colombia has led the implementation of a national sexuality education programme that builds on the pillars of gender equality, citizenship and human rights, as well as community participation. Prior to scaling up the programme, the Minister of Education insisted on building in an intensive monitoring and evaluation plan, which incorporated a rigorously tested self-administered questionnaire for students, as well as an evaluation of the school environment.

Evaluation has revealed that, in addition to improving students' knowledge of SRHR topics, the wider school and community environment also had a significant impact on young people's learning. Students with the highest levels of knowledge reported feeling that their classrooms were safe spaces where they could count on being treated fairly and with respect, particularly in communities where there was an absence of armed conflict. Teacher training was also found to be important, as those students whose teachers had been trained in citizenship and human rights demonstrated higher levels of knowledge.

Source: UNFPA. 2015. The Evaluation of Comprehensive Sexuality Education Programmes: A focus on the Gender and Empowerment Outcomes. New York, UNFPA; personal communication (Marta Carolina Ibarra, Universidad Los Andes, 8 June 2015).



indicators must also be focused on the planned outcomes of that particular CSE programme, which should reflect the needs and context of young people in that setting (Ketting et al, 2015). For example, in many Southern African countries, measuring improvements in HIV knowledge and related skills remains critical. In other settings, such as Europe, for example, measuring attitudes towards sexual diversity, or competencies with regards to accessing health services, may be prioritized.

Essential topics are those that have the greatest direct impact on HIV prevention and include: life skills such as communication and negotiation; sexual and reproductive health information; and, HIV-specific information.

BOX 3: CORE GLOBAL INDICATOR FOR MONITORING AND EVALUATION OF EDUCATION SECTOR RESPONSE TO HIV AND AIDS

Indicator 3: Life skills-based HIV and sexuality education

Topics/Content	
Generic life skills	
Essential topics	Decision-making/assertiveness
	Communication/negotiation/refusal
	Human rights empowerment
Desirable topics	Acceptance, tolerance, empathy and non-discrimination
	Other gender life skills
Sexual and reproductive health (SRH)/Sexuality Education (SE)	
Essential topics	Human growth and development
	Sexual anatomy and physiology
	Family life, marriage, long-term commitment and interpersonal relationships
	Society, culture and sexuality: values, attitudes, social norms and the media in relation to sexuality
	Reproduction
	Gender equality and gender roles
	Sexual abuse/resisting unwanted or coerced sex
	Condoms
	Sexual behaviour (sexual practices, pleasure and feelings)
	Transmission and prevention of sexually transmitted infections (STIs)
Desirable topics	Pregnancy and childbirth
	Contraception other than condoms
	Gender-based violence and harmful practices/rejecting violence
	Sexual diversity
	Sources for SRH services/seeking services
	Other content related to SRH/SE
HIV and AIDS-related specific content	
Essential topics	Transmission of HIV
	Prevention of HIV: practising safer sex, including condom use
	Treatment of HIV
Desirable topics	HIV-related stigma and discrimination
	Sources of counselling and testing services/seeking counselling, treatment, care and support
	Other HIV and AIDS-related specific content

Source: UNESCO. 2013. *Measuring the Education Sector response to HIV and AIDS – Guidelines for the construction and use of core indicators*. Paris, UNESCO.

3.5 INCLUSIVE WAYS OF DELIVERING CSE

Achieving universal access to good quality CSE requires specific strategies for reaching marginalized young people who are out of school. Young people who face discrimination and abuse of their human rights – including the right to education – are at greatest risk of poor SRH outcomes. Young people who face particular challenges in accessing education may also be at increased risk of HIV (re-)infection and sexual and gender-based violence. This includes young people with disabilities, young people without parental care, young migrants, young workers, pregnant and married girls, and those from key populations such as young people who sell sex, young people living with HIV, young transgender people, young people using drugs and young men who have sex with men.

Failing to provide marginalized adolescents and young people with CSE will deepen the social exclusion that many experience, limiting their potential and putting their health, futures and lives at greater risk. NGOs have played an important role in developing innovative strategies for reaching vulnerable and hard-to-reach young people through internet and mobile technologies, new media, community and youth centres, as well as sport. Many of the most successful interventions have been developed in partnership with young people (Villa-Torres and Svanemyr, 2015). These complementary delivery methods capitalize on existing CSE mechanisms by accurately assessing what young people want, use and can currently access. CSE that includes community-based components – including involving young people, parents and teachers in the design of interventions – results in the most significant change.

CASE STUDY 8: CSE REACHES OUT-OF-SCHOOL CHILDREN AND YOUNG PEOPLE

In many countries, the state and civil society have found innovative solutions to ensuring that children who are out of school can still benefit from sexuality education.

In the Arab states, Y-PEER – a peer-to-peer youth network – reached more than 1.4 million young people with SRH messages and training using a theatre-based peer education approach. In Egypt, a network of local NGOs provides reproductive health education to boys and girls aged 15–17 backed by the National Council for Childhood and Motherhood, with support from UNFPA and UNICEF.

In Guatemala, the Population Council and UNFPA are scaling up 'Abriendo Oportunidades' (Opening Opportunities), a programme for vulnerable girls who are either in school, out of school, married, unmarried or teenage mothers, that offers a comprehensive curriculum of health, sexuality and life skills.

Source: UNFPA. 2014. Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender. New York, UNFPA.



CASE STUDY 9: USING MOBILE TECHNOLOGIES TO REACH VULNERABLE YOUNG PEOPLE IN NIGERIA



Education as a Vaccine (EVA) – an NGO based in Abuja, Nigeria – harnesses the technologies that adolescents and young people already access to develop innovative ways of communicating about SRH information, and linking young people to youth-friendly services. In a context challenged by religious polarization, advancing sexuality education at a policy level and in schools has been limited in Nigeria, making this type of out-of-school provision vital.

Working in partnership with one state government, EVA is using Information and Communication Technology (ICT) and cyber cafes to deliver CSE through e-learning, with content developed by young people themselves. EVA also piloted a 24-hour phone, email and text messaging service that allows young people to reach out to trained professionals anonymously with urgent SRH-related questions. The response to this service has been overwhelming with more than 10,000 texts received each month.

EVA also bridges the gap between education and services by mapping youth-friendly SRH services, including HIV and STI testing and treatment, contraception, pregnancy testing and gender-based violence (GBV), and by inviting young people to rank the relative ‘youth friendliness’ of different services .

Source: Personal communication (Fadokemi Akinfaderin, Education as a Vaccine, Nigeria, 19 May 2015).



4

ANALYSIS OF COUNTRY DATA

4. ANALYSIS OF COUNTRY DATA

The country tables in Annex 1 provide an overview of the situation regarding CSE across 48 countries. They summarize information on national curricula, policy and implementation of CSE in schools. Data was generated through a rapid situational analysis using existing resources and studies. In some countries detailed information was available following the application of the SERAT tool at a national level. Other regions have conducted an in-depth review of policies and strategies required, for example, to implement and scale-up sexuality education (Asia Pacific region) (UNESCO, 2012a) and prevention education (Eastern Europe and Central Asia) (UNESCO, 2013b) or a detailed review of sexuality education curricula across different countries (East and Southern Africa) (UNESCO/UNFPA, 2012). For other countries, the available data was relatively limited. This combination of approaches allowed for a rapid situational assessment in the countries selected, while having the significant limitation of failing to provide a fully comparative study.

The country summaries include information that illustrates the contextual situation – for example, regarding young people’s

knowledge levels regarding HIV, gender norms and the adolescent national fertility rate – and data on the status of CSE implementation. The table presents information on CSE’s position within the national curriculum (whether it is stand-alone or integrated), whether it is mandatory or optional, the age groups covered, whether teacher training is provided (noting that, even where training is delivered, coverage may be patchy) and whether a national policy exists to provide a mandate for CSE in schools. Additionally, all the country curricula were assessed against three standardized benchmarks, in line with an agreed set of indicators (UNESCO, 2013a) outlining international standards for CSE. These include in the curricula:

- Teaching on generic life skills (e.g., decision making, communication, negotiation skills, gender equality).
- Teaching on sexual and reproductive health and sexuality education (e.g., human growth and development, relationships, reproductive health, sexual abuse, transmission of STIs).
- Teaching on HIV transmission and prevention.

4.1 KEY FINDINGS FROM THE COUNTRY DATA

4.1.1 Policy level

Increased international and regional support for CSE, as well as investment in programming and technical support, is evident at the policy level. Almost 80 per cent of the countries in this assessment have policies or strategies that support CSE.

Despite this increased political will, there remains a significant gap between the numerous global and regional policies in place and the actual implementation on the ground. Five years on from the LAC Declaration, just over half of the countries had implemented the recommendations (IPPF and Democracia y Sexualidad, 2012). Despite all countries in ESA now reporting having a policy or strategy to promote life skills-based HIV education for young people, many face ongoing challenges in their implementation. Few strategies or policies are fully

operationalized and there remains a need to strengthen nationwide coordination and monitoring mechanisms to support multi-sectoral implementation.

Almost 80 per cent of the countries in this assessment have policies or strategies that support CSE.

Despite this increased political will, there remains a significant gap between the numerous global and regional policies in place and the actual implementation on the ground.

BOX 4: REGIONAL POLICIES

Asia-Pacific: 21 out of 25 countries' national HIV strategies/plans referenced the role of education; most targeted in-school young people, mentioned capacity development of teachers and promoted HIV and life skills education. Cambodia and Papua New Guinea have established HIV policies for the education sector.

Eastern Europe and Central Asia: All countries covered in the assessment had national policies supporting CSE – with the exception of Uzbekistan, Kazakhstan and the Russian Federation – providing a cornerstone for the delivery of life skills-based health education, with HIV and SRH education being central.

West and Central Africa: Most countries in the assessment have an education sector policy on HIV and AIDS, completed by a strategy that creates an enabling environment for the delivery of life skills-based HIV and sexuality education. SERAT studies

show that, 12 out of 13 countries have a plan that supports the implementation of a sexuality education programme.

Latin America and the Caribbean: In 2008 health and education ministers signed a declaration affirming a mandate for national school-based sexuality and HIV education, as well as endorsing the increased availability of adolescent-friendly reproductive health services.

Eastern and Southern Africa: Ministers of health and education from 20 countries affirmed and endorsed the Ministerial Commitment on CSE and SRH services for adolescents and young people in December 2013, setting specific targets to ensure access to high-quality, comprehensive, life skills-based HIV and sexuality education and appropriate youth-friendly health services for all young people.

4.1.2 CSE position within the curriculum

The majority of countries report providing life skills-based sexuality and HIV education in the curriculum at secondary level. Countries across ESA have integrated (or are in the process of integrating) CSE across both primary and secondary schools, as well as during teacher training. In Asia and the Pacific, less than half (43 per cent) of countries have integrated sexuality education at primary level, while 22 out of 28 countries reported doing so at secondary level (UNESCO, 2012a).

The analysis differentiates between 'integrated' approaches, where issues of sexuality and HIV prevention were incorporated and discussed in mainstream mandatory subjects across the curriculum – most commonly Biology, People and the World/People and Health, Basics of Life Safety – and those where CSE was delivered as a 'stand-alone' subject, either focusing solely on CSE or where this was a key focus of life skills-based health education, such as Healthy Lifestyles or Life Skills. The number of countries delivering stand-alone vs. integrated approaches was fairly evenly split. Some countries – particularly those in the Asia Pacific and EECA regions – offered additional, optional courses that addressed HIV prevention, in particular, in more depth.

In the EECA region, educational programmes that address sexuality and HIV prevention are usually taught at secondary level and are integrated into a mandatory, life skills-based subject. Alternatively, they are integrated into at least one 'mainstream' mandatory subject, such as Biology, People and Health or Basics of Life Safety. The majority also offer optional courses, usually at secondary level. However, the limited duration of courses and piecemeal approach in many countries

means that the potential of CSE to translate knowledge into assertive attitudes and behaviour change among young people is not yet being fully realized.

The annual progress review following the ESA Commitment demonstrates the very significant progress made in translating this aspect of the commitment into action. The majority of the 21 countries (14 at primary level, 13 at secondary) have already incorporated life skills-based sexuality education into the curriculum through a combination of integrated and stand-alone approaches (UNESCO with UNAIDS, UNFPA, UNICEF, WHO, 2014). A number of these countries have either already made this examinable or have plans to do so, at both primary and secondary levels. Several countries – including Angola, Burundi, Kenya, Rwanda, South Sudan and Zimbabwe – are still in the process of updating their life skills-based sexuality and HIV education curriculum within the scope of ongoing national curriculum reform processes.

4.1.3 Curriculum content

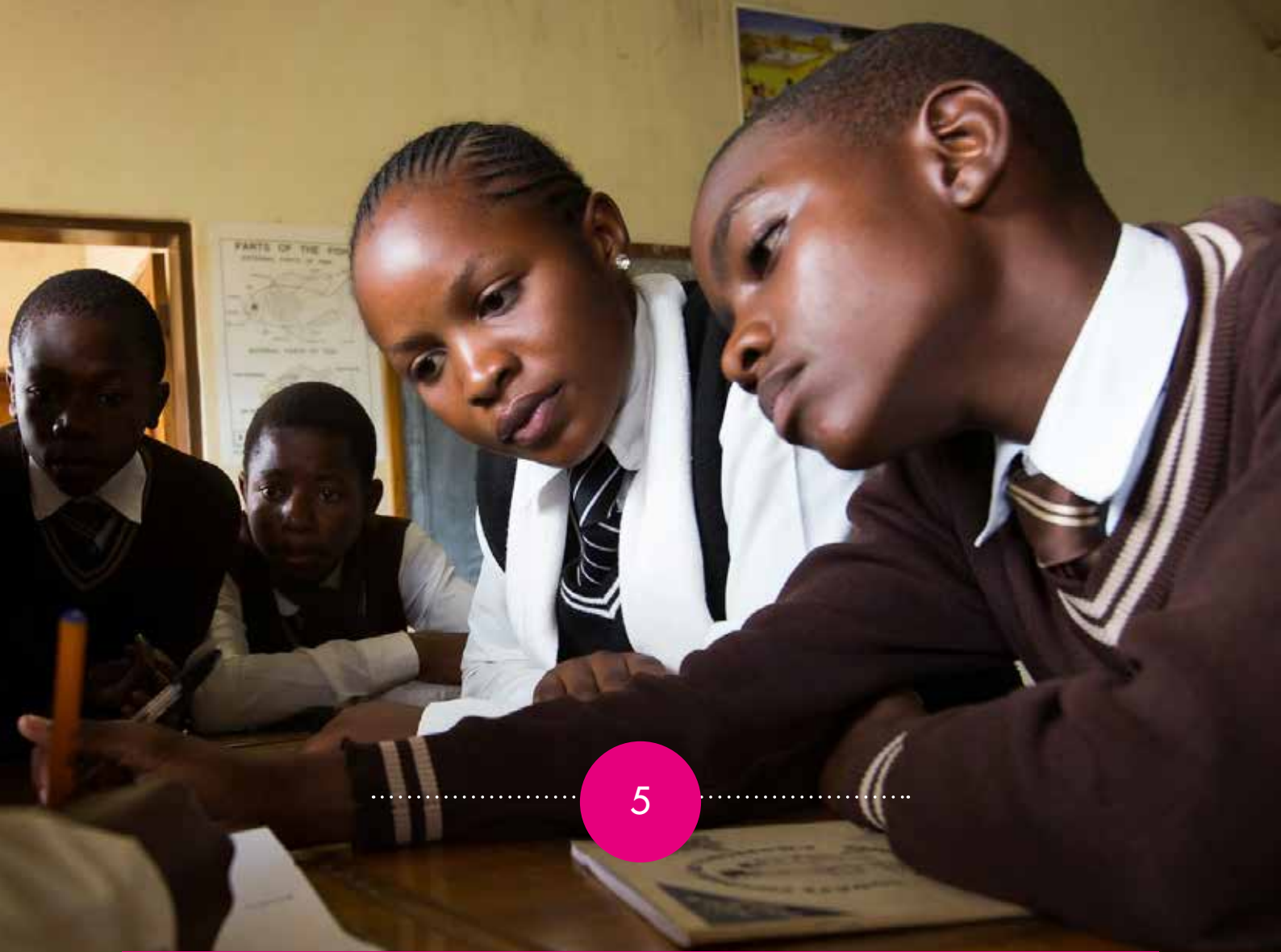
There has been increased recent focus on strengthening curricula in some countries – particularly those across ESA and countries such as Thailand, China and India in Asia – although this remains a critical need. In terms of curriculum design, insufficient focus is placed on developing key competencies, including critical thinking, and on examining how gender norms, religion and culture influence learners' attitudes and behaviour (International AIDS Society, AIDS 2014).

In 2012, just over half the countries in LAC reported teaching information on SRH, HIV prevention, gender issues, human rights,

Despite most ESA countries reporting training teachers on sexuality education, the review of HIV education in ESA countries (Tiendrebeogo et al, 2003) found that teachers frequently focused on knowledge rather than skills and used didactic methods rather than engaging pupils through participatory approaches. A recent study in Tanzania (Matungwa et al, 2012) demonstrated teachers' inability to discuss issues relating to sexuality, sex, condom use and family planning and their belief that discussing issues relating to masturbation, condoms, sexual pleasure and homosexuality was counter to community norms, culture and religion. Increasingly, teacher training programmes in the region are now focusing on examining personal attitudes and values in order to improve comfort and confidence as well as the content and teaching skills required (Save the Children, unpublished workshop manual and training manual – see Bibliography).

Brazil offers a positive example. In the state of São Paulo, an inclusive and transformative approach to teacher training on sexuality education has been developed that allows teachers to explore their own personal attitudes to various issues, including sexual diversity, before then supporting them to develop the skills to teach these complex subjects (UNICEF, 2010). In Namibia, the Rainbow Project runs workshops for teachers exploring social inclusion/exclusion based on teachers' own experiences, including issues affecting gay, lesbian, bisexual and transgender people (UNESCO, 2012c).

In EECA, a number of countries reported insufficient teacher preparation to deliver high-quality prevention education. Teacher training for CSE is often limited in scope. It is usually delivered only through in-service training, with the result that teachers often feel uncomfortable discussing sensitive issues and do not consistently use participatory methodologies to engage pupils fully in health and life skills education. Without adequate training and sensitization to the issues, teachers may potentially re-enforce harmful messages to young people – sometimes backed by harmful and punitive national laws. This perpetuates stigma and discrimination in the community and may be particularly damaging to vulnerable young people who may be living with HIV or coming to terms with their own sexuality.



5

CONCLUSION

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Evidence demonstrates clearly that CSE contributes to HIV prevention, as well as broader SRH and gender equality outcomes. As such, CSE is a critical enabler within the HIV response and should therefore form part of any national HIV response, while education more broadly remains an important development synergy. UNAIDS has recently cited comprehensive age-appropriate sexuality education as one of five key recommendations to fast track the HIV response and end the AIDS epidemic among young women and girls across Africa (UNAIDS and African Union, 2015).

Young people themselves are increasingly demanding their right to sexuality education, as witnessed over the last five years through a number of calls to action. The development of *International Technical Guidance on Sexuality Education* (2009), the *European Standards for Sexuality Education* (2010) and the UNFPA *Operational Guidance for Sexuality Education* (2014) have all represented key milestones in defining CSE and providing support for countries to identify CSE key components based on the best available evidence. These technical guides, along with programme support and engagement from a wide range of stakeholders, have facilitated

the process of implementing, measuring and assessing national CSE programmes to ensure that they meet agreed international standards.

The data generated through this situational analysis reflects the increased political commitment and attention given to CSE at a global level. The vast majority of countries are now actively embracing the concept and engaging in the process of supporting – or strengthening – its implementation at a national level. This has resulted specifically in ongoing attention to curricula revision in many countries, integration of CSE into the national curriculum and the development and roll-out of effective teacher training.

Continued advocacy and support are required to ensure that these gains are sustained and to integrate evidence and lessons – including specifically the need to address gender and rights within CSE – to strengthen the delivery of CSE in practice. Young people around the world need comprehensive, age-appropriate sexuality education to develop their self-esteem and gain the knowledge and skills to make conscious, healthy and respectful choices about relationships and sexuality.

ANNEXES

ANNEX 1: TABLE OF DATA ON ADOLESCENT HEALTH AND PROVISION OF CSE IN SELECT COUNTRIES

Country	ADOLESCENT HEALTH AND SOCIAL DATA					DATA ON PROVISION OF CSE					
	HIV %	HIV % young people 15–24*	Young people's knowledge of HIV (%) ⁱ	Women's attitudes related to wife beating (%) ⁱⁱ	Adolescent fertility rate ⁱⁱⁱ	CSE place in curriculum ^{iv}	Reflects (international) standards? ^v	Age groups covered ^{vi}	Mandatory / optional? ^{vii}	Teacher training ^{viii}	National policy ^{ix}
Angola	2.4	F 1.2 M 0.6	45		167	In progress –stand-alone	Under review to meet standards	Primary and secondary	Mandatory	Yes	Yes
Argentina	0.4	0.2	93	2	54	Both a stand-alone subject and integrated across the curriculum	Yes	Primary and secondary	Mandatory	Yes	Yes
Armenia	0.19	F < 0.1 M < 0.1	20	9	27	Stand-alone	Yes	Primary and secondary	Mandatory	Yes	Yes
Azerbaijan	0.15	F < 0.1 M 0.1	5	49	39	Stand-alone	Yes	Primary: Grades 1–4; Secondary: Grades 5–9	Mandatory	Yes	Yes
Belarus	0.49	F 0.5 M 0.3	63	4	20	Integrated	Partial	Primary: Grades 1–4 and Secondary: Grades 5–11)	Integrated into mandatory subjects. Optional HIV prevention curriculum	Yes	Yes
Botswana	21.8	F 6 M 3.5	47		43	Integrated	Under revision to meet standards	Primary and secondary Grades 2–9	Integrated into mandatory subjects	Yes	Yes
Brazil	0.5	F 0.2 M 0.4	49		70	Stand-alone	Yes	Primary and secondary	Mandatory	Yes	Strategy yes, but no law
Burundi	1	F 0.2 M 0.1	46	73	30	In progress	Under review to meet standards	Primary and secondary	Unknown	Yes	Yes
Cambodia	0.74	F 0.2 M 0.2	45	46	44	Stand-alone	Yes	Primary (Grades 5–6) and secondary	Optional (implemented in 9 out of 25 states)	Yes	Yes
Cameroon	4.3	F 1.9 M 1	31	47	113	Integrated	Yes	Primary and secondary	Mandatory and examinable	No	Yes
Central African Republic	3.8	F 1.5 M 0.9	24	80	97	Integrated	Yes	Primary and secondary	Early implementation stage	Yes	Yes
Chad	2.5	F 0.9 M 0.5	78	62	147	Integrated	Yes	Primary and secondary	Mandatory	Yes	Yes

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	HIV %	HIV % young people 15–24*	Young people's knowledge of HIV (%)	Women's attitudes related to wife beating (%) ⁱⁱ	Adolescent fertility rate ⁱⁱⁱ	CSE place in curriculum ^{iv}	Reflects (international) standards? ^v	Age groups covered ^{vi}	Mandatory / optional? ^{vii}	Teacher training ^{viii}	National policy ^{ix}
China	<0.1	No data	55		9	Partially integrated	No	Primary and Secondary	Mandatory but not implemented	Required by policy, not in practice	Yes
Colombia	0.5	0.2	24.1 (refers to females only)		68	Both a stand-alone subject and integrated across the curriculum	Yes	Primary and secondary	Yes	Yes	Yes
Côte d'Ivoire	2.7	F 1 M 0.7	18	48	126	Unknown	Yes	Primary and secondary	Unknown	Yes	Yes
Democratic Republic of Congo	1.1	F 0.5 M 0.3	17	76	134	Integrated	No	Primary and secondary	Mandatory and examinable	No	Yes
Ethiopia	1.2	F 0.5 M 0.4	28	68	76	Integrated	Yes	Primary and secondary	Mandatory	No	Yes
Ghana	1.3	F 0.4 M 0.3	29	44	57	Integrated	Yes	Primary and secondary	Mandatory	Yes	Yes
Guatemala	0.6	F 0.3 M 0.3	23		95	Stand-alone	No	Primary and secondary	Optional	Yes	Yes
Haiti	2	F 0.9 M 0.6	32	17	41	Not in the curriculum	N/A	None	N/A	N/A	No
India	0.3	<0.1 - 0.2	40	47	32	In progress	No	Secondary (Grades 9–11)	Optional. Some states outlaw life skills education	Yes	No
Indonesia	0.5	F 0.5 M 0.4	14	35	48	Integrated	Partial	Secondary	Optional	Yes	No
Jamaica	1.8	F 0.6 M 0.9	39	5	69	Stand-alone	Yes	Primary and secondary	Mandatory	Yes	Yes
Kazakhstan	0.2	no data	32	12	29	Integrated	No	Primary and secondary	Integrated	No	No
Kenya	6	F 2.8 M 1.7	69	53	18	In progress. Life skills curriculum existing	Under revision to meet standards	Primary and secondary	Mandatory life skills	Unknown	Yes
Kyrgyzstan	0.24	F <0.1 M 0.3	35	34	28	Stand-alone	Yes	Secondary	Mandatory	Some (includes e-learning)	Yes
Lesotho	22.9	F 10.5 M 5.8	36	37	86	Integrated (primary), stand-alone (secondary)	Yes	Primary and lower secondary.	Mandatory	Unknown	Yes
Malawi	10.3	F 3.8 M 2.4	42	13	143	Stand-alone	Yes	Primary and secondary	Mandatory and examinable	Yes, partial	Yes
Mozambique	10.8	F 6.1 M 2.7	35	23	133	Integrated	Under revision to meet standards	Primary and secondary	Mandatory and examinable	Unknown	Yes
Myanmar	0.6	F 0.3 M 0.2	48		11	Unknown	Unknown	Primary and secondary	Unknown	Unknown	Unknown
Namibia	14.3	F 4.8 M 2.7	64	35	52	Stand-alone	Yes	Primary and secondary	Mandatory and assessed	Yes	Yes
Nepal	0.2	F <0.1 M < 0.1	28	23	72	Integrated (Grades 6–8); Stand-alone (Grades 9–10)	Partial	Secondary	Mandatory (Grades 9–10)	No	Yes
Papua New Guinea	0.6	F 0.2 M 0.1	23		61	Stand-alone	Partial	Primary and secondary	Mandatory	Yes, partial	Yes

Country	ADOLESCENT HEALTH AND SOCIAL DATA					DATA ON PROVISION OF CSE					
	HIV %	HIV % young people 15–24*	Young people's knowledge of HIV (%)	Women's attitudes related to wife beating (%) ⁱⁱ	Adolescent fertility rate ⁱⁱⁱ	CSE place in curriculum ^{iv}	Reflects (international) standards? ^v	Age groups covered ^{vi}	Mandatory / optional? ^{vii}	Teacher training ^{viii}	National policy ^{ix}
Republic of Moldova	0.6	F 0.4 M 0.5	38		29	Stand-alone	Yes	Secondary Grades 8–11	Mandatory	Yes	Yes
Russian Federation	0.8 - 1.4	No data	37	11	26	Integrated	No	Primary and secondary	Integrated into mandatory subject	Yes, but poor support for teachers	No
Rwanda	2.9	F 1.2 M 0.9	51*	56	32	In progress	Under revision to meet standards	Upper primary and secondary	Mandatory	Unknown (No?)	In progress
South Africa	19.1	F 13.1 M 4	29*		49	Stand-alone	Yes	Life skills primary and secondary, SRH/HIV secondary	Mandatory and examinable	Unknown	Yes
South Sudan	2.2	F 1.1 M 0.6	No data	79	72	In progress	Under development to meet standards	N/A	N/A	No	No
Swaziland	27.4	F 12.4 M 7.1	56*	28	69	Stand-alone	Yes	Primary (Upper Level) and secondary (Upper Level)	Mandatory and examinable	Yes	Yes
Tajikistan	0.3	F <0.1 M 0.1	13	60	41	Stand-alone	In progress	Secondary Grades 7–9	Optional	Partial	Yes
Tanzania	5	F 3.2 M 1.7	48*	54	121	Integrated	Yes	Primary and secondary	Mandatory and examinable	Yes	Yes
Thailand	1.1	F 0.3 M 0.3	37	13	40	Integrated	Yes	Secondary	Mandatory but not implemented	No	Yes
Country	HIV %	HIV % young people 15–24*	Young people's knowledge of HIV (%) ⁱ	Women's attitudes related to wife beating (%) ⁱⁱ	Adolescent fertility rate ⁱⁱⁱ	CSE place in curriculum ^{iv}	Reflects (international) standards? ^v	Age groups covered ^{vi}	Mandatory / optional? ^{vii}	Teacher training ^{viii}	National policy ^{ix}
Uganda	7.4	F 4.2 M 2.4	37*	58	122	Integrated	Yes (in process for secondary)	Upper primary and secondary	Mandatory (examinable from 2017)	Yes	Yes
Ukraine	0.8	F 0.4 M 0.1	40	3	25	Stand-alone	Yes	Primary and secondary	Mandatory	Partial	Yes
Uzbekistan	0.18	F <0.1 M <0.1	13	70	37	Stand-alone	No	Secondary	Optional	Partial	No
Viet Nam	0.4	F <0.1 M <0.1	42	36	29	Integrated	Partial	Secondary Grades 6–12	Mandatory	Partial	Yes
Zambia	12.5	F 4.5 M 3.4	35	62	122	Integrated	Yes	Upper primary and secondary	Mandatory and examinable	Unknown	Yes
Zimbabwe	15	F 6.6 M 4.1	55	40	58	In progress	Under revision to meet standards	Primary and secondary	Mandatory	Yes	Yes

* Note that some countries regularly track HIV prevalence data, with countries in Eastern and Southern Africa preferring to focus on HIV incidence among young people – the number and distribution of new infections – as a better measure for assessing the dynamics of HIV transmission, particularly in countries with a more generalized epidemic.

Adolescent health and social data:

- Percentage of young women and men from 15–24 years old who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
- This column shows data on the globally used world development indicator – 'Percentage of women aged 15–45 who believe a husband/partner is justified

in hitting or beating his wife/partner for any of the following five reasons: argues with him; refuses to have sex; burns the food; goes out without telling him; or when she neglects the children.' Sources: <http://www.data.unicef.org/child-protection/attitudes.html>
<http://www.afric-dev.info/wp-content/uploads/2015/07/2015-Africa-Scorecard-on-Institutionalised-Violence-Against-Women-Girls-Fn...pdf>

iii. Adolescent fertility rate is the number of births per 1,000 women ages 15–19.

Comprehensive sexuality education data:

- iv. Integrated: CSE is integrated into mainstream mandatory subjects across the curriculum such as Biology. Stand-alone: CSE is taught as part of a life skills-based health education programme such as Healthy Lifestyles or Life Skills.
- v. Does the curriculum meet standardized benchmarks to ensure quality, including teaching on 1) generic life skills (e.g., decision making, communication, negotiation skills); 2) sexual and reproductive health (SRH) and sexuality education (e.g., human growth and development, relationships, reproductive health, sexual abuse, transmission of STIs); 3) HIV transmission and prevention.
- vi. Which age groups are taught CSE? In some countries, secondary enrolment is low, so primary CSE is the only opportunity to reach young people through formal education.
- vii. If included in the curriculum, is CSE teaching compulsory? Note that even where compulsory, many teachers do not feel comfortable teaching aspects of a CSE curriculum, so coverage may be patchy.
- viii. Are teachers trained to deliver CSE? Where teacher training exists but is known not to reach all teachers, this has been noted. In other cases, 'Yes' may not always mean complete coverage but that some teacher training does take place.
- ix. Is a national policy in place that provides a mandate for a CSE curriculum to be taught in schools?

ANNEX 2: DEFINITIONS OF CSE

International Conference on Population and Development. 1994. Programme of Action, paragraphs 4.29, 7.37, 7.41, and 7.47

Sexuality education to promote the well-being of adolescents; it specifies key features of such education.

- Education should take place both in schools and at the community level, be age-appropriate, begin as early as possible, foster mature decision making, and specifically aim to improve gender inequality.
- Such programmes should address specific topics, including gender relations and equality, violence against adolescents, responsible sexual behaviour, contraception, family life and sexually transmitted infections (STIs), HIV and AIDS prevention.

UNESCO, UNAIDS, UNFPA, UNICEF, WHO. 2009. *International Technical Guidance on Sexuality Education*

CSE is an age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, non-judgemental information.

WHO & BzGA. 2010. *Standards for Sexuality Education in Europe: A framework for policy makers, education and health authorities and specialists*

Sexuality education means learning about the cognitive, emotional, social, interactive and physical aspects of sexuality.

Sexuality education starts early in childhood and progresses through adolescence and 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.

It enables them to make choices that enhance the quality of their lives and contribute to a compassionate and just society.

All children and young people have the right to have access to age-appropriate sexuality education.

In this definition, the primary focus is on sexuality as a positive human potential and a source of satisfaction and pleasure. The

clearly recognized need for knowledge and skills required to prevent sexual ill-health comes second to this overall positive approach. Furthermore, sexuality education should be based on internationally accepted human rights, in particular the right to know, which precedes prevention of ill health.

IPPF. 2010. *IPPF Framework for Comprehensive Sexuality Education (CSE)*

A rights-based approach to comprehensive sexuality education seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality – physically and emotionally, individually and in relationships. It views 'sexuality' holistically and within the context of emotional and social development. It recognizes that information alone is not enough. Young people need to be given the opportunity to acquire essential life skills and develop positive attitudes and values.

Comprehensive sexuality education must help young people to:

Acquire accurate information: on sexual and reproductive rights; information to dispel myths; references to resources and services.

Develop life skills: such as critical thinking, communication and negotiation skills, self-development skills, decision-making skills; sense of self; confidence; assertiveness; ability to take responsibility; ability to ask questions and seek help; empathy.

Nurture positive attitudes and values: open-mindedness; respect for self and others; positive self-worth/esteem; comfort; non-judgemental attitude; sense of responsibility; positive attitude towards their sexual and reproductive health.

Comprehensive sexuality education covers a broad range of issues relating to both the physical and biological aspects of sexuality, and the emotional and social aspects. It recognizes and accepts all people as sexual beings and is concerned with more than just the prevention of disease or pregnancy. CSE programmes should be adapted to the age and stage of development of the target group.

UNFPA. 2014. *Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender*

CSE is age-appropriate, curriculum-based education, which enables in-and out-of-school children and young people, according to their evolving capacity, to:

- Acquire accurate information about human sexuality, sexual and reproductive health, growth and development, anatomy and physiology;
- Explore and nurture positive values and attitudes concerning sexual and social relationships; and,
- Develop life skills that encourage critical thinking, gender-sensitive communication and negotiation and decision making, as well as fostering a sense responsibility for their own behaviour and respect for the rights of others.

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This publication provides a global review of the current status of comprehensive sexuality education (CSE) implementation and coverage. It draws on specific information about the status of CSE in 48 countries, generated through analysis of existing resources and studies.

The report examines the evidence base for CSE and its positive impact on health outcomes, takes stock of political support for CSE, and examines how the various global and regional commitments have had an impact at national levels on the delivery of CSE in practice.

The current review represents the first in a series of periodic reports that aims to monitor the global implementation of CSE.

For more information on UNESCO's work on comprehensive sexuality education, visit

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